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# Referral to specialist consultations in France in 2006 and changes since the 2004 Health Insurance reform

## 2004 and 2006 Health, Health Care and Insurance surveys

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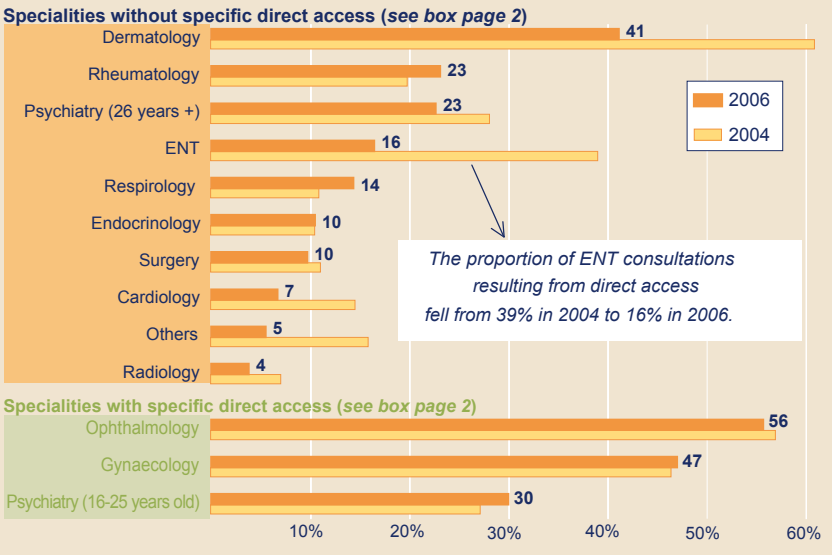
The August 2004 Health Insurance reform seemed to have had substantial impacts on the patients' access to and use of specialist care. According to data published in the Health, Health Care and Insurance Surveys in 2004 and 2006, the proportion of consultations obtained by patients through direct access fell considerably, especially for dermatology and ENT, which both had high levels of consultation in 2004. Concurrently, for many specialties, there was a rise in referral access to specialists by general practitioners (most usually the Preferred Doctor), the number varying according to specialty. Lastly, the number of consultations advised by the specialists themselves remained fairly stable.

All other things being equal, the determinants of direct access to specialist care (other than gynaecologists and ophthalmologists) changed slightly between 2004 and 2006. The influence of social environment and level of education appeared to decline slightly, while household size became significant. The proportion of direct access consultations with specialists was lower for persons living in households with three members and higher than for those living alone.

**The share of specialist consultations resulting from direct access in 2004 and in 2006, according to declarations made to the ESPS survey**




Source: IRDES - Data: ESPS 2004-2006

This study presents an analysis of the distribution of modes of referral to specialist care in 2006 (direct access[1], referral by the preferred doctor or other) and their changes between 2004 and 2006. It follows on from that carried out in 2004 before the Health Insurance reform introducing the preferred doctor scheme and the coordinated healthcare circuit (Le Fur *et al.*, 2006). It uses the 2004 and 2006 Health, Health Care and Insurance surveys (French acronym: ESPS) during which a description was requested of the most recent consultation with a specialist during the last twelve months (*Cf.* box p. 5). The study only analyses the structure of patients modes of referral to specialist consultations. Therefore it does not deal with health care non seeking behaviours, or the level of activity of specialists, as the latter for certain specialities, especially clinical, is known to have decreased following the introduction of the reform[2].

1 In this study, the therm «direct access» is defined as all demands made to a specialist directly (self-referral) rather than by referral by a doctor or other healthcare personnel (access made at the patient's initiative, their entourage or another person).

2 This observation features in addendum no. 12 of the national convention of doctors, concluded between the French national health insurance and the unions signing the convention in March 2006. This addendum mentions the following specialities: dermatology, ENT, rheumatology, physical treatment and physiotherapy, endocrinology and cardiology. Different measures to re-evaluate certain treatments specific to these specialities have been introduced progressively following this observation.

## BACKGROUND...

**The law of August 2004 reforming Health Insurance brought about a new organisation of healthcare based on two principles in particular: the preferred doctor and the coordinated healthcare circuit. These were applied in full on 1 January 2006. Patients of 16 years old and over who wanted optimal coverage of their care by National Health Insurance must choose a preferred doctor who is responsible for coordinating their contacts with specialists.**

**Patients can still contact specialists directly, though less coverage is allocated for these consultations. However, for certain cases the reform permits patients to contact gynaecologists, ophthalmologists or psychiatrists without being subjected to a financial penalty. Such access is known as specific direct access.**

**This study takes stock of the different patients' modes of referral to consult a specialist in 2006, and of changes occurring to these modes between 2004 and 2006 and the modifications of the determinants of direct access to specialists during this period.**

## Modes of referral to specialist consultations in 2006

### In 2006, 3 out of 10 of patients' consultations with specialists resulted from direct access while 7 out of 10 resulted from referrals by a doctor (ESPS survey)

In 2006, 57% of the respondents aged 16 and over declared that they had consulted an independent or hospital specialist at least once during the 12 months prior to the ESPS survey.

According to the patients, out of every 100 consultations with specialists described in the survey, 28 resulted from direct access, whereas 70 were subsequent to a referral made by a general practitioner. Information is lacking on the two remaining consultations.

On further analysis and according to the patients:

– of the 28 consultations resulting from direct access, only one took place in spite of contraindication by the preferred doctor;

– of the 70 consultations referred by general practitioners, 32 were subsequent to demands made by the specialists themselves in order to follow the patient, up 30 resulted from a referral by the preferred doctor, 6 were referred by other specialists or healthcare personnel[3] and less than 2 consultations were referred by a general practitioner other than the preferred doctor.

### Direct access to specialists is half as frequent for patients having chosen a preferred doctor

According to French National Health Insurance Fund for Salaried Workers (French acronym: CNAMTS), (CNAMTS 2007), in November 2006 nearly 80% of persons covered by health insurance over 16 years of age, *i.e.* 40 million people, had indicated their preferred doctor of which 99.5% had chosen a general practitioner[4].

According to the 2006 ESPS survey (*Cf.* figure p. 3):

– ***for patients declaring they have an preferred doctor,*** direct access involves an average of 26% of all consultations with specialists.

This proportion is 48% for specialities with specific direct access (ophthalmology, gynaecology and psychiatry for patients under 26) and 13% for the specialities without specific direct access (*Cf.* box opposite). For the latter, this share of direct access differs according to speciality. It is high for dermatology (38% of consultations) and rheumatology (23% of consultations) though not so high for ENT and psychiatry for patients aged 26 and over (15% of consultations). It is lower for the other

3 Of these 6 consultations, 4 were referred by other specialists (this number was too low for individualisation [oncologists, neurologists, etc.]) and 2 by other healthcare providers (dentists, company nurses, etc.) or by doctors whose speciality was unknown.

4 According to the 2006 ESPS survey, 93% of the respondents declared that they usually went to the same general practitioner or family doctor before the reform was introduced. What is more, the general practitioner in question was chosen as preferred doctor in 92% of cases (Dourgnon *et al.*, 2007).

DEFINITION

### Specialist care use in 2006, as redefined by the 2004 Health Insurance reform

The first measures of the 2004 Health Insurance reform were introduced in July 2005 and the reform was applied from 1 January 2006. It encourages patients aged 16 and over to avoid seeking specialist care without their preferred doctor's referral. Nevertheless, they can still consult directly any specialist doctor, and are not obliged to choose a Preferred Doctor. However, such consultations are considered as being outside the coordinated healthcare circuit, they are less well reimbursed by National Health Insurance (60% in 2006 versus 70% 2005[1]) and can give rise to an authorised extra statutory fee by sector 1[2] specialists. These extra charges are subject to both price and volume ceilings.

The specialties concerned by these measures are: dermatology, rheumatology, psychiatry (26 years old and over), ENT, respirology, endocrinology, surgery, cardiology, radiology, etc. (termed as "specialities without specific direct access").

The three exceptions to this rule, to which patients can obtain specific direct access, but only under certain conditions are:

– gynaecology, , when the consultations take place periodically in the framework of screening, contraception, pregnancy or when the consultation is requested for an abortion;

– ophthalmology, for prescriptions of corrective lenses and for monitoring glaucoma;

– psychiatry, for patients aged 16 to 25 years.

Notice that patients can consult any doctor directly under certain circumstances such as in an emergency, when far from home, if the Preferred Doctor is absent, etc…

1 This rate of reimbursement was fixed at 50% in September 2007, then at 30% in January 2009

2 In sector 1, physicians' fees are regulated administratively but both the lower copayment rate and the authorised extra statutory fee remain at the patient's expense, since they are not covered by most supplementary health insurance contracts.

METHOD

## Direct access or access through referral by the attending physician: differences between the declarations by patients and coding of doctors

The reform obliges physicians to specify the patients' situation with regards to the coordinated healthcare circuit on the statement of the treatment given ('feuille de soins'). Indeed, the invoicing procedures depend on the patients' situation: if they are out of the coordinated healthcare circuit, then their consultation is reimbursed at a lower rate by Health Insurance, and their physician can charge them an extra statutory fee (unreimbursed). The statement of the treatment given therefore provides National Health Insurance Fund (CNAMTS) with information on patients' use of specialist care: "In one year – from July 2005 to July 2006 – almost all the patients who had chosen their preferred doctor conformed to their coordinated healthcare circuit"[1] and that "less than 2% of consultations (general practitioners and specialists combined) with persons who had chosen a preferred doctor did not conform to the coordinated healthcare circuit" (CNAMTS, 2006/06/06), in other words they consulted specialists through direct access. Furthermore, according to the High Council for the Future of Health Insurance (Haut Conseil pour l'Avenir de l'Assurance Maladie, French acronym: HCAAM) over the same period, only 3.3% of consultations with sector 1 specialists gave rise to an authorised extra-statutory fee (HCAAM, 2007). However, according to the Health, Health Care and Insurance survey, at least 13% of specialist consultations without specific direct access of patients that had chosen a Preferred Doctor were not part of the coordinated treatment circuit.

What explanations can be found for the higher figures for direct access in the survey than those found in the Health Insurance data? Apart from several minor measurement problems[2], the differences observed lead to questions on doctors' practical application of the reform and patients' understanding of it.

Some physicians could declare direct access consultations as referral consultations, in order not to penalise their patients. Indeed, they may fear that the additional fee and the bigger co-payment displease their patients which could induce them to not come again.

Regarding patients, as with the referralmodes, direct access is subject to wide interpretation of what has often been a verbal dialogue between the doctor and their patient. This leads to questions like how do patients interpret phrases uttered by specialists, such as "if it doesn't get better, don't hesitate to come," or "come back if you can't stand the treatment" during a preliminary consultation? Will the patient declare having consulted the specialist on their own initiative or in response to the specialist's own advice?

Another frequent advice given by general practitioners and preferred doctors is "if it doesn't get better (following the treatment I've prescribed for you), you should see a dermatologist". Who then is the initiator of the decision to consult a specialist between the patient and the doctor? How will the patient present the situation to the dermatologist? Will they tell the specialist that they have come on their own initiative or that they had been referred by their preferred doctor? To get optimum reimbursement for their consultation, they would be better off saying the latter, which in this case is true on a formal level, even if they have no doctor referral letter to present.

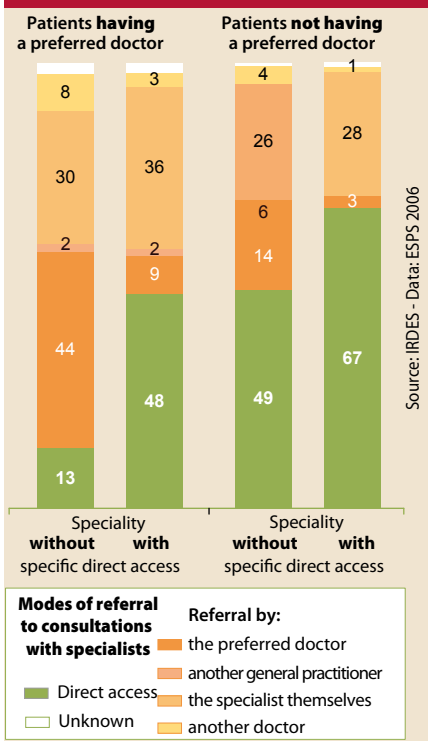
Having said that, the patient can also consult a dermatologist on their own initiative and, provided that they have a preferred doctor, nothing prevents them from saying that they consult upon their preferred doctor's referral.

Whatever the case, these different sources of information reveal the doctors' and patients' differing perception and use of coordinated healthcare circuit, underlining difficulties in achieving clear understanding of the concept of "direct access". These difficulties have certainlyhadanimpactregardingthe practical application of the reform.

[1] CNAMTS (2006). Le parcours de soins coordonnés par le médecin traitant en 2006. Communiqué de presse octobre 2006.

[2] The results of the ESPS survey risk slightly overestimating direct access. Indeed, we do not have information in the survey on the urgency, the patient's distance from their attending physician or the absence of the latter, all circumstances provided for by the reform and which keep the patient in the coordinated health care circuit, even if they consulted on their own initiative.

**Distribution of modes of referral, to specialists in 2006, according to declarations to the ESPS survey**




specialities and especially for radiology (3% consultations).

Among these specialties without specific direct access, a large proportion of the consultations were referred by the preferred doctor (44%) or resulted from requests made by the specialists themselves in order to follow the patient up (30%).

– ***for patients who had not chosen a preferred doctor***, direct access was considerably higher, since, according to their declarations, it concerned 58% of all consultations with specialists:

- more than two thirds of consultations of ophthalmology and gynaecology, specialties with specific direct access;
- nearly half the consultations of other specialties without specific direct access.

This initial analysis therefore highlights the different behaviours of patients who have not chosen a preferred doctor and who are considered as being outside the coordinated healthcare circuit by Health Insurance. Consequently, they are subject to a reduction of coverage. It also shows that among the patients having declared their preferred doctor, a non-negligible percentage state that they had direct access to specialists whose specialties are without specific direct access. These patients should therefore be considered as being outside a coordinated healthcare circuit implemented by Health Insurance, unless in the case of emergency, when the patient is far from home or when the preferred doctor is absent. These results of the 2006 ESPS survey are higher than those of National Health Insurance's data (*Cf.* box above).

## Progression of modes of referral to specialists between 2004 and 2006

### The proportion of consultations with direct access decreased between 2004 and 2006

All specialties taken together, the proportion of direct access to independent and salaried specialists declared by patients has decreased since the introduction of the coordinated healthcare circuit, falling from 32% in 2004 to 28% in 2006. At the same time, the share of use of specialist care following the referral of a general practitioner or that of the specialist themselves has increased.

These initial results therefore highlight a change in the modes of referral to specialists between 2004 and 2006, with the change occurring from the first year of introducing the coordinated healthcare circuit.

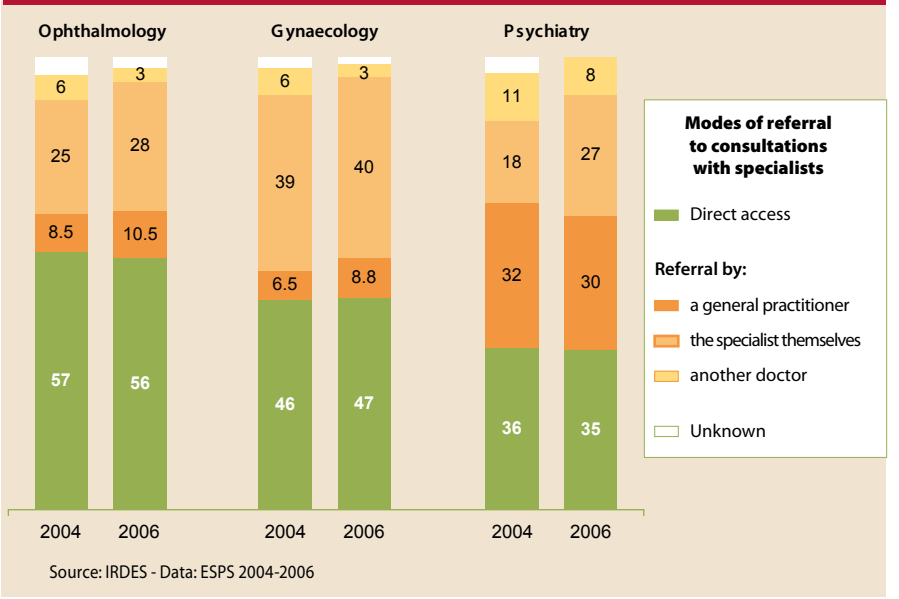
These changes in modes of referral to specialists vary from one speciality to another, in particular between specialties with specific direct access, *i.e.* – gynaecology, ophthalmology and psychiatry for patients aged under 26 – and the other specialties.

### Specialities with specific direct access: the share of direct access by patients remained stable

Modes of referral changed little on the whole for gynaecology and ophthalmology, specialities for which the coordinated healthcare circuit provides direct access. In particular, the proportion of direct access consultations remained the same between 2004 and 2006.

However, the share of consultations referred by general practitioners rose significantly between the two surveys for gynaecologists (+ 35%) and for ophthalmologists (+ 24%). Nonetheless, given the low proportion of consultations referred by general practitioners for these specialities, this increase has little effect on the global structure of the different modes of referral to these specialities (*Cf.* figure above).

**Distribution of modes of referral to three specialities with specific direct access in 2004 and 2006, according to declarations made to the ESPS survey**




Source: IRDES - Data: ESPS 2004-2006

As for consultations with psychiatrists for patients under 26 years old, an increase can be seen in the number of consultations resulting from requests made by the psychiatrists themselves, whereas the proportions of other modes of referral changed only slightly.

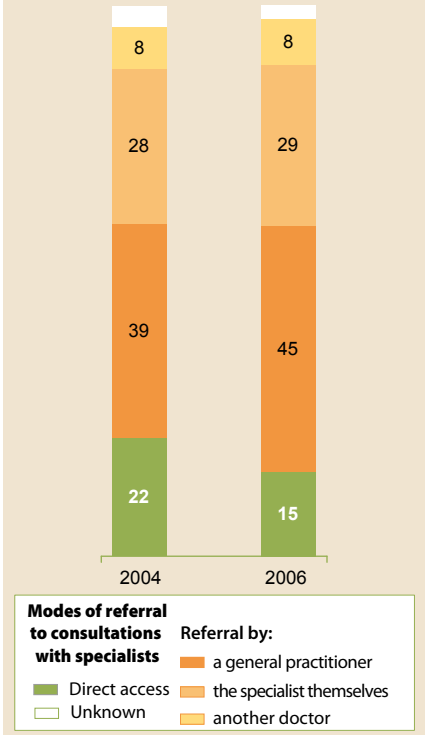
### Specialities without specific direct access: the share of direct access has fallen, though changes differ

It should be remembered that the focus here is on the changes between 2004 and 2006 regarding how patients proceed in obtaining consultations with specialists rather than on changes in the number of consultations.

The introduction of the coordinated healthcare circuit appears to have had a considerable effect on the patients' modes of referral to consult specialists whose specialities are without specific direct access. Thus, in 2006, the respondents declared that out of 100 consultations (or visits) performed by these specialists 15 followed direct access[5] by patients *versus* 22 in 2004.

At the same time, the survey shows a steep rise in the number of consultations resulting from referrals by general practitioners, 45 consultations out of 100 in 2006 *versus* 39 in 2004. Lastly, overall, there is hardly any increase in the share of referrals made by specialists themselves (*Cf.* figure below). However,

**Distribution of modes of referral to specialities without specific direct access in 2004 and 2006 according to declarations to the ESPS survey**




Source: IRDES - Data: ESPS 2004-2006

5 This figure of 15% is different from that of 13% mentioned previously which concerned the share of direct access only by patients who had chosen a preferred doctor in 2006. To analyse the change in direct access between 2004 and 2006, we compared direct access for all patients, without distinction between those who had declared a preferred doctor to the National Health Insurance from others since this formality did not exist in 2004.

this general change varies according to speciality.

### *A steep fall for five specialities, especially dermatology and ENT*

According to patients, the proportion of consultations resulting from direct access has fallen in varying proportions for five specialities[6]: dermatology, from 61 to 41% (-33%); ENT, from 39 to 16% (-58%); psychiatry, from 28 to 23% (- 20%); cardiology, from 15 to 7% (-55%) and radiology, from 7 to 4% (-41%). This drop in the share of consultations by direct access obviously impacts the other modes of referral (*Cf.* figure opposite):

– for dermatology, it is wholly counterbalanced by a rise of the share of referrals made by general practitioners;

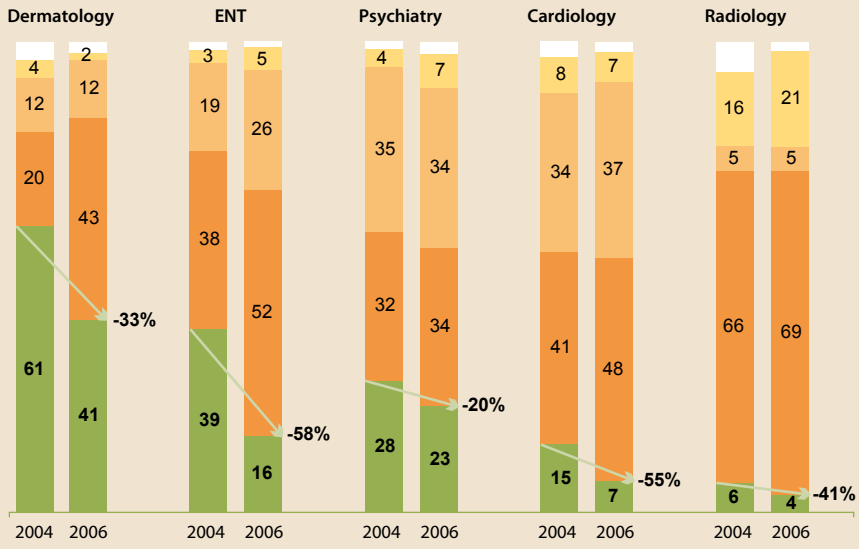
– for ENT, about two thirds of the share are offset by an increase in the number of consultations linked to referrals by general practitioners while one third is offset by an increase in the number of consultations demanded by ENT specialists themselves;

– for psychiatry, the fall is offset by a slight increase in the number of consultations following referrals by general practitioners and other specialists and healthcare personnel;

– for cardiology, it is counterbalanced by the rise in consultations following referrals by general practitioners and by a slight increase in referrals resulting from demands by cardiologists themselves;

– lastly, for radiology, an increase can be observed in the share of demands following referral by a general practitioner and there is an even more marked increase in the share of demands referred by another specialist or medical personnel.

**Distribution of modes of referral to specialities for which direct access fell considerably between 2004 and 2006, according to declarations made to the ESPS survey**




Source: IRDES - Data: ESPS 2004-2006

### *Little change for rheumatology, respirology, surgery and endocrinology*

The proportion of specialities with direct access remained fairly stable between 2004 and 2006 for four specialities: rheumatology, respirology, surgery and endocrinology. However, several changes were noted for the other modes of referral. The following was noted for:

– rheumatology: there was a slight increase in the proportion of consultations in direct access and also for those resulting

6 Changes in modes of referral in gastroenterology are not isolated in the detailed analyses, since different methods were used to collect the data in 2004 and 2006. Likewise for "other specialities" which gathered a aggregate revealing little information.

SOURCES

#### The Health, Health Care and Insurance survey (ESPS)

**The Health, Health Care and Insurance Survey (ESPS)** has been carried out by IRDES since 1988. Initially annual and then bi-annual from 1998, it questioned about 8,000 households and 22,000 people in 2006.

The sample is composed of households comprising at least one person covered by one of the three main Health Insurance funds (salaried workers' fund, agricultural workers' and farmers' fund, and fund for self-employed). The survey permits studying, at individual level, the relations between health status, access to healthcare, supplementary health insurance coverage and socio-economic status.

In both 2006 and 2004, the respondents (which differ from year to year) filled-in a self-administered questionnaire on their health and consumption of healthcare. They are asked particularly whether they have consulted at least one specialist over the previous twelve months and to describe the last consultation with the specialist concerned. In addition, the must specify how they contacted this doctor: on their own initiative or following a referral by a doctor, thus the data are declarative.

During the 2006 ESPS survey, the questions on methods of access to specialists were slightly modified in comparison to the 2004 survey to take into account the introduction of the form relating to the preferred doctor and coordinated healthcare circuit. Thus the motive for a consultation with a specialist corresponding in 2004 to "following a referral by a general practitioner" was broken down in 2006 into two motives "following a referral by my preferred doctor" and "following a referral by another general practitioner". Furthermore, the motive which in 2004 was "nobody, I consulted the specialist on my own initiative" was also separated into two parts: "nobody, I consulted the specialist on my own initiative in spite of the opinion of my preferred doctor being to the contrary" and "nobody, I consulted the specialist on my own initiative".

The other motives remained the same: "the same specialist told me return", "another specialist doctor" and "other".

The descriptive data presented in this publication are weighted to take into account both the structure of the population surveyed and the annual number of consultations with specialists (Allonier *et al.*, 2008).

from referral by a general practitioner. Conversely, the share of consultations following referral by the rheumatologist themselves decreased;

– endocrinology: as with respirology, there was a substantial rise in the proportion of consultations following referral by a general practitioner and a fall of referrals made by these specialists, respirologists;

– surgery: there was a decrease in the share of consultations resulting from referral by a general practitioner and a simultaneous increase for those following requests made by the surgeon themselves. This change contrasts with that of the other specialities.

In all, this analysis of changes in the modes of referral to specialist consultations, especially to those whose specialities without specific direct access, shows that there is a trend towards making the general practitioner the privileged means to consult specialists. This occurred as from the first year following the introduction of the coordinated healthcare circuit.

However, according to the patients, 15% of consultations with these specialists result from direct access. Is this a constant share of direct access or can it decrease still further? The additional reduction of 10 points in the rate of reimbursement for consultations performed outside the coordinated healthcare circuit (with 50% coverage by National Health Insurance since September 2007, *versus* 60% since the application of the reform of 1 January 2006) is intended to reduce this rate still further.

## Have the determinants of direct access changed between 2004 and 2006 ?

The previous descriptive analysis highlighted certain changes in the patients' modes of referral to specialist consultations between 2004 and 2006. Using a model (*Cf.* box below), we now seek to assess, all other things being equal, the respective influences of sociodemographic variables on direct access to specialists in 2004 and in 2006.

This model only concerns consultations with specialists without specific direct access, since the reform is aimed at these specialities.

### Separate analyses of the effects of different variables for 2004 and 2006

#### *Direct access to specialists: in 2006, the effects of social environment, level of education and household size differ in comparison with 2004*

Between 2004 and 2006, the determinants of direct access to consultations with specialists without specific direct access changed though no great upheaval was observed (*Cf.* table page 7).

The influence of social environment[7] on the probability of consulting a specialist in direct access decreased in 2006 *versus* 2004. Indeed, according to the patients, although the share of consultations with direct access by persons living in the households of farmers and unskilled workers was lower than that of salaried employees in both 2004 and 2006[8], these differences were no longer significant in 2006. In other words, the fall in direct access seems to have been less steep for patients living in the households of farmers and unskilled workers than for those living in the households of salaried employees. This therefore contributes towards bringing the levels closer together and erasing the significativity of the differences recorded.

As for level of education, changes are apparent. Whereas in 2004, the rate of direct access was significantly higher for people with university education in comparison to those with secondary education, the difference between these two groups was no longer significant in 2006. The drop in direct access was therefore proportionally higher in 2006, all other things being equal, for persons with university education than for those with secondary education. Concerning persons with very low levels of education (primary school and persons

7 The social environment corresponds to all the members of the household to the occupation and socioprofessional category of the head of the household.

8 All other things being equal and especially at comparable household incomes.

METHOD

### Method of analysing the determinants of direct access to specialists

The analysis method used, *i.e.* **multivariate analysis**, permits measuring all other things being equal the effects of several patient characteristics on direct access to specialist consultations.

Only consultations with specialists without specific direct access (all specialities except gynaecology and ophthalmology) were chosen for patients who had consulted a specialist during the 12 months prior to the survey. The analysis was performed using a selection model on all the persons whether or not they had consulted a specialist. This model was necessary to avoid biasing the study since the fact of not consulting a specialist can be related to the same determinants as those explaining direct access to specialists.

The separate analysis of the model for 2004 and that of 2006 did not allow studying the change (upwards or downwards) of the level of direct access during the period. Therefore a model grouping the two years with interactions between the survey year and each explanatory variable was implemented.

The **variables introduced in these analyses** are the following:

– **variables describing the patients' socioeconomic situation:** total household income, level of education, main occupation, socioprofessional category of the head of the household, supplementary insurance coverage, number of members in the household;

– **control variables:** age, gender, self-perceived status health*, size of town, place of consultation (in the town or in a hospital), the speciality of the last specialist consulted.

* *This indicator is measured by the following general question: "How do you perceive your general health status". The responses proposed are: very good, good, average, poor, very poor.*

without any schooling), the figures for 2004 and 2006 show significantly lower levels of direct access than for persons having reached a corresponding level at secondary school.

In 2004, household size had no influence on the proportion of consultations by patients who consulted in direct access a specialist without specific direct access. Conversely, in 2006, a strong link could be observed between this mode of referral and household size. The larger the latter, the more the proportion of consultations with direct access decreased. In comparison with patients living alone, those living in households with three or more members consulted significantly less in direct access in 2006.

In both 2004 and 2006, the probability of consulting specialists in direct access (excluding gynaecologists and ophthalmologists) was significantly higher for women and for patients living in households whose incomes were higher than €3,100 in comparison to those living in households whose incomes ranged from €1,300 to €2,200.

### *There is little change in the effects of self-assessed health status and the place of consultation (surgery or hospital) between 2004 and 2006*

In both 2004 and 2006, consultations attended by patients who did not consider themselves to be in good health (average to poor health status) result more often from direct access than those attended by patients who perceived themselves as being in good health (good to very good health status).

Likewise, the proportion of consultations resulting from direct access is lower for consultations performed in hospitals than those performed in the surgeries of specialists or in the homes of the patients.

### *In 2006, the proportion of direct access for ENT and psychiatry consultations was not significantly different from that recorded for dermatology*

As seen previously, in 2004 dermatology was the speciality for which the largest number of consultations resulted from

**Model of probability of consulting directly specialists without specific direct access in 2004 and 2006**
**All specialities excluding ophthalmology and gynaecology♦**

♦ **All the psychiatric consultations have been incorporated in the models,** including those of patients under 26 years old, in order to avoid problems of co-linearity (in principle these are consultations with specific direct access). However, they are not very common in our sample.

| | Model in 2004 | Model in 2006 |
|---|---|---|
| | Coefficients | Coefficients |
| **Gender** | | |
| *Male* | *Ref.* | *Ref.* |
| Female | 0.15*** | 0.18*** |
| **Level of education** | | |
| Primary, no schooling | -0.19** | -0.29*** |
| *Bachelor degree* | *Ref.* | *Ref.* |
| Master's degree | 0.08 | -0.06 |
| PhD | 0.18*** | 0.11 |
| **Social environment** | | |
| Farmer | -0.31** | -0.28* |
| Craftsman, shopkeeper, executive manager | 0.00 | -0.11 |
| Senior manager and intellectual profession | 0.11 | -0.02 |
| Intermediate professions | 0.05 | -0.05 |
| *Employee* | *Ref.* | *Ref.* |
| Skilled manual worker | -0.10 | -0.11 |
| Unskilled manual worker | -0.23** | -0.16 |
| **Monthly household income** | | |
| Less than € 1,300 | -0.11 | -0.09 |
| *From 1,300 to € 2,200* | *Ref.* | *Ref.* |
| From 2,200 to € 3,100 | 0.05 | 0.03 |
| More than € 3,100 | 0.17*** | 0.24*** |
| **Number of members in household** | | |
| *One member* | *Ref.* | *Ref.* |
| Two members | -0.02 | -0.15* |
| Three members | -0.07 | -0.33*** |
| Four members or more | -0.08 | -0.41*** |
| **Self-perceived health** | | |
| *Good or very good health* | *Ref.* | *Ref.* |
| Less good health | 0.21** | 0.22*** |
| **Last consulted** | | |
| *Dermatologist* | *Ref.* | *Ref.* |
| ENT | -0.4*** | -0.24* |
| Psychiatrist | -0.8*** | -0.21 |
| Rheumatologist | -0.63*** | -0.46*** |
| Other specialist[1] | -1.03*** | -0.66*** |
| **Place of consultation** | | |
| *Surgery* | *Ref.* | *Ref.* |
| Hospital | -0.19*** | -0.16** |

As the variables main occupation, age, size of town and supplementary health insurance (universal health insurance, supplementary health insurance outside universal health insurance and absence of supplementary health insurance) were not significant, they are not included in the table.

Significativity thresholds: *10%, **5%, ***1%.

1 This aggregate groups all the other specialities that have a relatively low to very low proportion of direct access.

**Note for the reader**: this table shows the influence of different variables on the probability of consulting a specialist in direct access. The value 0,17*** indicating the level of monthly household income in 2004 is interpreted as follows: all other things being equal, the probability of patients living in a household with a monthly income of more than €3,100 consulting in direct access a specialist is 0,17 times higher than that of patients living in reference households with a monthly income from €1,300 to less than €2,200; this effect being significant at a threshold of 1%.

Source: IRDES - Data: ESPS 2004-2006

direct access, but this proportion fell steeply in 2006.

Although the proportions of ENT and psychiatry consultations resulting from direct access in 2006 remained lower than those observed for dermatology, these differences were no longer statistically significant. This means that the decrease observed in 2006 for ENT and psychiatry was, all other things being equal, less considerable than that observed for dermatology. As for the other specialities, in both 2004 and 2006, the probability of direct access was significantly lower than for dermatology, thereby confirming the observations.

## Analysis combining 2004 and 2006

When all the data of the two years are combined in a single model, there is very little difference between these coefficients and those in the table on page 7.

This model, which permits studying the change between 2004 and 2006 of the value of the coefficients linked to different variables, does not highlight any significantly statistical difference between the two years in question.

Nonetheless, there is a moderate effect ($p<10$) of household size with a fall in direct access for households with three members or more in comparison to persons living alone. This effect appears difficult to explain, as it concerns both households with three members (thus small) and much larger households. Regarding the latter, which are often disadvantaged, it is possible to surmise that the possible fear of financial penalties keeps them from consulting specialists without referral.

*In conclusion, the 2004 and 2006 ESPS surveys have provided us with the opportunity of studying the behaviour of the populations, regarding access to specialist care, just before and just after the introduction of the 2004 Health Insurance reform implementing the principle of preferred doctor and coordinated healthcare circuit.*

*As shown by a previous IRDES study (Dourgnon et al., 2007), the great majority of the respondents usually relied on the same general practitioner or family doctor before the introduction of the reform and in most cases designated this doctor as their preferred doctor. This observation leads us to conclude on the following specific point: the reform merely confirmed the pre-existing situation. On the other hand, our study shows that from the first year of implementation of the reform, the patients declared that they had considerably changed their behaviour regarding their referral to specialists without specific direct access (all specialities except gynaecology, ophthalmology and psychiatry for patients under 26). Therefore the share of direct access consultations fell, especially for dermatology, ENT and also for psychiatry, cardiology and radiology. At the same time, the share of consultations following referrals by general practitioners (usually the preferred doctor) has risen substantially, except for psychiatry. On the contrary, the proportion of consultations referred by the specialists themselves remained fairly stable. For the other specialities, the share of direct access is lower or hardly changed, despite a generally more limited increase of referrals by the preferred doctor. Lastly, persons who had not chosen an preferred doctor said they consulted a specialist in direct access far more often than those who had chosen one, and by consequence appeared ready to assume the financial consequences of their choice.*

*Naturally, these changes in behaviour relating to the period 2004-2006 are liable to undergo further change through time, reflecting the different amendments to the reform, possible reforms to be implemented and changes in the perceptions of patients and doctors. To monitor these evolutions, the questions related to modes of referral to specialist consultations have not been changed between the 2006 and 2008 editions of the ESPS survey. A study on the changes of the level of use of specialist care by the population between 2004 and 2006 is also planned, making it possible to broach the question of possible health-care non-seeking behaviours. This study will rely on the data gleaned from the ESPS surveys as well as the consumption of specialist care gathered by National Health Insurance.*

## Further information


- Allonier C., Dourgnon P., Rochereau T. (2008), *Enquête sur la Santé et la Protection Sociale 2006*, Rapport IRDES n° 1701.
- CNAMTS (2006/06/06). Médecin traitant et parcours de soins coordonnés. Premier bilan. Point d'information mensuel, 7p.
- CNAMTS (2007). Chiffres et repères. Edition 2006. Paris : CNAMTS.
- CNAMTS (2007/01/23). En deux ans, le parcours de soins coordonnés par le médecin traitant est entré dans les moeurs. Point d'information mensuel, 7p.
- Dourgnon P., Guillaume S., Naiditch M., Ordonneau C. (2007), Les assurés et le médecin traitant premier bilan après la réforme, *Questions d'économie de la santé* (124).
- HCAAM (2007). Note sur les conditions d'exercice et de revenu des médecins libéraux adopté par le Haut Conseil pour l'avenir de l'Assurance maladie.
- Le Fur Ph., Lengagne P. (2006), Modes d'accès aux spécialistes : état des lieux avant la mise en place du parcours de soins coordonnés, *Questions d'économie de la santé* (106).
- Ministère de la Santé et des Solidarités (2006). Arrêté du 23 mars 2006 portant approbation de l'avenant n° 12 à la Convention nationale des médecins généralistes et des médecins spécialistes. Journal officiel de la République française, n° 76, 4768.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