IRDES

Did 2006 French Gate keeping reform led patients to renounce to specialist care for financial reasons?

An assessment of the reform using self assessed unmet needs

Paul Dourgnon

CHEPA Seminar Dec 10 2008

Objective of the Research

- To provide an evaluation of the impact of the "Médecin traitant" (Preferred Doctor (PD)) Reform on Access to Specialist Care
- Using specific self-assessed data on Health Care Needs

Two types of insights

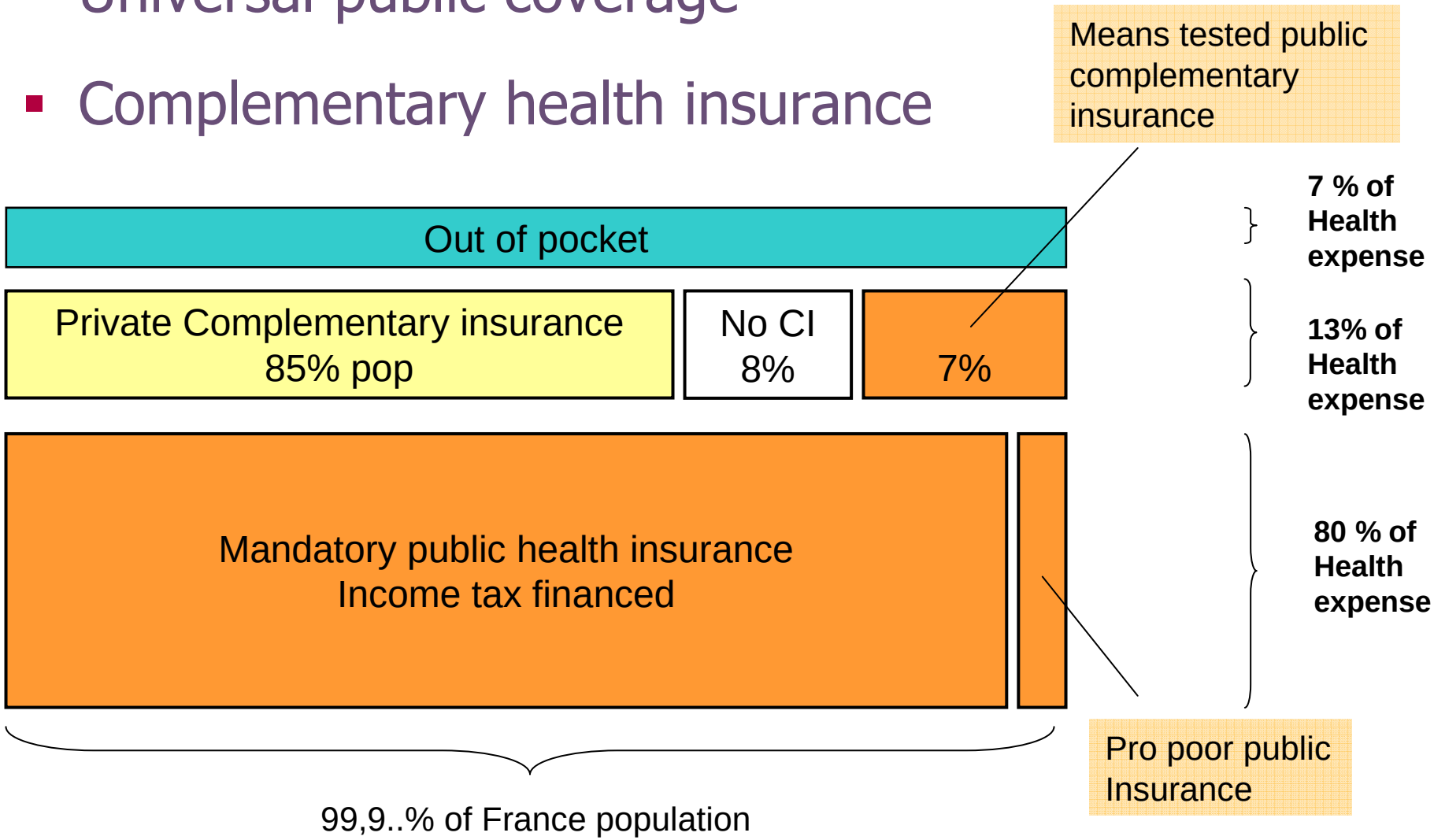
- Policy Evaluation
- Methodological issue: can we derive tools from the « usual » self-assessed questions on unmet need ?

Overview

1. Brief outline of French ambulatory care system
2. Goals and means of the 2004-06 "Preferred Doctor" (PD) reform
3. Evaluating the impact of the PD reform on access to Specialist Care
   - Data and Methods
   - Evaluation Results
   - Methodological Discussion

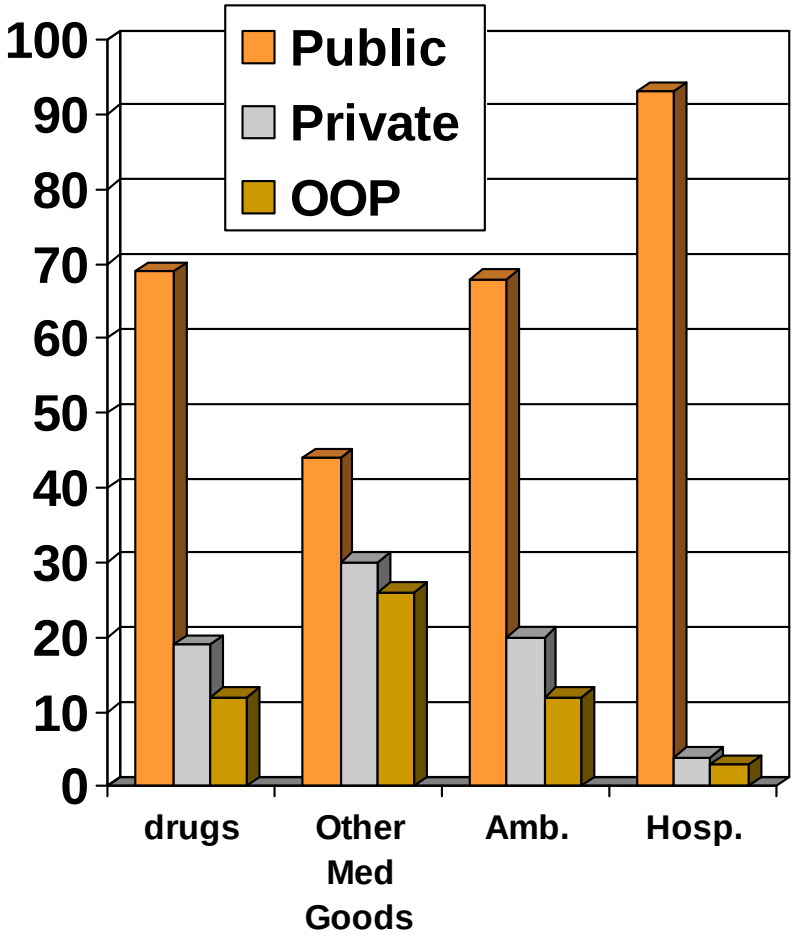
French health care system (1)

- Universal public coverage
- Complementary health insurance



What Complementary insurance plans cover

- Dental care
- Optics
- Physician Care
- Drugs
- Some inpatient care



Ambulatory Care

- GPs : 1.7 per 1000 vs. 1.0 SPs: 1.7 vs. 1.1
- Self employment and Freedom of installation
- Specialists mainly in private ambulatory practices
- Fee for service for all + upfront payment
- Agreed fees = basis for public reimbursement
- … plus overbilling for some doctors (“tact and moderation”)
- weak control by the regulator of physician performance and no sanction

Physicians (1)
A fragmented remuneration system

- Sector 1: Regulated sector
- Sector 2: Weakly regulated sector
  - No new admission for more than 20 years (phased out)
  - Reopening in the public debate

Patients
Who pays what ?

Public Health Insurance	Cost Sharing	Overbilling

Ex. GP visit (sector 1) standard Fee= €21

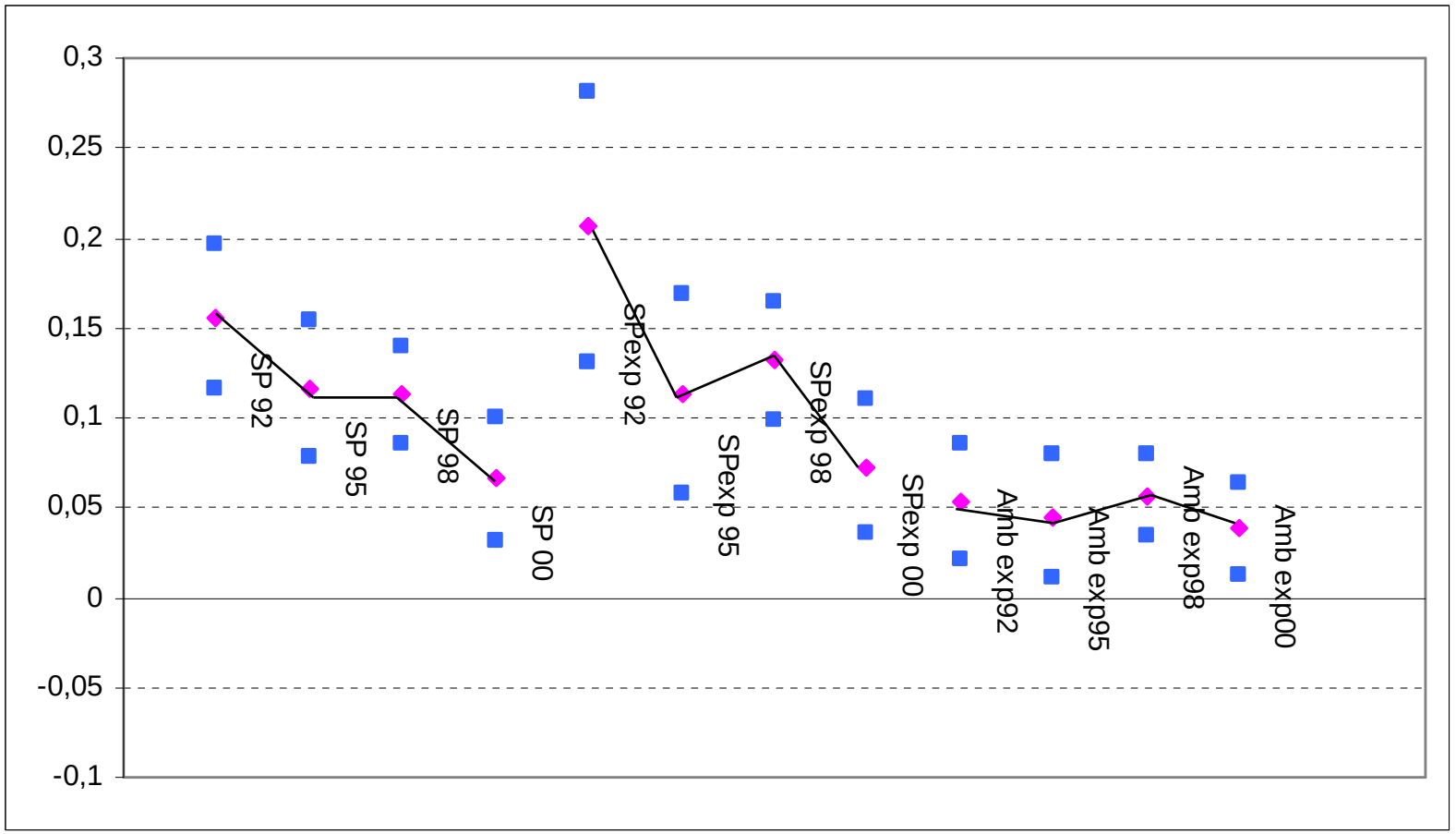
€21 = €14 socially reimbursed + €7 reimbursed by the complementary insurance or out of pocket

Non socially reimbursed around 3% of income

System (1)

- Regulated through financial demand side only = Copayment + Upfront
- Efficient ?
- Impact on equity
  - no real inequality in GP utilization
  - Documented Income inequalities in Specialist use
  - Some discrimination in access to Specialist care for those benefiting from means tested complementary insurance (refusals)

Income inequalities in ambulatory care in the 90's



Challenges to the system

- France
  - Ageing
  - Increasing expenditure
  - Access to Specialist care for the working poor
  - Health Human resources shortage (?)
  - Tackling Social health Inequalities (?)
  - Capacity to undertake reforms
- Canada
  - Ageing
  - Increasing expenditure
  - Waiting times
  - Health Human resources shortage
  - Tackling Social health Inequalities

The preferred doctor reform

From Hidden to lost agenda

The core elements

- A gate keeper
- Coordinated Health care pathway
- Patient medical electronic record
- An exhaustive centralized information system
- A touch of capitation …

Declared objectives

- Regulating unnecessary access to specialist
- Better quality of care through enhanced care coordination
- Medical Expenses Containment

But which implied in fact

- Higher cost sharing for the patients
- Increased fees of the specialties which "lost" direct access
- The specialist keeps the power to decide if the patient is or is not complying with the pathway

What happens

- No PD or direct access
  - Rate of reimbursement reduced from 70% to 60%
  - Supplemental fee = 17,5% more (max)
- PD
  - Rate of reimbursement still 70 %, but two visits instead of one

Specialist sector 1

- Before
- Direct acces :
- €30
- NR=0.3*30=€9

- After
- PD:
  - GP 0.3*21=€6
  - SP 0.3*30=€9
  - Total €15
- Direct Access
  - 0.4*30 + 0.175*30
  - Total €17

How much do I pay ?

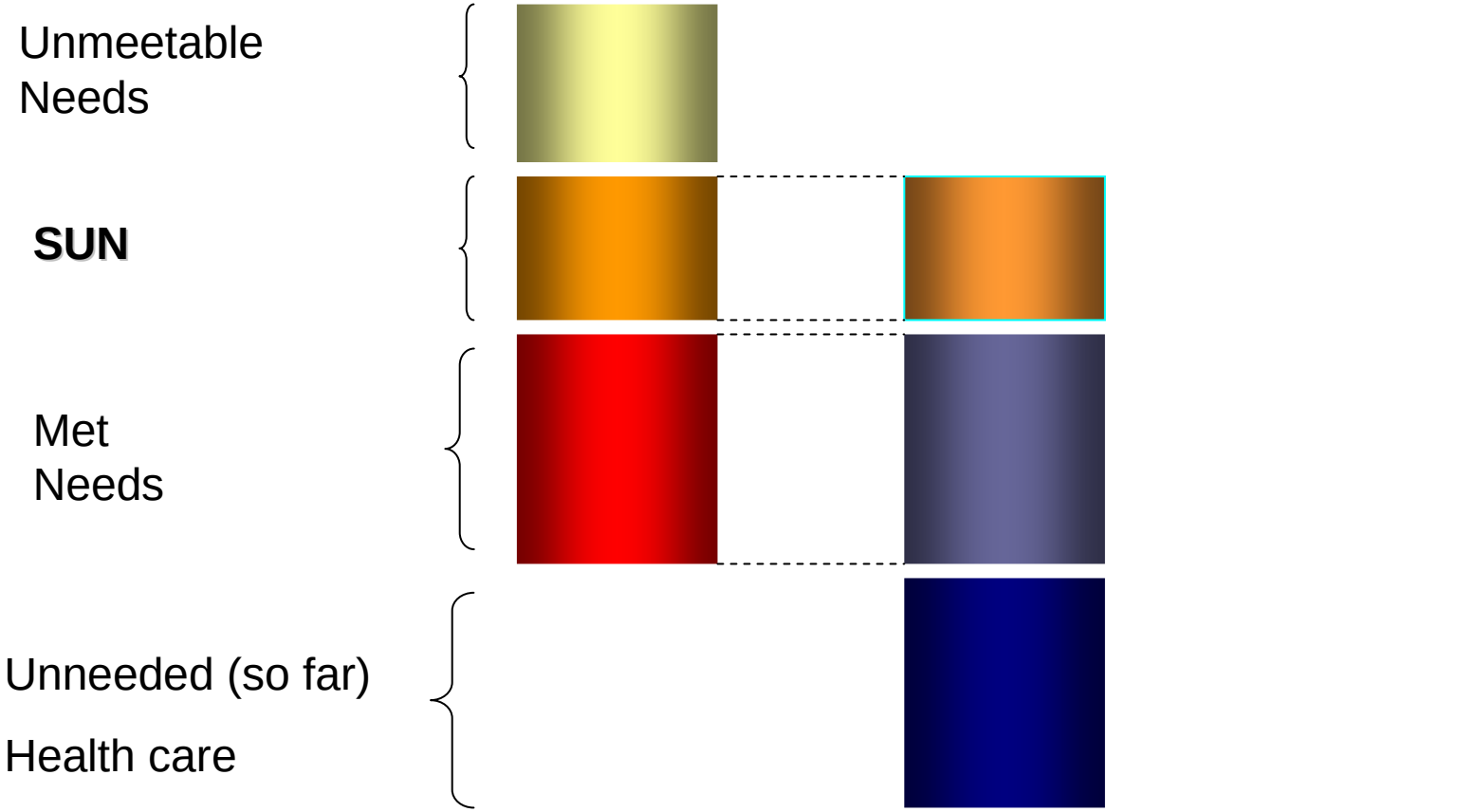
- a complex set of rules
- And the specialist decides *in fine*

Evaluating the PD reform

- Raises specific questions of policy evaluation:

1. What is the aim of the reform ?
2. How to disentangle with concomitant changes in the system ?
3. Use of specific questions more than usual data on access

Self Assessed unmet needs (SUN) : a confrontation between need and expectancies



SUN in the literature

- What we know about SUN
  - Positively associated with
    - Gender=female
    - Education
  - Negatively associated with:
    - Age
    - Having an insurance
    - Income
  - Inconclusive:
    - Minority
- Multivariate analysis of SUN in 2002, 2004, 2006

DATA

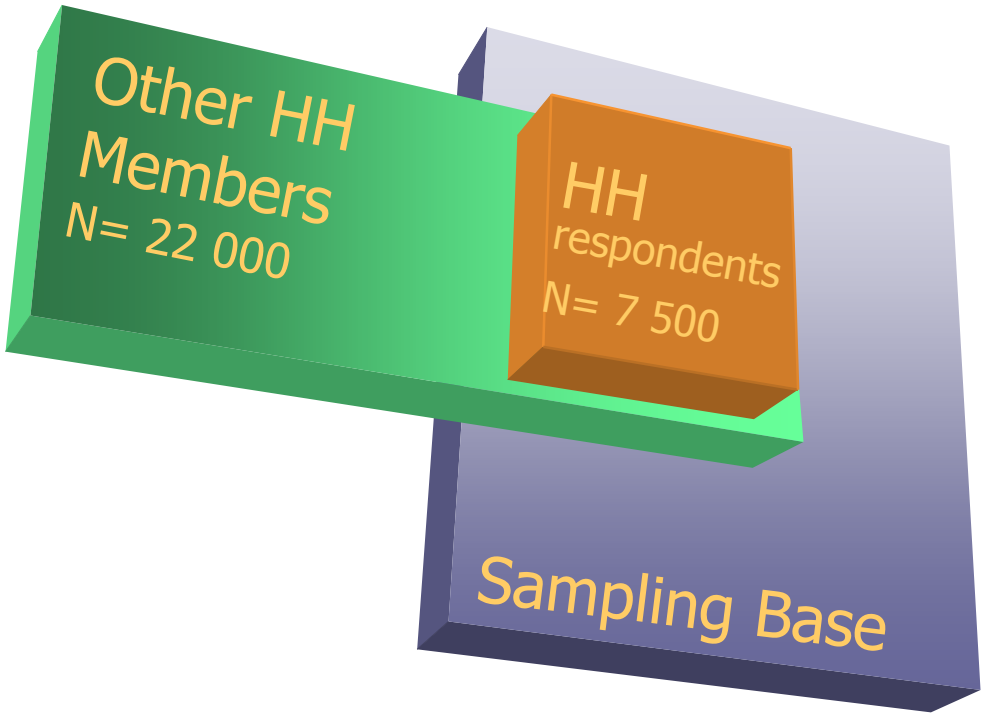
The Survey

How to address SUN ?

The Health, Health Care and Insurance Survey ESPS

- A general population survey
- Every two years since 1988
- A Panel, drawn from the main sickness funds
- Representative of more than 96% of French population (except overseas)

ESPS 2006: The data we use



SUN questions (1)

- The usual SUN question:

« During the past 12 months, was there ever a time when you felt you needed health care but gave up on it for economic reasons?"

- Yes

"On what type of health care did you give up?"
… *open question* "Specialist Visit"

SUN questions (2)

- The PD SUN question:

Since July 2005, Public Health Insurance promotes the choice of a PD by the insured. The PD role is to follow and orient patient in the health system, especially toward specialists

Since the reform, was there ever a time when you gave up on consulting a specialist ?

- Yes
- No
- No need of specialist since reform took place

SUN questions (3)

Among the following reasons, which are those that led you to renounce to consult a specialist?

(non exclusive items)

- 1. **You did not have the money to seek specialist care**
- 2. It was too difficult to have to go first to your preferred doctor first to access specialist
- 3. **You wanted to access directly to the specialist but it had become too expensive**
- 4. You did not have the time for Professional or familial reasons
- 5. You feared visiting the doctor, having to do exams, to take treatment
- 6. You did not know any good doctor
- 7. For other reasons ; please explain …
- 8. don't know
- 9. refusal

SUN questions (4)

SUN general question

- Any type of care = 14,3%
- Specialist care = 3,2%

SUN PD question

- Any reason = 5,3%
- Financial reason =2,7%

Sample representativity (1)

Raw Sample

- Gender:
  - Women=59%
  - Men=41%
- Age:
  - 18-39=34%
  - 40-64=47%
  - 65+=19%
- HH size
  - Single=13%
  - More=87%

Weighted Sample

- Gender:
  - Women=52%
  - Men=48%
- Age:
  - 18-39=37%
  - 40-64=45%
  - 65+=18%
- HH size
  - Single=13%
  - More=87%

Sample representativity (2)

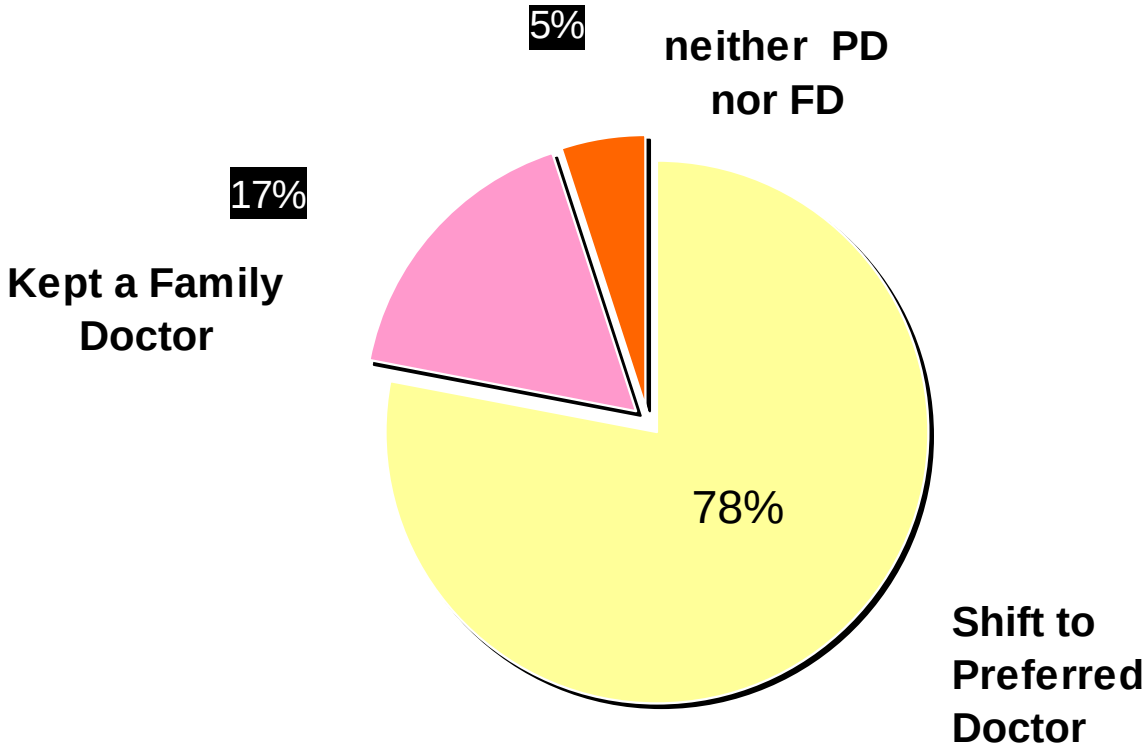
Comparison between hh respondants and other adults from the individual sample

- No SAH difference controlled by age, gender and SAH, number of visits

A few results on the implementation

- 8 of 10 insured had contracted with a PD by mid 2006 with diverse motivations:
  - 80% think the PD is mandatory
  - 44% not to be financially harmed
  - 30 % to help the sickness funds to save money
  - 16 % think PD will improve quality of care provided to them
- For 8/10 insured, the PD replaced the family doctor informal scheme

A substitution with the former informal Family Doctor



The model

- SUN = f(Age, Gender, SAH, Education, Income, Insurance Status, HH size, PD)

Variables distributions (1)

- PD SUN : 2.7 %
- Gender: female 59%
- Age :
  - 20-39: 34%
  - 40-64: 47%
  - 65-79: 14%
  - 80+: 5%
- SAH = average, poor, very poor: 25%
- PD: 89%
- Insurance Status:
  - Pro poor Complementary Insurance Plan: 7.5%
  - Private Insurance:85.5%
  - No Complementary insurance: 7%
  - Cost sharing Exoneration: 17%
- N=1276

Variables distributions (2)

- Income per consumption unit
  - refusal:14%
  - Income quintiles: 17% per category
- Education:
  - None:2%
  - Primary school:18%
  - School:34%
  - High school:17%
  - University degree:29%
  - Other, no response: negligible

An additional cost sharing impact

Effect	Point Estimate	
Gender :female	2.107	**<.0001**
age40_64	1.139	0.4414
age65_79	0.396	**0.0058**
age80	0.182	**0.0070**
No complementary ins.	2.135	**0.0008**
Public pro poor complementary ins.	0.335	**0.0054**
Exoneration from copayment for long term illness	0.816	0.3650
Income : refusal	0.821	0.4589
Income : 2nd quintile	1.057	0.8137
Income : 3rd quintile	0.736	0.2409
Income : 4th quintile	0.701	0.1872
Income : 5th quintile	0.537	**0.0327**
Education : none	1.277	0.6259
Education secondary school	0.667	0.1142
Education high school	0.835	0.4119
Education : university degree	1.009	0.9642
sah_poor	1.634	**0.0093**
sah_nonresp	1.531	**0.0576**
PD	1.362	0.2265

Satisfying results based on unsatisfying data

- Quasi separation of those who said they gave up on SP care since the reform and those whop renounced for SP care for economic reasons in the past 12 months
- But look alike: structurally linked to the same variables

	SUN specialist=yes	SUN specialist=no	Total
PD SUN= yes	23%	77%	100%
PD SUN=no	2%	98%	100%

Some hints but no clear image

- Those who tend to give aberrant tend to be:
  - older
  - More often women
  - Non respondent to SAH