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Republic of Germany,
and United States,
1981-83

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Data are presented comparing ambulatory medical care in France, Republic of Germany, and United States. Analysis focuses on office-based ambulatory care provided by general practice physicians and selected medical specialists. Data were derived from independent sample surveys conducted in the three countries. Survey methods and the characteristics of the health services systems are also described and compared.

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Preface

Historically, the provision of medical care has been associated with institutions: alms houses, rest homes, and, more recently, hospitals. The hospital sector has come to dominate the health services systems of all developed countries and most developing countries. As efficacious treatments and preventive measures emerged, ambulatory care, particularly at the earliest stages of the natural history of disease, became a practical alternative to hospital care and expanded rapidly. More and more patients took their health problems, and even their social problems, to physicians at earlier stages. Today the great bulk of medical care throughout the world is given in ambulatory settings.

Accompanying the advent of unequivocally useful treatments was a proliferation of diagnostic and other therapeutic maneuvers, many of which now, as in the past, are of dubious benefit. This proliferation was largely confined to hospital inpatient care which, as it expanded in size, scope, and specialization, consumed an ever greater proportion of health services expenditures. The imbalances between the hospital and ambulatory sectors, between general and specialty care, between early and late treatment, between prevention and palliation all contributed to escalating costs and growing public disenchantment with the management of health services systems. Above all came the recognition that the first physician to see the patient is the principal arbiter of how the patient's problem is to be managed and, consequently, of how much is to be spent. The decision to continue treating the patient's problem on an ambulatory basis or to have the patient admitted to a hospital, especially for care by a specialist or super-specialist, is critical for the nature and quality of the care and for the total costs.

In most countries (France is an exception), specialists tend to prefer inpatient hospital care; general practitioners and family physicians tend to choose ambulatory care settings in their own offices or in health centers, clinics, or outpatient departments of hospitals. In some countries there are statutory or professional limitations on who can practice where. The ratios and mixes of physicians, equipment, and facilities vary widely within and among countries.

What, then, should be the optimum balance between general and specialty care, among specialists of different types, between ambulatory and inpatient hospital care and among hospitals of different types, and between prevention and treatment? One approach to resolving these issues is to generate better information about the characteristics of health services systems, their activities, and, eventually, their relative outcomes or benefits. For the most part, countries have emphasized

vital statistics as the basis for understanding their health problems and health services. A few countries have started to develop statistics on hospital activities, and a still smaller number are generating data about ambulatory care. Although international comparisons of vital statistics have been conducted for decades, and a few comparisons of hospital care have been undertaken, there have been virtually no organized international comparisons of ambulatory care. Accordingly, this initial descriptive analysis of ambulatory care statistics from three western industrialized countries was undertaken to assess the dimensions of the similarities and differences and to stimulate further study.

A larger prospective study involving more countries, larger samples, and identical data collection methods for core minimum data sets eventually may be desirable, but this exploratory study seemed a reasonable beginning. The participants in the study share common concerns about the overall problems addressed, as well as expertise about the statistical, operational, and clinical aspects of the data sets compared. From larger universes of physicians and of patient encounter data from the three countries, subsets of essentially comparable physician groups and patient encounter data were selected for common analysis. The latter was limited to office-based, face-to-face encounters that constitute the major component of ambulatory care in all three countries. It is this component of care that offers the major alternative to inpatient hospital care and, hence, presents the greatest opportunity for prevention, early treatment, and containment of health services costs.

The emphasis on the data selection process was on functional equivalence and realistic comparability, rather than on excessive precision with respect to classifications, working arrangements, clinical traditions, and reimbursement schemes. The comparisons are based on best estimates augmented where possible by standard errors; they are designed more to illustrate relationships and orders of magnitude than to measure exact differences. This study was not designed to suggest that one pattern of resources, organization, or reimbursement is better or worse than another. The main purpose is to suggest where the search might be started for creating health information systems designed to assist in organizing balanced health services arrangements that can provide equitable access to efficacious services, which will improve health status and will moderate costs.

Kerr L. White, M.D.

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Symbols

- - - Data not available
 - . . . Category not applicable
 - Quantity zero
 - 0.0 Quantity more than zero but less than 0.05
 - Z Quantity more than zero but less than 500 where numbers are rounded to thousands
 - * Figure does not meet standard of reliability or precision (more than 30 percent relative standard error)
 - # Figure suppressed to comply with confidentiality requirements
-

Ambulatory Care: France, Federal Republic of Germany, and United States

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Summary

This study describes the results of a comparison of ambulatory medical care data for France, the Federal Republic of Germany (FRG), and the United States of America (U.S.). Data for this comparison were derived from independent national sample surveys in ambulatory care systems of the three countries in 1981–83. The French data set resulted from a sample of physicians who had been asked to document all patient-physician contacts for a specified 3-day period during 1982–83. The FRG survey of patient-physician contacts was performed in the fourth quarter of 1981 and the first quarter of 1982. Sample physicians reported for a sample of patient-physician contacts during two consecutive weekdays, the reporting periods being spread across the two calendar quarters in a balanced fashion. Survey physicians had been drawn at random from almost all ambulatory care specialties. U.S. survey data were obtained through a random sample of physicians reporting for a sample of their patient-physician contacts for a whole week, with the reporting weeks being spread across the whole year of 1981. Because regular office hours generally do not take place on weekends, Sundays were excluded in the French survey; in the FRG survey Saturdays and Sundays were excluded as reporting days. Although the French and the U.S.

study universes consisted of almost all physicians practicing ambulatory medical care in the respective countries, the FRG physicians were drawn from five regions of the country systematically selected to represent the Federal Republic of Germany with respect to demographic population characteristics and physician specialty distribution. The universes of physicians and patient-physician encounters of the three national studies varied according to the ambulatory medical care systems of the respective countries.

Data sets for this international comparison were derived from the respective national studies by selecting personal patient-physician contacts (in the physician's office or in the patient's home—referred to as "encounters") with eight physician specialties (general practitioners, pediatricians, obstetricians/gynecologists, internists, psychiatrists/neurologists, dermatologists, ophthalmologists, and otorhinolaryngologists). Patient variables used in the international comparison are patient age, sex, visit status, reason for encounter, and disposition. Yearly rates of personal patient-physician encounters in ambulatory medical care were estimated. Crude and age-sex standardized rates were computed for selected patient and physician characteristics.

Selected results

All three countries are among the group of western industrialized nations with high gross national products per capita (above U.S. \$10,000 per year), moderate economic growth (2–4 percent), and relatively low unemployment rates (range: 4.4 percent for the Federal Republic of Germany to 7.5 percent for the United States in 1981).

The health services systems of the three countries are described by the following structural and access characteristics:

- Higher physician per population ratios in the two European countries compared with the United States
- Higher proportions of physicians in ambulatory care among all practicing physicians in France and the United States compared with the Federal Republic of Germany
- Higher hospital bed ratios per 1,000 population in the Federal Republic of Germany than in the other two countries
- Higher specialist to generalist ratios in ambulatory care in the United States compared with the European countries
- The majority of the French and German populations being covered by comprehensive health insurance, compared with 80 percent of the U.S. population with coverage mostly for hospital care.
- The patients' paying a varying proportion of the ambulatory medical care bill out of pocket (in the United States, 30 percent; in France, 20–25 percent; and in the Federal Republic of Germany, less than 10 percent on the average of the ambulatory medical care bill)

Characteristics of the ambulatory medical care systems are as follows:

- Free choice of physicians for patients in ambulatory medical care in the three countries
- Independent, self-employed, office-based physicians as the major providers of care
- Ambulatory care mostly delivered in office settings, even though in all three systems ambulatory care physicians are permitted to supervise patients in hospitals
- Physicians being remunerated on a fee-for-service basis, with the fee schedules either being freely set or negotiated between carrier and physicians

With respect to direct encounters between patients and physicians in ambulatory care it is observed that annual age-sex standardized rates of personal patient-physician encounters per person ranged from 10.4 (Federal Republic of Germany) to 6.8 (France) to 2.7 (United States). All three countries

report relatively high proportions of total direct physician encounters as being associated with the eight study physician specialty groups (88 percent for France, 92 percent for the Federal Republic of Germany, and 81 percent for the United States). Ambulatory physician densities do not explain the observed variability in rates because they are highest in France, intermediate in the United States, and lowest for the Federal Republic of Germany. One explanation for the relatively high FRG encounter rates may be the higher frequency of physicians' recommendations to their patients to return (more than 50 percent of encounters) and relatively high referral rates (7.5 percent of encounters).

Almost two-thirds of personal patient-physician encounters in ambulatory medical care in France are accounted for by generalists. This compares with a little more than 50 percent in the Federal Republic of Germany and less than one-third in the United States. Therefore, the degree of generalist responsibility for total ambulatory care is highest in France, intermediate in the Federal Republic of Germany, and lowest in the United States. However, this international study did not examine the content of care delivered in a typical ambulatory care contact of each of the three countries. Such comparisons might provide explanations for the different encounter volumes observed or might determine whether there is possible substitution of high encounter rates combined with short contact times by lower encounter rates combined with longer contact times.

In the framework of this international comparison, it is of interest to examine whether the different levels of personal patient-physician encounter rates per population of the three countries were related to similar relative distributions across patient or physician characteristics. It was hypothesized that observing similar distributions of encounters by patient characteristics might be interpreted as suggesting similar need distributions of patients seeking ambulatory care across countries.

Examining rates of encounters by patient age and sex yields almost identical distributions for the three countries though at different levels of magnitude. Furthermore, when examining diagnostic entries by major International Classification of Diseases (ICD) category and selected specific medical diagnoses, it is found that these distributions also agree fairly well. Thus, despite substantial differences in the overall level of use of ambulatory medical care services in the three countries, the relative distributions of encounters agree by patient age and diagnostic category of patient reason for contact. Estimates of Pearson-product moment correlation coefficients among the relative frequencies of the first 17 major ICD diag-

nostic categories confirm this finding:

<i>Country</i>	<i>Pearson-product moment correlation coefficients</i>	
	<i>Federal Republic of Germany</i>	<i>United States</i>
France	0.80	0.78
Federal Republic of Germany	0.86

Even though personal patient-physician encounter rates among the three countries are related as 1:2.4:4 (United States:France:Federal Republic of Germany), the relative distributions of these encounters among diagnostic categories and patient age agree relatively well. However, the responsibility of physician specialty groups for these encounters varies among countries. Because this international comparison did not investigate the

severity of morbidity presented in the course of encounters between patients and their physicians, it is uncertain whether conditions treated in ambulatory care settings of the United States (a country with a low encounter rate) are more severe on the average than those in the two European countries.

The study results are of interest because they seem to suggest that similar encounter distributions by patient demographic and illness characteristics may be the result of similar morbidity distributions in the three countries' populations despite substantial differences in the respective health services systems characteristics.

On the basis of the results of this study, it may be concluded that patient demographic and morbidity characteristics are more important in determining the structure of encounters in ambulatory care (shape of relative distributions), while health services systems characteristics appear to be more important in determining the volume of services delivered.

Introduction

The data presented in this report are derived from surveys conducted in France, the Federal Republic of Germany (FRG), and the United States of America (U.S.).

The French data are from the *Enquête Morbidité et Thérapeutique Médicale* (Survey of Morbidity and Medical Care) conducted by the Centre de Recherche d'Étude et de Documentation en Économie de la Santé (1981) (Health Economy Research Study and Documentation Center, formerly the Division d'Économie Médicale du Centre de Recherche pour l'Étude et l'Observation des Conditions de Vie). The FRG data were collected by the Zentralinstitut für die kassenärztliche Versorgung in der Bundesrepublik Deutschland (1988) (Central Research Institute of Health Insurance Physicians) in its survey entitled *Erhebung über die Versorgung im ambulanten Sektor durch niedergelassene Ärzte* (Survey Among Ambulatory Care Physicians). The U.S. data come from the National Ambulatory Medical Care Survey (NCHS, 1983a) conducted by the National Center for Health Statistics.

The surveys were conducted independently in each country. The agency responsible for each survey developed its design and materials taking into consideration its particular data needs, health services system, available resources, and relationship with its medical community. As a result, the survey designs varied among the three countries, and each survey included data items, terms, and design features not found in the others. There are, however, many aspects of the designs and data

items that are common to the three surveys and that enable selective comparisons to be made concerning ambulatory medical care in the three countries. As a consequence, the principal participants from each of the surveys have collaborated to develop and analyze a limited but informative common set of ambulatory medical care data for France, the Federal Republic of Germany, and the United States. The results of that effort are presented in chapter 3 of this report.

In chapter 1, a summary comparison of the health services systems in the three countries is presented, and significant economic and social factors affecting the use of health services are described. Differences and similarities that have a direct bearing on the data used in the analysis are discussed.

In chapter 2, the methods, definitions, and instruments for each of the three surveys are described and compared. In addition, the manipulations and adjustments needed to derive comparable data from the three surveys are explained. An understanding of this information is necessary for proper interpretation of the data presented in the results section. The data analysis and results are presented in chapter 3 and in detailed tabulations after chapter 3.

Survey instruments for all three surveys are displayed in appendix I, including English translations of the French and FRG forms. Reference population figures are provided in appendix II.

Chapter 1

Health services systems in France, the Federal Republic of Germany, and the United States

In France, the Federal Republic of Germany (FRG), and the United States (U.S.) the behavior of the different factors in the health services system depends on general demographic and economic characteristics of the population as well as on the organization, financing, and structure of health services. The relative importance of each of these factors has not yet been measured definitively. However, each must be taken into account in any comparative study. In this report, where ambulatory medical care services provided in France, the Federal Republic of Germany, and the United States are compared, it is clear that understanding the comparative analysis requires an understanding of related information for the three countries. For example, information must be available on such factors as the age structure of the population; the respective roles of hospital-based and office-based physicians, physicians in salaried practice, and physicians in fee-for-service practice; and the scope of medical services provided by generalists and specialists.

In this chapter, the common characteristics and the main differences among these three countries are reviewed briefly.

Demography, health status, and economic indicators

France, the Federal Republic of Germany, and the United States are all western democracies that share a common cultural heritage and societal values; all three rank among the most industrialized countries in the world. Despite these general similarities, closer examination reveals important demographic and economic differences.

Estimated in 1981 at nearly 224 million people, the population of the United States is roughly four times larger than that of either of the two European countries (France, 54 million; the Federal Republic of Germany, 62 million). Other differences in demographic characteristics that influence the provision of health services are the geographic distribution and the age structure of the population (table A).

- In the United States, where the population density of 25 persons per square kilometer is very low, easy access to health services facilities for everyone tends to be more difficult to achieve than in the European countries where there are much higher population densities (France, 98 persons per square kilometer; the Federal Republic of Germany, 248 persons per square kilometer).

- It is well known that morbidity increases rapidly with age after 50 years; therefore, medical needs are probably greater in the Federal Republic of Germany where the proportion of population aged 65 years and over (15.2 percent) is higher than in France (13.5 percent) or the United States (11.1 percent).
- Two major demographic changes during the past decade have probably exerted opposite effects on the growth of the health care services field. First, the slowdown in the rate of population growth that took place in all three countries could have acted to moderate utilization; but, on the other hand, the growth of the elderly portion of the population has certainly been a factor tending to increase health services utilization.

Not enough relevant indicators exist to allow a global comparison of the health status of the three populations. However, in 1981 the commonly cited mortality indicators show that France had the lowest infant mortality rate, 9.7 deaths per 1,000 live births, compared with 11.6 in the Federal Republic of Germany and 11.9 in the United States. The ranking of the countries according to life expectancies varies according to the age or sex considered (table A).

Some quantitative parameters provide general insight into the economic situation in each country. A comparison of gross national product (GNP) per capita, expressed in U.S. dollars or in purchasing power parity, shows that U.S. residents are more affluent than their European counterparts. In 1981, the GNP per capita in the United States (\$12,647) was 14 percent higher than in the Federal Republic of Germany (\$11,076 (in U.S. dollars) and 20 percent higher than in France (\$10,552 (in U.S. dollars)) (Organization for Economic Co-Operation and Development, 1985).

Despite the oil crisis of 1973, all three countries have experienced economic growth characterized by an average annual rate of increase in the GNP per capita of 3.5 percent in the Federal Republic of Germany, 3.2 percent in France, and 3.4 percent in the United States (1975–1980). However, in recent years unemployment has increasingly become a major concern in all three countries. In 1981, the percent of unemployed adults among the civilian active population was 5.5 percent in the Federal Republic of Germany, 7.3 percent in France, and 7.5 percent in the United States.

These general economic difficulties, which tend to limit

Table A. Selected demographic data: France, the Federal Republic of Germany, and the United States, 1981

Characteristic	Country		
	France	Federal Republic of Germany	United States
	Number		
Population:			
Total in thousands.....	53,966	61,713	223,688
Per square kilometer.....	98	248	25
	Percent		
Average annual increase, 1970–80.....	0.56	0.11	1.05
	Percent distribution		
Age structure:			
All ages.....	100.0	100.0	100.0
Under 15 years.....	21.9	17.2	22.7
15–44 years.....	43.1	44.8	46.5
45–64 years.....	21.4	22.8	19.7
65 years and over.....	13.5	15.2	11.1
	Percent female		
Sex structure:			
All ages.....	51.3	52.2	51.7
Under 15 years.....	48.8	48.7	48.9
15–44 years.....	49.5	48.6	51.1
45–64 years.....	51.2	53.6	52.6
65 years and over.....	61.3	64.7	59.1
	Number per 1,000 population		
Birth rate.....	14.9	10.1	15.8
Crude mortality rate.....	10.3	11.0	8.6
	Number per 1,000 live births		
Infant mortality rate.....	9.7	11.6	11.9
	Life expectancy		
	Years		
Male:			
At birth.....	70.4	70.5	70.4
At age 40 years.....	33.4	33.2	33.9
At age 60 years.....	17.3	16.6	17.5
Female:			
At birth.....	78.5	77.1	77.9
At age 40 years.....	40.4	38.9	40.1
At age 60 years.....	22.3	20.9	22.5

SOURCES: France: Institut National de la Statistique et des Études Économiques, D Q Chi and N. Guignon. 1982. La situation démographique en 1981. *Les Collections de l'INSEE. Série D, No. 94.* Paris. Institut National de la Statistique et des Études Économiques, B. Faure. 1985. La situation démographique en 1983—Mouvement de la population. *Les Collections de l'INSEE. Série D, No. 109.* Paris.

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United States: U.S. Bureau of the Census. *Statistical Abstract of the United States—1981.* 1981. 105th Edition. Washington: U.S. Government Printing Office.

the level of financial resources available for health services, combined with the rapid rise of health services costs in the three countries, have confronted policymakers with the problem of finding more efficient means of financing and providing care.

Health services systems

During the past 30 years, the health services systems of France, the Federal Republic of Germany, and the United States have developed at a rapid pace. In all three countries a broad array of services is available to the population, and dif-

ferent health insurance systems have been introduced to facilitate financial access to health services. Despite fundamental similarities, the health services system in each country has unique characteristics with respect to size, composition and organization of resources, patterns of use, and flow of funds.

Health services resources

Personnel constitutes a major component of the resources used to produce health services. The three countries do not gather data on the same personnel categories, or on the same institutions. Therefore, comparisons of the total number of persons employed in the health sector can lead to erroneous conclusions. When analysis is restricted to physicians (table B),

Table B. Number and rate per 100,000 population of active physicians in patient care, by type of practice and physician specialty: France, the Federal Republic of Germany, and the United States, 1981

Type of physician practice and specialty	Country		
	France	Federal Republic of Germany	United States
	Number		
Patient care	108,054	144,224	389,369
General practitioners.....	66,024	75,936	58,897
Specialists	42,030	68,288	330,472
Office-based practice	73,295	60,652	288,038
General practitioners.....	45,206	26,793	49,947
Specialists	28,089	33,859	238,091
	Number per 100,000 population		
Patient care	201	234	174
General practitioners.....	123	123	26
Specialists	78	111	148
Office-based practice	136	98	129
General practitioners.....	84	43	22
Specialists	52	55	106

NOTE: "Office-based practice" corresponds to "médecins libéraux." Those physicians may have this practice on a full-time or part-time basis.

SOURCES: France: Les professions de santé et d'action sociale. Situation au 1/1/83. Evolution entre 1971 et 1983. SOLIDARITÉ-SANTÉ Etudes Statistiques Nos. 5-6, 1984.

Federal Republic of Germany: *Statistik der Bundesärztekammer. Tätigkeitsbericht 1982.* Table 3, pp. 19 and 20.

United States: Department of Physician Data Services. 1983. *Physician Characteristics and Distribution in the U.S., 1982 Edition.* American Medical Association. Chicago: Division of Survey and Data Resources.

the following relationships may be seen:

- The physician-to-population ratio is higher in the two European countries (more than 200 physicians in patient care per 100,000 population) than in the United States (174 in 1981); but in each country, regional and urban-rural differences continue to exist.
- The specialist-to-general-practitioner ratio was much higher in the United States where pediatricians and internists also deliver services that in France are mainly delivered by general practitioners.
- The ratio of office-based physicians to total physicians in patient care was higher in the United States (0.74) and in France (0.68) than in the Federal Republic of Germany (0.42); this is in accordance with the Federal Republic of Germany's relatively strict division between physicians in the ambulatory and the inpatient sectors.

In all three countries the hospital sector mainly serves inpatients and includes general as well as specialized hospitals (psychiatric, for example). The number of beds available per 1,000 inhabitants appears to be higher in the Federal Republic of Germany (11.3) and in France (10.6) than in the United States (6.0); however, when nursing home beds in the United States are included in the comparison, the differences between the ratios of institutional beds to population in the United States and the European countries narrow. Hospitals also provide care to ambulatory patients, though much more often in the United States than in France and in the Federal Republic of Germany.

The rates of admissions to general short-term hospitals per 1,000 population are very similar in the three countries: 157 in the Federal Republic of Germany (Bundesministerium für Jugend, Familie und Gesundheit, 1985), 166 in France (Min-

istere des Affaires Sociales et de la Solidarité National, 1982-83), and 169 in the United States (U.S. Bureau of the Census, 1981), but the length of stay is longer in the two European countries (14.7 days in the Federal Republic of Germany, 13.2 days in France, and 7.9 days in the United States). Thus, the average number of days per hospital episode spent in general hospitals is higher in the European countries.

Health insurance

The major health services difference between the United States and the two European countries is that in France and the Federal Republic of Germany virtually the entire population (99 percent in France and 92 percent in the Federal Republic of Germany) is covered by compulsory health insurance; in the United States only a relatively small part (about 20 percent) of the population is covered by the two major public programs: Medicare for persons aged 65 years and over and the disabled, and Medicaid for individuals and families with incomes below specified levels. The rest of the population may subscribe to a nonprofit (Blue Cross/Blue Shield) or a for-profit commercial insurance plan to get some financial coverage for their health care expenditures. Nongovernmental health insurance plans covered about 80 percent of the total civilian population in 1981; much of this insurance, however, is primarily for inpatient hospital care and includes significant deductibles and copayments for ambulatory care.

In each country, the contributions of the insurance plans to the medical care expenses vary according to the type of care. Generally speaking, hospital care is better covered than ambulatory care or drugs.

- In the U.S. system, nearly all plans require that the patient pay some part of the cost through the practice of annual

deductibles and copayment. However, the variety of situations ranges from total coverage (for example, Medicaid hospital patients) to total patient payment without reimbursement (generally the case for nonprescribed drugs).

- In France the patient generally pays the provider directly and afterward seeks reimbursement for a part of his expenses. The copayment rate varies according to the type of care (25 percent for ambulatory care, 20 percent for hospitalization). However, there are many exceptions to the rule. For most hospital care the patient does not pay at all and in other special cases the copayment is waived.
- In the Federal Republic of Germany, except in the case of most prescribed drugs for which the patient bears a minor part of the cost, the users of services generally do not pay the provider (physicians, hospitals, and so forth) directly out of pocket nor do they know the cost of the care they receive because providers are paid directly by the health insurance fund.

Health expenditures

The distribution of health expenditures by type of care and source of funds in the three countries is influenced by different health insurance programs, the percents of the population covered by them, and the mix of services used.

To compare health expenditures among the three countries, it is essential to make sure that the health expenditure data to be compared cover the same array of services. Therefore, the definition adopted by the Organization for European Community Development for the evaluation of total health expenditures (Organization for Economic Co-Operation and Development, 1985) (table C) has been used. From these estimates it can be seen that the share of health expenditures in the GNP was higher in the United States (9.7 percent in 1981) than in France (8.9 percent) and in the Federal Republic of Germany (8.3 percent).

To compare the average per capita expenditure for health services, exchange rates or purchasing power parities can be

used. In both cases, the per capita expenses in the United States appear to be higher than in the two European countries.

Although comparing the structure of expenses by source of financing cannot be done precisely because financing mechanisms vary, the Organization for Economic Co-Operation and Development (1985) indicates that the share of health expenditures financed by the public sector in 1981 was much higher in the Federal Republic of Germany (69.8 percent) and France (71.8 percent) than in the United States (49.6 percent). Direct payments by the consumers represent a larger share of the personal health expenditures in the United States (32 percent) (Health Care Financing Administration, 1982) than in France (Centre de Recherche d'Étude et de Documentation en Économie de la Santé, 1986) (21 percent) and the Federal Republic of Germany (10 percent) (Bundesministerium für Jugend, Familie und Gesundheit, 1983).

Characteristics of ambulatory care systems

In the case of general practitioners as well as specialists, the great majority of patients in the three countries enjoy free choice of physicians for ambulatory care, and most medical services are provided to ambulatory patients by independent, self-employed, office-based physicians. The contribution of hospital-based or other salaried physicians to ambulatory care accounts for less than 15 percent of total visits in France and the United States and much less in the Federal Republic of Germany.

Patients of the FRG statutory health insurance scheme are required to present a voucher to the physician each quarter of the year for which they wish ambulatory care. In case of referral, a referral voucher usually is issued by the referring physician. This does not prevent the patient from going to the physician of his or her choice.

In all three countries, office-based physicians may continue to supervise patients during their hospital stays. In France, however, this possibility applies only to patients in rural hospitals and sometimes in private hospitals. In the United States, it applies to physicians with hospital privileges, held by most

Table C. Total and per capita health expenditures: France, the Federal Republic of Germany, and the United States, 1981

Expenditure	Country		
	France	Federal Republic of Germany	United States
Total health expenditure			
10 ⁶ national currency ¹	278,206	128,670	285,828
As a percent of GNP	8.9	8.3	9.7
Per capita health expenditure			
National currency ¹	5,155	2,086	1,243
Exchange rate dollars	949	923	1,243
Purchasing power parity dollars	883	851	1,243

¹National currency is the franc in France; the mark in the Federal Republic of Germany; and the dollar in the United States.

NOTE: GNP = gross national product.

SOURCE: Computations based on estimates of GNP and health expenditures by the Organization of European Community Development, 1985. *La Santé en Chiffres—1960–1983*. Dépenses, Coûts, Résultats. Paris: Organization of European Community Development, p.12.

physicians. In the Federal Republic of Germany, the separation between the ambulatory sector and the hospital sector is relatively strict. Very few office-based physicians in the Federal Republic of Germany have hospital privileges (about 9 percent of ambulatory care physicians). In the United States, out of a total of 45 hours per week devoted to patient care, general practitioners spend 11.2 hours in hospitals and specialists spend 16 hours. In France, activity in hospitals is less important, with 2.8 hours for general practitioners and 11.5 hours for specialists (Centre de Recherche, pour l'Étude et l'Observation des Conditions de Vie, 1983).

In all three countries, most ambulatory services provided by private office-based physicians are compensated on a fee-for-service basis. There are differences among the countries, however, in the process by which the monetary amount per unit of service is determined and in the extent of the patients' direct involvement in the physician's compensation (table D):

- In France and the Federal Republic of Germany, most physicians are constrained by fees negotiated between doctors' associations and health insurance funds; in the United States, in general, physicians are free to set their fees on a procedure-by-procedure basis subject only to the limit imposed by market forces.
- In France and the Federal Republic of Germany, remuneration of physicians is based on fee schedules and relative value scales. In the Federal Republic of Germany, the Official Schedule (GOA) and the Substitute-Health-Insurance-Fund Schedule of Medical Fees (E-GO) contain monetary fees, whereas the Assessment-Schedule of Statutory-Fund Medical Services (BMA) is a point-rating schedule. In the BMA and the fee schedule used in France, the prices of medical procedures are determined by two components: the relative value scale (number of points (*Punkte*) in the Federal Republic of Germany, or *lettres* in France) on the fee schedule and the value of the basic unit. In the Federal Republic of Germany a service such as a blood pressure measurement is associated with a fixed number of basic units (points). Over time the monetary value of the basic unit is moved up and down more often than the fee schedule is changed. In the United States, although they may choose to use one of the existing

relative value scales, generally the physicians are free to fix the price of their services.

- In the Federal Republic of Germany, for services provided to the members of the statutory health funds, the physicians are paid directly by their organization, which acts as an intermediary between the health insurance funds and the physicians; thus the patient does not know the cost of the treatment received. In the United States and in France, the general situation is quite different: not only does the patient usually pay the physician when the services are received, but the patient also has to bear a copayment amount because reimbursement from insurance generally does not correspond to the total price of the services.

When the results of the surveys of ambulatory care in France, the Federal Republic of Germany, and the United States are compared later in this report, it may be useful to refer to the data presented in this short comparative summary of the health services systems in all three countries to suggest possible explanations for the observed differences or similarities among the countries.

The usefulness of this background information can be illustrated by these examples and by the questions they pose:

- It has been shown from the health services utilization household surveys in different countries that demographic, morbidity, and socioeconomic factors exert definite influences on the utilization of different types of services. It is also thought that the severity of morbidity presented to physicians could vary with these factors (Kohn and White, 1976). It will doubtless be interesting to examine the extent to which differences in the demographic, morbidity, and socioeconomic structures of France, the Federal Republic of Germany, and the United States may be considered responsible for observed differences in the volume and pattern of use of ambulatory services.
- Health services systems in different countries may differ with respect to the distribution of responsibility for patient care among the ambulatory and hospital sectors. The fact that hospital and ambulatory care sectors may be organized differently within and across countries will influence the volume and structure of encounters in each. Uncoor-

Table D. Access to physicians and payment and reimbursement mechanisms in ambulatory care: France, the Federal Republic of Germany, and the United States, 1981-83

Item	Country		
	France	Federal Republic of Germany	United States
Access to physicians	Free access to general practitioners or specialists	Free access to general practitioners or specialists; 4 vouchers/year; referral voucher	Free access to general practitioners or specialists
Compensation of physicians:			
Method	Fee for service	Fee for service	Fee for service
Fee	Negotiated	Negotiated	Market forces
Physician payment	Patient	Health insurance funds	Patient or health insurance
Patient reimbursement	Health insurance funds with copayment	Compulsory insurance with small copayment	Health insurance with deductible and copayment
Population covered (in percent)	99	92	80

NOTE: The information in this table applies to the most common occurrences, but a variety of exceptions exists in each country.

dinated ambulatory and hospital components might affect the volume and nature of services performed. Another area of difference could be the amount of high technology medical equipment located in the offices of private practicing physicians. Another might be the locale where the care of the elderly takes place: in hospitals, in nursing homes, or in ambulatory settings close to the patient's home. Such varying distributions of responsibility will be reflected in the data compared; in particular, the specific tasks of the ambulatory care sector will be affected. The sharing of responsibility between ambulatory and hospital sectors will reflect in other ways on the specific sets of observed ambulatory care data. In a country where traditional office-based ambulatory medical care is extended by home health services or support for home care of the severely ill, this will be part of the volume of services observed. On the other hand, ambulatory encounter data will vary depending on whether services such as surgical aftercare or drug dependency treatment are provided predominantly in ambulatory settings or in specialized institutional settings.

- The scope of the physician's activities as well as the physician/population ratio are factors that can influence the use of health services. It is generally agreed that increased numbers of physicians made available to a given population result in higher utilization of medical services by the

population, leading to lower output per physician (in number of patients). Can the differences in the quantity and mix of visits per physician be related to the availability of physicians and to different ratios between general practitioners and specialists?

- Physicians as well as patients face incentives related to different factors including rules for access, method of compensation for services, and nature of financial coverage by the sick funds or insurance plans. Comparison of the three national systems may be useful to test the influence of out-of-pocket payment, copayment, and free services on the behavior of physicians as producers and prescribers of diagnostic procedures and pharmaceutical goods as well as on the behavior of patients as consumers of health services. To the extent that the three countries differ with respect to the percent of the population covered for ambulatory medical services and the amount of the average medical bill covered, differences in volume and structure of services are expected.
- In social systems with much similarity in population characteristics, as in the three countries compared, and differences in ambulatory medical care systems, it is of interest to investigate the volume and nature of physician-patient encounters to better understand which factors (physician, patient, or health system) most influenced the actual encounters observed.

Chapter 2

Survey methods and analytical approach

The data presented in chapter 3 are derived from three independent surveys conducted in France, the Federal Republic of Germany (FRG), and the United States of America (U.S.). To properly understand and interpret the data analysis presented in this report, it is necessary to understand the methods and instruments of the three surveys and how they relate to one another. A summary comparison of the survey methods is shown in table E. Definitions of key terms used in this report are provided as the last section in this chapter. In the discussion that follows, the major design features of the three surveys are compared and contrasted. Emphasis is given to similarities and differences in design that may affect data comparability. A

more detailed description of each survey is available from the individual sponsors (Centre de Recherche d'Étude et de Documentation en Économie de la Santé, 1981; NCHS, 1983a; Zentralinstitut für die kassenärztliche Versorgung in der Bundesrepublik Deutschland, 1988).

It is important to note that the analysis presented in this report involves subsets of the data produced by the three original surveys. This has been necessary to develop comparable data bases for the three countries. Explanations of how these subsets are derived and how data adjustments were made to develop comparable data bases are discussed in the following sections.

Table E. Summary of ambulatory care survey methods: France, the Federal Republic of Germany, and the United States

Item	Country		
	France	Federal Republic of Germany	United States
Responsible organization	Centre de Recherche d'Étude et de Documentation en Économie de la Santé (CREDES) 1 rue Paul-Cezanne Paris, France 75008	Zentralinstitut für die kassenärztliche Versorgung in der Bundesrepublik Deutschland Herbert-Lewin Str. 5 D-5000 Köln 41 Federal Republic of Germany	U.S. Public Health Service (PHS) National Center for Health Statistics (NCHS) 3700 East-West Highway Hyattsville, Md. 20782
Study title	Enquête Morbidité et Thérapeutique Médicale	Erhebung über die Versorgung im ambulanten Sektor durch niedergelassene Ärzte	National Ambulatory Medical Care Survey
Abbreviation of study title	EMTM	EVaS	NAMCS
General type of survey	Probability sample survey of office-based physicians and their patient contacts		
Purpose	Collection of general purpose data describing the public's use of ambulatory medical care services, the characteristics of ambulatory patients, and the characteristics of physicians practicing ambulatory care for multiple applications		
Contact universe	Face-to-face patient contacts with office-based physicians in office and home settings	Face-to-face and telephone contacts with office-based physicians and their staffs in office setting	Face-to-face contacts with office-based physicians and their staffs in office setting
Physician universe	All office-based physicians except general surgeons, neurosurgeons, urologists, anesthesiologists, and radiologists	Ambulatory care, office-based physicians entitled to serve compulsory health insurance patients excluding anesthesiologists, radiologists, child psychiatrists, oral surgeons, neurosurgeons, and selected small specialties	All office-based physicians excluding radiologists, anesthesiologists, pathologists, and those employed by the Federal Government
Units of observation	Office-based physicians and patient contacts	Office-based physicians and patient contacts	Office-based physicians and patient contacts
Type of patient contact sample	Multistage, probability, cluster	Multistage, probability, cluster	Multistage, probability, cluster
Geographic coverage	Continental France	Bremen, Hessen, Pfalz, Nordbaden, and Südbaden	All States except Alaska and Hawaii
Data collection period	May 1982 through April 1983	Nov. 9 through Dec. 21, 1981, and Feb. 22 through April 2, 1982	January through December 1981
Length of physician observation	3 consecutive activity days	2 consecutive activity days (Monday through Friday)	7 consecutive days
Method of physician induction	Mail and telephone	Mail	Personal interview

Data sources—general

The French data used in this analysis are from the *Enquête Morbidité et Thérapeutique Médicale (EMTM)* conducted by the Centre de Recherche d'Étude et de Documentation en Économie de la Santé, a private, nonprofit research center. The EMTM, conducted from May 1982 through April 1983, involved a probability sample of office-based (private practice) physicians representative of the entire country of France. The sample physicians provided information for each patient encounter during an assigned 3-activity-day period. The purpose of the EMTM was to collect and analyze detailed data concerning the patients and medical practices of private physicians. The data were to serve multiple purposes and, generally, to improve the knowledge and understanding of the structure and distribution of ambulatory medical care in France.

The FRG data are from the *Erhebung über die Versorgung im ambulanten Sektor durch niedergelassene Ärzte (EVaS)* (Survey Among Ambulatory Care Physicians) conducted by the Zentralinstitut für die kassenärztliche Versorgung in der Bundesrepublik Deutschland (Central Research Institute of Health Insurance Physicians in the Federal Republic of Germany), a private, nonprofit foundation in the Federal Republic of Germany. The EVaS was conducted in the winter of 1981 and the spring of 1982, and involved a probability sample of office-based physicians in five geographic subareas of the Federal Republic of Germany. Sample physicians provided information for a systematic random sample of patient contacts during an assigned 2-activity-day period. This survey was designed to provide multipurpose data concerning the contents of ambulatory care and the diagnostic and therapeutic behavior of major groups of ambulatory medical care physicians.

The U.S. data used in this analysis are from the National Ambulatory Medical Care Survey (NAMCS) conducted by the National Center for Health Statistics of the U.S. Public Health Service, a Federal Government agency. NAMCS was conducted throughout 1981 among a probability sample of office-based physicians representative of the total United States exclusive of Alaska and Hawaii. Physicians in the sample provided information concerning a systematic random sample of patient encounters during an assigned 7-day period. The purpose of NAMCS was to provide a multipurpose data base describing the demographic and medical characteristics of patients using the services of office-based physicians.

The specific purposes of the French, FRG, and U.S. surveys are related to their individual health services systems and particular data needs. In reviewing the purposes stated by the sponsoring agency for each study, however, it is apparent that all three surveys had a common underlying purpose, namely to provide general purpose data that describe the use of ambulatory medical care services by the population and the provision and prescription of health services by physicians. This includes data describing selected demographic and medical characteristics of the patients, the nature of the medical services ordered and provided, and the characteristics of the physicians providing the services. Each survey provides data that are intended to serve multiple purposes relating to health services research, epidemiology, health care services, medical education,

and health manpower, with implications for health services planning, priority setting, resource allocation, and costs.

Sample design

The basic sample design and approach to data collection were similar for the three surveys, although the specific methods and procedures varied. The three sample designs all involved multiple stages of sample selection. Most important, all three designs had the same elementary sampling unit—an ambulatory patient encounter with a physician.

The French survey used a two-stage sample. The first stage of selection involved a stratified random sample of 1,837 physicians selected from a list of all physicians in France having a private practice, excluding radiologists and surgeons. In the second stage, patient encounters were sampled by assigning each sample physician to a 3-day reporting period (3 activity days) during the 1-year survey period—May 1982 through April 1983. Patient encounter data then were obtained for every encounter during each physician's 3-day period, a total sample of 72,426 encounters for the year. Reporting periods were assigned so that approximately the same number of physicians were reporting each day of the year (Sundays were excluded). The specialty distribution of the physician sample was adjusted to assure proper representation within major geographic regions.

The FRG and U.S. surveys involved multistage cluster samples. In both, the first stage was the selection of geographic areas. For the second stage, physicians were randomly selected within these areas with the specialty distribution of the sample approximating the distribution of all physicians in the areas. In the third stage, patient encounters were sampled by assigning physicians to reporting periods and systematically sampling encounters within the reporting periods.

In the Federal Republic of Germany, five geographic areas were selected in a nonrandom, controlled manner to approximate the national distribution with respect to physician specialty and population characteristics. The five areas selected were Bremen, Hessen, Pfalz, Nordbaden, and Südbaden. Within these areas, a sample of 893 physicians was randomly selected from a list of nearly all office-based physicians. Each was randomly assigned to a 2-day reporting period either during November-December 1981 or February-March 1982 (Saturdays and Sundays were excluded from the sample). Physician specialties were uniformly distributed across the reporting periods. During the 2-day reporting period, encounter forms were completed for a systematic sample of encounters. The individual encounter sampling rate per physician varied from 10 to 50 percent depending on the expected number of encounters per day. The total sample of encounters numbered 13,571.

The first stage of the U.S. sample included 87 geographic areas (counties or standard metropolitan statistical areas) randomly selected with probabilities proportional to their populations. A sample of 2,333 physicians was randomly selected within these areas from a list of all office-based physicians. Each was randomly assigned to a 1-week reporting period during 1981, so that about equal numbers of doctors were

reporting each week. Within the assigned week, patient visits were sampled at a rate that varied from 20 to 100 percent depending on the expected number of encounters. All days of the week were included, and the sample of encounters totaled 43,366 for the year.

Sample sizes for physicians and patient encounters and physician universe information are summarized in table F for the three surveys. Note that sample sizes are presented for the full survey in each country as well as for the data subsets used in the international comparative analysis presented in chapter 3.

The physician universes used for sample selection differed somewhat among the surveys because of differences in the health services systems. Each physician sample, however, was representative of the private, office-based physicians providing ambulatory medical care. The definitions of "physician," "private," and "office-based" are, of course, not entirely synonymous in France, the Federal Republic of Germany, and the United States, but the functional component of the ambulatory medical care systems involved in these surveys is essentially the same in the three countries.

Scope of coverage

The scope of the three surveys differed with respect to such factors as geographic coverage, time period for data collection, physician specialties sampled, and type of physician-patient encounters included in the sample. Therefore, as noted previously, data from each survey were adjusted to produce comparable statistics from each country for the present analysis. Ground rules were established to assure comparability among the three data sets. In summary, these rules were as follows:

1. *All data tabulations are weighted estimates that represent the particular survey universe*—Encounter data from each survey were inflated, using appropriate statistical methods, to produce estimates of encounter volume representative of its sampling universe. In general, this was done by using the reciprocals of the probabilities of selection for the respective sample designs.
2. *All data are adjusted to reflect annual estimates*—Annualized estimates were generated by inflating each reporting

period by the appropriate factor. For example, the U.S. data were collected during a 1-week reporting period. All U.S. data were, therefore, inflated by a factor of 52 to produce annual estimates. The French and U.S. data represent annual estimates for the whole of France and the 48 contiguous States, respectively. The FRG data represent the five subregions of the Federal Republic of Germany in which the survey was conducted. These regions were selected because they reflect the whole of the Federal Republic of Germany with respect to population and physician specialty characteristics.

3. *All data represent all days of the week when office-based care is regularly available*—Although the U.S. data include all days of the week, Saturday and Sunday were not represented in the FRG data. Ambulatory medical services are available in the Federal Republic of Germany through an emergency service arrangement on these days but are quite rare, so that their exclusion is considered appropriate and of negligible consequence. For similar reasons, Sundays are not included in the French data.
4. *Patient encounters are defined to include only personal (face-to-face) contacts with physicians in the physician's office or patient's residence*—The types of ambulatory patient contacts included in the samples differed somewhat among the three original surveys. For example, telephone contacts and contacts with physicians' staff members are included in some but not all of the surveys. To assure comparability in the data presented in this report, however, all tabulations used in the comparative analysis include only encounters in the patient's residence and physician's office in which direct, personal contact with the physician occurred. (Encounters in the patient's residence are not included in the U.S. data. Because home encounters are rare in the United States (less than 1 percent of all contacts), their exclusion should have a negligible impact on the U.S. data (NCHS, 1983b)).
5. *The data represent only those physician specialties common to all studies*—The physician specialties included in the three surveys varied, the major difference being the exclusion of general surgeons, orthopedists, and urologists from the French survey. This difference and other minor

Table F. Number of physicians, physician response rates, and patient encounters for the ambulatory care surveys used in this report: France, the Federal Republic of Germany, and the United States, 1981–83

Item	Country		
	France	Federal Republic of Germany	United States
Number of physicians in country ¹	118,000	171,569	485,123
Number of physicians in patient care in country	82,779	144,224	389,369
Number of physicians in ambulatory care	81,838	60,652	288,038
Number of physicians in sample universe	70,697	² 11,180	247,216
Number of eligible physicians in sample	1,837	893	2,333
Number of physicians responding	1,350	551	1,807
Response rate of physicians (in percent)	74	62	78
Number of patient contacts in sample	72,426	13,571	43,366
Number of sample physicians used in current analysis	1,300	466	1,175
Number of patient encounters used in current analysis	69,517	12,375	33,913

¹Total of all physicians in country including patient care, administrative, research, and so forth.

²5 regions only; 11,605 physicians in ambulatory care in these 5 regions.

specialty differences were resolved in the data tabulation process for the comparative analysis in this report by including only those physician specialties common to all three surveys. The common data items and specialties included in this analysis are as follows:

<i>Data item</i>	<i>Category/comments</i>
<i>Patient</i>	
Age	Age in years: obtained directly or calculated from date of birth
Sex	a. Male b. Female
Diagnoses/problem/ reason for encounter	Recorded by physician: best assessment at time of encounter
Visit status	a. New patient (to the physician's office) b. Known patient
Disposition	a. Return visit scheduled b. Refer to another physician c. Admit to hospital d. Return to referring physician
<i>Physician</i>	
Age and sex Specialty	a. General and family medicine b. Internal medicine and its subspecialties (including cardiology, gastroenterology, pneumology, and rheumatology) c. Pediatrics d. Obstetrics and gynecology e. Psychiatry and neurology f. Dermatology g. Ophthalmology h. Otorhinolaryngology
Type of practice	a. Solo b. Group
Nonphysician office personnel	Medically trained

Data collection procedures

The French survey was conducted by telephone and mail. After a letter of introduction, physicians on the survey staff telephoned the sample physicians to solicit their participation. Those who agreed to cooperate were sent survey materials to complete and return according to written instruction. Further telephone contacts were made to assure that respondents understood their task and completed the survey forms on schedule.

The FRG survey was done primarily by mail. An initial mailing contained introductory materials, a physician questionnaire, and telephone numbers of persons available to answer technical questions about the survey. A second mailing included copies of the patient encounter form, instructions for completing and returning the survey materials, and a final physician data form.

The U.S. survey involved an introductory letter to each sample physician followed by a telephone call for an appoint-

ment and a personal visit by a survey representative. All survey materials were delivered by the representative, and instructions were given in verbal and written form. Further visits and telephone calls were made as needed to assure the physician's complete participation.

Each physician in each of the surveys received a physician questionnaire and patient encounter forms. The process of completing these forms and their general content are similar for all three surveys. The physician questionnaire was self-administered (except in the United States where it was completed during the personal interview) and obtained basic information about the physician and the practice. The encounter forms, used to record information about physician-patient encounters, were completed by the physician or the office staff during the assigned reporting period for the designated sample of encounters. These forms generally were completed near the time of the encounter, so that most information was recorded from knowledge of the events which had just occurred. Retrospective completion of materials by reference to medical records was discouraged. The patients were not directly involved in data collection and normally were not aware of the survey. All three surveys used methods to assure the confidentiality of the patient and physician data.

Physician participation was entirely voluntary in all surveys. In the FRG and the United States, no remuneration was offered for participation. In the French survey, participating physicians were offered payment of approximately \$40 (U.S.) or their choice from a selection of books. In all surveys, copies of that country's study results were provided to participating physicians.

Survey instruments

As noted above, there were two basic survey instruments used in the surveys—the physician questionnaire and patient encounter form. These forms for the three surveys (with English translations of the French and FRG forms) are reproduced in appendix I. The physician questionnaire was used to obtain information about the sample physician and the physician's practice. The amount and content of data requested in this form varied among the three surveys. For this report, however, only three data items from these forms concerning the physician are used, and these items are essentially the same for all three surveys. These items are (1) age, sex, and specialty of physicians; (2) the physician's type of practice (solo or group); and (3) office staff information.

The second, and most important, survey instrument was the patient encounter form. Again, the data items vary somewhat among the three surveys, but a number of encounter data items are common to all three and have similar definitions and response categories. A description of the common data items is shown in rule 5 in the preceding section. It is this set of data items that forms the basis for the comparative analysis of ambulatory care in France, the Federal Republic of Germany, and the United States that is presented in chapter 3.

Some of the common data items require additional explanation. Patient age is available from all surveys, though date of birth was actually collected in the FRG and U.S. surveys. This information, along with patient sex, is identical in all studies.

Diagnosis was recorded in all surveys, but in a slightly different manner in the French survey. The FRG and U.S. surveys instructed the physician to record first a principal diagnosis related to the reason for visit, and then to record other diagnoses in order of importance. In the French survey, there was no order suggested for listing of the diagnoses. In all three surveys, the diagnostic label recorded on the form was the physician's best assessment at the time of the encounter. This label may or may not have been expressed in conventional medical terms, and it may or may not have been made on the basis of diagnostic test results or other definitive information.

For purposes of this report, diagnostic tabulations are based on all listed diagnoses. That is, in tabulating the number of encounters for a given diagnosis, all encounters with that diagnosis are counted regardless of the order in which the diagnosis was listed. Encounters with multiple diagnoses, therefore, are counted multiple times.

Visit status refers to whether the patient is new to the physician's practice, or had been seen before (new or known patient). Other explanations for particular data items are provided in the analysis section of this report as the data are compared for the three countries.

Data processing

In the French, FRG, and U.S. surveys, completed survey materials were mailed by participating physicians to the respective survey organizations. After routine clerical review and edit checks, data items not precoded were manually coded and verified. Of particular interest is the coding of diagnoses that were recorded in written form by the physicians. In France, coding of diagnoses was done by physicians employed by the Centre de Recherche d'Étude et de Documentation en Économie de la Santé for that purpose using a specially designed software package. In the Federal Republic of Germany and the United States, coding was done by nonphysician personnel instructed and experienced in the coding of medical data. In the Federal Republic of Germany, physicians were available to resolve difficult coding problems. The *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death (ICD-9)* (World Health Organization, 1977) was used in the French survey and the *International Classification of Diseases, 9th Revision, Clinical Modification* (Public Health Service and Health Care Financing Administration, 1980) in the U.S. survey. In the Federal Republic of Germany, a modification and German translation of the "Reason for visit classification" (Wagner, Schach, and Schwartz, 1984) was used. These categories then were assigned to an ICD-9 category by a physician familiar with the data and expert in the ICD-9 classification system. The FRG and French diagnostic codes were verified by a second coder. The U.S. data were coded by two independent coders and differences were resolved by a third coder. In the United States and the Federal Republic of Germany, the data for each study were converted to machine-readable form for additional edit checks by computer.

Reference populations

The rates shown in this report are based on the population estimates shown in table I of appendix II. For France, this rep-

resents the total civilian population as of December 31, 1981. The FRG figures represent the December 31, 1981, civilian population in the five subareas of the Federal Republic of Germany in which the EVaS was conducted. The U.S. figures represent the civilian population exclusive of Alaska and Hawaii as of December 31, 1981.

As may be noted in appendix II, the age and sex distributions vary for the three countries. Because health status and use of the health services system are related to age, selected data in this report were adjusted to compensate for the age-sex variability. This was done using the direct method to calculate age-sex standardized encounter rates. The January 1, 1980, French population (shown in table II of appendix II) was used as the standard population.

Standard errors

Estimates of standard errors are provided for selected statistics to enable the reader to judge precision and to test differences. Differences tested in this report were done using the *t* test. Design-specific estimates of standard errors were calculated for each of the three surveys. Detailed methods and formulas may be obtained from the original research (Centre de Recherche d'Étude et de Documentation en Économie de la Santé, 1981; NCHS, 1983a; Zentralinstitut für die kassenärztliche Versorgung in der Bundesrepublik Deutschland, 1988).

Definitions of selected terms

Patient contact—Any contact between patient and physician or physician's staff for professional reasons; includes telephone consultations and excludes, for example, contacts exclusively to make an appointment, drop off a specimen, or pay a bill.

Patient encounter—A face-to-face contact, for professional reasons, between a physician and a patient in the physician's office or the patient's residence. (Telephone consultations are excluded.)

Physician—A person who is licensed or otherwise entitled to practice medicine according to the laws and customs of the individual's locality.

Study physicians—Physicians included in the detailed data analysis presented in this report. Includes physicians in the EMTM, EVaS, and NAMCS surveys who are in selected specialties common to all three surveys.

Ambulatory patient—Person making a patient-physician contact who is not hospitalized at the time of the contact.

EMTM—Enquête Morbidité et Thérapeutique Médicale (Survey of Morbidity and Medical Care): French survey of physicians in office practice and their patient encounters conducted in 1982 and 1983.

EVaS—Erhebung über die Versorgung im ambulanten Sektor durch niedergelassene Ärzte (Survey Among Ambulatory Care Physicians): Federal Republic of Germany survey of physicians in office practice and their patient contacts conducted in the fourth quarter of 1981 and the first quarter of 1982.

NAMCS—National Ambulatory Medical Care Survey: U.S. survey of physicians in office practice and their patient contacts conducted in 1981.

Chapter 3

Results—Comparison of ambulatory care in France, the Federal Republic of Germany, and the United States

Selected characteristics of ambulatory care physicians

Although physicians have the major responsibility in France, the Federal Republic of Germany (FRG), and the United States (U.S.) for the provision of ambulatory medical care services, the characteristics of the physicians and their practices differ in the three countries.

Physician specialty

Generalists (general and family practice physicians) constitute the largest specialty group in all three countries, but their relative contribution to the provision of ambulatory care varies greatly. Among study physicians, generalists account for 68 percent of physicians in France, and in the Federal Republic of Germany they are 51 percent. In the United States, however, only 28 percent of study physicians are generalists. Combining all primary care physicians (generalists, internists, pediatricians, and obstetricians/gynecologists) brings the figures to 86 percent for France and 84 percent for the Federal Republic of Germany, but still accounts for only 76 percent of the U.S. ambulatory care study physicians (table G). (In this study, "internist" for France includes the specialties of internal medicine, cardiology, gastroenterology, pneumology, and rheumatology.)

From another perspective, it may be seen in table H that the number of physicians per 1,000 persons also varies considerably among the three countries, particularly within specialties. The density of generalists is four times higher in France than in the United States and twice as high as in the Federal Republic of Germany. This major difference is only partly offset by a higher density of specialists in the United States.

For the specialists covered by the study (internists, pediatricians, obstetricians/gynecologists, psychiatrists, dermatologists, ophthalmologists, and otorhinolaryngologists), the density in the United States is 31 percent higher than in France and the Federal Republic of Germany. The density of internists, pediatricians, psychiatrists, and obstetricians/gynecologists is higher in the United States than in the Federal Republic of Germany and France. The density is identical in all three countries for ophthalmologists and slightly lower in the United States for dermatologists and otorhinolaryngologists. The density in the Federal Republic of Germany is higher than in France only for internists and obstetricians/gynecologists, and is exceptionally low for psychiatrists.

These structural differences by specialty may well reflect a different allocation of tasks among physicians and, as a consequence, a different case mix of patient complaints and treatment regimens by specialty for each country.

Physician age and sex

Physicians practicing in the Federal Republic of Germany are by far the oldest, with 28 percent of them aged 60 years and over, compared with 18 percent in the United States and only 9 percent in France. Conversely, the highest percent of physicians under 40 years is found in France, with 48 percent, compared with 34 percent in the United States and only 24 percent in the Federal Republic of Germany.

Women represent 20 percent of the medical profession in the Federal Republic of Germany, 13 percent in France, and 8 percent in the United States. Female physicians are clearly younger on average than male physicians in France and the United States, where more than half of female physicians are under age 40 years. The Federal Republic of Germany, on the

Table G. Percent distribution of encounters and study physicians by physician specialty group: France, the Federal Republic of Germany, and the United States, 1981-83

Physician specialty group	Country					
	France		Federal Republic of Germany		United States	
	Encounters	Physicians	Encounters	Physicians	Encounters	Physicians
	Percent distribution					
Total	100	100	100	100	100	100
Generalists	74	68	59	51	39	28
Primary care specialists ¹	13	18	29	33	43	48
Other ambulatory care specialists ²	13	15	12	16	18	24

¹Internists, pediatricians, and obstetricians/gynecologists.

²Psychiatrists/neurologists, dermatologists, ophthalmologists, and otorhinolaryngologists.

Table H. Number and rate per 1,000 population of physicians, by specialty: France, the Federal Republic of Germany, and the United States, 1981

Physician specialty	Country					
	France		Federal Republic of Germany ¹		United States	
	Number	Number per 1,000 population	Number	Number per 1,000 population	Number	Number per 1,000 population
Total ambulatory care physicians	81,838	1.513	11,605	0.977	286,526	1.273
All study physicians	70,697	1.307	10,211	0.860	174,461	0.775
General and family practitioners	47,748	0.883	5,212	0.439	49,416	0.220
All study specialists	22,949	0.424	4,999	0.421	125,045	0.555
All primary care specialists	12,617	0.233	3,349	0.282	83,148	0.369
Internists ²	6,256	0.121	1,780	0.150	43,845	0.195
Pediatricians	2,556	0.047	562	0.047	18,464	0.082
Gynecologists/obstetricians	3,535	0.065	1,007	0.085	20,839	0.093
Other ambulatory care specialists:						
Psychiatrists/neurologists	3,807	0.070	326	0.027	20,605	0.092
Dermatologists	1,631	0.030	333	0.028	4,708	0.021
Ophthalmologists	2,882	0.053	591	0.050	11,241	0.050
Otorhinolaryngologists	2,012	0.037	400	0.034	5,343	0.024
Specialists outside of study ³	⁴ 11,141	0.206	⁵ 7,394	0.117	⁶ 112,065	0.498

¹5 regions only.

²General internal medicine, cardiology, gastroenterology, pneumology, and rheumatology.

³Surgeons and surgical specialties.

⁴Includes radiologists and anesthesiologists.

⁵Includes urologists and orthopedists.

⁶Includes doctors of osteopathy.

other hand, shows similar age distributions for males and females (table J).

Type of practice and personnel support

Just as the organization of the health services systems in France, the Federal Republic of Germany, and the United States differs, so too does the organization of each physician's office practice. The methods for providing health services to ambulatory or home-care patients vary greatly from one country to another, especially for services delivered by private practice physicians.

In France, 62 percent of physicians are in solo practices. In addition, French physicians employ very few nonphysician, medically trained personnel: only 13 staff per 100 physicians in solo practice. Medical practice in France, therefore, is generally organized on the basis of physicians working alone in their offices. In the Federal Republic of Germany, on the other hand, nearly 90 percent of the physicians are in solo practice, and they are assisted by numerous trained medical staff: 277 staff per 100 physicians in solo practice. The United States has the lowest percent of solo practice physicians (55 percent) and occupies a middle point in number of staff members: 90 staff per 100 physicians in solo practice (see tables K and L).

In France and the Federal Republic of Germany, specialists employ relatively more trained medical personnel than generalists; however, in the United States the reverse is true.

Volume and rate of ambulatory physician-patient contacts and encounters

All physician-patient contacts

The encounter rates with ambulatory physicians are quite different for the populations of France, the Federal Republic of

Germany, and the United States. Table M and figure 1 show rates per person for all ambulatory contacts, for ambulatory encounters (face-to-face contacts) with all office-based physicians, and for encounters with the generalists and specialists included in this study. In all three groups, the rates are highest for the Federal Republic of Germany and lowest for the United States. When all contacts are considered (including telephone consultations), the rate in the United States is 4.6 contacts per person per year, and in the Federal Republic of Germany is 14.3 contacts per person per year. The FRG rate is more than three times greater than the U.S. rate and twice the French rate (table N).

Encounters with study physicians

As noted previously, the analysis presented here is based only on direct encounters with study physicians. This restriction results in the exclusion from the analysis of all telephone contacts, patient encounters in hospital outpatient departments, and encounters with certain surgical specialties. Encounter rates based only on encounters with study physicians, therefore, are lower than those given in the preceding paragraph, but the reduction is quite different for the three countries. This restricted definition of "encounter" produces a particularly large reduction in the U.S. rate (54 percent) because a large proportion of physician-patient contacts are in hospital ambulatory clinics and through telephone consultation. The reduction in the Federal Republic of Germany is 32 percent, largely due to the elimination of telephone consultations. The rate in France is reduced only about 15 percent because telephone consultations and hospital ambulatory encounters are infrequent. Therefore, most ambulatory care in France is accounted for by the physicians included in the study.

Table J. Number and percent distribution of office-based physicians by age and sex: France, the Federal Republic of Germany, and the United States, 1981-83

Physician age and sex	Country					
	France ¹	Federal Republic of Germany ²	United States ³	France ¹	Federal Republic of Germany ²	United States ³
	Number of physicians			Percent distribution		
All physicians	70,697	11,605	286,526	100.00	100.00	100.00
SEX						
Female	9,353	2,270	24,181	13.23	19.56	8.44
Male	61,344	9,335	262,345	86.77	80.44	91.56
AGE						
All physicians						
Under 30 years	926	40	10,163	1.31	0.35	3.55
30-39 years	33,122	2,687	86,248	46.85	23.15	30.10
40-49 years	16,529	3,487	74,979	23.38	30.05	26.17
50-59 years	14,033	2,196	63,012	19.85	18.92	21.99
60 years and over	6,087	3,195	52,124	8.61	27.53	18.19
Females						
Under 30 years	326	19	2,106	3.49	0.84	8.71
30-39 years	4,514	479	10,343	48.26	21.10	42.77
40-49 years	2,447	732	5,643	26.16	32.25	23.34
50-59 years	1,359	498	3,577	14.53	21.94	14.79
60 years and over	707	542	2,512	7.56	23.88	10.39
Males						
Under 30 years	595	21	8,057	0.97	0.23	3.07
30-39 years	28,605	2,208	75,905	46.63	23.65	28.93
40-49 years	14,084	2,755	69,336	22.96	29.51	26.43
50-59 years	12,674	1,698	59,435	20.66	18.19	22.66
60 years and over	5,386	2,653	49,612	8.78	28.42	18.91

¹Private practice physicians eligible for study.

²Office-based, health insurance physicians in 5 study regions.

³Non-Federal, office-based physicians.

Table K. Number and percent distribution of office-based physicians by type of practice and specialty group: France, the Federal Republic of Germany, and the United States, 1981-83

Physician specialty and type of practice	Country					
	France ¹	Federal Republic of Germany ²	United States ³	France ¹	Federal Republic of Germany ²	United States ³
	Number			Percent distribution		
All physicians	70,697	11,605	286,526	100.00	100.00	100.00
Solo	44,073	10,301	158,439	62.34	88.76	55.30
Other	26,624	1,304	128,087	37.66	11.24	44.70
Generalists						
Solo	29,909	4,600	32,239	62.64	88.26	65.24
Other	17,839	612	17,177	37.36	11.74	34.76
Specialists						
Solo	14,164	5,701	126,200	61.72	89.18	53.22
Other	8,785	692	110,910	38.28	10.82	46.78

¹Private practice physicians eligible for study.

²Office-based, health insurance physicians in 5 study regions.

³Non-Federal, office-based physicians.

Encounters with the study physician, however, do represent the great majority of all direct office and home encounters with ambulatory patients, including 88 percent of French, 92 percent of FRG, and 81 percent of U.S. direct encounters (tables O and P). In particular, encounters with the study

physicians resulted in 2.1 encounters per person per year in the United States, followed by France with 6 encounters per person per year; the FRG rate is the highest at 9.7 encounters per person per year. The FRG rate is 4.6 times greater than the U.S. rate and 1.6 times greater than the French rate. When

Table L. Rate of nonphysician medical personnel in the offices of solo practice physicians by specialty group: France, the Federal Republic of Germany, and the United States, 1981-83

Physician specialty	Country		
	France	Federal Republic of Germany ¹	United States ¹
	Rate per 100 physicians		
All physicians	13	277	90
Generalists	10	267	101
Specialists	20	289	85

¹ Full-time equivalents estimated from survey results.

specialty is considered, the FRG rates are highest for generalists and all specialists except psychiatrists (table 1). The French rates are higher than the U.S. rates for generalists and all specialists, except internists and pediatricians.

As noted in chapter 1, the age structure of the population is different in the three countries with the FRG population being oldest on the average and the U.S. population being youngest. Given the substantial influence of age on health services utilization, it is important to consider age in any comparison of utilization rates. Standardized rates have been calculated, therefore, using the 1980 French population by age groups as the base population. This standardization produces a slight reduction in the FRG rate and a slight increase in the U.S. rate.

As noted in the first section of this chapter, the distributions of generalist and specialist physicians differ in the three countries. Similarly, the distributions of encounters with generalists and specialists differ for the three countries as seen in table G.

Although generalists account for 74 percent of encounters in France, they account for 59 percent of encounters in the Federal Republic of Germany and only 39 percent in the United States. In all three countries generalists account for a higher proportion of patient encounters than the proportion

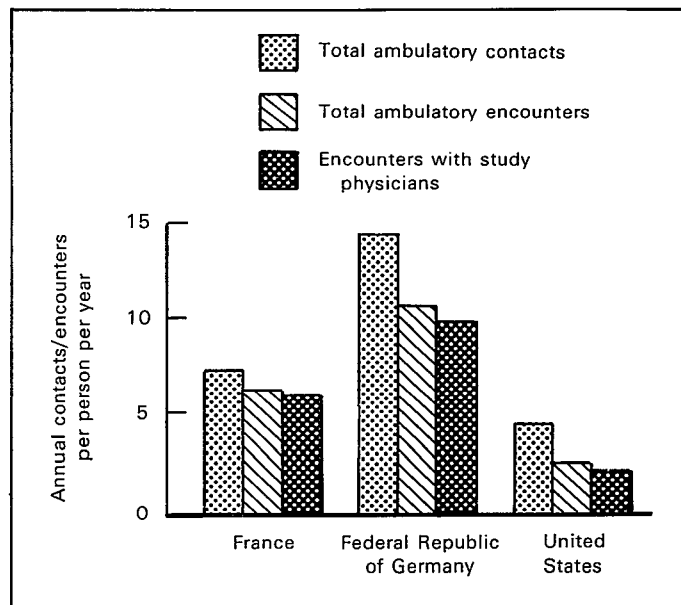


Figure 1. Number of annual ambulatory contacts and encounters per person by type of contact: France, the Federal Republic of Germany, and the United States, 1981-83

they represent of all physicians. For the two specialist groups in table G the reverse is true. In particular, generalists account for 39 percent more encounters in the United States, 16 percent more encounters in the Federal Republic of Germany, and 9 percent more encounters in France than would correspond to their share of physicians.

Although free choice of physician may be exercised in all three countries, patients use primary care specialists (internists, pediatricians, and obstetricians/gynecologists) more often in the United States and the Federal Republic of Germany than in France. Consequently, the combined total of encounters for generalists and primary care specialists represents about the same percent of total encounters in all three countries, 82 to 88 percent of total encounters. It would seem that ambulatory patient services provided by generalists in France

Table M. Annual rate per person of ambulatory contacts and encounters and number of encounters with study physicians: France, the Federal Republic of Germany, and the United States, 1981-83

Type of contact	Country		
	France	Federal Republic of Germany	United States
	Rate per person per year		
All ambulatory contacts ¹	7.1	14.3	4.6
Ambulatory encounters with all physicians ²	6.8	10.6	2.6
Ambulatory encounters with study physicians	6.0	9.7	2.1
Standard error	(0.080)	(0.125)	(0.116)
Ambulatory encounters with study physicians (standardized)	6.0	9.5	2.2
	Number in thousands		
Encounters with study physicians	326,470	115,741	473,618
Reference population	54,085	11,874	223,688

¹ Contacts are all contacts for medical care including telephone, hospital outpatient, doctor's office, patient's home, and other noninstitutional settings.

² Encounters are contacts in office and home, excluding telephone, hospital outpatient department, and so forth.

NOTE: Standard error values are in parentheses.

Table N. Number and crude and standardized annual rates per 1,000 population of physician-patient contacts: France, the Federal Republic of Germany, and the United States, 1981-83

<i>Item</i>	<i>Country</i>		
	<i>France</i> ¹	<i>Federal Republic of Germany</i> ¹	<i>United States</i> ²
Total number of contacts in thousands	384,000	169,279	1,038,616
Crude rate of contacts per 1,000 population	7,100	14,256	4,643
Reference population in thousands	54,085	11,874	223,688
Standardized rate of contacts per 1,000 population	7,100	13,795	4,761

¹Includes office and telephone contacts by patients.

²Includes office, telephone, and hospital ambulatory contacts by patients.

Table O. Number and crude and standardized annual rates per 1,000 population of physician-patient encounters: France, the Federal Republic of Germany, and the United States, 1981-83

<i>Item</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
Total number of encounters ¹ in thousands	369,109	126,363	585,177
Crude rate of encounters per 1,000 population	6,825	10,642	2,616
Standard error of crude rate	81	109	144
Standardized rate of encounters per 1,000 population	6,825	10,388	2,677

¹Includes direct encounters with patients in physician's office or patient's residence.

Table P. Number and crude and standardized annual rates per 1,000 population of physician-patient encounters with study physicians: France, the Federal Republic of Germany, and the United States, 1981-83

<i>Item</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
Total number of encounters ¹ in thousands	326,470	115,741	473,618
Crude rate of encounters per 1,000 population	6,037	9,747	2,117
Standard error of crude rate	80	125	116
Standardized rate of encounters per 1,000 population	6,037	9,522	2,162

¹Includes only direct encounters with study physicians included in data used in this report.

are provided by generalists and primary care specialists in the Federal Republic of Germany and the United States.

Encounter rates are thought to be linked to physician density, although, as noted earlier, utilization of health services depends on many factors such as the organization of health services and the division of labor between the ambulatory and hospital sectors. In the data presented here, however, the physician density and encounter rates for ambulatory patients do not necessarily vary in the same direction. For example, the physician density is highest in France and the encounter rate is highest in the Federal Republic of Germany. This holds true for generalists and practically all specialists.

Characteristics of ambulatory care encounters

Although there are significant differences in the encounter rates for ambulatory care in France, the Federal Republic of Germany, and the United States, a closer examination of the

encounters with generalists and specialists in this study shows some striking similarities.

Patient age and sex

Percent distributions of encounters by age and sex are similar for the three countries, particularly for France and the Federal Republic of Germany. The small differences that are seen are attributable largely to differences in the age distributions of the populations. This becomes clear in table 2 which shows the percent distribution and the encounter rate by age and sex.

Patterns of encounter are similar when patient's sex is considered. In all three countries, about 60 percent of the encounters are with female patients. The rate of encounter per 1,000 population is about 40 percent higher for females than males in France and the Federal Republic of Germany, and about 55 percent higher in the United States. In all three countries, encounter rates for females are considerably higher in the

middle age groups; male and female rates are similar for the young and the elderly.

As previously observed, the encounter rate for the Federal Republic of Germany is considerably higher than the rate in France and the United States, with the U.S. rate being the lowest. This order holds true for each age and sex group shown in table 2. However, despite the actual values of the rates for the three countries, the highest rates of encounter for each country are for the very young and very old, and the rate increases with age for all other age groups (figures 2 and 3). These same patterns are seen within each sex group, except for males in the age group 2–14 years where the encounter rate is higher than the next older age group. The fact that this anomaly in the encounter rate distribution appears for all three countries is further indication that the patterns of use of health services by age and sex are similar in the three countries, at least proportionally.

Visit status

Data concerning the use of physician office services by new and known patients are shown in tables Q and 3. New patients are those who have never been seen before for medical reasons by the solo physician or by any of the physicians in a group practice setting. Known patients are those who have been seen previously in the practice either for their current condition or for a previous problem.

The majority of ambulatory care encounters in all three countries are with known patients (table R). The proportion of new encounters is similar for France and the United States, but the Federal Republic of Germany (18.5 percent) had a proportion of new encounters about 30 percent higher than the 13- to 14-percent encounters with new patients found in France and

the United States (table R). Males in all three countries are slightly more likely to make new encounters than females. The widest difference is in France where 16 percent of male encounters are new compared with 13 percent for females (table S).

Some portion of the difference in the percent of new and known encounters between the Federal Republic of Germany and the other two countries is thought to be due to differences in survey methods. The French and U.S. surveys used separate and discrete items concerned only with establishing whether the patient was new or known to the physician's practice. The FRG survey, on the other hand, obtained this information in a subpart of a larger question that likely tended to result in an underreporting of known patients. (This information is derived from item 8 in the French survey, item 30 in the FRG survey, and item 10 in the U.S. survey encounter forms displayed in appendix I.)

The proportions of new and known patient encounters vary by age of patient in a similar manner in all three countries. The age group 25–44 years accounts for the highest percent of new encounters, making about 30 percent of all new encounters (table 3). However, within age groups, the highest proportion of new encounters is made by patients age 15–24 years (table S). Nearly one-fourth of the encounters in this age group are new encounters in France and the Federal Republic of Germany, and nearly one-fifth are new in the United States. This might be expected because this age group is the most mobile and includes emerging adults who may visit an "adult care physician" for the first time. The two younger age groups have slightly lower proportions of new encounters and after age 24 years the proportions of new encounters decrease steadily with increasing age in each country. When new encounters are examined by age within each sex group, this same pattern is observed for females and males, with one exception. For males,

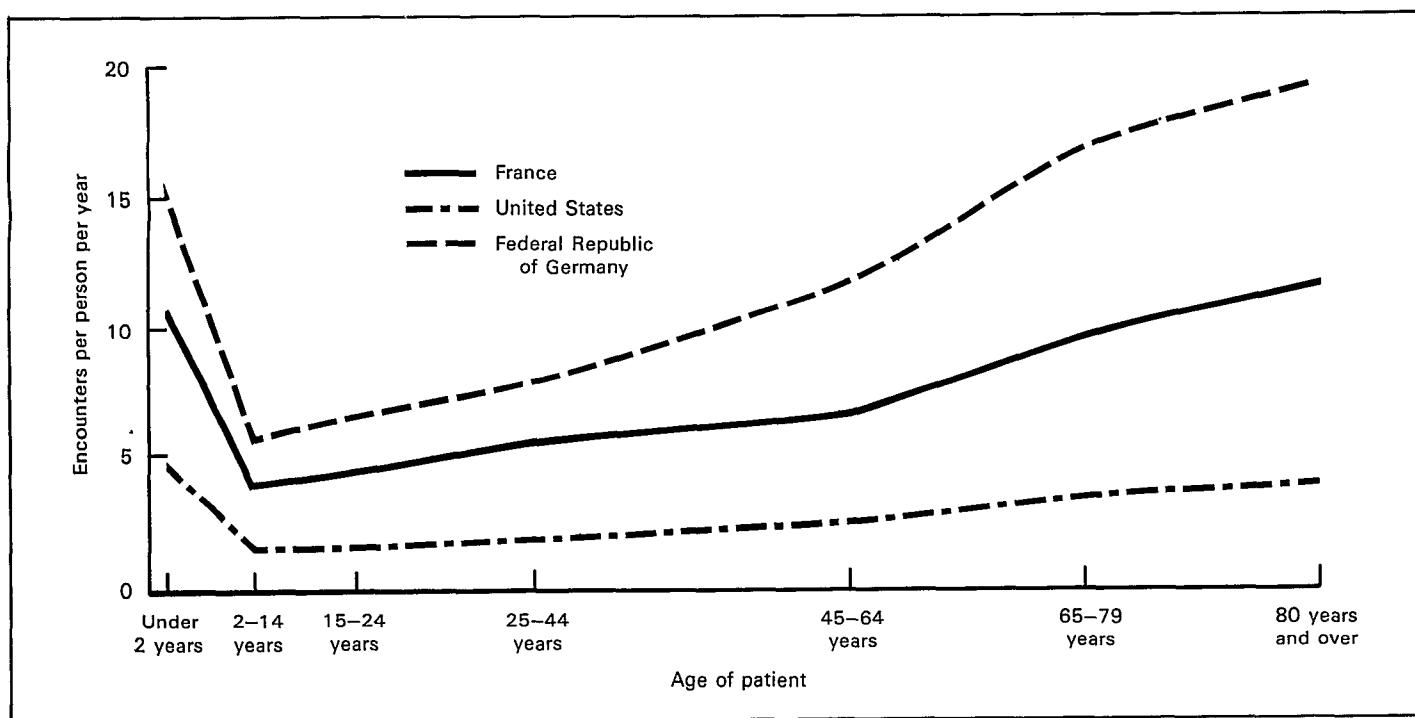


Figure 2. Annual rate of encounters per person by patient age: France, the Federal Republic of Germany, and the United States, 1981–83

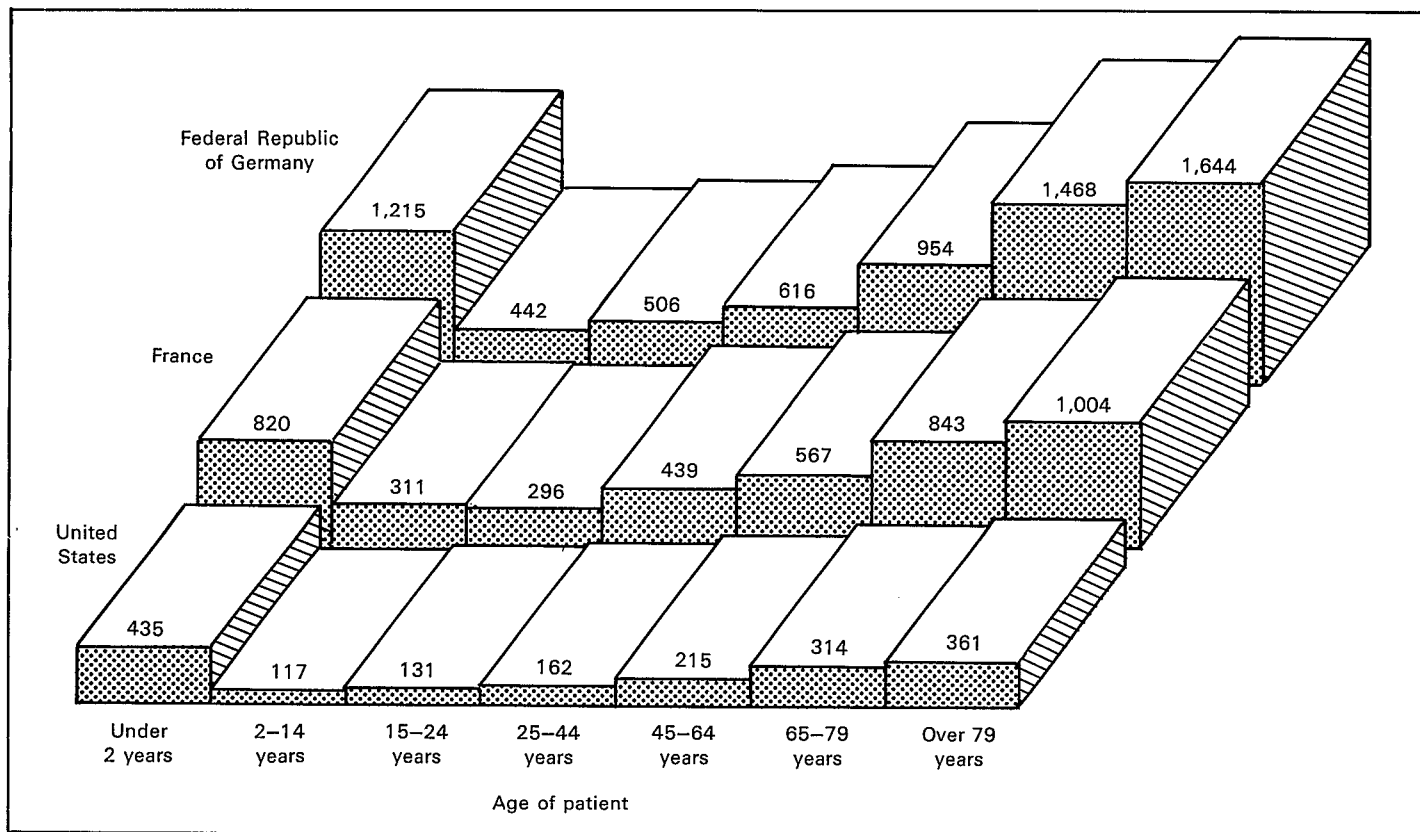


Figure 3. Rate per 100 population of encounters of patients known to the physician by patient age: France, the Federal Republic of Germany, and the United States, 1981-83

relatively high proportions of new encounters are found in the age groups 25-44 years as well as in the groups 15-24 years.

Visit rates also show similar patterns. This is graphically illustrated in figure 3 which shows rates per 100 population of known patient encounters by patient age. Though the rates are highest in the Federal Republic of Germany and lowest in the United States for each age group, the patterns by age are similar.

Disposition

Information concerning the physician's disposition decision was obtained in item 10 in the French encounter form, items 87-96 in the FRG study, and item 14 of the U.S. questionnaire. The U.S. and FRG data were collected in similar fashion, each using a separate question dealing exclusively with disposition and having comparable disposition categories for selection by the respondent. The French form, on the other hand, included selected disposition categories with categories of therapy prescribed. This is likely to have affected the comparability of results in the studies, particularly with the disposition of return visit planned, and may account in large part for the low percent of encounters in this category for France. The categories of disposition compared among the three countries are return visit planned, referral to other physician, admit to hospital, and return to referring physician. These data are contained in tables 4-7.

The physician's disposition Return visit planned in the French survey meant that the physician gave the recommendation to return soon; however, in the FRG and the U.S. studies

this was defined differently. There the recommendation was to return at specified time, which would include long-term arrangements as well as short-term followup appointments. The United States had the highest percent of Return visit planned (60 percent of all encounters) dispositions, with the Federal Republic of Germany having a slightly lower percent (56 percent). According to the French study, only 19 percent of the encounters resulted in this disposition. As noted previously, a significant portion of this difference is thought to be due to the survey design. In addition, it seems probable that in France the ambulatory care provided during one consultation constitutes a wider range of diagnostic and therapeutic services by the doctor and his personnel, compared with the United States and the Federal Republic of Germany where the same services may be performed in the course of several consultations, leading to the higher rate of return visit planned. This assumption is partly confirmed by the duration of the patient-physician encounter, which is 15 minutes in France, about 12 minutes in the United States, and about 10 minutes in the Federal Republic of Germany. On the other hand, one might expect a high rate of Return visit planned to lead to an increased number of encounters per person. However, the highest rate of Return visit planned is for the United States (table 4), which has the lowest encounter rate. Only the Federal Republic of Germany has a relatively high value for both rates. Thus, the meaning of Return visit planned seems to vary among the three countries in the data collection process and with respect to the patient's interpretation of the physician's instruction.

Table Q. Number, crude and standardized annual rate per 1,000 population of encounters, and percent distribution of encounters by visit status, and by patient sex, according to visit status: France, the Federal Republic of Germany, and the United States, 1981-83

Item	Country					
	Encounters with known patients			Encounters with new patients		
	France	Federal Republic of Germany	United States	France	Federal Republic of Germany	United States
Number of encounters per year in thousands						
Total.....	279,457	94,293	411,650	47,058	21,452	61,967
Female.....	168,932	56,938	257,819	25,739	12,515	37,417
Male.....	110,526	37,355	153,831	21,273	8,937	24,550
Encounters in percent of total encounters						
Total.....	85.60	81.47	86.92	14.41	18.53	13.08
Crude rates of encounters per 1,000 population						
Total.....	5,167	7,941	1,840	870	1,807	277
Female.....	6,087	9,209	2,227	927	2,024	323
Male.....	4,197	6,564	1,426	808	1,570	228
Standardized rates of encounters per 1,000 population						
Total.....	5,167	7,736	1,888	869	1,786	274
Encounters in percent:						
Female.....	60.45	60.38	62.63	54.74	58.34	60.38
Male.....	39.55	39.62	37.37	45.25	41.66	39.62

Table R. Percent distribution of encounters with study physicians by patient status: France, the Federal Republic of Germany, and the United States, 1981-83

Patient status	Country		
	France	Federal Republic of Germany	United States
Percent distribution			
All patients.....	100.0	100.0	100.0
Known patients.....	85.6	81.5	86.9
New patients.....	14.4	18.5	13.1

When the physician's specialty is considered, psychiatrists/neurologists and dermatologists are among the specialists with the highest rate of Return visit planned per 100 encounters in all three countries—an indication of the long-term therapy common in these practices (table 4).

Referral to other physician generally is a formal document or referral recommendation to a particular physician or physician group, although in all three countries a formal referral is not necessary to see another physician.

As might be expected, Referral to other physician was most frequent in the Federal Republic of Germany with about 8 percent of encounters resulting in that disposition category (table 5). In contrast, the corresponding figures are about 5 percent for France and 3 percent for the United States. The higher FRG rate is probably due to the policies of the FRG health insurance system. In the Federal Republic of Germany, patients may see a specialist without a previous referral. In spite of this, most of them ask their family doctor (usually a general prac-

Table S. Rate of encounters by new patients per 100 total encounters by patient age and sex: France, the Federal Republic of Germany, and the United States, 1981-83

Age and sex	Country		
	France	Federal Republic of Germany	United States
All patients			
All ages.....	14.47	18.53	13.08
Under 2 years.....	18.74	21.19	10.77
2-14 years.....	18.72	23.06	14.31
15-24 years.....	23.20	24.14	19.47
25-44 years.....	16.72	21.74	16.00
45-64 years.....	11.38	16.61	9.92
65-79 years.....	7.89	13.42	8.17
80 years and over...	6.04	14.00	7.36
Female			
All ages.....	13.22	18.02	12.67
Under 2 years.....	19.16	25.23	12.26
2-14 years.....	18.94	20.62	14.79
15-24 years.....	21.07	25.63	18.78
25-44 years.....	13.95	19.39	13.84
45-64 years.....	10.99	16.64	9.63
65-79 years.....	7.94	13.48	8.15
80 years and over...	5.79	15.72	8.33
Male			
All ages.....	16.18	19.31	13.76
Under 2 years.....	18.37	17.15	9.32
2-14 years.....	18.52	25.40	13.86
15-24 years.....	26.94	21.96	21.04
25-44 years.....	21.88	25.64	21.08
45-64 years.....	11.94	16.57	10.34
65-79 years.....	7.82	13.30	8.20
80 years and over...	6.61	10.05	5.24

titioner or internist) to provide a referral that entitles them to see a specialist. The compulsory sickness funds do not require this procedure, but recommend that referrals be handled in that way.

In all three countries, these referrals include referrals for treatment, for specialized care, and for second opinions. In the Federal Republic of Germany, referrals to hospital ambulatory services are also included because these services may only be used on a regular basis with a formal referral document.

Generalists in France and the Federal Republic of Germany had the highest rate of referral to other physicians (about 5 and 9 referrals per 100 encounters, respectively). In the United States, however, the highest rate was for internists (about 4 referrals per 100 encounters). Generalists, internists, and pediatricians accounted for nearly all referrals to other physicians (85 to 91 percent) in all three countries.

During physician office encounters, the disposition decision to admit to hospital (for inpatient care) was rare in all three countries, being less than 2 per 100 ambulatory encounters in each country (table 6). The rates in the Federal Republic of Germany and the United States were the same (1.7 per 100 encounters), and the French figure was slightly lower (1.4). In all three countries, the specialty (among the specialties included in this study) with the highest rate of encounters resulting in an admit to hospital disposition is otolaryngology. In total volume, generalists account for the majority of visits with an admit to hospital disposition—about two-thirds of such visits in France and the Federal Republic of Germany and about one-third in the United States.

Return to referring physician is also a rare disposition decision in ambulatory care, particularly in the United States (0.6 per 100 encounters, table 7). The FRG and French figures are somewhat higher (2.0 and 2.7, respectively). However, there is wide variation by specialty. Internists account for a substantial portion of encounters resulting in this disposition. About 60 percent of such encounters in France and about 35 percent in the Federal Republic of Germany and the United States were attributed to internists. In France, about 30 percent of internist encounters resulted in a return of the patient to the referring physician. Psychiatrists and neurologists had the highest such percent in the Federal Republic of Germany and the United States (13.0 percent and 2.8 percent, respectively).

Reasons for physician encounters

In all three surveys, physicians recorded the reason(s) for each patient encounter, generally as a medical problem or diagnosis. For France a single, simple question was asked: "Diagnoses or reasons for the encounter." The physician accordingly noted one or more diagnoses or reasons without specifying which was the most important in motivating the patient to seek health services. On the other hand, the FRG and U.S. survey forms contained two types of questions: (1) "reason for visit in patient's words" and (2) "diagnosis or problem" as determined by the physician. In both items, multiple entries were to be recorded in order of significance with the most important listed first. Data from the second question are used in this analysis even though the phrase "reason for encounter" is sometimes used to describe the information.

There are two other conditions that must be described to understand these data. First, in France all entries in the diagnosis question were coded according to the ICD-9 (World Health Organization, 1977). In the Federal Republic of Germany, as many as nine entries were coded according to a modification of the "Reason for visit classification" (Wagner, Schach, and Schwartz, 1984) and subsequently recoded into the ICD categories. In the United States, a maximum of three entries could be coded according to the ICD-9-CM (Public Health Service and Health Care Financing Administration, 1980). As a result, in all three countries, there often was more than one diagnostic entry for an encounter: an average of 1.4 for the United States, 1.8 for France, and 2.5 for the Federal Republic of Germany.

The lower figure for the United States is probably the result of coding no more than three entries for any encounter. The higher figure for the Federal Republic of Germany is partly the result of coding up to nine entries for each encounter and possibly due in part to insurance procedures. In spite of the fact that data collection for this study and the FRG insurance administrative processes in ambulatory care were completely separate, it is possible that data collection for the study was affected by the insurance process. In particular, FRG ambulatory care physicians accumulate diagnostic entries over the 3-month life of each insurance fund voucher for each patient. This habit may have affected the number of survey diagnoses entered during the FRG survey.

Second, the diagnosis data used in this study were tabulated on the basis of *all* coded entries. Therefore, the data reflect the total of all diagnoses that exist for patients making ambulatory encounters to generalists and selected specialists included in this study. The data do not reflect the incidence or prevalence of disease in the population. Chronic conditions, for example, which motivate more encounters per person or time period than acute conditions, will probably have a higher proportion of encounters in the study than would correspond to their prevalence in the population. Similarly, as the number of existing conditions increases with age, older patients and their often chronic conditions will also be disproportionately represented in the data. Because of these known limitations, this analysis primarily considers encounter rates and relative distributions when comparing data from the three countries.

Major ICD categories

In table T, the diagnostic entries are aggregated according to the ICD-9 major chapter groupings and are expressed as percent distributions for each country.

Comparisons between the countries are most meaningful when percent distributions are examined because of the differences among the countries in the numbers of coded diagnoses, and the disparity in the proportion of diagnoses in three somewhat amorphous categories: special conditions; symptoms, signs, and ill-defined conditions; and other and unknown. If the above categories are eliminated, the relative distributions in table T show that encounters related to mental disorders and conditions in the perinatal period are relatively more frequent in France. Encounters associated with endocrine, nutritional, and metabolic diseases and immunity disorders; diseases of the blood and the blood-forming organs; diseases of the circulatory

Table T. Percent distribution of diagnostic entries by International Classification of Diseases, 9th Revision, categories: France, the Federal Republic of Germany, and the United States, 1981-83

International Classification of Diseases category	Country		
	France	Federal Republic of Germany	United States
	Percent distribution		
Total	100.00	100.00	100.00
Infectious and parasitic diseases	2.45	2.54	3.10
Neoplasms	1.30	2.03	1.86
Endocrine, nutritional, and metabolic diseases and immunity disorders	3.58	6.18	4.60
Diseases of the blood and blood-forming organs	0.37	0.94	0.59
Mental disorders	6.89	4.47	4.62
Disorders of the nervous system and sense organs	7.72	8.54	10.99
Diseases of the circulatory system	16.22	24.21	13.58
Diseases of the respiratory system	11.84	11.34	13.76
Diseases of the digestive system	6.94	6.40	4.69
Diseases of the genitourinary system	3.80	5.56	5.10
Complications of pregnancy, childbirth, and puerperium	0.42	0.23	0.30
Diseases of the skin and subcutaneous tissue	3.47	3.57	5.44
Diseases of the musculoskeletal system and connective tissue	8.47	10.88	6.11
Congenital anomalies	0.24	0.27	0.25
Certain conditions originating in the perinatal period	0.09	0.02	0.04
Symptoms, signs, and ill-defined conditions	14.18	3.33	3.77
Injuries and poisoning	2.70	2.78	5.38
Special conditions, other and unknown codes	9.32	6.71	15.83

system; and diseases of the musculoskeletal system are relatively more frequent in the Federal Republic of Germany. Encounters in the categories of infectious and parasitic diseases; disorders of the nervous system and sense organs; diseases of the respiratory system; diseases of the skin and subcutaneous tissues; and injuries and poisonings are relatively more frequent in the United States, compared with the respective relative frequencies (percents) of the other two countries. There is, however, considerable similarity in the general distribution of diagnostic entries in the three countries. This is apparent in figure 4, which illustrates that the distributions of diagnoses by major ICD-9 categories have similar shapes for the three countries.

Selected index diagnoses and reasons for encounter

A comparison of the diagnoses and reasons for seeking medical care services was performed at a more specific level for 15 commonly encountered (index) medical problems and for 6 types of preventive and administrative health problems (table U).

The differences observed in table W and figure 5 are related to previously noted differences in the number of diagnoses per encounter in the three countries, and probably also to differences in the probabilities of seeking health care services for various health problems in the three countries. Because these two factors are confounded, it is not possible to determine the contribution of each.

As with the broad diagnostic categories, an examination of the percent distributions for these specific diagnoses provides a more revealing comparison among the three countries (table 8 and figure 6). Of the 15 medical problems selected, arthritis, depression, and insomnia are relatively more frequent in France. Diagnoses occurring relatively more frequently in the Federal Republic of Germany are ischemic heart disease, diabetes

mellitus, bronchitis, and contact dermatitis. In the United States, upper respiratory disease, otitis media, and diseases of the sebaceous glands are relatively more frequently reported in encounters with the study physicians. While there seem to be more entries with respect to chronic problems in the Federal Republic of Germany, acute problems in the United States are more dominant among the selected medical problems. The 15 selected medical problems represent about one-third of total diagnostic entries in each of the 3 countries. The relatively low figures observed in the United States for insomnia, depression, and back pain can be partly explained by the fact that these diseases are frequently treated by psychologists and osteopathic physicians, two types of medical care practitioners not within the scope of this study.

The six preventive and administrative health problems selected accounted for 6.6 percent of diagnostic entries in France, 9.7 percent in the United States, and only 1.3 percent in the Federal Republic of Germany. The low FRG figure may be partly due to methods of diagnostic coding.

Monitoring of normal pregnancy accounted for about 4 percent of physicians' female diagnoses in the United States but less than 1 percent in France and in the Federal Republic of Germany. The monitoring of well children under age 3 years accounted for about 3 percent of diagnoses in the United States, about 1 percent in France, and only 0.07 percent in the Federal Republic of Germany. As noted previously, the low FRG numbers may be the result of diagnostic coding methods. The low frequency of inoculation or vaccination diagnoses in the United States and the Federal Republic of Germany is probably related to the fact that these are often performed during well-child visits or in public clinics. Also, inoculations usually would not be recorded on the U.S. or FRG encounter forms as a diagnosis or reason for the encounter.

Encounters for contraception are much more frequent in France than in the United States and the Federal Republic of

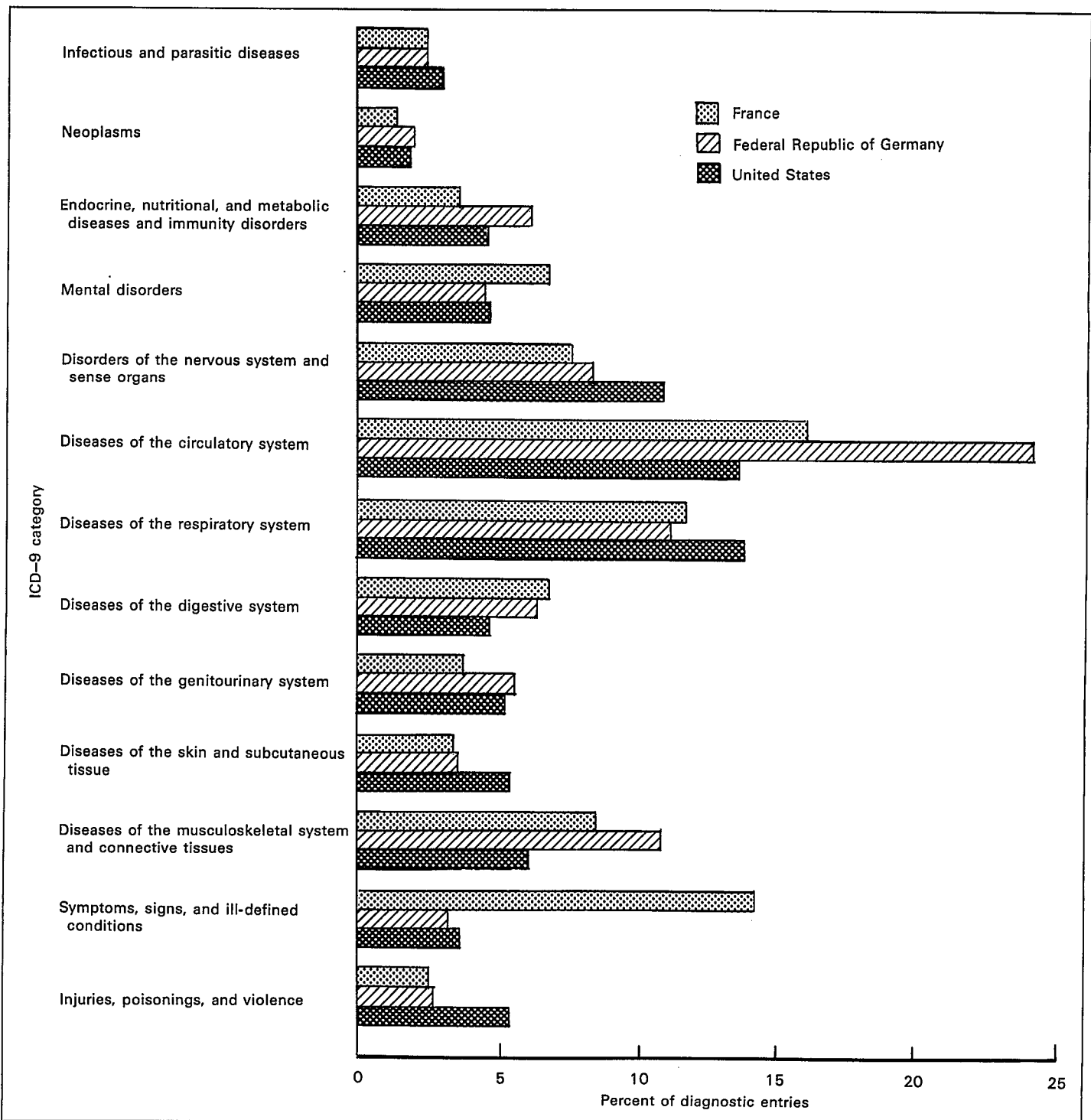


Figure 4. Percent of diagnostic entries in major International Classification of Diseases, 9th Revision, categories: France, the Federal Republic of Germany, and the United States, 1981-83

Germany; this service is often performed in the United States in special clinic settings or may take place in institutional settings in the Federal Republic of Germany. These facilities are not included in this study.

Physician specialty

As noted earlier, generalists accounted for 74 percent of encounters in France, 59 percent in the Federal Republic of

Germany, and only 39 percent in the United States. Most of the index diagnoses follow a similar pattern (table Y). In France, all of the index diagnoses are associated with generalists' encounters much more frequently than specialists' encounters except refractive error and diseases of the sebaceous glands. Similarly, in the Federal Republic of Germany, all but three of the index diagnoses are associated with generalists' encounters more frequently than specialists' encounters. In the United

Table U. Specific (index) diagnoses and preventive care categories used in analysis and the corresponding International Classification of Diseases codes

<i>International Classification of Diseases category</i>	<i>Code</i>	<i>International Classification of Diseases category</i>	<i>Code</i>
Medical problem		Medical problem—Con.	
Essential hypertension	401	Insomnia	780.5
Back pain	720–724	Diseases of the sebaceous glands	706
Neurosis	300–301	Contact dermatitis	692
Ischemic heart disease	410–414	Asthma	493
Arthritis	725–729		
Upper respiratory diseases (pharyngitis, tonsillitis, laryngitis, sinusitis, acute respiratory infections)	460, 461, 463, 465, 472, 477	Preventive care	
Diabetes mellitus	250	Normal pregnancy	V22
Bronchitis	466, 499	Well-child visit	V20
Refractive and accommodation errors	367	General medical examination	V70
Depression	309.0, 309.1, 311	Inoculation/vaccination	VO3–VO6
Otitis media	309.1, 381, 381.4	Contraception, family planning	V25
		Administrative visit (examination for work, school or insurance)	V68

Table W. Number of diagnostic entries per 100 encounters for selected index medical and preventive care categories: France, the Federal Republic of Germany, and the United States, 1981–83

<i>Diagnostic category</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
		Rate per 100 encounters	
Total entries for study physicians	181.24	---	142.84
Medical problem			
Total of selected problems	62.87	82.37	51.73
Essential hypertension	9.59	15.60	9.07
Back pain	6.04	9.85	1.97
Neurosis	5.06	1.55	3.54
Ischemic heart disease	3.89	9.22	3.95
Arthritis	6.17	5.50	3.94
Upper respiratory disease	11.48	8.17	10.69
Diabetes mellitus	2.29	7.78	3.82
Bronchitis	2.99	9.17	2.81
Refractive error	1.96	4.12	2.31
Depression	3.81	2.23	0.77
Otitis media	1.79	0.48	4.28
Insomnia	3.97	0.60	0.03
Diseases of the sebaceous glands	0.67	1.93	2.12
Contact dermatitis	1.17	3.30	1.37
Asthma	1.83	2.26	1.08
Preventive care			
Total of selected preventive care visits	12.04	3.13	13.87
Normal pregnancy	2.65	2.10	9.04
Well-child visit	2.17	0.18	4.42
General medical examination	0.85	0.05	1.66
Inoculation/vaccination	2.08	0.33	0.12
Contraception, family planning	3.30	1.21	0.55
Administrative visit (examination for work, school, or insurance)	2.06	0.40	1.49

States, on the other hand, only three of the diagnoses are associated more frequently with generalists' than specialists' encounters.

The six health and administrative problems selected for comparison (table Y) show quite similar patterns by specialty

from the Federal Republic of Germany and the United States (French data for these categories are unavailable). Encounters with specialists account for the majority of these diagnoses for four of the six categories in the United States and the Federal Republic of Germany.

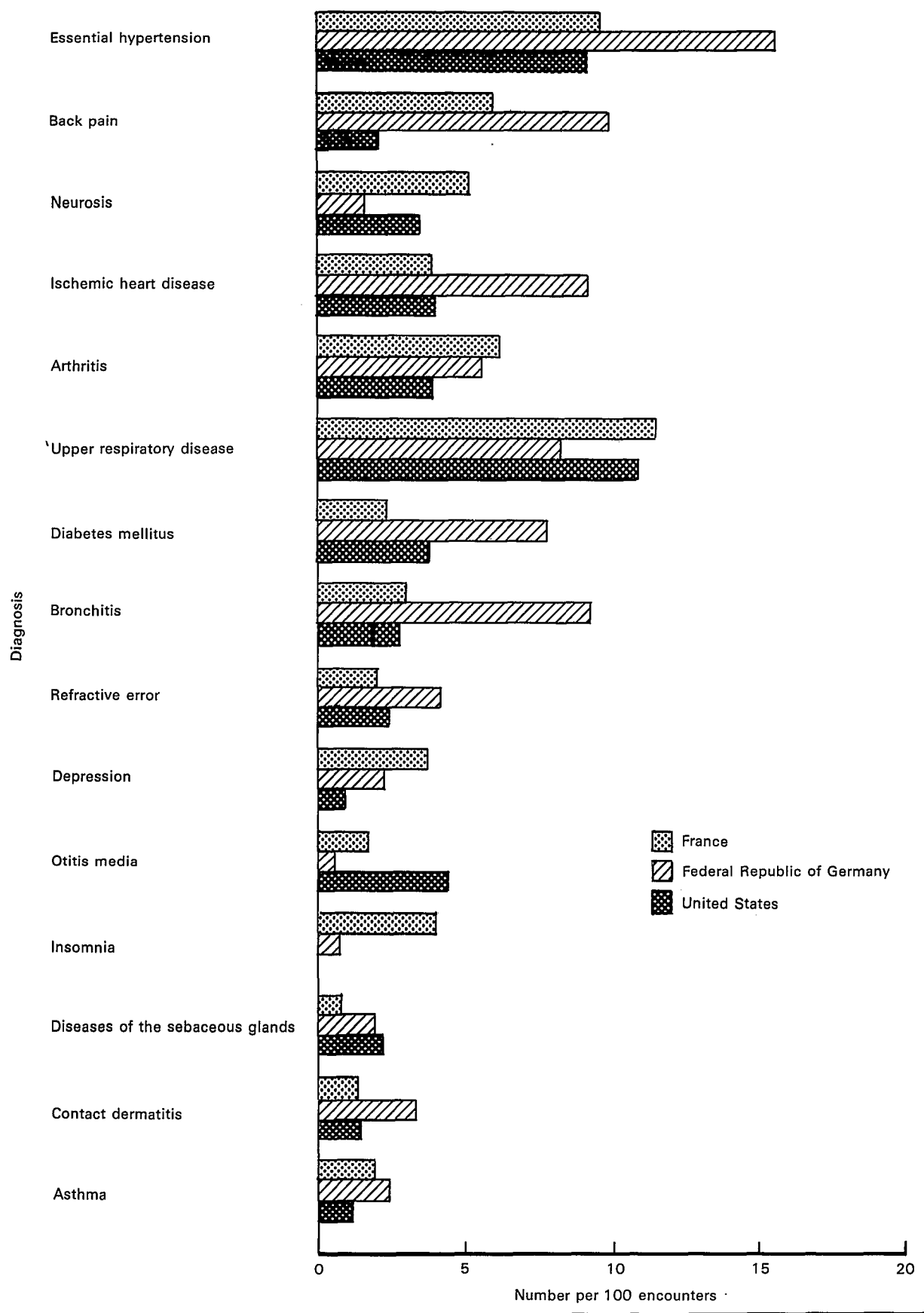


Figure 5. Number of diagnostic entries per 100 encounters for selected diagnoses: France, the Federal Republic of Germany, and the United States, 1981-83

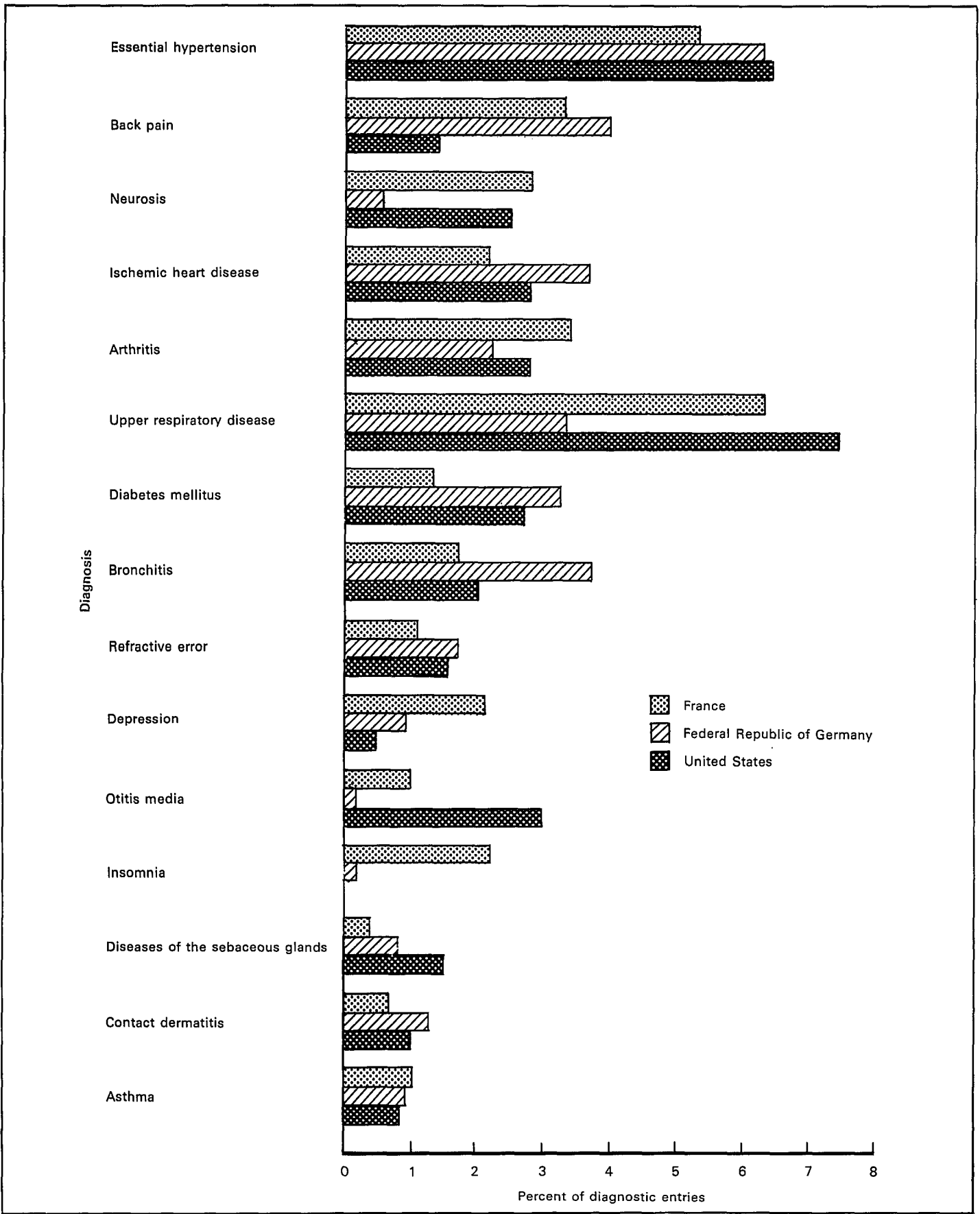


Figure 6. Percent of diagnostic entries for selected diagnoses: France, the Federal Republic of Germany, and the United States, 1981-83

Table Y. Percent distribution of diagnostic entries for selected index medical and preventive care categories by type of physician: France, the Federal Republic of Germany, and the United States, 1981-83

Diagnostic category	Country					
	France		Federal Republic of Germany		United States	
	Generalists	Specialists	Generalists	Specialists	Generalists	Specialists
Medical problem						
Total of selected problems.....	82.06	17.94	65.36	34.64	42.0	58.1
Essential hypertension.....	93.63	6.37	75.08	24.92	52.4	47.6
Back pain.....	84.20	15.80	76.66	23.34	48.6	51.4
Neurosis.....	65.68	34.32	63.60	36.40	20.6	79.4
Ischemic heart disease.....	86.75	13.25	66.04	33.96	32.4	67.6
Arthritis.....	88.64	11.36	81.04	18.96	56.6	43.4
Upper respiratory disease.....	84.56	15.44	50.54	49.46	51.4	48.6
Diabetes mellitus.....	91.29	8.71	74.21	25.79	47.9	52.1
Bronchitis.....	91.86	8.14	69.31	30.69	61.3	38.7
Refractive error.....	2.11	97.89	1.93	98.07	2.9	97.1
Depression.....	83.71	16.29	66.38	33.62	41.6	58.4
Otitis media.....	59.11	40.89	10.36	89.64	27.2	72.8
Insomnia.....	94.46	5.54	74.86	25.14	25.3	74.7
Diseases of the sebaceous glands.....	36.94	63.06	48.93	51.07	12.6	87.4
Contact dermatitis.....	73.76	26.24	56.01	43.99	38.7	61.3
Asthma.....	83.19	16.81	67.72	32.28	33.8	66.2
Preventive care						
Total of selected preventive care visits.....	---	---	33.33	66.67	28.0	72.0
Normal pregnancy.....	---	---	22.94	77.06	20.1	79.9
Well-child visit.....	---	---	8.02	91.98	16.9	83.1
General medical examination.....	---	---	41.07	58.93	35.5	64.5
Inoculation/vaccination.....	---	---	60.90	39.10	61.8	38.2
Contraception, family planning.....	---	---	14.84	85.16	19.4	80.6
Administrative visit (examination for work, school, or insurance).....	---	---	62.50	37.50	67.1	32.9

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Table 1. Number, percent distribution, crude and standardized annual rates per 1,000 population, and standard error of crude rates of encounters by physician specialty: France, the Federal Republic of Germany, and the United States, 1981-83

Physician specialty	Country		
	France	Federal Republic of Germany	United States
Number of encounters in thousands			
Total ambulatory care physicians.....	369,109	126,363	585,177
All study physicians.....	326,470	115,741	473,618
Generalists.....	242,657	68,801	183,669
All primary care specialists.....	42,889	33,238	202,945
Internists.....	17,944	18,093	86,651
Pediatricians.....	10,170	6,472	62,991
Obstetricians/gynecologists.....	14,775	8,673	53,303
All other study group specialists.....	40,924	13,702	87,004
Psychiatrists/neurologists.....	9,312	1,696	19,681
Dermatologists.....	7,596	3,455	23,262
Ophthalmologists.....	14,995	4,958	31,608
Otorhinolaryngologists.....	9,021	3,593	12,453
Other specialists in ambulatory care.....	42,639	10,622	111,559
Percent distribution			
Total ambulatory care physicians.....	100.00	100.00	100.00
All study physicians.....	88.45	91.59	80.94
Generalists.....	65.74	54.45	31.39
All primary care specialists.....	11.62	26.30	34.68
Internists.....	4.86	14.32	14.81
Pediatricians.....	2.76	5.12	10.76
Obstetricians/gynecologists.....	4.00	6.86	9.11
All other study group specialists.....	11.09	10.84	14.87
Psychiatrists/neurologists.....	2.52	1.34	3.36
Dermatologists.....	2.06	2.73	3.98
Ophthalmologists.....	4.06	3.92	5.40
Otorhinolaryngologists.....	2.44	2.84	2.13
Other specialists in ambulatory care.....	11.55	8.41	19.06
Rate of encounters per 1,000 population			
Total ambulatory care physicians.....	6,825	10,642	2,616
All study physicians.....	6,037	9,747	2,117
Generalists.....	4,487	5,794	821
All primary care specialists.....	793	2,799	902
Internists.....	332	1,524	387
Pediatricians.....	188	545	282
Obstetricians/gynecologists ¹	532	1,403	460
All other study group specialists.....	757	1,154	387
Psychiatrists/neurologists.....	172	143	88
Dermatologists.....	140	291	104
Ophthalmologists.....	277	418	141
Otorhinolaryngologists.....	167	303	56
Other specialists in ambulatory care.....	788	895	499
Standardized rate of encounters per 1,000 population			
Total ambulatory care physicians.....	6,825	10,388	2,677
All study physicians.....	6,036	9,522	2,163
Generalists.....	4,487	5,566	844
All primary care specialists.....	793	2,838	900
Internists.....	332	1,435	425
Pediatricians.....	188	720	276
Obstetricians/gynecologists ¹	532	1,337	420
All other study group specialists.....	757	1,118	402
Psychiatrists/neurologists.....	172	133	87
Dermatologists.....	140	282	103
Ophthalmologists.....	277	402	155
Otorhinolaryngologists.....	167	301	57
Other specialists in ambulatory care.....	788	866	514

¹Based on female population only.

Table 1. Number, percent distribution, crude and standardized annual rates per 1,000 population, and standard error of crude rates of encounters by physician specialty: France, the Federal Republic of Germany, and the United States, 1981-83—Con.

<i>Physician specialty</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
		Standard error of crude rates of encounters per 1,000 population	
Total ambulatory care physicians.....	---	140	144
All study physicians.....	---	136	116
Generalists.....	---	118	49
All primary care specialists.....	---	54	53
Internists.....	---	46	23
Pediatricians.....	---	13	18
Obstetricians/gynecologists.....	---	26	15
All other study group specialists.....	---	42	23
Psychiatrists/neurologists.....	---	9	7
Dermatologists.....	---	31	8
Ophthalmologists.....	---	13	11
Otorhinolaryngologists.....	---	23	5
Other specialists in ambulatory care.....	---	33	30

Table 2. Number, percent distribution, annual rate per 1,000 population, and standard error of rates of encounters by patient age and sex: France, the Federal Republic of Germany, and the United States, 1981-83

Age and sex	Country		
	France	Federal Republic of Germany	United States
Number of encounters in thousands			
All patients.....	326,533	115,741	473,617
SEX			
Female.....	194,770	69,452	295,236
Male.....	131,763	46,289	178,381
AGE			
All patients			
Under 2 years.....	17,079	3,619	33,759
2-14 years.....	41,678	10,110	60,175
15-24 years.....	34,517	13,165	65,698
25-44 years.....	82,129	26,813	122,420
45-64 years.....	78,109	31,026	104,894
65-79 years.....	54,639	24,779	69,119
80 years and over.....	18,382	6,229	17,552
Female			
Under 2 years.....	7,978	1,811	16,736
2-14 years.....	19,652	4,952	29,463
15-24 years.....	21,987	7,820	45,844
25-44 years.....	53,508	16,768	85,829
45-64 years.....	45,531	17,378	63,120
65-79 years.....	33,272	16,404	42,246
80 years and over.....	12,842	4,319	11,998
Male			
Under 2 years.....	9,101	1,808	17,023
2-14 years.....	22,026	5,158	30,712
15-24 years.....	12,530	5,345	19,854
25-44 years.....	28,621	10,045	36,591
45-64 years.....	32,578	13,648	41,774
65-79 years.....	21,367	8,375	26,873
80 years and over.....	5,540	1,910	5,554
Percent distribution			
All patients.....	100.00	100.00	100.00
SEX			
Female.....	59.65	60.01	62.34
Male.....	40.35	39.99	37.66
AGE			
All patients			
Under 2 years.....	5.23	3.13	7.13
2-14 years.....	12.76	8.74	12.71
15-24 years.....	10.57	11.37	13.87
25-44 years.....	25.15	23.17	25.85
45-64 years.....	23.92	26.81	22.15
65-79 years.....	16.73	21.41	14.59
80 years and over.....	5.63	5.38	3.71
Female			
Under 2 years.....	4.10	2.61	5.67
2-14 years.....	10.09	7.13	9.98
15-24 years.....	11.29	11.26	15.53
25-44 years.....	27.47	24.14	29.07
45-64 years.....	23.38	25.02	21.38
65-79 years.....	17.08	23.62	14.31
80 years and over.....	6.59	6.22	4.06
Male			
Under 2 years.....	6.91	3.91	9.54
2-14 years.....	16.72	11.14	17.22

Table 2. Number, percent distribution, annual rate per 1,000 population, and standard error of rates of encounters by patient age and sex: France, the Federal Republic of Germany, and the United States, 1981-83—Con.

Age and sex	Country		
	France	Federal Republic of Germany	United States
Male—Con.			
Percent distribution			
15-24 years	9.51	11.55	11.13
25-44 years	21.72	21.70	20.51
45-64 years	24.72	29.48	23.42
65-79 years	16.22	18.09	15.06
80 years and over	4.20	4.13	3.11
Rate of encounters per 1,000 population			
All patients	6,037	9,747	2,117
SEX			
Female	7,018	11,233	2,550
Male	5,004	8,134	1,653
AGE			
All patients			
Under 2 years	10,752	15,400	4,870
2-14 years	4,048	5,739	1,370
15-24 years	4,060	6,677	1,622
25-44 years	5,546	7,872	1,924
45-64 years	6,744	11,441	2,386
65-79 years	9,604	16,950	3,414
80 years and over	11,360	19,119	3,899
Female			
Under 2 years	10,293	15,803	4,938
2-14 years	3,908	5,768	1,372
15-24 years	5,079	8,161	2,233
25-44 years	7,418	10,107	2,629
45-64 years	7,685	12,004	2,731
65-79 years	9,978	17,912	3,596
80 years and over	11,204	18,844	4,175
Male			
Under 2 years	11,190	15,017	4,803
2-14 years	4,182	5,712	1,368
15-24 years	3,003	5,274	994
25-44 years	3,767	5,750	1,182
45-64 years	5,758	10,796	2,004
65-79 years	9,075	15,336	3,124
80 years and over	11,740	19,772	3,635
Standard error of rates of encounters per 1,000 population			
SEX			
Female	101	70	92
Male	72	60	61
AGE			
All patients			
Under 2 years	391	92	234
2-14 years	95	39	59
15-24 years	78	65	68
25-44 years	88	74	73
45-64 years	112	137	93
65-79 years	194	221	140
80 years and over	252	244	234
Female			
Under 2 years	328	137	296
2-14 years	85	52	66
15-24 years	113	91	94
25-44 years	173	114	105
45-64 years	137	159	112
65-79 years	205	318	151
80 years and over	232	320	283

Table 2. Number, percent distribution, annual rate per 1,000 population, and standard error of rates of encounters by patient age and sex: France, the Federal Republic of Germany, and the United States, 1981-83—Con.

<i>Age and sex</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
	Standard error of rates of encounters per 1,000 population		
Male			
Under 2 years	362	123	279
2-14 years.....	97	59	66
15-24 years	55	93	56
25-44 years	67	96	54
45-64 years	101	184	90
65-79 years	177	258	156
80 years and over.....	223	317	309

Table 3. Number, percent distribution, and crude rate per 1,000 population of new patient encounters by age and sex: France, the Federal Republic of Germany, and the United States, 1981-83

Age and sex	Country		
	France	Federal Republic of Germany	United States
All ages			
Number in thousands per year			
Total	47,058	21,452	61,967
Under 2 years	3,201	767	3,636
2-14 years	7,802	2,331	8,613
15-24 years	8,009	3,178	12,787
25-44 years	13,730	5,828	19,591
45-64 years	8,893	5,152	10,401
65-79 years	4,313	3,325	5,648
80 years and over	1,110	871	1,291
Female			
Total	25,742	12,515	37,417
Under 2 years	1,529	457	2,051
2-14 years	3,722	1,021	4,357
15-24 years	4,633	2,004	8,611
25-44 years	7,467	3,252	11,877
45-64 years	5,004	2,891	6,079
65-79 years	2,643	2,211	3,443
80 years and over	744	679	999
Male			
Total	21,316	8,937	24,550
Under 2 years	1,672	310	1,586
2-14 years	4,080	1,310	4,256
15-24 years	3,376	1,174	4,177
25-44 years	6,263	2,576	7,714
45-64 years	3,889	2,261	4,321
65-79 years	1,670	1,114	2,204
80 years and over	366	192	291
All ages			
Percent distribution			
Total	100.00	100.00	100.00
Under 2 years	6.80	3.58	5.87
2-14 years	16.58	10.87	13.90
15-24 years	17.02	14.81	20.64
25-44 years	29.18	27.17	31.62
45-64 years	18.90	24.02	16.78
65-79 years	9.17	15.50	9.11
80 years and over	2.36	4.06	2.08
Female			
Total	100.00	100.00	100.00
Under 2 years	5.94	3.65	5.48
2-14 years	14.46	8.16	11.64
15-24 years	18.00	16.01	23.01
25-44 years	29.01	25.98	31.74
45-64 years	19.44	23.10	16.25
65-79 years	10.27	17.67	9.20
80 years and over	2.89	5.43	2.67
Male			
Total	100.00	100.00	100.00
Under 2 years	7.84	3.47	6.46
2-14 years	19.14	14.66	17.34
15-24 years	15.84	13.14	17.01
25-44 years	29.38	28.82	31.42
45-64 years	18.24	25.30	17.60
65-79 years	7.83	12.47	8.98
80 years and over	1.72	2.15	1.19

Table 3. Number, percent distribution, and crude rate per 1,000 population of new patient encounters by age and sex: France, the Federal Republic of Germany, and the United States, 1981-83—Con.

<i>Age and sex</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
		Rate per 1,000 population	
All ages			
Total	870	1,807	277
Under 2 years	2,016	3,264	525
2-14 years	758	1,323	196
15-24 years	942	1,612	316
25-44 years	927	1,711	308
45-64 years	768	1,900	237
65-79 years	758	2,274	279
80 years and over	686	2,672	287
Female			
Total	928	2,024	323
Under 2 years	1,973	3,974	605
2-14 years	740	1,139	203
15-24 years	1,070	2,092	419
25-44 years	1,035	1,960	364
45-64 years	845	1,997	263
65-79 years	793	2,414	293
80 years and over	649	2,965	348
Male			
Total	809	1,570	228
Under 2 years	2,057	2,583	447
2-14 years	775	1,451	190
15-24 years	809	1,158	209
25-44 years	824	1,475	249
45-64 years	687	1,789	207
65-79 years	709	2,040	256
80 years and over	775	1,979	190

Table 4. Number, percent distribution, rate per 1,000 population, and rate per 100 encounters of encounters with Disposition of return visit planned, by physician specialty: France, the Federal Republic of Germany, and the United States, 1981-83

<i>Physician specialty</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
		Number in thousands	
All specialists.....	63,135	64,874	286,246
		Percent distribution	
All study physicians.....	100.00	100.00	100.00
Generalists.....	68.25	58.80	33.36
Internists.....	4.65	16.82	20.93
Pediatricians.....	1.73	4.55	10.87
Obstetricians/gynecologists.....	3.43	6.91	14.21
Psychiatrists/neurologists.....	9.60	1.87	5.76
Dermatologists.....	4.98	4.15	5.53
Ophthalmologists.....	4.26	3.34	6.91
Otorhinolaryngologists.....	3.10	3.55	2.42
		Rate per 1,000 population	
All study physicians.....	1,167	5,464	1,280
Generalists.....	797	3,213	427
Internists.....	54	919	268
Pediatricians.....	20	248	139
Obstetricians/gynecologists.....	40	378	182
Psychiatrists/neurologists.....	112	102	74
Dermatologists.....	58	227	71
Ophthalmologists.....	50	182	88
Otorhinolaryngologists.....	36	194	31
		Rate per 100 encounters	
All study physicians.....	19.34	56.05	60.44
Generalists.....	17.76	55.44	52.00
Internists.....	16.36	60.32	69.16
Pediatricians.....	10.74	45.58	49.42
Obstetricians/gynecologists.....	14.66	51.71	76.29
Psychiatrists/neurologists.....	65.11	71.70	83.77
Dermatologists.....	41.36	77.97	68.11
Ophthalmologists.....	17.92	43.96	62.54
Otorhinolaryngologists.....	21.73	64.10	55.63

Table 5. Number, percent distribution, rate per 1,000 population, and rate per 100 encounters of encounters with Disposition of referral to another physician, by physician specialty: France, the Federal Republic of Germany, and the United States, 1981-83

Physician specialty	Country		
	France	Federal Republic of Germany	United States
		Number in thousands	
All specialists.....	15,205	9,082	12,137
		Percent distribution	
All study physicians.....	100.00	100.00	100.00
Generalists.....	82.46	70.91	42.06
Internists.....	5.83	15.40	30.46
Pediatricians.....	2.78	3.78	12.89
Obstetricians/gynecologists.....	1.79	4.79	7.82
Psychiatrists/neurologists.....	1.97	0.95	2.22
Dermatologists.....	1.66	1.39	1.40
Ophthalmologists.....	1.35	1.43	2.10
Otorhinolaryngologists.....	2.16	1.35	1.04
		Rate per 1,000 population	
All study physicians.....	281	765	54
Generalists.....	232	542	23
Internists.....	16	118	17
Pediatricians.....	8	29	7
Obstetricians/gynecologists.....	5	37	4
Psychiatrists/neurologists.....	6	7	1
Dermatologists.....	5	11	1
Ophthalmologists.....	4	11	1
Otorhinolaryngologists.....	6	10	1
		Rate per 100 encounters	
All study physicians.....	4.66	7.85	2.56
Generalists.....	5.17	9.36	2.78
Internists.....	4.94	7.73	4.27
Pediatricians.....	4.15	5.30	2.48
Obstetricians/gynecologists.....	1.84	5.02	1.78
Psychiatrists/neurologists.....	3.22	5.07	1.37
Dermatologists.....	3.33	3.65	0.73
Ophthalmologists.....	1.37	2.62	0.81
Otorhinolaryngologists.....	3.64	3.42	1.01

Table 6. Number, percent distribution, rate per 1,000 population, and rate per 100 encounters of encounters with Disposition of admit to hospital, by physician specialty: France, the Federal Republic of Germany, and the United States, 1981-83

<i>Physician specialty</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
		Number in thousands	
All specialists.....	4,651	1,990	8,005
		Percent distribution	
All study physicians.....	100.00	100.00	100.00
Generalists.....	67.23	66.68	31.37
Internists.....	7.46	10.85	22.05
Pediatricians.....	1.51	2.96	5.61
Obstetricians/gynecologists.....	4.54	8.34	19.00
Psychiatrists/neurologists.....	4.24	1.61	2.99
Dermatologists.....	1.12	0.00	0.31
Ophthalmologists.....	2.32	3.82	7.55
Otorhinolaryngologists.....	11.59	5.73	11.13
		Rate per 1,000 population	
All study physicians.....	86	168	36
Generalists.....	58	112	11
Internists.....	6	18	8
Pediatricians.....	1	5	2
Obstetricians/gynecologists.....	4	14	7
Psychiatrists/neurologists.....	4	3	1
Dermatologists.....	1	-	-
Ophthalmologists.....	2	6	3
Otorhinolaryngologists.....	10	10	4
		Rate per 100 encounters	
All study physicians.....	1.42	1.72	1.69
Generalists.....	1.29	1.93	1.37
Internists.....	1.93	1.19	2.04
Pediatricians.....	0.69	0.91	0.71
Obstetricians/gynecologists.....	1.43	1.91	2.85
Psychiatrists/neurologists.....	2.12	1.89	1.21
Dermatologists.....	0.68	0.00	0.11
Ophthalmologists.....	0.72	1.53	1.91
Otorhinolaryngologists.....	5.97	3.17	7.15

Table 7. Number, percent distribution, rate per 1,000 population, and rate per 100 encounters with Disposition of return to referring physician, by physician specialty: France, the Federal Republic of Germany, and the United States, 1981-83

<i>Physician specialty</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
		Number in thousands	
All specialists.....	8,864	2,310	3,054
		Percent distribution	
All study physicians.....	100.00	100.00	100.00
Generalists.....	10.15	26.71	15.00
Internists.....	59.53	35.45	35.07
Pediatricians.....	3.44	0.39	7.43
Obstetricians/gynecologists.....	2.28	4.07	15.03
Psychiatrists/neurologists.....	7.93	9.52	17.71
Dermatologists.....	2.59	1.30	0.65
Ophthalmologists.....	7.30	17.23	7.63
Otorhinolaryngologists.....	6.77	5.32	1.47
		Rate per 1,000 population	
All study physicians.....	164	195	14
Generalists.....	17	52	2
Internists.....	98	69	5
Pediatricians.....	6	1	1
Obstetricians/gynecologists.....	4	8	2
Psychiatrists/neurologists.....	13	19	2
Dermatologists.....	4	3	-
Ophthalmologists.....	12	34	1
Otorhinolaryngologists.....	11	10	-
		Rate per 100 encounters	
All study physicians.....	2.72	2.00	0.64
Generalists.....	0.37	0.90	0.25
Internists.....	29.41	4.53	1.24
Pediatricians.....	3.00	0.14	0.36
Obstetricians/gynecologists.....	1.37	1.08	0.86
Psychiatrists/neurologists.....	7.55	12.97	2.75
Dermatologists.....	3.03	0.87	0.09
Ophthalmologists.....	4.31	8.03	0.74
Otorhinolaryngologists.....	6.65	3.42	0.36

Table 8. Number, percent distribution, and rate per 1,000 population of diagnostic entries for selected index medical and preventive care categories: France, the Federal Republic of Germany, and the United States, 1981-83

<i>Diagnostic category</i>	<i>Country</i>		
	<i>France</i>	<i>Federal Republic of Germany</i>	<i>United States</i>
		Number in thousands	
All diagnostic entries	598,923	285,975	676,532
		Percent distribution	
All diagnostic entries	100.00	100.00	100.00
Medical problem			
Total of selected problems	34.69	33.34	36.22
Essential hypertension	5.29	6.32	6.35
Back pain	3.33	3.99	1.38
Neurosis	2.79	0.63	2.48
Ischemic heart disease	2.15	3.73	2.77
Arthritis	3.40	2.22	2.76
Upper respiratory disease	6.33	3.31	7.49
Diabetes mellitus	1.26	3.15	2.67
Bronchitis	1.65	3.71	1.97
Refractive error	1.08	1.67	1.61
Depression	2.11	0.90	0.54
Otitis media	0.99	0.20	3.00
Insomnia	2.19	0.24	0.02
Diseases of the sebaceous glands	0.37	0.78	1.48
Contact dermatitis	0.65	1.34	0.96
Asthma	1.01	0.91	0.75
Preventive care			
Total of selected preventive care visits	6.64	1.27	9.71
Normal pregnancy	0.87	0.53	3.94
Well-child visit	1.20	0.07	3.10
General medical examination	0.47	0.02	1.16
Inoculation/vaccination	1.15	0.13	0.08
Contraception, family planning	1.82	0.49	0.39
Administrative visit	1.14	0.02	1.04
All other diagnostic entries	58.67	65.39	54.07
Medical problem			
		Rate per 1,000 population	
Total of selected problems	3,795	8,029	1,095
Essential hypertension	579	1,521	192
Back pain	364	960	42
Neurosis	305	151	75
Ischemic heart disease	235	899	84
Arthritis	372	536	83
Upper respiratory disease	693	796	226
Diabetes mellitus	138	758	81
Bronchitis	181	894	59
Refractive error	118	401	49
Depression	230	217	16
Otitis media	108	47	91
Insomnia	239	59	1
Diseases of the sebaceous glands	41	188	45
Contact dermatitis	71	322	29
Asthma	110	220	23
Preventive care			
Total of selected preventive care visits	727	305	293
Normal pregnancy ¹	186	247	230
Well-child visit	131	18	94
General medical examination	51	5	35
Inoculation/vaccination	125	32	3
Contraception, family planning	199	118	12
Administrative visit	124	4	32

¹Female population only.

Appendixes

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Appendix I

Survey instruments

France

EMTM encounter form and English translation

1 PATIENT N°		QUESTIONNAIRE SÉANCE			2 DATE				
3 SEXE <input type="checkbox"/> masculin <input type="checkbox"/> féminin	4 AGE _____ ans si nourrisson _____ mois	5 OCCUPATION <input type="checkbox"/> actif <i>sinon</i> <input type="checkbox"/> femme au foyer <input type="checkbox"/> élève, étudiant <input type="checkbox"/> retraité <input type="checkbox"/> chômeur <input type="checkbox"/> Autre, <i>préciser</i>		6 PROFESSION actuelle ou ancienne	7 LIEU <input type="checkbox"/> au cabinet <input type="checkbox"/> au domicile <input type="checkbox"/> autre, <i>préciser</i>	8 Ce patient vous a-t-il déjà consulté ? <input type="checkbox"/> oui <input type="checkbox"/> non			
9 DIAGNOSTICS ou motifs de la séance A B C D E F					N° d'ordre du ou des médicament (s) prescrit (s)	Cette affection est-elle en cours de traitement ou sous surveillance médicale ?			
						oui	non et ne l'a jamais été	non mais l'a déjà été	ne sait pas
10 SUITES <i>si nécessaire cocher plusieurs cases</i> 1 <input type="checkbox"/> aucune 2 <input type="checkbox"/> pharmacie 3 <input type="checkbox"/> analyses 4 <input type="checkbox"/> examens radiologiques 5 <input type="checkbox"/> envoi au médecin traitant 6 <input type="checkbox"/> envoi au spécialiste, <i>lequel</i> 7 <input type="checkbox"/> soins infirmiers 8 <input type="checkbox"/> kinésithérapie 9 <input type="checkbox"/> hospitalisation 10 <input type="checkbox"/> patient à revoir prochainement 11 <input type="checkbox"/> arrêt de travail ou scolaire 12 <input type="checkbox"/> autre, <i>préciser</i>				11 ACTES DE SOIN, DE DIAGNOSTIC OU DE PRÉVENTION effectués au cours de cette séance par vous-même ou un assistant, en dehors de l'examen clinique habituel.					
12 EFFETS THÉRAPEUTIQUES RECHERCHÉS <i>pour chaque médicament, dans l'ordre de la prescription</i> 1 4 2 5 3 6									

VISIT QUESTIONNAIRE (English translation)

1 PATIENT N° <input style="width: 100px;" type="text"/>			2 DATE <input style="width: 100px;" type="text"/>											
3 SEX <input type="checkbox"/> male <input type="checkbox"/> female	4 AGE _____ years for infants _____ months	5 OCCUPATION 1 <input type="checkbox"/> currently employed 2 <input type="checkbox"/> housewife 3 <input type="checkbox"/> student 4 <input type="checkbox"/> retired 5 <input type="checkbox"/> unemployed 6 <input type="checkbox"/> other, specify	6 PROFESSION current or former	7 SITE (where physician sees patient) 1 <input type="checkbox"/> office 2 <input type="checkbox"/> home 3 <input type="checkbox"/> other, specify	8 The patient Has this patient consulted you before? <input type="checkbox"/> yes <input type="checkbox"/> no									
9 DIAGNOSES or reasons for visit A B C D E F			Prescription number(s) of prescribed medications	Is condition currently being treated or under medical surveillance?										
				YES	NO never has been	NO but was in past	Don't know							
10 ACTIONS (check all that apply) 1 <input type="checkbox"/> none 2 <input type="checkbox"/> pharmacy 3 <input type="checkbox"/> lab tests 4 <input type="checkbox"/> x-ray 5 <input type="checkbox"/> return to treating physician 6 <input type="checkbox"/> sent to specialist (specify specialty) 7 <input type="checkbox"/> nursing care 8 <input type="checkbox"/> physiotherapy 9 <input type="checkbox"/> hospitalization 10 <input type="checkbox"/> patient scheduled for early return visit 11 <input type="checkbox"/> no work or school 12 <input type="checkbox"/> other (specify)			11 THERAPEUTIC, DIAGNOSTIC, OR PREVENTIVE SERVICES performed this visit by doctor or assistant in addition to usual examination.											
12 Therapeutic effect desired for each medication in order of prescriptions (number is to agree with prescription number in item 9) <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 10%;">1</td> <td style="width: 80%;">.....</td> <td style="width: 10%; text-align: center;">4</td> </tr> <tr> <td>2</td> <td>.....</td> <td style="text-align: center;">5</td> </tr> <tr> <td>3</td> <td>.....</td> <td style="text-align: center;">6</td> </tr> </table>						1	4	2	5	3	6
1	4												
2	5												
3	6												

CREDOC

Division d'Économie Médicale

ENQUETE MORBIDITE THERAPEUTIQUE MEDICALE

ANNEXE 2

QUESTIONNAIRE ANONYME

MEDECIN

cocher la ou les case(s) correspondante(s)

1. SEXE: Masculin Féminin

2. ANNEE DE NAISSANCE:

3. ANNEE DE THESE:

4. ANNEE DE 1^{re} INSTALLATION:

5. ETES-VOUS: Généraliste
 Spécialiste *préciser*

Par ailleurs êtes-vous:

compétent *préciser*

compétent exclusif *préciser*

6. AVEZ-VOUS UNE ORIENTATION OU UNE DISCIPLINE PARTICULIERE:

(ex. homéopathie, acupuncture, gériatrie)

oui non

Si oui, laquelle:

7. AVEZ-VOUS DES TITRES HOSPITALIERS OU UNIVERSITAIRES:

oui non

Si oui, lesquels:

8. DANS QUELLE REGION ETES-VOUS INSTALLE :

- | | | |
|---|--|--|
| <input type="checkbox"/> Ile-de-France (75, 77, 78, 91, 92, 93, 94, 95) | <input type="checkbox"/> Lorraine (54, 55, 57, 88) | <input type="checkbox"/> Midi-Pyrénées (09, 12, 31, 32, 46, 65, 81, 82) |
| <input type="checkbox"/> Champagne-Ardenne (08, 10, 51, 52) | <input type="checkbox"/> Alsace (67, 68) | <input type="checkbox"/> Limousin (19, 23, 87) |
| <input type="checkbox"/> Picardie (02, 60, 80) | <input type="checkbox"/> Franche-Comté (25, 39, 70, 90) | <input type="checkbox"/> Rhône-Alpes (01, 07, 26, 38, 42, 69, 73, 74) |
| <input type="checkbox"/> Haute-Normandie (27, 76) | <input type="checkbox"/> Pays de la Loire (44, 49, 53, 72, 85) | <input type="checkbox"/> Auvergne (03, 15, 43, 63) |
| <input type="checkbox"/> Centre (18, 28, 36, 37, 41, 45) | <input type="checkbox"/> Bretagne (22, 29, 35, 56) | <input type="checkbox"/> Languedoc-Roussillon (11, 30, 34, 48, 64) |
| <input type="checkbox"/> Basse-Normandie (14, 50, 61) | <input type="checkbox"/> Poitou-Charentes (16, 17, 79, 86) | <input type="checkbox"/> Provence-Alpes-Côte d'Azur (04, 05, 06, 13, 83, 84) |
| <input type="checkbox"/> Bourgogne (21, 58, 71, 89) | <input type="checkbox"/> Aquitaine (24, 33, 40, 47, 64) | <input type="checkbox"/> Corse (20) |
| <input type="checkbox"/> Nord-Pas-de-Calais (59, 62) | | |

9. TYPE DE LA COMMUNE D'INSTALLATION :

- rurale
- bourg ou ville isolée
- banlieue
- ville, centre d'une agglomération
- autre *préciser*

10. NOMBRE D'HABITANTS DE L'AGGLOMERATION DANS LAQUELLE VOUS EXERCEZ :
(ou de la commune si celle-ci est isolée)

- | | |
|--|---|
| <input type="checkbox"/> 1 à 999 | <input type="checkbox"/> 50 000 à 99 999 |
| <input type="checkbox"/> 1 000 à 4 999 | <input type="checkbox"/> 100 000 à 299 999 |
| <input type="checkbox"/> 5 000 à 9 999 | <input type="checkbox"/> 300 000 et plus, hors agglomération parisienne |
| <input type="checkbox"/> 10 000 à 49 999 | <input type="checkbox"/> agglomération parisienne |

11. L'ESSENTIEL DE VOTRE CLIENTELE EST-ELLE ISSUE :

- d'une zone
- agricole
 - industrielle
 - résidentielle
 - mixte *préciser*

12. EXISTE-T-IL DES FACTEURS DE RISQUE PARTICULIERS LIES A L'ENVIRONNEMENT
DANS LA ZONE OU VOUS RECRUTEZ VOTRE CLIENTELE :

- oui non

Si oui, lesquels :

13. QUELLE DISTANCE SEPRE VOTRE LIEU D'EXERCICE : (en kilomètres)

- du Centre Hospitalier Universitaire ou Régional le plus proche :
- du Centre Hospitalier le plus proche :
- de l'hôpital public le plus proche :
- de l'établissement privé d'hospitalisation le plus proche :

14. QUEL EST VOTRE MODE D'ACTIVITE :

- libéral intégral
- libéral à temps partiel avec activité salariée hospitalière
- libéral à temps partiel avec activité salariée autre qu'hospitalière
- autre préciser

15. SI VOUS EFFECTUEZ UNE ACTIVITE SALARIEE :

- combien d'heures y consacrez-vous par semaine: heures
- dans quel cadre l'exercez-vous :

16. EXERCEZ-VOUS VOTRE ACTIVITE LIBERALE :

- de façon individuelle
- en cabinet de groupe d'une même spécialité
préciser le nombre de médecins du groupe (y compris vous-même):
- en cabinet pluridisciplinaire
préciser le nombre de médecins du groupe (y compris vous-même):
- autre préciser

17. EMPLOYEZ-VOUS DANS VOTRE CABINET UN PERSONNEL PARA-MEDICAL :

(infirmière, kinésithérapeute, ...)

- oui non

Si oui, quelle est sa qualification :

18. DISPOSEZ-VOUS AU CABINET DE L'UN DES APPAREILS SUIVANTS :

- | | | |
|---|---|---|
| <input type="checkbox"/> électrocardiographe | <input type="checkbox"/> fibroscope | <input type="checkbox"/> audiomètre |
| <input type="checkbox"/> échographe | <input type="checkbox"/> phonomécanographe | <input type="checkbox"/> impédancemètre |
| <input type="checkbox"/> microscope | <input type="checkbox"/> appareil de Holter | <input type="checkbox"/> matériel d'assistance respiratoire |
| <input type="checkbox"/> appareil de radiographie | <input type="checkbox"/> électroencéphalographe | <input type="checkbox"/> podoscope |
| <input type="checkbox"/> appareil de radioscopie | <input type="checkbox"/> électrorétinographe | <input type="checkbox"/> autres préciser |

19. ENVISAGEZ-VOUS DANS L'ANNEE A VENIR L'ACQUISITION DE NOUVEAUX MATERIELS :

- oui non

Si oui, lesquels :

20. PENSEZ-VOUS UTILE DE TENIR UN FICHER MEDICAL POUR CHACUN DE VOS PATIENTS :

- oui, mais je n'ai pas le temps de le faire
- oui, mais je ne peux le faire par insuffisance de secrétariat ou manque de place
- oui, mais je ne le fais pas, n'ayant pas trouvé de fiches de relevé bien adaptées
- oui et je m'astreins à le faire
- non, cela me paraît inutile, je connais suffisamment bien mes patients.
- autre *préciser*

21. SI VOUS TENEZ UN FICHER PAR MALADE, QUAND REPORTEZ-VOUS LES RENSEIGNEMENTS SUR LA FICHE :

- pendant la consultation
- immédiatement après la consultation
- en cas de visite pendant la visite
- en cas de visite au retour à votre cabinet
- en fin de journée
- en fin de semaine
- autre *préciser*

22. VEUILLEZ NOUS FAIRE PART DE VOS OBSERVATIONS SUR LA PRESENTATION, L'UTILISATION OU LA FORMULATION DU PRESENT QUESTIONNAIRE ET DES DOSSIERS PATIENTS :

23. AU VU DES QUELQUES RESULTATS PRESENTES DANS LE "DEPLIANT CREDOC" JOINT, QUELS SONT LES POINTS DE RECHERCHE QUE VOUS SOUHAITERIEZ VOIR DEVELOPPER A PARTIR DE CETTE ENQUETE :

PHYSICIAN QUESTIONNAIRE

(English translation)

1. SEX : Male Female

2. YEAR OF BIRTH :

3. YEAR OF THESIS :

4. YEAR OF FIRST PRACTICE :

5. ARE YOU : General Practitioner
 Specialist please specify
 "Competent"¹

6. DO YOU WORK IN A PARTICULAR FIELD : Yes No

*if yes, state which :
(ex. Homeopathy, Acupuncture, Geriatrics)*

7. DO YOU HOLD A PARTICULAR POST IN A HOSPITAL OR UNIVERSITY : Yes No

if yes, state which :

¹ *A physician is "competent" or exclusive "competent" :*

– whether he practices both his own speciality and general medicine or another speciality (recognized or not)

– or he practices a particular medical qualification not recognized as a speciality.

8. PLACE OF PRACTICE :

- | | |
|---|--|
| <input type="checkbox"/> Ile-de-France (75, 77, 78, 91, 92, 93, 94, 95) | <input type="checkbox"/> Pays de la Loire (44, 49, 53, 72, 85) |
| <input type="checkbox"/> Champagne-Ardenne (08, 10, 51, 52) | <input type="checkbox"/> Bretagne (22, 29, 35, 56) |
| <input type="checkbox"/> Picardie (02, 60, 80) | <input type="checkbox"/> Poitou-Charentes (16, 17, 79, 86) |
| <input type="checkbox"/> Haute-Normandie (27, 76) | <input type="checkbox"/> Aquitaine (24, 33, 40, 47, 64) |
| <input type="checkbox"/> Centre (18, 28, 36, 37, 41, 45) | <input type="checkbox"/> Midi-Pyrénées (09, 12, 31, 32, 46, 65, 81, 82) |
| <input type="checkbox"/> Basse-Normandie (14, 50, 61) | <input type="checkbox"/> Limousin (19, 23, 87) |
| <input type="checkbox"/> Bourgogne (21, 58, 71, 89) | <input type="checkbox"/> Rhône-Alpes (01, 07, 26, 38, 42, 69, 73, 74) |
| <input type="checkbox"/> Nord-Pas-de-Calais (59, 62) | <input type="checkbox"/> Auvergne (03, 15, 43, 63) |
| <input type="checkbox"/> Lorraine (54, 55, 57, 88) | <input type="checkbox"/> Languedoc-Roussillon (11, 30, 34, 48, 66) |
| <input type="checkbox"/> Alsace (67, 68) | <input type="checkbox"/> Provence-Alpes-Côte d'Azur (04, 05, 06, 13, 83, 84) |
| <input type="checkbox"/> Franche-Comté (25, 39, 70, 90) | <input type="checkbox"/> Corse (20) |

9. KIND OF AREA :

- rural
- village or isolated town
- suburbs
- town or city center
- other, please specify

10. NUMBERS OF INHABITANTS IN PLACE OF PRACTICE :

- | | |
|---|---|
| <input type="checkbox"/> 1 to 999 | <input type="checkbox"/> 50,000 to 99,999 |
| <input type="checkbox"/> 1,000 to 4,999 | <input type="checkbox"/> 100,000 to 299,999 |
| <input type="checkbox"/> 5,000 to 9,999 | <input type="checkbox"/> 300,000 and more, except Paris' district |
| <input type="checkbox"/> 10,000 to 49,999 | <input type="checkbox"/> Paris' district |

11. THE MAJORITY OF YOUR PATIENTS COME FROM :

- | | |
|--|--------|
| <input type="checkbox"/> agricultural | } Zone |
| <input type="checkbox"/> industrial | |
| <input type="checkbox"/> residential | |
| <input type="checkbox"/> mixed, please specify | |

12. ARE THERE ANY PARTICULAR ENVIRONMENTAL RISK FACTORS WHERE YOUR PATIENTS LIVE :

- Yes No

if yes, please specify:

13. DISTANCE FROM PLACE OF PRACTICE TO THE NEAREST : (in kilometers)

- Central teaching or regional hospital
- Hospital center
- Public hospital
- Private hospital

14. MANNER OF PRACTICE :

- Private practice only
- Private and hospital activity
- Private and nonhospital activity
- Other, please specify

15. IF YOU ARE AN EMPLOYEE :

- how many hours a week : hours
- type of work :

16. IN YOUR PRIVATE PRACTICE ARE YOU :

- alone
- with partners practicing the same specialty
state number of partners (including yourself) :
- multidisciplinary practice
state number of partners (including yourself) :
- other, please specify

17. DOES YOUR PRACTICE EMPLOY AUXILIARY STAFF:

- Yes No

if yes, please specify their qualifications:

18. DOES YOUR PRACTICE POSSESS ANY OF THE FOLLOWING APPARATUS:

- | | | |
|--|--|---|
| <input type="checkbox"/> electrocardiograph | <input type="checkbox"/> fibroscope | <input type="checkbox"/> audiometer |
| <input type="checkbox"/> ultrasonograph | <input type="checkbox"/> phonomechanograph | <input type="checkbox"/> impedancemeter |
| <input type="checkbox"/> microscope | <input type="checkbox"/> Holter's recording | <input type="checkbox"/> respiratory monitor |
| <input type="checkbox"/> radiography apparatus | <input type="checkbox"/> electroencephalograph | <input type="checkbox"/> podoscope |
| <input type="checkbox"/> radioscopy apparatus | <input type="checkbox"/> electroretinograph | <input type="checkbox"/> others, please specify |

19. IN THE NEXT YEAR DO YOU INTEND TO ACQUIRE NEW EQUIPMENT :

- Yes No

if yes, which:

20. DO YOU THINK IT USEFUL TO KEEP A MEDICAL FILE ON EACH OF YOUR PATIENTS :

- yes, but I have no time to do so
- yes, but I can not do it due to lack of space or heavy secretarial schedule
- yes, but I do not do it because of the lack of adequately adapted medical files
- yes, by requirement
- no, as I know my patients well enough it seems useless
- other, please specify

21. IF YOU KEEP A FILE ON EACH PATIENT, WHEN DO YOU FILL IN YOUR FILE :

- during the office visit
- immediately after office visit
- during a home visit
- on arrival at your office after medical visit
- at the end of the day
- at the end of the week
- other, please specify

22. PLEASE STATE YOUR COMMENTS ON THE PRESENTATION, THE USE OR THE FORMULATION OF THIS QUESTIONNAIRE AND OF THE PATIENT' S FORM :

23. IN RELATION TO THE RESULTS IN THE ATTACHED "DEPLIANT CREDOC" WHAT RESEARCH WOULD YOU LIKE TO SEE DEVELOPED :

Federal Republic of Germany

EVaS encounter form and English translation



Nummer
201205 *

Nummer
201205 *



Zentralinstitut für die kassenärztliche Versorgung in der Bundesrepublik Deutschland

Erhebung über die ambulante Versorgung durch niedergelassene Ärzte

Diese Teile können von der Arzthelferin ausgefüllt werden.

Bitte für jeden dritten Patienten den Erhebungsbogen ausfüllen und danach ein neues Blatt beginnen.

Namen der Patienten (als Gedächtnisstütze)

1. _____

2. _____

3. _____
(Erhebungsbogen ausfüllen)

Dieser Teil verbleibt beim Arzt. Wir bitten um Aufbewahrung.

Erhebung über die ambulante Versorgung durch niedergelassene Ärzte.

Zentralinstitut für die kassenärztliche Versorgung in der Bundesrepublik Deutschland
Haedenkampstraße 5
5000 Köln 41
Tel. 0221/402001

Geschlecht <input type="checkbox"/> männlich <input type="checkbox"/> weiblich	krankenversichert <input type="checkbox"/> bei AOK, BKK, IKK, LKK, Knappschaft, o. ä. <input type="checkbox"/> bei Ersatzkasse <input type="checkbox"/> privat	<input type="checkbox"/> Patient von außen überwiesen <input type="checkbox"/> zur Mit-/Weiterbehandlung <input type="checkbox"/> zur Konsiliar-/Auftragsbehandlung <input type="checkbox"/> zur Unfallvorstellung
Geburtsjahr 15 - 18 Bei Säuglingen Alter in Monaten 19 - 20	Form der Konsultation <input type="checkbox"/> Patient kommt selbst <input type="checkbox"/> Patient hat Arzt gesprochen <input type="checkbox"/> Patient schickt anderen <input type="checkbox"/> Arztgespräch mit Angehörigen <input type="checkbox"/> telefonischer Kontakt <input type="checkbox"/> Hausbesuch - Besuch im Heim <input type="checkbox"/> Arzt wurde gerufen <input type="checkbox"/> Routinebesuch <input type="checkbox"/> Patient in der Praxis bekannt <input type="checkbox"/> Patient war wiedereinbestellt	Tag der Konsultation <input type="checkbox"/> Mo <input type="checkbox"/> Di <input type="checkbox"/> Mi <input type="checkbox"/> Do <input type="checkbox"/> Fr
Nationalität <input type="checkbox"/> deutsch <input type="checkbox"/> türkisch <input type="checkbox"/> italienisch <input type="checkbox"/> jugoslawisch <input type="checkbox"/> spanisch <input type="checkbox"/> sonstige	Grund der Konsultation <input type="checkbox"/> Vorsorge <input type="checkbox"/> Krankheit <input type="checkbox"/> Unfall <input type="checkbox"/> Notfall <input type="checkbox"/> Patient will Bescheinigung für AU/Krankengeld <input type="checkbox"/> Patient will Überweisung <input type="checkbox"/> Patient will Rezept <input type="checkbox"/> anderes, was?	

Bitte geben Sie das **jetzige Anliegen des Patienten** (Beschwerden, Probleme, auch nichtmedizinische Anliegen) möglichst in seinen Worten wieder.
Wichtigstes Anliegen:

Patient kommt **deswegen** zum ersten Mal

Problemschwere aus der Sicht des Patienten

geringfügig
 mittel
 gravierend

sonstige Anliegen:

Behandlung und Leistungen anlässlich dieser Konsultation

Vorsorge

Schwangerschaft
 Krankheitsfrüherkennung bei Kindern
 Jugendarbeitsschutz
 Krebsfrüherkennung
 Impfung

Präventive Leistungen im folgenden bitte nicht noch einmal angeben.

Diagnostik

Anamnese
 körperliche Untersuchung
 EKG
 Blutdruckmessung
 Röntgen
 Entnahme von Untersuchungsmaterial
 Labor

sonstige diagnostische Leistungen, welche?

Therapie

Rezept
 Medikamentenmuster
 Ärztl. Gespräch, Beratung
 Therapeutisches Zuhören
 Psychotherapie
 Physikalische Therapie
 Injektion, excl. Impfung
 Chirurgische Leistung
 Verband
 sonstige therapeutische Leistungen, welche?

AU

erstmals verlängert

Hauptdiagnose (nur zum wichtigsten Anliegen des Patienten)

Diagnose:

akut, und zwar seit

heute 73
 74 75 76 77 78
 Tagen Wochen
 Wieviele Kontakte seither deswegen?
 79 80

chronisch, und zwar seit

weniger als einem Jahr
 mehr als einem Jahr
 Wieviele Kontakte deswegen ungefähr im Quartal?
 83 84

postoperative Nachbehandlung

Problemschwere aus der Sicht des Arztes

geringfügig
 mittel
 gravierend

andere Diagnosen in der Reihenfolge ihrer Wichtigkeit:

Behandlungsplan

weitere Konsultation

unnötig
 wiederbestellt
 telefonischer Kontakt
 bei Bedarf

Überweisung an anderen Arzt

Mit-/Weiterbehandlung
 Konsiliar-/Auftragsbehandlung
 Unfallvorstellung
 Rückkehr zum überweisenden Arzt
 Einweisung ins Krankenhaus
 sonstiges (z. B. Kur, Beratungsstelle), was?

Dauer des persönlichen Arzt-Patienten-Kontaktes in Minuten:

97 - 98



Number 207398 *

Number 207398 *

Central Research Institute of the Health Insurance Physicians in the Federal Republic of Germany

SURVEY AMONG AMBULATORY CARE PHYSICIANS

(English translation)

These parts may be filled in by the doctor's assistant

Please complete this form for every third patient and then please use a new form.

Patients' names (as memory aid)

- 1. _____
2. _____

3. _____ (complete form)

This part remains with the physician. Please keep

Survey among ambulatory care physicians

Central Research Institute of Health Insurance Physicians in the Federal Republic of Germany Haedenkampstr. 5 D-5000 Köln 41 Phone: (0221) 402001

Form sections: SEX, HEALTH INSURANCE, DATE OF BIRTH, TYPE OF CONSULTATION, NATIONALITY, REASON FOR CONSULTATION, DAY OF CONSULTATION

Form sections: Please fill in the patient's reasons (complaints, problems, also non-medical reasons) for this visit, MOST IMPORTANT REASON: Seriousness of patient's problem evaluated by patient, Other reasons for contact

Form sections: MEDICAL TREATMENT AND SERVICES (this consultation), PREVENTIVE Services, THERAPEUTIC Services, DIAGNOSTIC Services, DISABILITY-certificate

Form sections: PRINCIPAL DIAGNOSIS (corresponding to the most important reason), Diagnosis, Seriousness of patient's problem evaluated by physician, Other diagnoses by order of importance

Form sections: DISPOSITION THIS VISIT, DURATION OF PERSONAL DOCTOR-PATIENT CONTACT in minutes

KASSENÄRZTLICHE VEREINIGUNG SÜDBADEN
Körperschaft des öffentlichen Rechts

78 FREIBURG I. BR.,
Sundgaullee 27
Telefon 0761/82075



**Zentralinstitut
für die kassenärztliche Versorgung
in der Bundesrepublik Deutschland**
Rechtsfähige Stiftung

Haedenkampstraße 3
5000 Köln 41
Telefon (0221) 402001
Telex 8883 242 Kbvd

EINFÜHRUNGSFRAGEBOGEN

Erhebung über die ambulante Versorgung
durch niedergelassene Ärzte

Für die Erhebung über die ambulante Versorgung durch niedergelassene Ärzte bitten wir Sie, uns die nachfolgenden Fragen zu beantworten.

Arztstempel:

Datum: _____

(1) Wir haben Sie in Ihrer Eigenschaft als niedergelassenen Arzt für RVO- und Ersatzkassen ausgewählt.

Sind Sie noch niedergelassener Arzt für alle Kassen?

ja ()

nein ()

=====
Wenn Sie mit "nein" geantwortet haben, bitten wir Sie, den Fragebogen nicht weiter auszufüllen. Senden Sie den Bogen bitte im beiliegenden Freiumschlag an die KV zurück, da wir im Rahmen unserer Studie auch diese Angaben auswerten wollen.

Vielen Dank für Ihre Mitarbeit!
=====

(2) Sie sind

Ist das richtig?

ja ()

nein ()

Wenn nein, für welches Fachgebiet sind Sie zugelassen?

(bitte Gebietsbezeichnung eintragen)

(3) Praktizieren Sie allein oder mit anderen Ärzten
zusammen?

allein ()

in Gemeinschaftspraxis
(gemeinsame Abrechnung) ()

in Praxisgemeinschaft
(getrennte Abrechnung) ()

mit wieviel Ärzten außer
Ihnen selbst? -----
(Anzahl)

Welchen Fachgebieten gehören
Ihre Kollegen an?

Gebietsbezeichnung _____ Anzahl

(4) Wieviele nichtärztliche Personen einschließlich nicht bezahlter Personen (ohne Reinigungspersonal) sind in Ihrer Praxis tätig?

(Bitte	Zahl der	und	deren	eintragen)
	Personen		Positionen	
ganztags	-----	-----,	-----	-----
		-----,		-----
halbtags	-----	-----,	-----	-----
		-----,		-----
stundenweise	-----	-----,	-----	-----
		-----,		-----

(5) Gehören Sie einer Laborgemeinschaft an?

ja ()

nein ()

(6) Nennen Sie bitte die beiden wichtigsten apparativen Einrichtungen in Ihrer Praxis:

(7) Im Rahmen der geplanten Erhebung möchten wir Sie bitten, an zwei aufeinanderfolgenden Wochentagen über eine Auswahl von Kontakten in Ihrer Praxis zu berichten.

Wir nennen Ihnen nun die für Sie ausgewählten 2 Berichtst-
tage:

-----, das sind die

Wochentage Mo Di Mi Do Fr.

Sind Sie an mindestens einem dieser Tage ambulant tätig?

ja ()

nein ()

(8) Wenn Sie Frage (7) mit "nein" beantworten mußten, dann sind für Sie der _____, das sind Mo Di Mi Do Fr alternative Erhebungstage.

Sind Sie mindestens an einem dieser Tage ambulant tätig?

ja ()
nein ()

Wenn nein, dann wählen Sie bitte eines der folgenden Tagespaare:

----- Mo Di Mi Do Fr ()

----- Mo Di Mi Do Fr ()

----- Mo Di Mi Do Fr ()

(9) Bitte geben Sie für eine typische Woche Ihrer Praxis die Anzahl aller Patienten und Ihre Arbeitszeit für Sprechstunde und Hausbesuche (ohne Zeitaufwand für Verwaltungsarbeiten) pro Tag an.

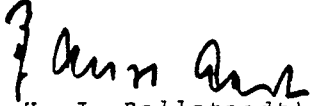
- Gemeinschaftspraxen: Beziehen Sie bitte Ihre Angaben auf Patientenzahl und Arbeitszeit aller Kollegen zusammen.
- Belegärzte: Berücksichtigen Sie bitte nur Ihre ambulanten Fälle.

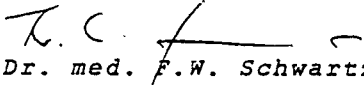
Wochentag	Anzahl der Patienten	Arbeitszeit
Montag	-----	-----
Dienstag	-----	-----
Mittwoch	-----	-----
Donnerstag	-----	-----
Freitag	-----	-----
Samstag	-----	-----
Sonntag	-----	-----

Wieviele Stunden benötigen Sie zusätzlich für Praxisverwaltung pro Woche?

ca. _____ Stunden

=====
Wir danken Ihnen für Ihre Mitarbeit und versichern Ihnen, daß Ihre Auskünfte nur dieser Studie dienen und von uns streng vertraulich behandelt werden.


(Dr. H. J. Ballstaedt)
1. Vorsitzender der KV Südbaden


(Dr. med. F.W. Schwartz)
Geschäftsführer des ZI

Induction Interview

(English translation)

We ask you to please answer the following questions for the survey among ambulatory care physicians (EVaS)

Stamp of physician

Date

You were chosen for the survey since you are entitled to physician services for RVO¹⁾ and Ersatzkassen²⁾-patients.

1. Are you a physician entitled to treat RVO and Ersatzkassen (compulsory health insurance) patients?

Yes

No (Please stop here and return form to the ZI)

2. You are (Physician specialty was listed) _____?

Is this correct?

Yes

No - which specialty do you practice? _____

3. Do you practice in a group or solo practice?

Solo, group

How many physicians are you, except for yourself? _____

Number

Which specialty do your colleagues belong to?

Specialty

Number

Specialty

Number

4. How many non-physician personnel work in your office (including non-salaried persons, but excluding cleaning personnel)?

Number of persons

Position

Full time _____

Half time _____

Hourly presence _____

¹⁾RVO, Reichsversicherungsordnung - Reich insurance regulations - Law establishing sickness funds/compulsory health insurance

²⁾EK, Ersatzkasse - Substitute health insurance fund

5. Do you participate in a cooperative laboratory organization (Labor-gemeinschaft)?

Yes

No

6. Please name the two most important pieces of equipment in your practice

- _____

- _____

7. In the framework of the planned investigation we wish to ask you to report about a sample of contacts to your office during two consecutive week-days. These are your reporting days.

_____ , _____
Dates Week-days marked

Will you be delivering ambulatory medical care on at least one of these days?

Yes

No

8. If you had to answer 'no' to question 7, then your alternate reporting days are

_____ , _____
Dates Week-days marked

Will you be delivering ambulatory medical care on at least one of these days?

Yes

No (Please choose one the following pairs of reporting days)

_____ , _____
Dates Week-days marked

_____ , _____
Dates Week-days marked

_____ , _____
Dates Week-days marked

9. Please list the number of patients and the time spent in patient contact (without administrative activities) for a typical week.

- Group practices: Please give total number of patients and total contact time for all partners
- Physicians who also care for hospital patients: Please include only ambulatory care patients

Week day	Number of patients	Time in patient care (hours)
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____
Sunday	_____	_____

How many hours do you need in addition for administrative tasks in the office?

_____ Number of hours

We thank you for your cooperation and assure that your responses will solely be used for this study. All data will be kept confidential.

Signature of the president
of the respective physicians'
organization

Signature of the Director
of the ZI



Arztstempel:

① 1. Erhebungstag

Datum:

Wieviele Praxiskontakte fanden insgesamt statt?

.....
(Anzahl)

② Zeitaufwand

Wieviel Zeit brauchten Sie etwa, um einen Erhebungsbogen auszufüllen?

.....
(Minuten)

③ 2. Erhebungstag

Datum:

Wieviele Praxiskontakte fanden insgesamt statt?

.....
(Anzahl)

④ Auswertungsergebnisse

Glauben Sie, daß Arztbefragungen einen Einblick in die Probleme der Arztpraxis gestatten?

.....
.....
.....

Wünschen Sie die Zusendung eines Ergebnisberichts?

- ja
- nein

FOR IHRE MITARBEIT BEDANKEN WIR UNS SEHR



(English translation)

Physician's stamp:

① 1st Reporting Day

Date:

How many office contact took place in total this day?

.....
(Number)

② Time Requirement

Required time to complete one encounter record form:

.....
(Minutes)

③ 2nd Reporting Day

Date:

How many office contacts took place in total this day?

.....
(Number)

④ Study in physicians' offices

Do you believe that studies in physicians' offices adequately reflect activities there?

.....
.....
.....

Do you wish to receive a report about the study?

yes

no

THANK YOU VERY MUCH FOR YOUR COOPERATION

United States

NAMCS encounter form

B No 382831

ASSURANCE OF CONFIDENTIALITY—All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

Department of Health and Human Services
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Statistics

B

No 382831

PATIENT LOG

As each patient arrives, record name and time of visit on the log below. For the patient entered on line #2, also complete the patient record to the right.

PATIENT'S NAME

TIME OF VISIT

1	
	a.m.
	p.m.

2	
	a.m.
	p.m.

Record items 1-15 for this patient.

CONTINUE LISTING PATIENTS ON NEXT PAGE

PATIENT RECORD NATIONAL AMBULATORY MEDICAL CARE SURVEY

1. DATE OF VISIT

Month / Day / Year

2. DATE OF BIRTH

Month / Day / Year

3. SEX

- 1 FEMALE
2 MALE

4. COLOR OR RACE

- 1 WHITE
2 BLACK
3 ASIAN/PACIFIC ISLANDER
4 AMERICAN INDIAN/ALASKAN NATIVE

5. ETHNICITY

- 1 HISPANIC ORIGIN
2 NOT HISPANIC

6. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT [In patient's own words]

- a. MOST IMPORTANT
b. OTHER

7. MAJOR REASON FOR THIS VISIT [Check one]

- 1 ACUTE PROBLEM
2 CHRONIC PROBLEM, ROUTINE
3 CHRONIC PROBLEM, FLAREUP
4 POST SURGERY/POST INJURY
5 NON-ILLNESS CARE (ROUTINE PRENATAL, GENERAL EXAM, WELL BABY, ETC.)

8. DIAGNOSTIC SERVICES THIS VISIT [Check all ordered or provided]

- 1 NONE
2 LIMITED HISTORY/EXAM.
3 GENERAL HISTORY/EXAM.
4 PAP TEST
5 CLINICAL LAB TEST
6 X RAY
7 BLOOD PRESSURE CHECK
8 EKG
9 VISION TEST
10 ENDOSCOPY
11 MENTAL STATUS EXAM.
12 OTHER (Specify)

9. PHYSICIAN'S DIAGNOSES

- a. PRINCIPAL DIAGNOSIS/PROBLEM ASSOCIATED WITH ITEM 6a.
b. OTHER SIGNIFICANT CURRENT DIAGNOSES

10. HAVE YOU SEEN PATIENT BEFORE?

- 1 YES 2 NO

IF YES, FOR THE CONDITION IN ITEM 9a?

- 1 YES 2 NO

11. MEDICATION THERAPY THIS VISIT NONE

[Using brand or generic names, record all new and continued medications ordered, injected, administered, or otherwise provided at this visit. Include immunizing and desensitizing agents]

a. FOR PRINCIPAL DIAGNOSES IN ITEM 9a.

1. _____
2. _____
3. _____
4. _____

b. FOR ALL OTHER REASONS

1. _____
2. _____
3. _____
4. _____

12. NON-MEDICATION THERAPY [Check all services ordered or provided this visit]

- 1 NONE
2 PHYSIOTHERAPY
3 OFFICE SURGERY
4 FAMILY PLANNING
5 PSYCHOTHERAPY/THERAPEUTIC LISTENING
6 DIET COUNSELING
7 FAMILY/SOCIAL COUNSELING
8 MEDICAL COUNSELING
9 OTHER (Specify)

13. WAS PATIENT REFERRED FOR THIS VISIT BY ANOTHER PHYSICIAN?

- 1 YES
2 NO

14. DISPOSITION THIS VISIT [Check all that apply]

- 1 NO FOLLOW-UP PLANNED
2 RETURN AT SPECIFIED TIME
3 RETURN IF NEEDED, P.R.N.
4 TELEPHONE FOLLOW-UP PLANNED
5 REFERRED TO OTHER PHYSICIAN
6 RETURNED TO REFERRING PHYSICIAN
7 ADMIT TO HOSPITAL
8 OTHER (Specify)

15. DURATION OF THIS VISIT [Time actually spent with physician]

Minutes

BEGIN DECK 3

CONFIDENTIAL*
NORC-4284

Form Approved
OMB No. 68R1498

FOR OFFICE USE ONLY:

(BATCH NO.)

--	--

 5-6/

(LOG NO.)

--	--	--	--

 7-10/

NATIONAL AMBULATORY MEDICAL CARE SURVEY
INDUCTION INTERVIEW

BEFORE STARTING INTERVIEW

1. ENTER PHYSICIAN I.D. NUMBER IN BOX TO RIGHT.
2. ENTER DATES OF ASSIGNED REPORTING WEEK IN Q. 2, P. 2.

(Phys. ID Number)

--	--	--	--

1-4/

TIME _____ AM
BEGAN: _____ PM

Doctor, before I begin, let me take a minute to give you a little background about this survey.

Although ambulatory medical care accounts for nearly 90 percent of all medical care received in the United States, there is no systematic information about the characteristics and problems of people who consult physicians in their offices. This kind of information has been badly needed by medical educators and others concerned with the medical manpower situation.

In response to increasing demands for this kind of information, the National Center for Health Statistics, in close consultation with representatives of the medical profession, has developed the National Ambulatory Medical Care Survey.

Your own task in the survey is simple, carefully designed, and should not take much of your time. Essentially, it consists of your participation during a specified 7-day period. During this period, you simply check off a minimal amount of information concerning patients that you see.

Now, before we get into the actual procedures, I have a few questions to ask about your practice. The answers you give me will be used only for classification and * analysis, and of course all information you provide is held in strict confidence.

1. First, you are a _____
(ENTER SPECIALTY FROM CODE ON FACE SHEET LABEL.)

Is that right? Yes X
No (ASK A) Y

A. IF NO: What is your specialty. (including general practice)?

(Name of Specialty)

--	--	--	--

11-13/

* The National Ambulatory Medical Care Survey is authorized by Congress in Public Law 93-353, section 308. It is a voluntary study and there are no penalties for refusing to answer any question. All information collected is confidential and will be used only to prepare statistical summaries. No information which will identify an individual or a physician's practice will be released.

2. Now, doctor, this study will be concerned with the ambulatory patients you will see in your office during the week of (READ REPORTING DATES ENTERED BELOW).

_____ / _____ (that's a _____ (that's a
month date Monday) through month / date Sunday)

Are you likely to see any ambulatory patients in your office during that week?

Yes (GO TO Q. 3) . . . X

No (ASK A) Y

A. IF NO: Why is that? RECORD VERBATIM, THEN READ PARAGRAPH BELOW

Since it's very important, doctor, that we include any ambulatory patients that you do happen to see in your office during that week, I'd like to leave these forms with you anyway--just in case your plans change. I'll plan to check back with your office just before (STARTING DATE) to make sure, and I can explain them in detail then, if necessary.

GIVE DOCTOR THE A PATIENT RECORD FORMS AND GO TO Q. 9, P. 6.

3. A. At what office location will you be seeing ambulatory patients during that 7-day period? RECORD UNDER A BELOW AND THEN CODE B.

B. FOR EACH OFFICE LOCATION ENTERED IN A, CODE YES OR NO TO "IN SCOPE."

IN SCOPE (Yes)

OUT OF SCOPE (No)

Private offices
 Free-standing clinics
 (non-hospital based)
 Groups, partnerships
 Kaiser, HIP, Mayo Clinic
 Neighborhood Health Centers
 Privately operated clinics
 (except family planning)

Hospital emergency rooms
 Hospital outpatient departments
 College or university infirmaries
 Industrial outpatient facilities
 Family planning clinics
 Government-operated clinics
 (VD, maternal & child health, etc.)

IN CASE OF DOUBT, ASK: Is that (clinic/facility/institution) hospital based?

Is that (clinic/facility/institution) government operated?

C. Is that all of the office locations at which you expect to see ambulatory patients during that week?

Yes X
 No Y

IF NO: OBTAIN ADDITIONAL OFFICE LOCATION(S), ENTER IN "A" BELOW, AND REPEAT.

A. Office Location	B. In Scope?	
	Yes	No
(1) _____	1	0
(2) _____	1	0
(3) _____	1	0
(4) _____	1	0

TOTAL IN-SCOPE LOCATIONS:

14/

IF ALL LOCATIONS ARE OUT OF SCOPE, THANK THE DOCTOR AND LEAVE.

4. A. During that week (REPEAT DATES), how many ambulatory patients do you expect to see in your office practice? (DO NOT COUNT PATIENTS SEEN AT [OUT-OF-SCOPE LOCATIONS] CODED IN 3-B.)

ENTER TOTAL UNDER "A" BELOW AND CIRCLE NUMBER CATEGORY ON APPROPRIATE LINE.

- B. And during those seven days (REPEAT DATES IF NECESSARY), on how many days do you expect to see any ambulatory patients? COUNT EACH DAY IN WHICH DOCTOR EXPECTS TO SEE ANY PATIENTS AT AN IN-SCOPE OFFICE LOCATION.

CIRCLE NUMBER OF DAYS IN APPROPRIATE COLUMN UNDER "B" BELOW.

DETERMINE PROPER PATIENT LOG FORM FROM CHART BELOW. READ ACROSS ON "TOTAL PATIENTS" LINE UNDER "A" AND CIRCLE LETTER IN APPROPRIATE "DAYS" COLUMN UNDER "B."

THIS LETTER TELLS YOU WHICH OF THE FOUR PATIENT LOG FORMS (A, B, C, D) SHOULD BE USED BY THIS DOCTOR.

LOG FORM DESCRIPTION	A.	B.						
	Expected total patients during survey week.	Total days in practice during week.						
A--Patient Record is to be completed for <u>ALL</u> patients listed on Log. 15-17/	ENTER TOTAL FROM Q. 4-A.	18/						
	<input type="text"/> <input type="text"/> <input type="text"/>	1	2	3	4	5	6	7
	1- 12 PATIENTS	A	A	A	A	A	A	A
	13- 25 "	B	A	A	A	A	A	A
B--Patient Record is to be completed for every <u>SECOND</u> patient listed on Log.	26- 39 "	C	B	A	A	A	A	A
	40- 52 "	C	B	B	A	A	A	A
	53- 65 "	D	C	B	B	A	A	A
	66- 79 "	D	C	B	B	B	A	A
C--Patient Record is to be completed for every <u>THIRD</u> patient listed on Log.	80- 92 "	D	D	C	B	B	B	B
	93-105 "	D	D	C	B	B	B	B
	106-118 "	D	D	C	C	B	B	B
	119-131 "	D	D	C	C	B	B	B
	132-145 "	D	D	D	C	C	B	B
*D--Patient Record is to be completed for every <u>FIFTH</u> patient listed on Log.	146-158 "	D	D	D	C	C	B	B
	159-171 "	D	D	D	C	C	C	C
	172-184 "	D	D	D	C	C	C	C
	185-197 "	D	D	D	D	D	D	D
	198-210 "	D	D	D	D	D	D	D
	211+ "	D	D	D	D	D	D	D

* In the rare instance the physician will see more than 500 patients during his assigned reporting week, give him two D Patient Log Folios and instruct him to complete a patient record form for only every tenth patient. Then you are to draw an X through the Patient Record on every other page of the two folio pads, starting with Page 1 of the pad. The physician then completes the Patient Log on every page, but completes the Patient Record on every second page.

5. FIND LOG FOLIO WITH APPROPRIATE LETTER AND CIRCLE LETTER, ENTER FIRST FOUR NUMBERS OF THE FORM AND NUMBER OF LINES STAMPED "BEGIN ON NEXT LINE" FOR THE B-C-D LOG FORMS (if no lines are stamped, enter "0") BELOW.

FOLIO					No. Lines Stamped "BEGIN ON NEXT LINE"	FOR OFFICE USE ONLY Number patient record forms completed.
Letter	Number					
A						
B						
C						
D						

19-23/
24-26/

6. HAND DOCTOR HIS FOLIO AND EXPLAIN HOW FORMS ARE TO BE FILLED OUT. SHOW DOCTOR INSTRUCTIONS ON THE POCKET OF FOLIO, ITEMS 8 and 12 ON CARD IN POCKET OF FOLIO AND ITEM DEFINITIONS ON THE BACK OF FOLIO, TO WHICH HE CAN REFER AFTER YOU LEAVE.

EMPHASIZE THAT EVERY PATIENT VISIT EXCEPT ADMINISTRATIVE PURPOSE ONLY IS TO BE RECORDED ON THE LOG FOR ENTIRE REPORTING PERIOD. FOR EXAMPLE, IF A MEDICAL ASSISTANT GAVE THE PATIENT AN INOCULATION, OR A TECHNICIAN ADMINISTERED AN ELECTROCARDIOGRAM AND THE PATIENT DID NOT SEE THE DOCTOR, THIS VISIT MUST STILL BE LISTED ON THE LOG.

RECORD VERBATIM BELOW ANY CONCERN, PROBLEMS OR QUESTIONS THE DOCTOR RAISES.

7. IF DOCTOR EXPECTS TO SEE AMBULATORY PATIENTS AT MORE THAN ONE IN-SCOPE LOCATION DURING ASSIGNED WEEK, TELL HIM YOU WILL DELIVER THE FORMS TO THE OTHER LOCATION(S). ENTER THE FORM LETTER AND NUMBER(S) AND NUMBER OF LINES STAMPED "BEGIN ON NEXT LINE" FOR THE B-C-D LOG FOR THOSE LOCATIONS BELOW, BEFORE DELIVERING FORM(S).

Location	FOLIO					No. Lines Stamped "BEGIN ON NEXT LINE"	FOR OFFICE USE ONLY: Number patient record forms completed
	Letter	Number					

27-31/
32-34/
35-39/
40-42/
43-47/
48-50/

8. During the survey week (REPEAT EXACT DATES), will anyone be available to help you in filling out these records (at each IN-SCOPE location)?

Yes (ASK A) . . . 1 51/
 No 2

A. IF YES: Who would that be?

RECORD NAME, POSITION AND LOCATION.

NAME	POSITION	LOCATION
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONALLY BRIEF EACH PERSON LISTED ABOVE.

EMPHASIZE THAT EVERY PATIENT VISIT DURING THE ENTIRE WEEK IS TO BE RECORDED ON THE LOG EXCEPT "ADMINISTRATIVE PURPOSE ONLY."

9. Do you have a solo practice, or are you associated with other physicians in a partnership, in a group practice, or in some other way?

Solo (GO TO Q. 10) . . . 1 52/
 Partnership . . (ASK A-C) . . . 2
 Group (ASK A-C) . . . 3
 <--- Other (SPECIFY AND ASK A-C) . . 4

IF PARTNERSHIP, GROUP, OR OTHER:

A. Is this a prepaid group practice? Yes . . (ASK [1]) . . . 1 53/
 No 2

[1] IF YES TO A: What per cent of patients are prepaid? _____ per cent 54-56/

B. How many other physicians are associated with you? NUMBER OF PHYSICIANS: _____ 57-59/

C. What are the specialties of the other physicians associated with you? (How many of these are there?)

Specialty	Number of Physicians
(1) _____	_____
(2) _____	_____
(3) _____	_____
(4) _____	_____
(5) _____	_____

D. CIRCLE ONE:

All physicians in this partnership/group practice have the same specialty 1 60/
 More than one specialty in this partnership/group practice . . 2

10. Now I have just one more question about your practice. (NOTE: IF DOCTOR PRACTICES IN LARGE GROUP, THE FOLLOWING INFORMATION CAN BE OBTAINED FROM SOMEONE ELSE.)

A. What is the total number of full-time (35 hours or more per week) employees of your (partnership/group) practice? Include persons regularly employed who are now on vacation, temporarily ill, etc. Do not include other physicians. RECORD ON BOTTOM LINE OF COLUMN A BELOW.

(1) How many of these full-time employees are a . . . (READ CATEGORIES BELOW AS NECESSARY AND RECORD NUMBER OF EACH IN COLUMN A.)

B. And what is the total number of part-time (less than 35 hours per week) employees of your (partnership/group) practice? Again, include persons regularly employed who are now on vacation, ill, etc. Do not include other physicians. RECORD ON BOTTOM LINE OF COLUMN B BELOW.

(1) How many of these part-time employees are a . . . (READ CATEGORIES BELOW AS NECESSARY AND RECORD NUMBER OF EACH IN COLUMN B.)

Employees	A.		B.	
	Full-time (35 or more hours/week)		Part-time (Less than 35 hours/week)	
(1) Registered Nurse	_____	11-13/	_____	35-37/
(2) Licensed Practical Nurse	_____	14-16/	_____	38-40/
(3) Nursing Aide	_____	17-19/	_____	41-43/
(4) Physician Assistant*	_____	20-22/	_____	44-46/
(5) Technician	_____	23-25/	_____	47-49/
(6) Secretary or Receptionist	_____	26-28/	_____	50-52/
(7) Other (SPECIFY) _____	_____	29-31/	_____	53-55/
TOTAL:	<input type="text"/>	32-34/	TOTAL: <input type="text"/>	56-58/

* Physician Assistant must be a graduate of an accredited training program for Physician Assistants (Physician Extenders, Medex, etc.) or certified by the National Board of Medical Examiners through the Certification Exam for Assistant to the Primary Care Physician.

BEFORE YOU LEAVE, AGAIN STRESS THAT EACH AND EVERY AMBULATORY PATIENT SEEN BY THE DOCTOR OR HIS STAFF DURING THE 7-DAY PERIOD AT ALL IN-SCOPE OFFICE LOCATIONS (REPEAT THEM) IS TO BE INCLUDED IN THE SURVEY, THAT EACH PATIENT IS TO BE RECORDED ON THE LOG, AND ONLY THE APPROPRIATE NUMBER OF PATIENT RECORDS COMPLETED.

Thank you for your time, Dr. _____. If you have any (more) questions, please feel free to call me. My phone number is written in the folio. I'll call you on Monday morning of your survey week just to remind you.

11. TIME INTERVIEW ENDED _____ AM
PM

12. DATE OF INTERVIEW
(Month) (Day) (Year)

COMMENTS:

INTERVIEWER NUMBER

--	--	--	--	--	--

INTERVIEWER'S SIGNATURE

FOR OFFICE USE ONLY:

No. of Patients Seen:

--	--	--

59-61/

Total Days in Practice during Week:

--

62/

Appendix II

Reference populations by country

Table I. Reference populations by age and sex: France, the Federal Republic of Germany, and the United States, December 31, 1981

Age and sex	Country		
	France ¹	Federal Republic of Germany ²	United States ³
All persons			
Total	54,085,000	11,874,000	223,688,000
Under 2 years	1,588,383	235,000	6,932,000
2-14 years	10,295,638	1,761,500	43,920,000
15-24 years	8,501,217	1,971,700	40,505,000
25-44 years	14,809,857	3,406,200	63,623,000
45-64 years	11,582,714	2,711,900	43,958,000
65-79 years	5,689,084	⁴ 1,461,900	20,248,000
80 years and over	1,618,107	⁴ 325,800	4,502,000
Female			
Total	27,751,933	6,183,100	115,781,000
Under 2 years	775,099	114,600	3,389,000
2-14 years	5,029,234	858,500	21,475,000
15-24 years	4,329,275	958,200	20,528,000
25-44 years	7,212,848	1,659,100	32,653,000
45-64 years	5,924,718	1,447,700	23,115,000
65-79 years	3,334,530	⁴ 915,800	11,747,000
80 years and over	1,146,229	⁴ 229,200	2,874,000
Male			
Total	26,333,067	5,690,900	107,906,000
Under 2 years	813,284	120,400	3,544,000
2-14 years	5,266,404	903,000	22,444,000
15-24 years	4,171,942	1,013,500	19,977,000
25-44 years	7,597,009	1,747,100	30,969,000
45-64 years	5,657,996	1,264,200	20,843,000
65-79 years	2,354,554	⁴ 546,100	8,601,000
80 years and over	471,878	⁴ 96,600	1,528,000

¹Civilian population.

²Total population for regions of Bremen, Hessen, Pfalz, Nordbaden, and Südbaden.

³Civilian population exclusive of Alaska and Hawaii.

⁴Estimate.

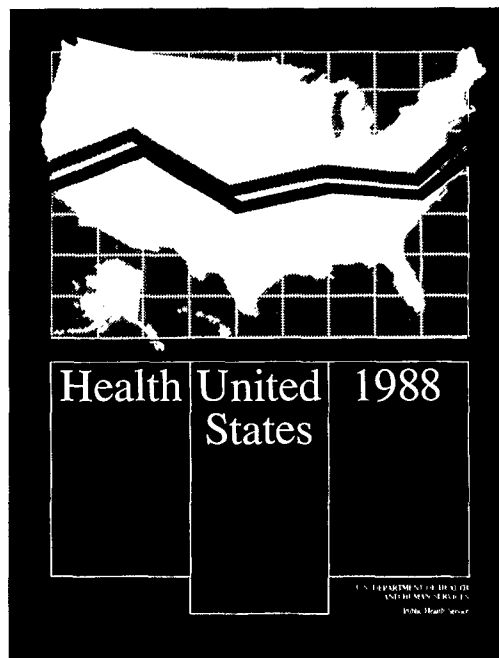
Table II. Population data by age and sex: France, January 1, 1980

[Data used to calculate standardized rates included in this report]

Age	Sex		
	Total	Female	Male
Number in thousands			
Total	53,587	27,340	26,247
Under 15 years	12,002	5,862	6,140
15-24 years	8,499	4,176	4,323
25-44 years	14,413	7,006	7,407
45-64 years	11,138	5,701	5,438
65 years and over	7,535	4,596	2,940

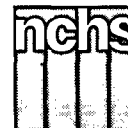
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