

The access to care of underserved populations: a research among free clinics on the Paris area.

(full text in English: free access by the publisher at <http://www.masson.fr.gate2.inist.fr/masson/portal/bookmark?Global=1&Page=18&MenuIdSelected=106&MenuItemSelected=0&MenuSupportSelected=12&CodeRevue4=RESPE&CodeProduct4=710&Path=REVUE/RESPE/2003/51/6/ARTICLE1110892548.xml&Locations=>)

I. Parizot, P. Chauvin

Research Team “Social determinants of health and health care”, INSERM U444, Saint-Antoine Faculty of Medicine, 27 rue de Chaligny, 75012 Paris. E-mail : pierre.chauvin@u444.jussieu.fr (Reprints: P. Chauvin)

Background: Over the past ten years, especially in urban areas, an increase in the number of persons experiencing serious social problems has led to the creation of free clinics intended for people without health insurance or those of modest means.

Methods: We present some of the results of a multidisciplinary (sociology and epidemiology) research project, carried out among patients consulting in five of these centres in the Paris area.

Results: Statistical and qualitative analyses show the diversity of the populations using these centres, why they use them, the nature of the services and help they use there, and in addition, the social relationships which are created in the context of these care facilities.

Conclusions: Results lead us to discuss lessons learned from the research which enhance our understanding of the determinants of health system use, not only among the vulnerable populations cared for in these centres, but perhaps for the population as a whole.

Multidisciplinary studies Qualitative methods Social factors Access to care Health care utilisation Social exclusion

INTRODUCTION

Paths leading to social exclusion are often accompanied by declining health status, regardless of whether this morbidity is the cause or the consequence of exclusion [1] . Considerable research, especially in Anglophone countries, has dealt with the relationships among socio-economic factors, life conditions and the health status of individuals [2] , [3] . It shows clearly that social precariousness is associated with an increased risk of morbidity, especially in the areas of mental health, infectious diseases such as tuberculosis or sexually transmitted diseases, as well as increased dependency on various substances (alcohol, drugs, tranquilizers...) [4] . In France, studies carried out since the 1990s [5] , [6] , [7] indicate that, while there are no illnesses specific to poverty, persons who are socially marginalised accumulate risk factors and morbid states, and present with pathologies at more advanced stages than do others [8] . A recent publication has addressed current thinking on the impact of the process of social exclusion on both health risks and health care, including self-care and care provided by the existing health system [9] .

Beginning in the mid 1980s, the “exclusion from health care” of different socially disadvantaged populations (without health insurance or of modest financial means) was brought to light and criticized in public debates. In order to deal with this situation, measures were taken (essentially in urban areas) to furnish these people with free care, initially through humanitarian associations, then

in hospital settings [10] . Apart from the diversity in their ways of functioning, the care they give and their institutional environment (hospitals, associations, communities, etc.), these facilities generally share the common attribute of having been created through the initiative and commitment of health care professionals. Their “success” has been based on the nearly systematic juxtaposition of two characteristics: a programme which combines free medical care and attention to social issues, in particular for those people whose social and health problems often seem inseparable; and the principle of immediate treatment regardless of means, of proof of health insurance, of identity papers or of visa status. These free clinics — “easy access consultations” or “transitional care facilities”, depending on the terms used and the principles declared by their founders — have, up to the end of the 1990s, treated an increasing number of persons, revealing at the same time the extent of the difficulties faced in gaining access to health care in our country. (The rising growth curve of attendance did not slow down until the creation of Universal Health Coverage in 2000, that is, subsequent to this research project.) The professionals establishing the first facilities of this type were often engaged simultaneously in running programmes, denouncing problems and bearing witness to situations of exclusion from the conventional health care system.

The impetus for this research project came from a request, made by these professionals to researchers in the areas of sociology and epidemiology, to find answers to some of their questions: Who are the patients who come to free clinics? What are their problems, medically speaking or otherwise? In what way do such centres meet, or not meet, their expectations? In line with this request, our task was to carry out multidisciplinary research among patients of free clinics in order to describe and understand their social and health situations. Our research problem involved us more generally in the determinants of health and health seeking behaviour of socially vulnerable populations. Our main hypothesis was that recourse to these centres did not depend solely on the financial situation and social protection coverage of these individuals. It was thus necessary to study a larger array of factors linked to their social condition (including looking at the processes and life events leading up to these conditions), as well as any use they may have made of other medical facilities. Moreover, we hypothesised that free health care centres were not necessarily the only kind of medical facility used by people in difficult circumstances, nor the kind used by them after their having attempted to consult in all other available facilities. It was thus necessary to analyse the strategies of individuals within the health care system, including, but also going beyond, the choice “to consult or not to consult”. From the sociological perspective of the project in particular, we tried to understand what happens in a free health care centre, beyond just medical care, and how that may influence health-seeking behaviours of persons in difficult circumstances. We were especially interested in the social relationships that are formed in the centres, and the way patients experience their consultation.

In order to encompass the diversity of populations using such centres, we wished to carry out a study in several different facilities, ones where patient recruitment, even when it is of people in difficult circumstances, is dissimilar from the point of view of health problems, life conditions and utilisation of health services.

For this article, we have chosen to present, in turn, the methods used, then some examples of health seeking behaviour of the study populations and links existing between their social characteristics (socio-economic situation, social isolation, social support, etc.) and their health seeking behaviours, and finally to discuss the limits and future directions of this kind of multidisciplinary and multi-centric research.

MATERIALS AND METHODS

The research team brought together for this project decided from the beginning to combine both sociological and epidemiological approaches, as well as qualitative and statistical methods. Initially,

a sociological study was carried out using a series of informal observations and interviews in four free clinics: three dispensaries run by Médecins du Monde (MDM) and one out-patient consultation (PASS) in a Parisian hospital (APHP). In all, nearly one hundred people consulting in these centres (30 at the hospital and 60 at Médecins du Monde centres) were given in-depth interviews, which covered basically their experiences in the centres attended, as well as their attitudes about assistance programmes and the health system in general. At the same time, fifty people working in these facilities were interviewed, recruited from among both volunteers and salaried employees. Nearly all these interviews were tape-recorded and integrally transcribed. In order to characterise the relationship patients developed with health care facilities they attended, a comprehensive approach was adopted: the discourse of people interviewed, as well as the way this discourse was organised, form the basis of analysis, which takes into account both the modality of service use and the meaning patients give to their experiences.

Secondly (and as an extension of the epidemiological research we carried out beforehand in some of the facilities studied [11] , [12] , [13]), a quantitative socio-epidemiological study was done in a sample of clients from five free clinics in the Paris area (three of which were investigated in the qualitative study): Médecins du Monde's centres in the 11 th Arrondissement of Paris, and at Gennevilliers; the Baudelaire facility (PASS of the Saint-Antoine hospital, APHP, in the 12 th Arrondissement of Paris); the Verlaine facility (PASS of Saint-Louis hospital, APHP, in the 10 th Arrondissement of Paris); and the CHAPSA at Nanterre (a reception and care centre for Parisian homeless picked up during rounds made by the Police Prefecture, the RATP (metropolitan underground) and the Samu social (emergency medical and social aid units)). The sociologists, the epidemiologists and the clinicians associated with the project, prepared a questionnaire. Its final version has 121 questions and covers the following topics: a detailed description of the social circumstances of the individual on the day of the study (and how long these have existed); a description of the person's attitudes, expectations and perceptions concerning the health care system in general, and more particularly concerning the facility in which he or she was being interviewed; the person's own evaluation of his or her felt state of health, medical antecedents, symptoms and reasons for consulting; as well as a description of his or her health seeking behaviours, especially during the past month (care itineraries, facilities visited and detailed reasons for consulting), during the past trimester (hospitalisations), and during the past six months (all contacts taken together). Using this approach, 500 persons were interviewed (100 persons chosen at random from each site) who fulfilled the following inclusion criteria: aged 18 years or older, coming to consult a physician at the free health facility, able to understand and speak French. The statistical analysis of data used the following methods: Chi2 test for the comparison of qualitative data, non parametric rank test (Wilcoxon) for comparison of quantitative variables, multiple correspondence analysis and ascending hierarchical classification (cluster analysis using the Ward method) for statistical quantification of the typology prepared from the interviews, and a logistic regression model for the multivariate analyses. All statistical analyses were done using SAS/STAT ®, version 6.12 (SAS Institute Inc., Cary, NC, 1996). The observations and interviews were carried out between 1996 and 1998 and the statistical sample interviewed in 1998.

RESULTS

Description of the population using these facilities

In the free hospital and association-based health centres, a majority of consultants are males, between 25 and 35 years of age. Eighty percent are of foreign nationality, 70% to 80% have a home (depending on the centres), and 62% are educated beyond the age of 15 years. However, around 55% are unemployed and the majority are without health insurance (62% at Saint-Antoine hospital and up to 83% at MDM centres). The CHAPSA at Nanterre is different from the other study sites in that its recruitment is 90% male, 78% French and 95% homeless. Also, half of the patients have

health insurance, so this is a population similar to the Parisian homeless population [14] , [15] . In all sites, the majority of people interviewed were unmarried (58%) or separated, widowed or divorced (17%). A quarter comes from rural areas, with the French twice as likely to come from there (41%) than are foreigners (19%, $p = 0.001$). It would appear that, in our study population, there is a phenomenon of urban migration, in addition to that of international immigration.

On the day of the interview, a third of people interviewed said they worked (except at CHAPSA where only 8% said they did). There were important differences between foreign nationals and the French: respectively 39% and 16% worked ($p = 0.001$). Among those that work, the large majority (79%) have undeclared employment, more frequently among foreigners (83%) than among the French (56%, $p = 0.001$). Finally, 36% of people said they had no means of support. In addition, many patients in free health care centres face social and affective isolation. For example, when they were asked about social support, 12% of respondents said they could count on no one for any of the depicted situations (in case of illness, for finding lodgings, financial support, moral support, etc.). For each situation taken separately, between 40% and 60% of respondents have no one to help them.

As concerns health, 50% of people interviewed described four or more symptoms, and 20% described at least eight symptoms. A history of back and joint pain (all causes taken together) is the most frequent problem found among those interviewed (40% of people interviewed, twice that found in the general population [16]). Mood and sleep problems are especially frequent, and, depending on the way questions were formulated (a combination of anxiety-depression symptoms, a diagnosis of “depression” or a “depressive condition”), between 30% and 57% of people were affected, a figure 4 to 6 times greater than for the general population. As concerns addictive behaviours, use of tobacco among males is higher (49%) than that estimated for the general population [17] . The proportion of those drinking to excess (defined by a score ≥ 2 on the CAGE test [18]) reaches 25% for the study population as a whole. Multivariate analysis shows that male sex, age over 40 years, homelessness and French nationality are all associated with a 2 to 4 times higher risk (statistically significant) of consuming excessive quantities of alcohol. Finally, it should be noted that a third of consultants had previously attended the centre where they were interviewed 1 to 2 times, 40% had come 3 to 9 times and a quarter of them were consulting for the first time.

Types of relationships established with free clinics

From a sociological perspective, in order to understand modes of health seeking behaviour it is necessary to go beyond the specific question of medical needs as defined by health professionals, as well as by patients themselves, in order to focus on other types of logic which influence the relationship with the health system [19] . In addition, in free clinics, the helping dimension of care interferes with the medical dimension and the social work undertaken. Analysis of interviews carried out in the hospital setting and in humanitarian centres shows that attitudes towards these dimensions, and thus the way use of facilities is experienced, differs according to the patient, and evolves over time for the same patient as well. Individuals' expectations towards the centre and their use of available services are in fact transformed as a function of changes in their health status and social situation, of changes in the way they view their situation, and over the course of a number of visits because of their interactions with personnel and the internalisation of norms in force at the centre. It has thus been possible to formally describe a “moral career” [20] , [21] for the vulnerable patient, corresponding to an institutional trajectory during which the relationship to the free care centre is transformed [22] . Initial recourse generally corresponds to isolated cases of using the centres: patients do not invest in a long-term relationship of medical or social follow-up. When patients are unable to obtain health insurance as a result of these first consultations, or when they do not wish to consult elsewhere, most patients become regular clients of the centre. Others continue using centres, but on an erratic basis. Analysis of the interviews has also led us to distinguish three types of relationships to the centre being frequented: distancing, settling in, and discrepancy.

This typology was subsequently identified and quantified by the socio-epidemiological study, in which fifteen questions on the relationships with care centres and assistance were administered to the study population. Only those who had already consulted in the centre prior to the day of the study answered all of these questions, that is to say 372 persons. The search for 3 clusters by ascending hierarchical classification (AHC) identifies three groups of modes of response, which are also identified by analysis of multiple correspondence (AMC), and which agree with the three types found during the analysis of the interviews: distancing, settling in and discrepancy (fig. 1) . In order to classify each individual in one or the other of the three types, we calculated 3 cumulative scores from the AHC (each one corresponding to the number of modalities concerning an individual, out of the list of the modalities of variables characteristic of the group), then classified the individual in the group for which his or her score was the highest. A similar method of classification was undertaken using the AMC. These two classifications were found to be in complete agreement and only 2 individuals could not be classified, because of the equivalence of some of their scores.

Distancing

The distancing relationship is characterised by strategies setting limits on the consultation in a free clinic, through detached interaction — or at least experienced as temporary — with members of the personnel, and by the desire that care should be limited to the problem at hand. These are generally people whose health status does not require middle or long-term follow-up, or who have only recently begun using the free clinic. The distance these people maintain in relation to the centre and its personnel is often the result of the humiliation they feel when they have recourse to assistance [23] . Being obliged to ask for free health care represents, in their eyes, a deterioration of their status and self-image. The comments of a 41-year-old woman clearly summarise this feeling: “I'm really not used to this and I'm really... embarrassed. (...) We've never arrived at this kind of a situation, you know, its... its tough! I think. It feels like we're asking for charity.” Of 500 patients interviewed by questionnaire, more than one out of two said they were embarrassed to ask for free care — and this was so regardless of sex, age, nationality, housing situation, employment status or social coverage. It will be noted as well that this feeling of embarrassment is found in each of the facilities studied, thus in both conventional centres (PASS at hospital) and in centres expressly intended for the poor. In reality, more than the nature of the centres they use, it is the necessity of having to depend on institutional assistance, which constitutes a humiliating ordeal for these patients. This is reflected in their consulting behaviour. Indeed, determined to preserve their dignity, they refuse to be seen in the eyes of others, or in their own eyes, as “living on benefits”. As a result, they often limit the number and frequency of their consultations. Thus, 43% of persons given a questionnaire at hospital and MDM said they would consult a physician more often if they had health insurance. And several patients questioned during interviews say they wait longer before consulting after appearance of symptoms than they did when they were better off financially, or even say they won't consult in the same centre for several health problems at the same time. According to the AMC and the AHC, the distancing relationship is characterised by the following modalities: would prefer consulting elsewhere if he or she had a choice; especially appreciates the professional qualities of the physicians at the centre; is neither very comfortable nor uncomfortable in the centre; finds the reception quite good; only consults when he or she cannot do otherwise (fig. 1) . This relationship applies to 40% of those interviewed (and having already consulted).

Settling in

Conversely, the settling in relationship is characterised by a frequency of use which is not limited by any feeling of humiliation, and by a relationship that includes follow-up care. Regular attendance at free clinics presupposes learning how the centre functions and its norms, but also an adaptation, which is both symbolic and of one's identity, to the implications of regular use of such a facility. In

a settling in relationship, patients transform the meaning of care received. It is no longer experienced as demeaning assistance, but is referred to more as a right to care and help, to which everyone is entitled. This enables them to continue their recourse without feeling embarrassment. They consult as though they had health insurance. Relationships with personnel are similarly transformed and are no longer limited to just technical and professional activities. Personal and affective bonds are created, which also contribute to transforming the meaning given to care. It takes on the form of social, medical and moral support, thus providing things essential to people in difficult circumstances, all the more important because they often live in a context of social isolation and deterioration of their self-esteem [24]. A patient at Médecins du Monde said: "It's not just a dispensary, it's really a friendly place. (...) Without Médecins du Monde, I think I would have been much more... I would have felt much more hopeless. The word comfort comes to mind, its... it's a key word: Médecins du Monde comforts people."

In some cases then, we see the creation of social ties in free clinics: social bonds of integration when interactions between patients and personnel become actual exchange relationships, the dynamics of which are close to those of friendship; social ties of citizenship as well, when individuals see themselves accorded the right of access to care, especially when they enter hospital and see that they are cared for the same way as are all hospital clients. The quality of the health care given, the quality of relationships with personnel, the concern of the latter to offer care showing respect, these are all things which patients in difficult circumstances may not find in the conventional health system, and which help them appreciate the centre they attend, to the extent that many of them say they prefer to consult there. According to the quantitative study, 31% of patients at MDM, 48% in the PASS and 29% at CHAPSA would wish to consult in the same place, even if they had the choice of going elsewhere. Over all, 53% of those questioned find themselves in a settling in relationship (defined, according to the AMC and AHC, by the following modalities: would prefer to consult in the same centre if he or she had the choice; finds the reception very good; feels very comfortable in the centre; especially appreciates the human qualities of the centre's physicians).

Discrepancy

The third type of relationship is marked by a discrepancy between expectations and norms of patients (concerning health, social assistance, care, etc.) and those of the personnel. These patients use the free clinic in the short and middle term, but their relationship to health is unstable, their medical demands are inconsistent and prescribed treatment regimens are rarely followed. Initiatives suggested by social workers are also rarely put into practice. This type of relationship generally concerns marginal people who have difficulty becoming established in a facility and conforming to the institutional constraints necessary for them to be cared for over the long term. Some of them are even reticent when they have found equilibrium in marginality, and they do not wish to renounce their marginal way of life. Usually, however, these people live in crisis and social isolation. Although they want to live a less marginal existence, their instability prevents any kind of regular social and medical care. Generally, relationships with personnel are unstable. Aggressive, sometimes violent behaviours may be displayed by these people, many of whom do not tolerate limits of any kind, or who suffer from psychiatric problems, drug addiction or alcoholism. Nevertheless, some of them do manage little by little to become more stable in their relationships with the care facility. According to the quantitative study, discrepancy affects a small proportion of consultants (7%). This type is characterised by the modalities: doesn't like anything about the centre's physicians; does not trust them; considers that auxiliary medical personnel are not friendly; is not comfortable in the centre.

Access to preventive care

The quantitative study permitted an investigation into how often people stated that preventive care was offered to them in the past. For example, among people with a family history of diabetes or dyslipidemia, many said they had already had laboratory tests (respectively 70% and 44% during the past year). More than one-half (57%) of them said they had already had at least one screening test for HIV infection. This number is higher than that estimated for a representative sample of the general population by Ensemble contre le sida in 1998 [25], except for the 25-34 year old group (respectively 59% and 76%). As concerns primary prevention of sexually transmitted diseases, 44% of people questioned said that a nurse or physician had already spoken to them about condoms. This percentage is significantly higher among people questioned in the hospital setting (54%) than at MDM (41%) or at CHAPSA (29%, $p = 0.001$). It is also significantly higher among women, people under 40 years of age and foreigners.

Among women, on the other hand, comparison of rates for PAP smears during the past 24 months shows that consultants to free clinics have fewer of these examinations than women in the general population [17], in particular between the ages of 30 and 40 years (respectively 38% vs. 91% say they had this test during the past 2 years). Similarly, they had fewer mammograms in the course of the past 3 years: respectively 19% and 72% of women between 40 and 49 years of age, and 31% and 60% of those over 50.

In summary, when compared with available data on the general population, those consultants interviewed stated an access to preventive care that is relatively frequent (corresponding to professional practices in the study centres which are apparently not limited to first line curative care, as they have been criticised for being), but less thorough than that observed in the general population, in particular as concerns the prevention of female cancers.

Recourse to the conventional care system

One out of two consultants (52%) has already forgone medical care for financial reasons. This mainly involved medical consultations (cited by 69% of those who mention forgoing care, that is twice as often as what is reported by the CreDES for the general population), as well as dental care (57%) and biological or specialised testing (24%). In addition, one out of two patients needed medicines without being able to obtain them. In all, 65% of patients stated they had given up on obtaining curative care or medicines.

It is interesting to note, using multivariate analysis and after adjusting for age, sex, study site and the presence of chronic illnesses, that forgoing care is significantly more frequent among people living alone (compared with those living in a couple), those who read French without difficulty, and those who are homeless (vs. the others), but also among those whose relationship to the free clinic corresponds to “distancing” (table I). These results are better understood when we know what the distancing relationship is, as illuminated by the sociological analysis of the interviews: those persons who feel humiliation at benefiting from free aid are more likely to forgo health care than those who do not experience free care as demeaning assistance.

In spite of this, recourse to available conventional care is not exceptional. Thus, a quarter of those interviewed have also consulted a private general practitioner during the past six months. This is more frequent among women (34% vs 22%, $p = 0.007$), people with a home (29% vs. 20%, $p = 0.02$) and, as could be expected, people with social coverage (35% vs 21%, $p = 0.001$). Using multivariate analysis, and after adjustment by age, sex, study site (itself correlated with homelessness) and declared chronic illnesses, recourse to private practitioners during the past 6 months is significantly less frequent if the person is without social coverage (especially so if that lack of coverage exceeds one year), if he or she has lived in France for less than 3 years, and if social support is weak (that is if the person has no one to count on for help in the majority of the 9

situations enquired about) (table II) . In this population, absence of health insurance, recent migration and social isolation thus constitute obstacles in access to conventional care.

At the same time, an examination of care itineraries over the past month shows quantitatively frequent recourse: 55% consulted a physician in the month preceding the quantitative study. This frequency is comparable to one for persons exonerated from paying a part of the consultation fee, or for those who have a “life-threatening risk”, according to Credes studies carried out in the general population (though done in the home setting). Care seeking is sometimes combined (primary care at MDM and specialised care in a PASS at hospital for example), but multiple recourse to several different free facilities for dealing with the same problem appears to be rare. Homeless persons are notable for their very frequent use of the centre in which they were interviewed, their nearly total abstention from using private practitioners, and the frequency of their hospitalisations (14% of all those interviewed had been hospitalised in the past 3 months, and the homeless have a 2 to 3 times higher rate of hospitalisation).

DISCUSSION

Three main lessons may be drawn from this study. First, both qualitative and quantitative results have confirmed the diversity of social situations and life conditions of clients to free clinics, beyond the fact they are composed of a majority of men, foreigners and persons without health insurance. Thus, we find numerous trajectories of individual lives, all nevertheless marked by processes of disengagement. While these do not affect everyone to the same degree, they may include individuals who were socially “integrated” before being confronted with social breakdown (the primary case in point being job loss or geographic migration as we noted, but other examples may be a separation or a health problem).

The second lesson to be drawn from this study is that, for this segment of the population (excluded from health insurance and/or with financial difficulties), the free nature of care proposed in these centres is an essential condition for consulting in them, but it does not guarantee by itself either the attendance or the satisfaction of clients. In particular, some patients experience the charitable nature of care as a “stigma”, and they afterwards attempt to restrict their use of such facilities. Generally, it is not until they are able to attribute a non-disparaging meaning to care, and are able to create an acceptable identity for themselves in the centres, that patients accept to enter into a regular care relationship. Related to this process of acceptance, we showed that free clinics are not only places providing medical care: they also create a space where social solidarity is practiced, a place where people can find themselves and where ties of social integration and citizenship may emerge [22] . From this perspective, and in spite of the fact this research was carried out prior to its implementation, this lesson may be particularly helpful in evaluating the consequences of putting in place Universal Health Coverage [26] : this policy is probably not sufficient to ensure that vulnerable populations adopt care seeking behaviours (and more broadly, health-related behaviours) adapted to their needs.

Another lesson to be drawn from the study is that it is no longer possible to contrast users of the conventional care system with the “excluded” for whom care is provided by free clinics, for at least three reasons. First, we have noted that, when the need arises, some of the latter consult both in the hospital system and private practitioners, especially those persons benefiting from sufficient social support to know about, understand and finance the use of the conventional system. Secondly, our analysis of lived experiences in the centres leads to the hypothesis that the humiliation felt from being given free care, or the discrepancy concerning health and medical norms, is such for some people that they give up on all care seeking (not only in free clinics, but also in the “classic” system as well). Finally, if identity (acquired through using medical facilities), social support and knowledge of facilities (and other characteristics not studied here, such as health beliefs or even

people's psychological strengths) all have an influence on care seeking behaviours of people in difficult circumstances, then it is reasonable to hypothesise that this is the case for the general population with regard to the whole of available provision of care.

From the perspective of social epidemiology, this study encourages the examination of these types of factors, still too rarely taken into account but capable of influencing the health and care seeking behaviours of the whole population. From a sociological perspective as well, the link established between acceptance of a status conferred in the health centre on the one hand, and the entering into a broader care relationship on the other, can doubtless be recognised in other contexts [27] . Therefore, in order to better understand therapeutic behaviours in general, the effect on one's identity of different modes of recourse to care should be further analysed.

Consequently, the main limit of our research is that it applies only to clinics consultants, that is, individuals who are a priori ill, who know of the facilities'existence and wish to use them (which, as we have seen, is not “apparent” for all of them). From this perspective, our study population is obviously not representative of all those individuals experiencing difficulties accessing and using the conventional health system. To go beyond this limitation, and also in order to describe the entire continuum of situations of vulnerability and their impact on health and health care utilisation, our current research is directed towards applying qualitative and quantitative methods (taken in part from this first research project) to the general population (using representative samples of populations living in urban districts, and, eventually, including the entire population of the Greater Paris Region) [28] .

Finally, the study presented here (and the current development of our research in the general population) has implications for — but also raises questions about — the meaning, the form and the contribution of the multidisciplinary approach intended from the beginning. Thus, the first part of this study, based on a sociological question concerning the social relationships that are formed in care centres, helped formulate further questions, based on conclusions taken from the analysis of the interviews, which were included in the socio-epidemiological questionnaire administered later. These questions targeted in particular the way people experienced medical care seeking, and their attitudes towards assistance. In return, the statistical analysis of these questions helped identify the typology developed in the sociological analysis of the interviews, and then to study its associations with specific social and medical characteristics of patients. But for all that, it seems to us that the importance of multidisciplinary research should not reside solely in the simple reciprocal illumination, or validation, of results obtained by those disciplines involved (even though this is already substantial... and still quite rare in French health research, contrary to what is done in some Anglophone countries [29] , [30] , [31]); nor should it reside in the reciprocal borrowing of qualitative and statistical research materials (which, moreover, are not specific to either of the two disciplines) [32] . Beyond the processes of contributing to knowledge, which differ between sociology and epidemiology (the concepts, the paradigms and the methods used refer back respectively to “sociological plausibility” and to statistical probability [33]), the difficulty and the stakes of multidisciplinary research are to develop projects (but also to finance them, then to publish the results), which are articulated around a commonly held understanding of the social determinants of health and recourse to care. Such projects should nevertheless — from our perspective — allow each discipline to formulate its own research questions in its own manner, that is, with its own choice of theory and its own reasoning processes.

This project was supported by INSERM, the Fond d'intervention en Santé Publique and the Institut de l'Humanaire. The authors would like to thank both professionals and volunteers at the study sites and the members of the research team established for the project (affiliations mentioned are those at the time of the study): Serge Paugam (CNRS), Jacques Lebas, Joëlle Saunière and Mickaël Guézelot (Saint-Antoine Hospital), Fabienne Bazin, Marguerite Guiguet, Françoise Le Pont and

Nicolas Puech (INSERM U444), Anne-Bénédicte de Montaigne and Anabelle Gilg-Soit-Ilg (Institut de l'Humanitaire), Jean-Marie Firdion (INED), Dominique Farge and Claire Georges (Saint-Louis Hospital), Jacques Hassin (CHAPSA), Zoubida Djelali and Catherine Richard (Médecins du Monde), Georges Ménahem and Johan Rouault (CREDES), Patrick Chérin and Michèle Lévy-Soussan (Pitié-Salpêtrière Hospital), Thierry Sainte-Marie (Kremlin-Bicêtre Hospital), Claire Doussaud (Consultest).

[1] Bouchayer F, ed. Trajectoires sociales et inégalités. Paris, Mire-Insee-Eres, 1994.

[2] Evans RG, Barer ML, Marmor TR, eds. Why are some people healthy and others not? New York, Aldine de Gruyter, 1994.

[3] Bartley M, Blane D, Davey Smith G, eds. The sociology of health inequalities. Oxford, Blackwell publishers, 1998.

[4] Chauvin P, ed. Prevention and health promotion of the excluded and the destitute in Europe. Amsterdam, IOS Press, 2002.

[5] Fatras JY, Goudet B, eds. RMI et santé. Paris, CFES, 1993.

[6] Lecomte T, Mizrahi A, Mizrahi A. Les bénéficiaires du RMI fréquentant les centres de soins gratuits. Paris, CreDES, 1991.

[7] Haut Comité de la Santé Publique. La progression de la précarité en France et ses effets sur la santé. Rennes, Editions ENSP, 1998.

[8] Lecomte T, Mizrahi A, Mizrahi A. Précarité sociale : cumul des risques sociaux et médicaux - enquête sur la santé et les soins médicaux en France, 1991-92. Paris, CreDES, 1996 : 33-44.

[9] Joubert M, Chauvin P, Facy F, Ringa V, eds. Précarisation, risques et santé. Paris, Editions Inserm, 2001, 474 p.

[10] Lebas J, Chauvin P, eds. Précarité et santé. Paris, Flammarion Médecine Sciences, 1998, 300p.

[11] Chauvin P, Mortier E, Carrat F, Imbert JC, Valleron AJ, Lebas J. A new out-patient care facility for HIV-infected destitute populations in Paris, France. AIDS Care 1997 ; 9: 451-59.

[12] Carrat F, Guézelot M, Chauvin P, Imbert JC, Valleron AJ, Lebas J. Accès à une couverture sociale des patients non assurés consultant en milieu hospitalier : une étude de cohorte historique au sein de la consultation 'Baudelaire'. Rev Epidémiol Santé Pub 1998; 46: 361-70.

[13] Chauvin P, Parizot I, Lebas J. Etat de santé, recours aux soins et modes de fréquentation des personnes en situation précaire consultant les centres de soins gratuits : le projet Précar. In: Joubert M, Chauvin P, Facy F, Ringa V, eds. Précarisation, risques et santé. Paris, Editions Inserm, 2001, 99-117.

[14] Firdion JM, Marpsat M, Lecomte T, Mizrahi A, Mizrahi A. Vie et santé des personnes sans domicile à Paris. Paris, CreDES, 1998.

[15] Marpsat M, Firdion JM, eds. La rue et le foyer. Paris, Presses Universitaires de France, 2000.

- [16] Dumesnil S, Grandfils N, Le Fur P, Mizrahi A, Mizrahi A. Santé, soins et protection sociale en 1996. Paris, CreDES, 1997.
- [17] Baudier F, Arènes J, eds. Baromètre santé des adultes 95/96. Paris, Editions CFES, 1997.
- [18] Samet JH, Rollnick S, Barnes H. Beyond CAGE, a brief clinical approach after detection of substance abuse. *Arch Intern Med* 1996; 156: 2287-2293.
- [19] Fainzang S. Les stratégies paradoxales. Réflexions sur la question de l'incohérence des conduites de malades. *Sci Soc Santé* 1997; 15: 5-22.
- [20] Becker HS. *Outsiders. Etudes de sociologie de la déviance*. Paris, Métailié, 1985.
- [21] Goffman E. *Asiles. Etudes sur la condition sociale des maladies mentales et autres reclus*. Paris, Editions de Minuit, 1968.
- [22] Parizot I. *Soigner les exclus. Identités et rapports sociaux dans les centres de soins gratuits*. Paris, Presses Universitaires de France, 2003.
- [23] Paugam S. *La disqualification sociale. Essai sur la nouvelle pauvreté*. Paris, Presses Universitaires de France, 1991, coll. Quadrige 2002.
- [24] Schnapper D. *L'épreuve du chômage*. Paris, Gallimard, 1994.
- [25] Ensemble Contre le Sida. Sida, l'opinion des français. *La lettre d'ECS* 1998; 12: 4-6.
- [26] Boisguérin B, Gissot C. L'accès aux soins des bénéficiaires de la CMU. *Etudes et résultats* 2002; 152 : 1-8.
- [27] Rosman S. *Sida et précarité. Une double vulnérabilité*. Paris, L'Harmattan, 1999.
- [28] Parizot I, Chauvin P, Paugam S, Firdion JM, eds. *Les mégapoles face au défi des nouvelles inégalités : mondialisation, santé, exclusion et rupture sociale*. Paris, Flammarion Médecine-Sciences, 2002.
- [29] Waddell, Petersen AR, eds. *Just health: inequality in illness, care and prevention*. Melbourne, Churchill Livingstone, 1995.
- [30] Williams SJ, Gabe J, Calnan M, eds. *Health, medicine and society: key theories, future agendas*. London, Routledge, 2000.
- [31] Goldman N. Social inequalities in health disentangling the underlying mechanisms. *Ann N Y Acad Sci* 2001; 954: 118-39.
- [32] Brannen J, ed. *Mixing methods: qualitative and quantitative research*. Aldershot, Avebury, 1992.
- [33] Fassin D. Qualifier les inégalités. In: Leclerc A, Fassin D, Grandjean H, Kaminski M, Lang T, eds. *Les inégalités sociales de santé*. Paris, La Découverte, 2000, 124-144.