

Patient Views for Self-Referral to Specialists

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Abstract

Background: Except in emergency cases, all patients should be seen first by a primary healthcare physician who decides whether a referral to secondary care is necessary. The present study examined the reasons for patient self-referral to specialists. **Methods:** A random sample of 1036 individuals was selected from people attending public outpatient clinics and specialists' offices in the private health sector. Of the sample, 40% were insured by the closed loop referral; 14% by the semi-closed-loop referral; and 46% were open referral. The data were analysed using χ^2 statistical test. **Results:** Of the closed-loop referral system patients, 6.8% were self-referred, as were 29.7% of semi-closed referral system patients and 75.5% of open referral system patients. There was a significant association between insurance type and patient self-referral to specialty care ($\chi^2 = 504$; $P < 0.0001$). The main reasons patients gave for by-passing GPs and self-referring to specialists were: the specialist's high degree of skill in the specific area of the health problem (54%); waste of time to see the GP for a referral (14.9%). **Conclusion:** The findings of this study demonstrate the high degree of difference in the rates of referral by GP and self-referral according to the healthcare delivery system.

Keywords: *Health insurance, Healthcare delivery system, Referral system, Iran*

Introduction

In any healthcare delivery system an appropriate structure is essential to promote comprehensive scope, continuity, integration of components and operational efficiency. Patients must be able to easily access healthcare workers and/or health centres in their own community. In the first contact with a healthcare practitioner, particularly if that contact is with a GP, 90% of patient needs can be met. If the initial problem cannot be managed, the decision will be made to refer the patient to a specialist or hospital outpatient department (1).

The referral system offers one strategy for making the best use of hospitals and tertiary healthcare services, but all patients should be seen first by a primary healthcare physician who decides whether a referral is necessary. In other words, access to hospital care should be through primary healthcare centres, except for emergency cases where patients may access the

hospital directly via the hospital's emergency department (2). This avoids system inefficiencies such as disadvantaged groups suffering from a lack of specialist care due to specialist doctors being overwhelmed by inappropriate self-referrals.

Active participation of the patient and their family (in the case of a minor) in the referral process leads to an effective outcome and a high level of satisfaction for care-givers and patients, and a reduction in health costs (3).

However, in spite of a referral structure, there may be situations where people by-pass a primary-care contact. Unnecessary self-directed referral makes the specialist system inefficient and leads to problems for the individual and the healthcare system, such as:

Accrual of unnecessary costs to the system

Payment difficulties for the patient.

Lack of comprehensive healthcare information for the patient.

Lack of planned referral and its benefits of continuity of care.

Lowered standards of specialist care due to overburdening.

Compromising the established referral system

Patient transportation problems.

Reduction in feedback and follow up after treatment procedures (4, 5).

Although it is thought that a referral system can lead to cost-effective utilization of health services, there is little published data about its effect on health services and its impact on the health of those in the community.

The present study examined patterns of patient self-referral direct to specialist (private) and hospital OPD clinics (public) in three health insurance (Rural Insurance, IKWC, Open system) structures in Kashan, and aimed to establish the reasons for patient self-referral to specialists in this city.

Materials and Methods

A random sample of 1036 individuals was selected from people attending outpatient clinics and specialist office visits in the private health sector. The sample size was estimated according to prior studies in which almost 50% patients were self-referred (calculated as $P=0.05$, confidence coefficient 95% and error coefficient 3% of the number of the sample size 1036). Of the subjects, 413 (40%) were insured by the IKWC; 145 (14%) by the rural health system insurance; and 478 (46%) were covered by social security, therapeutic services insurance, out of pocket and other cost-payment procedures (free to contact any caregiver).

The patients or parents (if the patient was a minor) were interviewed individually in the waiting room by means of a questionnaire before or after their specialist visit, regardless of their type of referral. The questionnaire contained a series of items about demographic factors, referral type and patient reasons for self-referral. In order to improve questionnaire validity and reliability, the researcher conducted a pilot study

on 100 subjects and consulted with experts and informed peers in the university.

In order to gather the data without error, interviewers were trained in two sessions, and the researcher as coordinator monitored and controlled the process of the research.

The self-referral rate in the triple insurance structure according to the public or private sector was calculated. The data were statistically analysed using a χ^2 test.

Ethical approval Ethical issues such as research planning, implementation, data analysis and presentation received ethical permission from the Research Deputy of Health, University Research Director. All health centres and physicians involved, and all patients or parents gave permission during the research implementation.

Results

The number of patients attending doctors' offices and outpatients' specialty clinics according to the type of referral in the private and public sector are shown (Tables 1-3). In the IKWC closed-loop referral system and the Rural Health System Insurance, 6.8% and 29.7% of patients were self-referred directly to the specialist and hospital, respectively. In the open referral system, 75.5% of patients were self-referred (Table 4).

Table 1: Referral type of patients from the Imam-Khomeini Welfare Committee (closed system) according to private or public sector specialist services

Sector	Referred n (%)	Self- referred n (%)	Other n (%)	Total n (%)
Public	3 (42.9)	3 (42.9)	1 (14.3)	7 (100)
Private	377 (93.1)	25 (6.2)	3 (0.7)	405 (100)
Other	1 (100)	0	0	1 (100)
Total	381(92.3)	28 (6.8)	4 (1)	413 (100)

Table 2: Referral type of Rural Health System Insurance (semi-closed system) patients according to private or public sector specialist services

Sector	Referred n (%)	Self-referred n (%)	Total n (%)
Public	57 (64)	32 (36)	89 (100)
Private	20 (76.9)	6 (23.1)	26 (100)
Other	25 (83.3)	5 (16.7)	30 (100)
Total	102 (70.4)	43 (29.6)	145 (100)

Table 3: Referral type of open referral-system patients according to private or public sector specialist services

Sector	Referred n (%)	Self-referred n (%)	Other n (%)	Total n (%)
Public	18 (13.6)	103 (78.0)	11 (8.3)	132 (100)
Private	53 (16.1)	246 (74.8)	30 (9.1)	329 (100)
Other	4 (23.0)	12 (70.6)	1 (5.9)	17 (100)
Total	75 (15.7)	361 (75.5)	42 (8.8)	478 (100)

Table 4: Referral source according to insurance structure type

Referral source	Rural Insurance n (%)	IKWC n (%)	Open system n (%)	Total n (%)
GP	102 (70.3)	381 (92.3)	75 (15.7)	558 (53.9)
Self	43 (29.7)	28 (6.8)	361 (75.5)	432 (41.7)
Other	0	4 (1.0)	42 (8.8)	46 (4.4)
Total	145 (100)	413 (100)	478 (100)	1036 (100)

GP, General practitioner; IKWC, Imam- Khomeini Welfare Committee.

There was a significant association between the structure of the healthcare system and patient self-referral to specialty care ($\chi^2= 504$; $P< 0.0001$ and coefficient Tchoupr off correlation = 0.6). The self-referral rate from the public sector was 60.5%, while from the private sector it was 36.4%. There was a significant association between type of sector and self-referral to specialty care ($\chi^2= 449$; $P< 0.001$). This is showed in Table 1. The reasons patients gave for bypassing GPs and self-referring to specialists are presented in Table 5.

Table 5: Private and public sector patients' reasons for self-referral according to private or public sector specialist services

Reason for self-referral	Private sector	Public sector	Total
	n (%)	n (%)	n (%)
Specialist high skills	156 (58.9)	68 (53.1)	224 (57)
Waste of time to see GP for referral	43 (16.2)	19 (14.8)	62 (15.8)
Poor information about referral system	26 (9.8)	16 (12.5)	42 (10.7)
Good communication with clients	11 (4.2)	4 (3.1)	15 (3.8)
Physician known to the family	12 (4.5)	2 (1.6)	14 (3.6)
Specialist costs a little more than that of GP	4 (1.5)	2 (1.6)	6 (1.5)
Specialist authority needed for prescription	7 (2.6)	0	7 (1.8)
Convenient location	2 (0.8)	0	2 (0.5)
Oversupply of specialists	0	3 (2.3)	3 (0.8)
Other	4 (1.5)	14 (10.9)	18 (4.6)
Total	265 (100)	128(100)	393(100)

Table 6: Referral type of patients according to subject's literacy

Literacy	Referred	Self-referred	Total
	n (%)	n (%)	n (%)
Illiterate	253(76.9)	76 (23.1)	329 (100)
Primary school	147 (55.9)	116 (44.1)	263 (100)
High school	69(47.9)	75(52.1)	144 (100)
Diploma	14(29.2)	34(70.8)	48(100)
University degree	9(18.4)	40(81.6)	49(100)
Total	492 (59.1)	341 (40.9)	833 (100)

Discussion

The marked reduction of patients from the IKWC structure (closed-loop referral system) attending hospital outpatient clinics and specialists' private offices compared with patients from the other two levels of the insurance system (Table 2, 3) suggests that the load on specialist services could be reduced. As a result, more of the specialists' time could be devoted to patients who need specialist care; consequently, standards of care will rise. These findings are different from another study (2) but similar to two other studies (6, 7).

A US study documented patterns of generalist and specialist utilization in various practical

settings, with a special emphasis on the point-of-service (POS) model, which gives enrollees the option to seek insurance-covered services from non-network providers (7).

In the present study, the three most frequently given reasons for patients by-passing GPs and self-referring to specialists (specialist's high degree of skill; waste of time seeing the GP for a referral; and poor information about the referral system) are similar to those given by patients in other studies (8-12) but differ from two other ones (13, 14).

In spite of a rapidly-growing trend in health insurance, the POS plan (which allows members to seek speciality services for a fee without

consulting with their primary-care physician beforehand or plan gatekeeper), the majority of patients enrolled in POS plans did not use their self-referral options. Having the option to self-referring is enough for most POS plan enrollees; 93% to 96% of the enrollees did not experience their POS option to obtain speciality care via self-referral during a 1-year interval. The potential downside of uncoordinated, self-referred service use in POS health plans is limited and counterbalanced by patient's higher satisfaction with specialist services (7).

However, a few patients who have been reported as self-referred were more satisfied with their specialists than the patients who were referred to a specialist by their physicians. The US study (7) cited perceived barriers to specialist care as one of the greatest sources of consumer's dissatisfaction with health maintenance organizations (HMO). Simply having the option to bypass the gatekeepers of managed care seemed to be enough for most people in POS health plans (7).

The POS plan, or open-HMO, is a combination of the traditional HMO-preferred provider network, and fee-for-service plans. POS plan members pay minimum fees for service within the network and for referrals authorized by the physician gatekeeper or primary care physician. The member's share of the cost increases for treatment outside the network and for self-referrals (15).

In part, the US study investigated HMO, and the researchers analysed data from three POS plans located in the Midwest, Northeast, and Mid-Atlantic regions of the USA. The analysis looked at nearly 500 000 plan members enrolled for a 6 to 12 mo period in 1996. Of the enrollees who chose to self-refer for treatment, 38% did so to save time and to choose their own specialists; 28% said they self-referred because they did not get along with their regular doctors (most often because the doctor refused to grant a referral to a specialist; 23% had an on-going relationship with a specialist; 8% were confused by the insurance company rules; and 3% said

they did not have a primary doctor. In addition, the study also found that only 16 to 20% of the charges to the insurance companies were from patient self-referrals (7). Other studies found that most patients who self-referred for specialty care were more satisfied with the physician they chose compared with patients treated by doctors pre-approved by the insurance gatekeeper (15-17). It is notable that in the present study, in spite of the rigid structure of IKWC, the patients were not charged more for consultations with contracted physicians.

In the present study there were some differences related to subjects regarding level of education. This finding is comparable with Gross study (18). Independent variables predicting preference for the gatekeeper model are: living on the urban periphery; sickness-fund membership; low level of education; being male; fair health status; having a permanent family physician; and being satisfied with the professional level of the family physician. In the US studies, a significant correlation was found between practising self-referral and preference for self-referral (18-20). In the present study, self-referral to the public sector was greater than to the private sector. This difference was statistically significant ($\chi^2 = 20.39$; $P < 0.001$). Such a difference may be caused by inflexible rules, low charges in the public sector, and peoples' opinions of the public sector as a philanthropic organization.

The author recommends that the referral system in all primary healthcare settings ensures equity of access to the secondary and tertiary healthcare network by all members of the community, including the socially vulnerable. In our community raising public awareness of the referral system and the relevance of the GP as the source of referral is recommended in order to gain public cooperation and achieve effective and efficient handling of referral tasks.

In conclusion, clarifying private and public sector role definitions and relationships, and continuous control and monitoring of the quality of care are recommended in order to increase con-

sumers' satisfaction and orderly access to the healthcare system.

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