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results

Background

Implemented in January 2006 The "Preferred Doctor " scheme is considered as a core element of the August 13th 2004 French Public Health Insurance reform. Even though not compulsory, it contains several financial incentives directed toward patients. While its main objective is to regulate access to specialists care, promoters of the reform claimed also broader justifications such as enhanced control of outpatient expenses, better quality of treatment and more equity in access to health care services.

The Health, Health Care and Insurance Survey carried out in 2006 makes possible to draw up an initial assessment of the impact of the reform through the opinions of the patients.

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Introducing Gate Keeping in France: first assessment of the preferred doctor scheme reform

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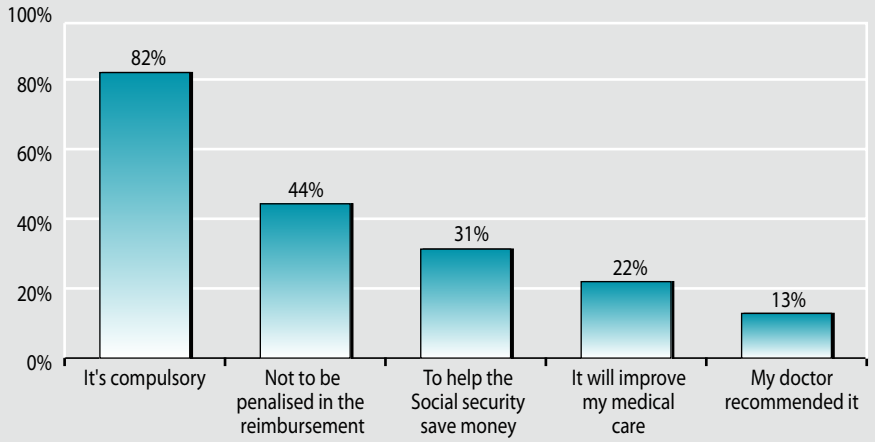
The Health insurance reform that came into effect in January 2006 encourages a "coordinated treatment pathway" (" parcours de soins coordonnés") in which the "Preferred Doctor " (Médecin Traitant) plays a central role: Chosen by the patient, he is supposed to carry out primary care and orients the patient towards specialist care.

After one year implementation, we draw up an initial assessment of the preferred doctor scheme, (cf. box below) based on data from the Health, Health Care and Insurance 2006 survey and from the national public sickness fund insurance (CNAMts). According to the latter in mid-2006 eight out of ten French had declared a preferred doctor to the fund1. The Health, Health Care and Insurance 2006 survey shows that persons voluntarily opting not to enter the scheme represent only 5% as the remaining (14%) declared having had no need to consult since the reform implementation. The new scheme is considered to be mandatory by a vast majority. The preferred Doctor very often replaces the previous family doctor informal scheme. The new system appears to be neutral regarding patient satisfaction with respect to medical treatment. Regarding specialist's access, less than 4% declared having given up for reasons directly related to the reform (they considered the new procedure too expensive or to complex). However, the survey data does not make possible to determine whether the care given up was actually medically unnecessary.

[1] *Cf* monthly information letter of the CNAMTS, 6 June 2006.

Why did you choose a preferred doctor?
Main answers declared in the Health and Social Protection 2006 Survey



Source: IRDES, ESPS 2006

Our analysis focuses on the following questions: who have opted for a Preferred Doctor and who have not? Why have some chosen and others not? Is there already an impact on access to specialists care and for who? Has the perceived quality of care changed or not?

Who declared a preferred doctor and why?

Eight out of ten persons who opted for the preferred doctor considered it as compulsory.

Although the scheme is not compulsory among the 6430 persons surveyed who declared having chosen an Preferred Doctor, a largely dominant share (82%) believe the procedure was compulsory. In reality they are free not to designate a Preferred Doctor but at the price of financial penalties applied to their reimbursement rate by the national sickness fund. This misunderstanding seems to originate from the communication on the reform by public authorities, the national sickness fund itself and the media. The main other reasons mentioned for opting are financial: near one out of two persons (44%) preferred not to be penalised in their reimbursements or civic: one out of three (31%) wished to help the sickness funds save money Finally, one out of five (22%) did so in order to improve their medical care but only 13% declared opting had resulted from a medical advice. (cf. figure p. 1).

The Preferred Doctor scheme substitutes to the informal family doctor scheme

Among those who chose a preferred doctor, 93% declared they had already a regular or family doctor. In that case, this doctor was almost systematically chosen (92%). In other words, in the immense majority of cases, the new scheme superimposed on the informal pre-existing scheme. This may explain why "improvement in care" was not considered a main reason for opting. In total, while 78% had a preferred doctor, 17% remained in the old family doctor configuration. The remaining 5% are globally younger and declare better health conditions.

Why choose a Preferred Doctor?

Several reasons could be given for opting for a Preferred Doctor. Trough the analysis of their correlations[2] specific responder's profiles emerge :

Improved care and savings for the health system are more often mentioned and associated by younger persons, with good health status and a higher than average education level.

Conversely, the supposedly compulsory character of the new scheme is often mentioned as a unique reason, especially among persons covered by the CMUC (means tested publicly funded complementary health insurance directed toward the poor : "Couverture Maladie Universelle Complémentaire"), among which six out of ten fall in this category. This also applies to older and less healthy persons and in this case is more frequently associated with medical advice. Other socioeconomic characteristics show little differential impact in the positioning of the insured relating to opting or not.

Overall, we observe that those less healthy and older probably entered the system during their medical care, in a context that may have made them resent it as mandatory. Conversely, the younger, healthier and better educated persons more often mention as reason for opting the broader objectives of the reform as quality of care or slowing health expenses.

Voluntary no complying remains marginal

Among the 22% persons not declaring a preferred doctor, the main reason declared was lack of time or no reason for consulting (14%), the will to remain free to choose a physician (5%), or having received no information from their doctor (3%). Therefore, real outliers who prefer

The preferred doctor: no obligation but financial sanctions for those who do not comply with GP referral system

The Preferred Doctor scheme, a referral system supposetely coordinated by the physician coined as "preferred " and chosen by each insured, was embedded in the Health insurance reform issued by law in August 2004 and beginning four month latter. From the 1st January 2005, French older than 16 years were asked to choose their Preferred Doctor and to declare him/her to the national public and mandatory sickness fund (CNAM) But the new "coordinated treatment pathway" came into effect only on the 1st January 2006.

Patients with GP referral: In the case the patient consults his Preferred Doctor or his/her replacement or another doctor being referred by his preferred doctor, he is reimbursed as before: 70% of the administratively fixed fee. But patients keep the possibility of consulting directly, in the case of a regular follow-up, gynaecologist or ophthalmologist without reimbursement penalties. Youngsters aged 16 to 25 also avoid penalties when consulting directly a psychiatrist. The access to dentists for dental care remains open.

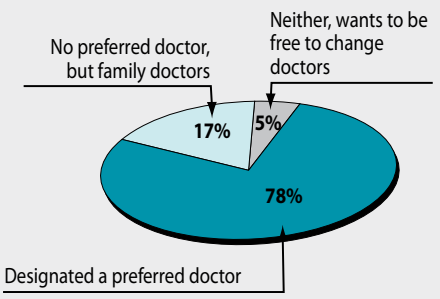
Those who have not opted for a Preferred Doctor or choose to have direct access to a specialist* without a referral are less reimbursed: 50% of the fixed fee. Furthermore, in the case one consults a sector 1 specialist «without GP referral» and «not in an emergency situation or when he is away from home", specialists may increase their consultation fees. This means that it is the specialist and not the GP who eventually decides whether to classify the patient "as with or without referral".

In order that financial penalties remain fully at the expense of the insured, the private complementary health insurances were given incentives not to modify their contracts to compensate this supplemental out of pocket money. For if they did so, they would no longer benefit from the fiscal advantages relating to the so called "responsible" health insurance contracts.

** In Sector 1 physician's fees are regulated administratively while in sector 2 physicians are free to rise them, the core level fees being set between 2 and 3 time the regulated fee. Almost 90% of the GP's are located in sector 1 while specialists are almost equally divided between them .*

2We use data analysis techniques (multiple correspondence analysis, classification techniques) to study all these correlations, followed by a logistic modelling (cf. methods box p. 3).

Situation of the insured in 2006 with respect to the attending physician



Source: IRDES, ESPS 2006

Methods: factorial data analysis and modelling

The data used in this analysis are by nature individual and declarative.

Two types of methods are used to analyse them. Factorial data analysis methods provide synthetic representations of vast sets of data. They are often combined with statistical classifications that enable to regroup individuals into homogeneous classes. These tools are used here to analyse simultaneously the reasons for choosing the preferred doctor, and the individual characteristics associated with these profiles.

Logistic regression modelling methods allow to study the impact of explanatory variables on the probability of occurrence of an event. We use this model when trying to explain what motivates the designation of the preferred doctor or to distinguish the specific effect of having a preferred doctor on renouncing to access specialists.

to remain outside the scheme and assume additional related expenses, only represents 5% of the entire population. These persons have also smaller and significant probability (75% vs. 92% in the overall population) of having a family doctor. This element seems to be a major factor of the "opting/not opting dilemma" as demonstrated by the following analysis. Designating an attending physician is mainly related to having a family doctor

Opting for a preferred doctor is mainly related to having a family doctor

Who does not opt for a preferred doctor and why? The study of the joint effect on the probability of not opting for a Preferred Doctor, of having a family doctor, economic and social status, and health status lead to the following results (cf. table p. 4):

The most influential factor is having a family doctor: the absence of a family doctor multiplies by more than five the probability of not having a preferred doctor. This definitively confirms the hypothesis that the system installed itself on a pre-existing informal scheme, the insured shifting to the new scheme naturally from the informal framework defining their relationships with their family doctor. In that regard, Men, young adults, working persons, and even more the unemployed, have a higher probability of not designating a preferred doctor. Conversely, older persons or persons in bad health are more inclined to opt for.

Having taken into account this factor, persons without private complementary insurance coverage, nor CMUC are three times more likely not to have a preferred doctor. Persons benefiting from CMUC, all other characteristics being equal, also have a relatively smaller disposition to designate a Preferred Doctor. Therefore not opting is not only linked to factors such as health condition or age but also to specific coverage status, this last result being observed elsewhere (cf. Assurance Maladie, 06/2006). Reasons for are numerous: First, no penalty actually applies to persons with CMUC who do not comply. Second as persons benefiting from CMUC see specialists less frequently, they have fewer reasons to designate a preferred doctor whose role is precisely to orient them towards specialists care. Finally, factors as rural or urban environment, type of profession or education level are not associated with a more frequent designation, once the previous mentioned factors have been taken into account.

The effects of the reform

Few changes felt in medical care

Our study lack sufficient time lag to accurately measure the effects of the reform on the quality of care. However the feeling of the patients may give us some initial hints. Eight out of ten persons (82%) felt there was no change in their follow-up. Only 5% had the feeling they were better followed while 2% had the opposite opinion. The remaining 11% had not consulted since and thus were not in a situation to observe any potential change.

Source of data: ESPS 2006 survey

The Health, Health Care and Insurance Survey (Enquête Santé Protection Sociale, ESPS) has been carried out by IRDES since 1988. First annually, then every two years since 1998. In 2006 approximately 8000 households and 22,000 persons were included.

The sample is composed of households insured by the three main sickness funds (CNAMts, MSA, RSI). The survey makes it possible to study, at the individual level, the relationships between health status, access to health services, complementary coverage and the socioeconomic status.

In 2006, ESPS included a specific module on preferred doctor which concerned the following points: choice and reason for the choice, or not, of a preferred doctor, impact felt on quality of care, renouncing specialist treatment since the reform. These questions were asked to one person in each household, which necessitated a reweighting in order to keep the representativeness of the data.

The weighing of the data used here takes into account the demographic characteristics of the participants, the size of the household, working status and the fact of having designated a preferred doctor; the latter scaling data is obtained from the CNAMts results, as the proportion of persons declaring having a preferred doctor is higher in the raw sample.

Modelling of the probability of not declaring having an attending physician

	Odds ratio	Pr > ChiSq
Male vs. female	**1.896**	**< 0.001**
Family doctor reference: no family doctor		
Having a family doctor	**0.217**	**< 0.001**
Age reference: less than 40 years		
to 40 to 65 years	**0.588**	**< 0.001**
to 65 years and older	**0.248**	**< 0.001**
Complementary insurance reference: having a complementary insurance		
CMUC beneficiary	**1.391**	**0.0227**
No complementary insurance or CMUC	**2.750**	**< 0.001**
Health status reference: good or fairly good health condition		
Health condition: very good	1.083	0.4355
Health condition : bad or very bad	**0.525**	**< 0.001**
Place of residence reference: big cities apart from Paris		
Rural setting	0.881	0.2773
Town with less than 20.000 inhabitants	0.912	0.4858
Town with less than 200.000 inhabitants	0.827	0.1303
Paris	1.085	0.5339
Level of studies reference: secondary education		
Level of studies: none	1.438	0.2625
Level of studies: primary studies certificate	**0.698**	**0.0448**
Level of studies: year 6 to year 9: CAP, BEP	0.864	0.2099
Level of studies: higher	1.078	0.5131

Reading guide: having a family doctor divides by approximately 5 the probability of not declaring having a preferred doctor.

In bold: significant at the 5% threshold

Source: IRDES, ESPS 2006

A significant impact on "declared renouncement" to specialist

One of the objectives of the reform is to "control" the access to specialist care. The reform encourages the insured not to consult directly the majority of specialist (see box p. 2), but to be addressed by his Preferred Doctor. However, three reasons may push the insured to differ or renounce consulting a specialist: referral refusal from the Preferred Doctor, additional financial costs and opportunity costs (wasted time) induced by the consultation of the Preferred Doctor, finally the additional financial cost associated with a direct access.

Only one out of twenty persons (5%) declares having "renounced to consult" a specialist, since the launching of the new scheme. But the rate of persons who did so for reasons directly related to the reform is only 3.7% ("too expensive for me", "too complicated having to see the preferred doctor first", "I wanted to see a specialist directly but it had become too expensive").

If the latter percentage is about the same order of magnitude as the drop in specialists fees observed over the first months of 2006[3], it is difficult to take it as a real measure of a decline in the access to specialist. Firstly, it has been shown (ref) that close to one out of ten French people do not consume health services over one year (8% in 2004) and that two out of three do not consult a specialist (64% in 2004). Secondly, the survey took place soon after the start of the reform: we already mentioned that 14% of the survey sample considered themselves as having had no reason to consult a specialist since the reform. Finally, because renouncement is a subjective notion, unsatisfied healthcare needs are not fully comparable from one individual to another. In particular, we do not know whether these renouncement concerned medically justified care or not.

However, although the level of "declared renouncement" is not conclusive in itself, the study of the influence on it of "opting for a PD" provide information on the impact of the reform on the access to specialists, once controlling for the perceived socio-economic situation and health effects of the individuals. Among the persons who renounce, the economic reason is observed in the same proportions, irrespective of whether they chose a preferred doctor or not. However, socio-economic profile and health condition being equal, the impact of opting on "renouncing specialist care" is significant. As it increases by 40% the probability of declaring having renounced.

* * *

These results constitute an initial assessment, one year after it's implementation, of the Preferred Doctor reform. However, the picture is still incomplete. As IRDES will benefit from more data from the information system of the national health sickness fund, we shall be able to undertake several research projects regarding the assessment of this reform focusing on: the equity of access to healthcare and any modifications of treatment pathways, and also medical practices (impact on the level and type of activity, healthcare coordination, etc.).

[3] *The specialisations which no longer have direct access (ENT, internal medicine, rheumatology, endocrinology, dermatology and physical re-education) have seen a decrease in fees of 2.2 to 5.6 % over the January – February 2006 period in comparison with the same period twelve months earlier (Health insurance, June 2006). It should be noted that these decreases were compensated on the whole.*

Further information

Assurance maladie (oct. 2006), *Le parcours de soins coordonnés par le médecin traitant en 2006.* Communiqué de presse.

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