One last effort. Are high out-of-pockets at the end-of-life a fatality?

Rosalind Bell-Aldeghi[1 2], Nicolas Sirven[1 3], Morgane Le Guern[2], Christine Sevilla-Dedieu[2].

Abstract

High concentration of health care expenditures (HCE) at the end-of-life is well established and can provoke financial hardship for households. To date, most evidence comes from the analysis of the American health system. Despite Medicare insurance and additional voluntary insurance, enrolees face catastrophic expenditure at the end-of-life. Such expenses are so high they can provoke financial hardship beyond death, putting children and widowers at risk of poverty.

Since there is evidence of high HCE at the end-of-life in all OECD countries (French et al.), we ask whether American results on out-of-pockets (OOP) are a fatality. To date, few studies have focused on household OOP as data including both social and private contributions is rare. This article presents evidence on OOP in France. The French insurance system is characterised by a mandatory social health insurance (SHI), that may be topped up by voluntary insurance. For historic reasons, in France, social claims of civil servants are managed by mutual insurances that also provide private complementary contracts. We use administrative (including income) and claim data from one of the largest of these mutual organisations, the *Mutuelle Générale de l'Éducation Nationale* (MGEN), which insures civil servants from the ministries of education, culture, research, sports and environment.

To assess the performance of SHI we analyse OOP before voluntary insurance; and to evaluate the performance of the health insurance system in its entirety, we study OOP after voluntary insurance. Using descriptive statistics, graphical evidence and generalised linear model estimations we find that out-of-pocket expenses increase in the last trimester of life and the French system is successful in protecting individuals from catastrophic OOP. In addition, we confirm that improving the pathways of care could generate savings, but that overall, these inefficiencies are supported by the health systems and do not translate in OOP. Conversely, OOP are driven by personal requirements (balance billing and individual rooms in for-profit hospitals). Finally, providing additional insurance against end-of-life OOP would be regressive.

[1] LIRAES (EA4470), Université de Paris Descartes, France.

[2] MGEN Foundation for Public Health, France.

[3] IRDES, Paris, France.