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Do the Transformations in Health Care Supply Correspond to General Medical Care Users' Concerns?

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Primary care supply is currently undergoing significant changes, notably in general medicine. This is occasioned by several different factors including: demographic change within the profession and organisational reforms, the ageing of the population and the progressive increase in incidence and prevalence of chronic disease as well as changes in health care consumers' expectations. Far from being specific to France, these changes fall within an international context that is paying more and more attention to the health care users' perspective in the organisation of the health care system.

Based on a qualitative analysis method (Delphi ranking method), this study aims to examine current transformations in general medical care (GP, group practices, continuity of care, etc.) from the users' perspective by identifying their major concerns.

Results show that the priority for general medical care consumers is the doctor-patient relationship and, more especially, information exchange. Users generally confer a high degree of importance to clinical quality (meticulousness of the medical examination, preventive action and health education…) and GPs' ability to coordinate care in a way that asserts their assigned role of 'gatekeeper' within the health system. On the contrary, factors related to the physician's characteristics (gender, age) or the medical structure within which the physician practices (multi-profession and multi-disciplinary or solo practice) have little importance.

In France, the supply of primary care, and notably general medicine, is undergoing significant changes related to demographic change within the profession and the adoption of organisational reforms.

After a significant increase between 1980 -2000, the number of self-employed general practitioners (GPs) remained globally stable and will progressively decline in terms of volume and even more in terms of density until 2020. This reduction in numbers is accompanied by inequalities in the geographic distribution of GPs with medical densities varying by as much as 100% in certain regions (ONDPS, 2008). This situation is likely to become worse in coming years due to demographic ageing and cessation of activity.

The demand for primary care has equally evolved with the conjugated effects of population ageing, changes in user expectations and an increase in the incidence and prevalence of chronic disease. On 31st December 2008, 8.3 million individuals suffered from at least one of the 30 long-term illnesses recognised under the National Health Insurance ALD scheme (15% of NHI general regime beneficiaries) against 6.5 millions individuals on October 31st 2004 (12% of NHI general regime beneficiaries) [Païta and Weill, 2009]. Since then, the number of new beneficiaries has increased on average by 300,000 individuals per year. This increase in the demand for health care gives rise to new needs, notably in terms of coordination, information or health

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education. These modifications in the demand for primary care have an impact on general medical practice.

The percentage of patients aged over 60, the number of patients presenting at least one long-term chronic illness, or the number of patients on the patient register presenting multiple comorbid conditions (Aulagnier et al., 2007) has an impact on the average duration of a consultation which globally lasts 16 minutes (Le Fur et al., 2009).

In the face of these various changes in the supply and demand of primary care, several responses have been provided within the profession, notably the development of salaried/mixed system of payment practices and group practices. The percentage of self-employed GPs declaring working in a group practice has thus increased from 43% in 1998 to 54% in 2009 (Baudier et al., 2010). In parallel, the role attributed to the GP within the health system has been modified by the adoption of reforms in the organisation of primary care.

Law n° 2004-810 of August 13th 2004 reforming the National Health Insurance scheme thus instituted the 'preferred GP' scheme aimed at improving the coordination and the quality of care. At the end of 2008, 85% of National Health Insurance general regime beneficiaries declared a 'preferred GP' that, in the majority of situations, was self-employed (Cnamts, 2009). This mission to improve the coordination of care was reasserted in the Law n°2009-879 of July 21st 2009 that defines the GP as a pivotal element in first contact care (primary care).

These developments are not specific to France. They fall within an international context that is paying more and more attention to health system users' viewpoint. The aim of this study is to analyse current transformations in primary care supply (group practice, GP, etc.) from the users' perspective by identifying their main concerns.

MÉTHOD

The Delphi 'ranking' technique

The Delphi method belongs to the family of consensus methods (focus groups, citizens' juries). Since its first uses in the 1950's, it has undergone various adaptations giving rise to variations such as the 'ranking-type' Delphi technique. One of the founding principles of the Delphi technique is the indirect interaction of respondents based on anonymous questionnaires comparing one individual's response to that of all the respondents (Group position). The individual can then either decide to maintain his/her response or modify it so that it converges with the group response. In the Delphi 'ranking' version, this technique is used to establish the degree of importance accorded to different items.

In this study, each survey round pursues a specific objective.

• The **first round** serves as a sorting mechanism for all the items used to describe the provision of general medical care. Respondents are questioned on the importance they grant to each of the 40 items using a 9 point scoring scale and 3 demarcation levels (*of no importance – fairly Important – extremely important*).

• The **second round** identifies the aspects of care respondents consider having the most importance. To do this, respondents choose the 5 aspects they consider being the most important among the 14 aspects proposed.

• The **third round** ranks items in order of importance in order to identify eventual priority areas. Respondents rank the 7 aspects identified as being extremely important in the previous round by order of importance. Several aspects may be equally ranked at the same level of importance in order to avoid a 'forced' classification. This is the 'ranking' round of the survey.

This iterative process relies on 'rule-based decision making' that progressively reduces the number of items used in the analysis.

• **From the first to the second survey round.** The 14 aspects selected satisfy the rule of decision-making 'being important' (at least 75% of scores must be in the [7-9] interval on the scoring scale. These thresholds were chosen in conformity with international literature that generally considers the [4-6] interval on the scoring scale as being the zone of indecision.

• **From the second to the third survey round.** The 7 aspects selected satisfy the rule of decision-making 'being the most important' (aspect selected by at least 33% of respondents).

REPÈRES

This study falls within the framework of the Prospère[1] team research programme on current evolutions in the primary care sector. It constitutes the first phase of a public health thesis (economics option) on the evolution of user opinions in the face of transformations in the general medical care supply. This research has led to an article to be published in Health Expectations: Krucien N., Le Vaillant M., Pelletier-Fleury N., "Do the organizational reforms of general practice care meet users' concerns?

[1] Multidisciplinary research partnership on the organisation of primary care (*Partenariat pluridisciplinaire de recherche sur l'organisation des soins de premiers recours*, www.irdes.fr/Prospere)

The method used to collect general medicine users' opinions

In research on health systems, users' opinions have been studied using different approaches, the most common being satisfaction surveys and, to a lesser degree, qualitative survey techniques (interviews, focus groups). These methods are both based on a description of care under different aspects covering several dimensions (accessibility, doctor-patient relationship, continuity of care, clinical quality). In order to identify users' concerns regarding primary care supply, we used a hybrid method belonging to the qualitative survey techniques; the Delphi 'ranking' method (Keeney et al., 2001) [Methods insert]. This method permits both the quantitative measurement of users' opinions and the indirect confrontation of responses in order to consolidate results. It has been presented as an approach adapted to the study of users' opinions (Ryan et al., 2001).

In this study, participants are general medicine users recruited within the general population using a non-probability sampling technique known as the 'snowballing' technique. It consists in recruiting participants according to 'profile' defined by socio-demographic characteristics. Its main specificity resides in the

T1

List of the 40 aspects of general medical care by dimension

Dimension of care	Number of aspects	List of aspects
Perceived quality of clinical care	8	Attention paid to the health problem's physical aspects – Prevention and health education – Meticulousness of the clinical examination – Attention paid to the health problem's psychological and social dimensions –Consultation length – Obtaining a medical examination – Obtaining a drugs prescription – The GP accepts the patient's demands in terms of prescription.
Doctor-patient relationship	9	The GP provides information on the patient's health problem – Clear explanations – Confidentiality of information– The GP provides information on the treatment and examinations – Shared medical decision– The GP knows the patient's medical history – The GP listens to the patient – Amiability – The GP knows the patient's personal history.
Organisation of care	11	Coordination of care – Waiting time before obtaining a consultation – Possibility of always consulting the same GP – Possibility of contacting the GP directly by telephone – The GP helps the patient to make an appointment with other health professionals – Geographical proximity– The GP accepts visiting the patient at home– Possibility of consulting without an appointment – Time spent in the medical structure waiting room– Cost of the consultation after reimbursement– Information on the estimated waiting time on arrival at the main medical structure.
Characteristics of the practice structure and the GP	12	Cleanliness of the medical structure – GP's reputation – Quality of medical structure reception – Opening hours – Ease of access to the medical structure (car park, handrail, etc.) – Atmosphere within the medical structure – Comfort of the medical structure – Provision of entertainment within the medical structure – The GP practices in a medical structure composed of other doctors, GPs or specialists, and paramedical health professionals– The type of GP.

Source: Survey on general medical care user expectations, 2009.

fact that recruited individuals can themselves become recruiters until the profile quotas have been reached. The aim of this approach is to select individuals with potentially very different view points thereby avoiding the creation of cliques.

Participant selection was carried out with the aid of 8 'user profiles' defined by 3 socio-demographic characteristics (age: less than 55 years old versus 55 and over; gender: male versus female; area of residence: rural zone versus urban zone[1]). These characteristics were retained in priority because in the literature they show a consistent effect on users' opinions whether expressed in terms of satisfaction or expectations. The aim of this sampling method is to obtain a selection of individuals with potentially very different view points on the theme under study so as to enrich the indirect confrontation of responses. Sample size was defined so as to obtain a minimum of 50 respondents and to maintain a diversity of profiles in each survey round. Working on an anticipated 20% non-response and termination rate between each round, 80 participants were recruited from May to June 2009. They were questioned on a description of primary care supply based on 40 aspects selected from a review of the literature, a pilot study and working group discussions (table 1). In order to limit the effects of presentational devices on participants' responses, the questions were randomly presented in the different questionnaires and the Delphi approach was limited to three survey rounds so as to avoid the forced convergence of responses.

[1] The classification of respondents in rural or urban zones was carried out using area of residence postal codes and based on INSEE typology.

A diversified panel of users

Throughout the different survey rounds, the sample of respondents remained globally stable in terms of age, gender and zone of residence thus ensuring a diversified representation of users' viewpoints on general medical care (table 2). The progressive reduction in the number of respondents during the different survey rounds is principally due to the late return of questionnaires that were thus not taken into account in the elaboration of successive questionnaires. In the first survey round (N =74), 11% of respondents declared having at least one of the 30 long-term chronic diseases recognized by the National Health Insurance, 93% had a preferred GP, 27% self-reported 'Very good or Excellent' health against 48% in 'good' health and 25% with a health status perceived as 'Satisfactory'. 38% of respondents' GPs are in 'solo practice' against 58% in a 'group practice composed exclusively of GPs'.

Users grant a high degree of importance to the doctor-patient relationship, and more particularly to information exchange

Responses in the first round of the survey revealed a total of 14 aspects satisfying decision rule n°1 (at least 75% of scores situated in the [7-9] interval on the scoring scale) [Methods insert]. These

T2

Evolution of respondent sample during the course of the survey

	Round n°1	Round n°2	Round n°3
Numbers	N=74	N=70	N=65
Response rate	92,5 %	94,6 %	92,9 %
Women	55,0 %	57,0 %	58,0 %
Under 55 years old	54,0 %	53,0 %	54,0 %
Rural zone	43,0 %	41,0 %	40,0 %

Source: Survey on general medical care user expectations, 2009.

aspects, whose high level of importance was consensual among users, essentially describe the doctor-patient relationship (8 out of the 14 aspects belonged to this dimension) [table3]. This result was confirmed by the second and third rounds of the survey. Among the 7 aspects concerning general medical care at the core of users' concerns, 5 are related to the doctor-patient relationship (Obtaining information on the health problem – GP's knowledge of the patient's medical history – Clarity of explanations – Obtaining information concerning the treatment). More precisely, 'obtaining information concerning the health problem' appears to be the main priority for almost 80% of users.

A study carried out among 3540 patients in different European countries gave globally similar results (Grol et al., 1999). Based on a description of general medical care in 40 aspects, the patients were asked to rate the importance of each aspect in order of priority. Overall results were then classified by order of priority. Among the 5 leading aspects, 3 concern the exchange of information between the doctor and the patient (During the consultation, the doctor should dispose of sufficient time to listen, talk to the patient and provide necessary explanations – The doctor must guarantee the confidentiality of all information concerning the patient – The doctor must tell patients everything they wish to know about an illness). These results concord with the idea that the patient wishes to play a more active role in the doctor-patient relationship, share the medical decision, better understand their health status and gain in independence. Although more and more users multiply their sources of medical information, the GP remains the main source for 50% of users (David & Gall, 2008).

The increase in the number of individuals on GP patient lists suffering from chronic diseases equally calls for redefining the modes of communication between the GP and the patient who can then be considered as a 'co-producer' of health care (Wensing et al., 1998). Health care users' concerns regarding information exchange is broached in the March 4th 2002 reform concerning patients' rights and the quality of the health care system by introducing the obligation to inform patients. However, the monitoring of its application has remained insufficient and the majority of initiatives aimed at improving patient information exchange have been developed within the hospital sector. In the primary care sector, a durable relationship between the doctor and the patient appears to be a prerequisite to establishing a trusting relationship enabling the exchange of information.

The 'perceived' quality of clinical care is equally at the core of general medicine users' expectations

The results of this study show that users attach a high level of importance to the 'meticulousness of the clinical examination', the 'elaboration of preventive and health education actions' and to the GP's ability to 'deal with the physical consequences of a health problem (pain-discomfort). A patient's ability to evaluate the clinical/medical quality of care is, however, the subject of a broad debate in international literature. Globally, satisfaction surveys indicate patients' low sensitivity to variations in the quality of clinical care. This result has, however, been criticised because of inadequacies in the description of the treatment or the inappropriateness of the method chosen (satisfaction survey). By revealing that certain aspects of 'perceived' quality of clinical care are among general medical care users' major preoccupations, our study shows that, from the users' perspective, the doctor-patient relationship is not in itself sufficient to ensure quality care. A study carried out among 160 patients in the United Kingdom (Cape, 2002) shows that the 'perceived' duration of a consultation has a relatively strong influence on the patient's perception of care. Consultation length in general practice is largely determined by patient characteristics and clinical context (reason for consulting). A significant increase in the percentage of patients suffering from chronic diseases on a GP's patient register will unavoidably require reorganising the practice (limiting consultation length, increasing waiting times, reducing the number of home visits). These changes can then be negatively perceived by patients in terms of quality of care in general medicine.

Coordination of care equally emerges as a user concern

Through the different rounds of the survey, the GP's role in the coordination of care emerged as one of the most important aspects. General medicine users value the role of the GP as 'gatekeeper' within the health system. Recently, the coordination of care received particular attention in the 2004 and 2009 health care reforms by respectively instituting the coordinated care path and the 'preferred GP' that reasserted the pivotal role played by the GP in the care of patients within the health system. The David & Gall (2008) study shows an increasing acceptance for the coordinated care scheme since its introduction and almost 75% of respondents consider that it has a positive impact on the quality of care. If the GP is to be effectively perceived as a key player in orienting patient care rather than a 'player rationing access to secondary care' [Grumbach et al., 1999], it seems necessary to complete the 'preferred GP' scheme with additional initiatives notably aimed at improving inter-professional cooperation.

T3 **Average score of importance by dimension of general medical care**

Dimension du soin	Number of aspects	Average score	Standard deviation	Median
Doctor-patient relationship	9	7.83	0.88	8.05
Perceived quality of clinical care	8	6.75	1.32	6.66
Organisation of care	11	6.96	0.50	6.73
Characteristics of the practice structure and the GP	12	4.97	1.75	5.38

Source: Survey on general medical care user expectations, 2009.

Little attention is paid to the GP's characteristics or the internal organisation of the medical practice

Among the 6 aspects of general medical care that can be considered as having little significance for the users, 5 describe the medical structure (multi-professional and/or multidisciplinary, solo practice) or the GP (gender, age). This result questions current trends in general medical practice towards group practice that has frequently been presented as a means of maintaining neighbourhood care facilities. Grouping together health professionals answers two principal motivations: on the one hand, the mutualisation of resources and costs enabling GPs to reorganise their medical practice and working time management and on the other, the adoption of a collective medical practice aimed at redefining patient care by developing cooperation between different health professionals intervening in a patient's care path (task sharing, etc) [ONDPS, 2008]. Even if users appear to accord little importance to the form of practice, it can nevertheless have major consequences on other aspects of general medical care that are primordial to the patient. It is thus difficult to anticipate the effects of associating health professionals in a group structure on patient satisfaction (multidisciplinary health centre, group practice, health centre). It closely depends on the aims behind establishing a group practice and its ability to maintain a quality doctor-patient relationship. At international level, various studies put forward medical practice size (determined by the number of practicing doctors or the volume of patients on the register) as a factor having a consistent effect on patients' perception of the quality of care. In their study of 220 patients in the United Kingdom, Baker & Streatfield (1995) show that an increase in the volume of patients is associated with a decline in the continuity of care and patients' accessibility to care. In a similar study involving 7,247 patients in England, Campbell et al. (2001) show that patients consider continuity of care to be better in smaller structures. At European level, this is confirmed by the study carried out by Wensing et al., (2008) showing that user evaluations of the quality of medical structures deteriorates with the increase in the number of practitioners.

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The quality of health care from the users' perspective has been the subject of growing attention over the last thirty years. Patient satisfaction is motivated by a dual objective; on the one hand 'clinical' through the relationship between satisfaction and therapeutic observance and on the other, 'political' with user participation in the health system more frequently put forward as a condition to the acceptability of reforms.

Evaluating the patient's perception of care thus constitutes a core factor in the quality of general medical care (Dedianne et al., 2003). Our study shows that the doctor-patient relationship, and more especially information exchange, holds a preponderant position in user preoccupations and incites rethinking the consultation in general medical practice from that angle. These 'new' user expectations have been recognized by the World Organization of Family Doctors (WONCA) in its definition of general medical practice that includes 'patient centred care' and 'personalised consultations' by means of a privileged doctor-patient relationship. Current developments in primary care supply (group practices, salaried/mixed system of payment practices, concentration of practices in urban districts, work time management) fall within the framework of a general sociological evolution that equally affects GPs' quality of life. Even if this study shows that, globally, current changes in general medical practice correspond to user expectations, the increase in the number of patients suffering from chronic diseases creates new constraints in terms of patient information exchange, and the continuity and coordination of care. In this respect, user expectations could be used as such as criteria to measure the performance of primary care. ♦

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