

**The preferred doctor scheme:
A political reading of a French experiment
of Gate-keeping**

**Michel Naiditch (Denis Diderot University, IRDES)
Paul Dourgnon (IRDES)**

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Michel Naiditch (Denis Diderot University; IRDES); Paul Dourgnon (IRDES)

Abstract

Study objective: Since January 2005 France is exploring a new scheme termed “preferred doctor” (*médecin traitant*) which can be considered as an innovative version of Gate Keeping in order to reduce the excess of postulated excess in health consumption, more especially access to specialist care. This paper describes the political process which lead to its implementation, tries to relate some of the scheme specific features with its results after one year implementation and tries to catch a glimpse for the next steps of the reform.

Material and methods: In order to measure the scheme impact on the “patient treatment pathway” and on physician income, we used a sample of 7198 individual from the 2006 “French health, Health Care and Insurance Survey “(ESPS),”including health, socioeconomic and insurance status and through a set of questions relating to patient’s understanding of the scheme and different data bases of the national sickness fund as well as different studies done by regulatory agencies

Results and discussion: First results after one year implementation show that most patients chose a preferred doctor, who in a vast majority happened to be their family doctor. A vast majority of patients also considered the scheme as mandatory. Impact on access to specialist care, as measured through self assessed unmet need for specialist care, appears not negligible, especially for the less well off and those not covered by a complementary insurance. In term of financial impact, the new constraints on access to ambulatory care seem to have been offset by rises in the fee schedules for the specialities which lost direct access.

We discuss why these short term weak outcomes are linked with a wicked system of the health system governance and to the political and professional context in which the scheme unfolded strongly and determined its structure and implementation pathway. On a more long range perspective, we analyse how the new scheme may nevertheless lead up to reinforced managed care reforms.

Keywords: Managed Care, Gate keeping, health care services utilization, unmet needs

Code JEL: I18

Paper objectives

Like almost all developed countries, France is confronted with escalating health costs driven by an intensive use of technology and growing consumption of services linked to aging and other factors. Evidence of inefficiencies in the organisation, provision and delivery of services as well as skewed financial incentives for health professionals and consumers are also a concern for regulators. Among the various tools aiming at regulating both the demand and the supply side, and even if non evidence based, Gate keeping (GK) has been advocated as one of the most powerful means to avoid unnecessary services through a better channelling of the demand for specialised care. A recent unpublished paper from OECD gives an overview of the various forms it may take (1). The United Kingdom with 95% of specialists working in hospitals and general practitioners (GPs) located in the primary care system is considered the standard for GK, notwithstanding recent reforms that give more choices to consumers. The US also uses gate keeping devices as a part of managed care, with mixed results depending on the type of constraints defining the system and the context of implementation (4). In a very different political and organisational setting German regulators have been trying to impose it for more than 15 years but it is only recently that some form of GK has been finally implemented.

Since January 2005 France is also exploring a new scheme termed “preferred doctor” (*médecin traitant*) which can be considered as an innovative version of GK (5). It stands as a core element of a broader plan introduced in August 2004, the last of a series of regulations introduced through out the last 25 years and that intended to change the structure of the French health care delivery organisation.

The French system is generally acknowledged to be of high quality (even if it does not perform well in terms of avoidable morbidity before 65) and to have high and equitable levels of access to medical care (6). Yet these positive features are affected by its recognised inefficiency and recurrent financial deficits. The field of primary care can be considered a strong driver of rising expenses during the last 15 years.(7)

Regarding gate keeping, four structural characteristics of the French primary care system organisation require attention: a high number of specialists practicing outside hospitals; the possibility of direct access by patients to specialists working whether in or out hospital; the coexistence of a regulated (sector 1) and a unregulated (sector2) sectors for payments, almost exclusively fee for services based (FFS), as only staffed hospital physicians are salaried; poor control by regulators over physician’s drug prescriptions, diagnosis procedures and care delivery that comply with evidence based practice (8).

The rationale for introducing GK rested on its theoretical potential to limit the “claimed” excessive number of consultations that arose from open access to a great number of specialists but also from a low rate of patient cost-sharing because the vast majority (92%) of patient benefit from reimbursements for services not or incompletely covered by the Public national sickness fund (NSF), by complementary health insurance. Complementary health insurance include means tested public

complementary insurance for the poor (Couverture maladie universelle complémentaire: CMUC); not for profit insurance contracts (Mutual insurance funds) and for profit insurers contracts, whether individual or group contract through firms.

This paper shows results after one year of implementation of this “preferred doctor scheme” French gate keeping version. We begin by giving a short retrospective of the political process that led to it. Then, based on a data sample of 7198 individuals from the 2006 “French health, Health Care and Insurance Survey” (ESPS), we show its impact on the patient treatment pathway. More specifically, by using information including health, socioeconomic and insurance status and through a set of questions relating to patients’ understanding of the scheme, we studied reasons given for adopting a preferred doctor; give differential profiles for those who opted for gate keeping and those who did not; analysis access to or renouncement of specialists and experiences with care since the beginning of the scheme. To assess the financial impact of the scheme on physician revenues and sickness fund expenses, we used different data bases of the national sickness fund and different studies done by regulatory agencies. Because our results show that the changes predicted by the promoters of the scheme moved slowly but also in unintended directions, we try to answer the following question: were these results predictable? We argue here that some specific features of the provision of primary care and a wicked system of governance, linked to the political context in which the scheme unfolded strongly determined its structure and “path implementation” and thus its short term outcomes. Nevertheless on a more long range perspective we look to conclude on how the new scheme may provide some insights about the directions of future reform.

Political background of the preferred doctor scheme

Since the early 1990s the concept of “gate keeping” spurred hot debate in France. Although promoted by various experts and policy-makers, it was strongly opposed by the majority of the politically powerful specialists unions. Only in 1998 did a first attempt at introducing a gate keeping formula take place. A first scheme called “referring doctor” advanced politically by government was endorsed and signed by the national sickness fund (NSF) and by the socio democrat oriented GPs union “MG France” which considered it an important element in its global strategy to enhance the political status of general practitioners (GPs) in relation with specialists. The scheme was a central piece of the “national agreement”, a renewable regulatory mechanism that defines for a specified period of time all the contracting arrangements regarding type and levels of payments for physicians working in the ambulatory sector.

This first scheme was to become a central piece in the debate surrounding the launching of the 2005 scheme.

Only GPs (from both regulated and unregulated payment sectors) could *volunteer* to become ‘referring doctors’. Once a GP did so, he could invite any of his *patients to sign an individual contract* by which

the patient recognized him as a first point of entry into the health care system for any episode of care. The patient thus agreed to access whether inpatient or outpatient specialists care, after a referral from his “referring doctor” and not to change of referring doctor during the one year period of the contract.

GPs had strong financial incentives to volunteer: a per capita annual payment of €46 in 2001 per contracting patient, which complemented their usual FFS revenue. The counterpart for the physician was a strong requirement to participate in health education programs, to keep patients’ medical records (not a legal requirement in France), coordinate care and prescribe cheaper drugs and/or generics. Referring GPs also accepted third-party payment procedure, meaning that patients did not have to pay to the doctor the part of the expense covered by the public health insurance in order to be reimbursed afterwards, which is the regular scheme for medical visits in France. This procedure embedded positive incentives for patients and doctors to contract but was not easily accepted by all physicians, many of them viewing it as contradicting the old and still strong credo for direct payment of physician by patients.

Overall the scheme appeared a failure. Unpublished assessment showed that the scheme was adopted only by 10% of GPs and by 1% of patients, 80% of them being old and chronically ill. This latter percentage shows that this type of patients had previously a “family doctor” that already played the role of the referring doctor, and who became in the new scheme their “official” referring doctor. This was a surprisingly poor achievement regarding the strong financial incentives embedded in the scheme. Failure can be explained by three factors. First potential volunteering GPs were not so numerous: MG France represented less than 30% of GPs; and a sizable minority inside the union stood against the scheme as did the others GPs unions because of their opposition to any capitation formula. Second, there were strong concerns inside the national sickness fund on the ground that the scheme would not bring savings but more expenses, and indeed data showed that some GPs enhanced their annual income by more than 60%. Third, others in the NSF viewed this agreement as a chip in the political bargaining process aimed at regulating primary care activities in which their “usual partners” were unions lead by specialists who fiercely opposed the “referent scheme” because it put their activity at financial risk, was a first attempt against the exclusive FFS remuneration system and threatened their dominant professional and political position.

The scheme had little publicity or success but it gave rise to a tense political climate not only between the majority of the physician unions and the National sickness fund but also between the Fund and the ministry of health affairs (4) for which it induced a major conflict with the medical profession. It is worth to note that if the government is formally not supposed to be a strong player in the negotiating process between unions and the sickness fund, in reality not only does it constantly interferes in the political strategy of the fund but it also takes a major part in the final political decisions. Until 2002 the main medical doctors union, the CSMF (*Confédération des Syndicats Médicaux Français*), relying on its dominant share of 50% of specialists and 35% of GPs, refused to sign any national agreement, forcing the ministry of health affairs and the NSF to unilaterally regulate the system. After the 2002 election

that brought back a conservative government and as the CSMF enjoyed success in the professional elections, specialists regained their usual place in the negotiation process. In January 2005, six months after the governmental plan was launched, the CSMF and two other physicians unions agreed to sign a new national agreement introducing the “preferred doctor scheme”. But they obtained as a counterpart from the government that the former “referring doctor scheme” would be dismantled, infuriating MGF but drawing political support from the majority of the other unions.

This political reward may nonetheless seem weak when balanced with the strong opposition to any form of gatekeeping. The new scheme appeared as a consequence in many ways a weak version of the previous unsuccessful referring doctor.

The preferred doctor scheme

This scheme establishes a system of “coordinated care pathways” with four main features:

1. A contract between the patient and the preferred doctor

Under the new scheme each patient over the age of sixteen is invited by the NSF to voluntarily select a physician, whether GPs or specialist, who becomes his “preferred doctor”. This physician is supposed to be the first point of contact with the health system for any given episode. The physician directly provides the care and/or can make a referral to a specialist, whether ambulatory or in hospital. In the new scheme, patients are allowed to change their preferred doctor at any time by simply informing the NSF. In exchange for this freedom however, they do not benefit from waiver of out of pocket payment at the end of the visit as they did in the referral doctor scheme even though they may be later on reimbursed by their supplemental coverage but only if they are “in line with” the following scheme’s rules.

2. Negative financial incentives for patients and positive rewards for physicians.

In the new scheme, GPs do not receive a *per capita* payment for the follow-up of each of their contracting patient (as was the case with the referral doctor scheme) but only for those suffering from chronic disease on a defined list (diabetes, severe hypertension, HIV, etc).

In this case, they receive an annual payment of €40 if they propose a treatment protocol.

GPs can charge extra fees to patients consulting them instead of their preferred doctor (except for emergency care) or to patients who have not selected a Preferred doctor. In these two cases, patients are twice penalised: the rate of public reimbursement for GPs’ visits is reduced from 70% to 50% (and from February 2009 to 30%) Financial sanctions also apply if a patient directly consults a specialist working in sector 1 (the only sector really concerned by the scheme). Specialists are entitled to charge

supplemental fee: (officially up to 17.5% of the fee, but in fact up to 25%). GPs are theoretically entitled to overcharge too, but it appears they so far, only rarely overcharged non compliant patients.

A very important, yet puzzling feature of the scheme, lies in the fact that the specialist himself, not the GP who makes the referral, is in charge of deciding and coding whether a patient is to be considered as referred or not. So in this scheme, the specialist can be considered as the “exit door” gate keeper”, the mirror image of the GP as the “front door” gate keeper.

3 A heterogeneous, opaque and complex system of fees

Rules do not apply to everyone and every specialist. Specialties such as Psychiatry and medical gynecology were allowed to keep direct access for specific services, children under sixteen can also access specialist directly for paediatrics consultations. These adjustments resulted in a heterogeneous set of fee schedules for various cases (more than 50) each reflecting a specific financial arrangement.

Moreover, in March 2006, in an amendment to the general agreement, the sickness fund agreed to compensate six specialties (rehabilitative care, dermatology, endocrinology, rheumatology, otolaryngology and internal medicine) since under the new scheme, their levels of activity were expected to decrease. In all these specialties, prices for certain procedures or services were increased or new categories of services were created. For example, the consultation fee for a specific coordination visit of a diabetic patient was increased by 10€.

4. Provisions for complementary insurance

In order to give form to the negative financial incentives directed at patients, the reforms had to tackle “offsetting effect” from comprehensive complementary coverage. In September 2005, the government therefore passed a law requiring that all complementary health insurers develop “responsible contracts” that would not reimburse financial penalties due to non compliance with the scheme, and for which they would be rewarded by tax deductions. These would be lost if they compensated financial penalties incurred by patients who failed to comply with the gate keeping rules.

Stakeholders position before the reform

The original provisions and subsequent adaptations of the scheme yielded mixed incentives so expected gains were difficult to anticipate even if some few experts expressed concerns. (9,10,11).

The majority of physicians did not support the scheme and agreed that it would add to the burden of administrative work without necessarily improving health care quality.

All complementary insurance companies were expected to offer only "responsible" contracts to their clients and most of them did so. Very few for profit insurers looked for potential gains through more active compensation policies (for example reimbursing financial penalties for direct access to specialists) as they did not see a large market potential there.

The *pharmaceutical industry* was less concerned with the scheme than with other regulations contained in the general agreement that aimed to reduce drug prescriptions whatever brand or generics.

Almost all Patients and consumers organizations stood against the new scheme because they generally had backed the philosophy of the former referent doctor scheme and its health focus and positive financial incentives. They considered the new scheme dangerous for non insured persons and feared it would induce a raise of the level of copayments and out of pocket expenses. They also believed that the new system was difficult to understand for most of their constituencies. Their influence was however weak.

First year Results

As of June 2007, 81% of patients had signed a contract with a preferred physician of which 99% were GPs¹. Although formally not compulsory, the scheme was considered such by 81 % of the sample, and by far the main reason for opting. The second most prevalent reason for contracting, which appears in line with the first one, was the fear of financial penalties (44%). Only 31% said they contracted because the scheme would help bring savings for the sickness fund. Only 16% declared they had joined because it would enhance the quality of care and only 13% said they had decided to opt in upon medical advice.

The 19% not opting patients could be split in two categories: Almost one quarter of them could be considered as having voluntarily chosen not to opt, thus assuming the risk of financial penalties while the remaining (¾) gave reasons not directly linked to the scheme. Interestingly *for the voluntarily not opting patients*, the rate of having a family doctor was significantly lower (72%) than in the overall population (92%). This group also appeared to be younger; with a better self assessed health status and a higher socio economic level.

The strongly dominant factor for opting was the pre-existence of a "regular family doctor" before the issuing of the law the probability for opting was 5 time larger than in the opposite case (OR=5.2). The other main factors positively correlated with opting were: benefiting of a complementary insurance (OR= 2.7); being more than 65 (compared to less than 40, OR=4); and having declared a poor health status (OR=2).

¹ Here we summarize the main results of a recent Irdes publication (12)

The rate of *self assessed unmet need for specialists* since the beginning of scheme was low (5 %) but significantly higher among those who had opted for a preferred doctor. Among those who declared having given up on specialist care, 70 % declared that their decision was directly linked with the new scheme regulations. Yet it is impossible to know from our data whether renouncement was linked with necessary care or not.

Finally patients assessed no change in health care quality since the reform was implemented.

Physicians are clearly better off financially

The specialists whose access could be threatened by gate keeping experienced just before the scheme really began a fall in their income of 2.2 % to 5.6% (comparing the 2006 jan/feb period to the same one in 2005) (13). But soon thereafter, their income rose fast and offset their initial loss (14). This is probably a result of the amendment of March 2006 that led to subsequent modifications of the fee schedules for these specialties. The income growth of GPs may have been driven by the introduction of the per capita payments linked to the management of severely ill patients which is estimated to amount on average €2,000 per GP per year (3.5% of their average revenue)

Of course one may question the accuracy of these data and the absence of a strong econometric study. Results may be blurred by concomitant changes that occurred in the level of the regular fees but also in the structure of the new physicians' procedure catalogue that came into use almost at the same time the scheme was introduced. The same caveat applies when considering the sickness fund's financial situation, the latest data a reduction of the public health insurance from € 5.9 billion in 2006 to € 4.6 billion in 2007, but mainly driven by a rise of the funding and not a containment of the costs (8)).

So if the global impact of the scheme on health expenses and access to specialist is not known, the direction is clearly not the one announced or expected.

The Preferred doctor scheme: a politically driven reform not based on evidence

These results are not surprising for the following reasons:

The scheme was sold rhetorically in a mix of political and public health arguments developed by both the NSF and the health ministry as the new director of the fund had been before at the head of the reimbursement structure of the NSF and then the cabinet director of the former health minister who had initiated the reform.

The first argument was that the new scheme would support and enhance the position of primary care physicians as key players in the system because they would gain new responsibilities from a new co-

ordinating function of health and social sectors professionals intervening in complex treatments involving outpatient and inpatient care. The second was that better channelling of patients would enhance the quality and equity in access of care. Ironically it is worth noticing that these two arguments may even more accurately apply to the former and condemned referent doctor scheme.

Unfortunately this new role for GPs relied strongly, as its promoters often insisted, on the successful implementation of the patient electronic medical records (DMP) which would allow the preferred physicians to access the extensive information they needed. When the DMP project was caught up in such difficulties that it completely stopped its implementation, two other arguments rose high on the rhetorical agenda: preventing unnecessary specialist consultations and slowing the sickness fund expenses, both of which based on assumptions not supported by evidence.

Inappropriate access to specialists

As seen before, the central role played by GPs in channelling patients to specialists seemed to exist already albeit implicitly as by 2002 nine out of ten members of the general public reported having a “usual” GP; and this proportion was even bigger among health system users. (15). Moreover, previous studies did not find evidence of excessive and/or avoidable consumption of medical services: the inflationary impact on outpatient costs due to unnecessary multiple contacts with physicians for a single health episode, although difficult to identify, had been estimated to have roughly a 0.1% effect on ambulatory costs.(16). Also, only 5% of health care pathways in 2003 involved direct access to specialists (17). Whether these visits were medically justified or not is difficult to assess. It appeared also that the main “referral structure” between doctors was “from specialist to specialists” (17), an issue the scheme did not address at all, not to say it may exacerbate it. Because the potential gain from reducing unnecessary and/or direct consultations with specialists was predictably marginal, one could anticipate only slight impact from the scheme itself on specialists visits and expenditure.

The pending issue of specialists’ fees

Given the need to reduce the rate of escalating costs in the NSF, there clearly existed a “hidden political agenda” which may adequately explain the scheme’s structure and its implementation pathway: Before the scheme was issued, a strong debate erupted about specialists fees: As noted above, each ambulatory physician in France is entitled either to join sector 1 where service’s prices and fees are administratively fixed or sector 2 where doctors can charge their patients up to 5 times more than in the former (on average 1.5 to 3 times). But since 1990, access to sector 2 has been closed for specialists already practicing in the regulated sector. They are thus trapped and put at a financial disadvantage compared not only to their colleagues in sector 2 but also to “freshman specialists”, new comers in the market and entitled for the vast majority to enter sector 2. The leaders in the struggle to overcome this disadvantage were the surgeon’s unions which urged for the creation of an “intermediate sector” which would be regulated but with higher fees.

Although the then conservative government viewed physicians as one of their most influential political clients (“they make the votes”: that is they represent the stakeholder group with the highest representation in both assembly and senate), its concern was that a positive answer would create a Pandora Box for all other specialists and lead to a totally unregulated price system. Just before the scheme was implemented the government therefore called for future negotiation to settle the issue. But all other specialists immediately asked to be included in the bargain while pressure from the generalist unions grew, seeking for equal treatment.

Alongside this debate, one of the strongest axes of government and sickness fund communication policy at that time in their push for reform was the blaming of patients health behaviours which were said to be responsible for a large share of the sickness fund deficits. Creating incentives to make consumers more responsible therefore rose in the political agenda. Similar appeals to accountability were also widely used in the social sector as a driver for the reform of the French social welfare state (18). Thus both the ministry of health and the NSF began to look for a compromise that could link patient behaviour to physician income. In this context, the design of the preferred doctor scheme appeared to be a good solution to the political dilemma for without any formal modification of the fees sector structure, it explicitly tied the increase of the “insider physician” fees to the correction of the “outsider patients” behaviour.

The preferred doctor scheme: a success or a failure so far?

Recalling Jamie Robinson’s statement that “managed care was an economic success but a political failure”, we argue that the reverse may apply to the preferred doctor scheme: it is a short term political success but an economic failure.

In the short range and in term of politics, the answer may be slightly positive.

The scheme clearly achieved a compromise with the majority of the professional unions by allowing them some of the financial rewards they sought. But their initial demand to create an “intermediate sector” is still high on the health agenda. As for “freedom of choice” for patient, by leaving them the possibility to opt or not, the scheme seemed to strike a good compromise between patient’s autonomy and the regulator’s wish to encourage a more efficient access to health care. Nevertheless our results show that the scheme was considered as compulsory by a large majority of patients.

But it is undoubtedly a short-term failure when judging the objective of transforming the provision and delivery of services and lowering expenses. First, for 92% of the population, the “preferred doctor scheme” only appears to be a formal substitution for the pre existing informal “family doctor” thus resulting in few changes in the patient’s treatment pathway.

Second the expected financial gains for the NSF from substituting GPs for specialists' contacts apparently have been offset by the remuneration adjustments made one year after the law was issued. These political concessions to specialists largely erased potential savings for the sickness fund coming from the scheme.

Third the reform's potential impact on equity in access to specialised care seems not to have been considered carefully by its proponents. During the 1990s specialist care showed the highest level of social inequality in health care consumption in France.(19) A reform in 2000 explicitly targeted the inequalities in access to care that arose from differences in ability to purchase complementary insurance by enabling those with lower incomes to benefit from a means tested publicly funded complementary health insurance (cmuc) which succeeded in reducing the gap in consumption between lower socio-economic groups and the population average (20). Substantial changes in the *monetary costs* (for the 8% of patient lacking complementary insurance or for "the group of cmuc eligible but not opting patients") *and in the non-monetary costs* ("too complicated and/or time consuming") incurred to access specialists care, could modify the above mentioned positive trend in access to specialised care. Our early results suggest that access to specialists after the reform should be closely monitored.

Conclusion: what lessons for the future of French health system reform?

On the short term, French gate keeping scheme failed to achieve its main concrete objective: to reduce costs due to unnecessary specialists visits. Quite paradoxically however, the reform which was introduced within a rhetorical frame focussed exclusively on the demand side regulation and patient responsibility put the regulator in position such as to shift the reform scope from demand to supply regulation, for two reasons. First, the PD reform proved that demand side regulation was inefficient in terms of costs containments. Second, the exhaustive information system developed alongside and the capitation payment introduced in the scheme enabled the fund to monitor, control, and orient GPs activity. The scheme may therefore be understood as a first attempt, through better regulation of the demand side, to begin regulate the supply side, revealing the emerged part of a more "long range political agenda".

The potential efficiency of any gate keeping scheme when it takes place in a health system like that of France and Germany where more than 50% of the specialists practice outside hospitals; The classical and seemingly more efficient gate keeping system presupposes a partition between primary care ruled by GPs and secondary and tertiary care ruled by hospital based specialists. So what the French experience suggests is that any mechanism seeking to better coordinate general and specialised care can not succeed unless strong measures are taken to regulate the supply side and in particular practice locations of the health professionals. In France an emerging shortage of specialists in public hospitals added to their mal distribution in the ambulatory sector recently gave decision makers an opportunity to move toward a more stringent regulation of the geographical setting of physicians.

Initially pushed by both the executive and the NSF, the proposal was postponed three weeks after resident physicians unions went on strike to oppose it. Evidently it shows that regulators are still not eager to tackle directly one of the main dimensions of the principle of French liberal medicine: the freedom for physicians to settle their practice where they please.

Second, even if slightly, reform has begun to change the way ambulatory GPs are paid because it introduces for all preferred doctors a new income flow through a per capita payment for patients with specific chronic illness. *Whether this may be considered a first move toward a more mixed system of remuneration* an evolution to which specialists and also a majority of GP's unions are still strongly opposed, remains an open question.

On the long run, it may be that the above mentioned i.e. unequal distribution of physicians drives the development of more group versus solo practices, an evolution which might, through well designed experimentations as the NSF wish to develop, lead to a more mixed payment system. But in the short term, per capita payment system may be a strong incentive for physicians to code more patients as chronically ill. These patients would then benefit from a 100% reimbursement rate, thus being exempted from co-payments for any treatment included in the corresponding protocol. As a side effect this would result in greater expenses for the health insurance funds but benefits the complementary insurers. Should these changes be justified by the health status of patients they would lead to a fairer distribution of costs between the basic public and complementary health insurance funds. But as the size of this group will naturally grow with aging, the need for a new accommodation among publicly funded expenses, private insurance co-payment, deductibles and out of pocket expenses will become hot questions in the political agenda regarding health system financing .It may thus lead to the emergence of a new social norm implying that all consumers even the severely ill contribute through deductibles to health financing with no 100% reimbursement rate exemption for the latter.

Finally a seldom mentioned but positive effect of the new scheme was to enhance the capacity of the sickness fund, by formally linking a well defined population to each GP to survey the patient's treatment pathway and physician's activity profiles. This entail that NSF has now tools to implement more individualised contracts with GPs and link them with a system of "pay for performance" as the NHS did, in the area of prevention and disease management.

But will the national sickness fund still *be* in a political position to use his newly improved information system to support strong regulation of the primary care sector? At this time the answer seems not clear and must be approached in the context of the global plan in which the scheme was embedded. This plan was supposed to create strong structural measures to enable the national sickness fund in a top down approach, to regulate the ambulatory sector with enhanced power and a reinforced national staff. Its new capacity would follow from a complete restructuring of it's internal organisation directed toward greater efficiency and the granting of new powers and more autonomy by a better balanced system of governance coming from a clarification of the respective roles of the NSF and the state.(6)

Nevertheless six months after the election of president Sarkozy it seems that the state is again taking the lead by moving toward a regulatory framework in which the political and technical decision making process regarding health and social care is to be strongly integrated at the regional level through the implementation of new health and social agencies (ARS). This expanded executive body which is supposed to integrate some of the workforce at the regional level of the Sickness fund will in turn induce major changes in the regulating power of its national level.

So it may be that the preferred doctor scheme, even if not yet successful and not endorsed by specialists but accepted by a large majority of patients, represents a first move in the attempt to transform our France's fragmented ambulatory sector into an organised primary care system. Only time will tell.

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