Olivier Saint-Lary, Claire Leroux, Cécile Dubourdieu, Cécile Fournier and Irène François-Purssell

Patients' views on pay for performance in France:

a qualitative study in primary care

Abstract

Background
Pay for performance was implemented in 2009 in France. The system was optional at first and then became widespread. Since 2012, it has been standard for most GPs. Several studies have attempted to investigate its efficiency and the GP's opinion of the system, but few studies have yet to examine the patient's view.

Aim
To gain an understanding of the views of French family practice patients about pay for performance.

Design and setting
Forty patients were interviewed between March and July 2013 in the Île-de-France region, of France.

Method
A qualitative study using semi-structured individual interviews, in primary care.

Results
Most of the patients did not know what pay for performance was and stated that they had not noticed any change in care since the system began. Some patients noted the possible benefits in the quality of care, such as an improvement in follow-up and prevention, better information provided by the GP, and a decrease in the volume of prescriptions and therefore health costs. Other patients were concerned about potential downsides, such as an overprescription of unnecessary medical treatments, an increase in health costs, patient selection, and standardised consultations that do not necessarily take into account the patient's individual concerns.

Conclusion
Since implementation of pay for performance, patients had not noticed any modification in their medical care. They could understand the need for change in the remuneration policy and expressed their agreement about performance-based remuneration if, and only if, it is not the cause of depersonalised health care.

Keywords
family medicine; patients' satisfaction; primary health care; quality of care; reimbursement incentives.

INTRODUCTION

The use of pay for performance in primary care has developed significantly over the past decade.[1] This scheme financially rewards GPs for achieving quality indicators linked to targets. In the UK, pay for performance has been used for all GPs since 2004 through the Quality and Outcomes Framework[2] which is an annual reward and incentive programme detailing GP practice achievement results. In the US, many pay-for-performance schemes developed through centres for Medicare and Medicaid services, and through private insurance.[3,4] In France, a voluntary pay-for-performance system, set up by public funds, was proposed to GPs in 2009 and one-third of the eligible GPs agreed to sign it.[5] Pay for performance was then implemented and has been used by nearly all GPs (97%) since January 2012.

The pay-for-performance programme's efficiency is still a matter for debate, particularly regarding its ability to generate a higher quality of care.[6–11] Numerous studies have estimated the efficiency of pay for performance regarding assessed indicators of improvement,[12–14] or cost cuts.[15]

As health systems vary in the ways they finance healthcare consumption and organise access to care, the results of the incentives created by pay-for-performance schemes are difficult to transfer from one system to another. For instance, most GPs in France and in the US are paid on a fee-for-service basis, whereas the UK historically uses capitation payments. Furthermore, GPs in France and the US operate in hospital-centred healthcare systems, whereas in the UK, GPs have a central position.[16] Despite these differences, a common set of characteristics and unexpected consequences related to pay for performance seems to exist.[4]

Qualitative studies have explored GPs' views about the effects of pay for performance in primary care in the UK, the US, and in France.[17–19] They all highlighted concerns about a decline in relational continuity of care, that is, doctors focusing on certain indicators being possibly less attentive to patients' needs. However, specific issues were raised in each country, mostly relating to the specificities of the relevant pay-for-performance scheme. For instance, UK GPs were concerned about the de-skilling of doctors as a result of enhanced nurse roles and the emerging presence of a dual agenda in consultations, that is, inappropriate attention on isolated aspects of care (targeted by indicators but having no link with the consultation) conflicting with the wider agenda of

O Saint-Lary, MD, PhD, senior lecturer, CESP INSERM U1018, Health Services Research; Département de Médecine Générale, UFR des Sciences de la Santé Simone Veil, Université Versailles Saint-Quentin en Yvelines, Montigny le Bretonneux, France. **C Leroux**, MD, GP and research associate; **C Dubourdieu**, MD, GP and research associate, Département de Médecine Générale, UFR des Sciences de la Santé Simone Veil, Université Versailles Saint-Quentin en Yvelines, Montigny le Bretonneux, France. **C Fournier**, MD, PhD, researcher in medical sociology, CERMES3, INSERM, Villejuif, France. **I François Purssell**, MD, PhD, professor of forensic medicine, head, Department of Forensic Medicine, University of Paris Descartes, France.

Address for correspondence
Olivier Saint-Lary, Département de Médecine Générale, UFR des Sciences de la Santé Simone Veil, Université Versailles Saint-Quentin en Yvelines, Montigny le Bretonneux, France.
E-mail: olivier.saint-lary@uvsq.fr

Submitted: 5 January 2015; **Editor's response:** 23 January 2015; **final acceptance:** 13 February 2015.

This is the full-length article (published online 27 Jul 2015) of an abridged version published in print. Cite this article as: **Br J Gen Pract 2015; DOI: 10.3399/bjgp15X686149**

How this fits in

Pay for performance was implemented across France in 2012. This study suggests that most patients did not notice any modification in care since the system was introduced. They could understand the need for a change in the remuneration policy and expressed their agreement about performance-based remuneration if, and only if, it is not the cause of depersonalised health care.

patient-centred care.[17] GPs in France did not mention these concerns but, like GPs in the US, they regretted the lack of exception reporting, which could increase the risk of patient selection: France has a predominantly liberal primary care system, where doctors can refuse to be the attending physician to a patient, for many reasons. They may refuse to treat a patient if they have very poor indicators. Doctors also found that pay for performance led to conflicts of interest, leading to a resurgence of the 'doctor knows best' mentality, which could be detrimental to patient autonomy.[19]

Patients' perceptions of the quality of a primary care consultation are based on the doctor's competence and perceived empathy or caring.[20] In France, a specific law also promotes the patient's right to autonomy (Patients' Rights Law of March 4, 2002) and patients attribute a very high importance to the 'doctor–patient relationship' dimension,[21] which could be challenged by pay for performance.

The patients' point of view about pay for performance has been inadequately studied and, to the authors' knowledge, only one study has explored the views of patients about the implementation of the UK pay-for-performance scheme.[22] Given the differences in the organisation of health systems in the UK and France, patients' opinions may differ. The aim of this study therefore was to gain an understanding of the views of French family practice patients about pay for performance.

METHOD

Sampling and recruitment of participants

A qualitative study was performed using semi-structured individual interviews, which followed the RATS qualitative research review guidelines.[23]

GPs practising in the Île-de-France region (in France) were selected from an online telephone directory according to their practice area in order to diversify participants' place of practice following socioeconomic and rural/urban criteria. GPs were asked, through a presentation performed during a consultation, to randomly invite two patients to take part in the study. One patient was to be registered with a pay for performance long-term condition disease (diabetes or hypertension) and the second one without.

The sample aimed to diversify participants according to age and sex criteria. The first GP included two patients randomly selected in his entire patient base. Further GPs were then asked to randomly select young or older patients, male or female, to ensure the diversity of the sample. The phone numbers of patients willing to participate in the study were given to the interviewers.

The number of interviews was not set in advance. The objective was to achieve data saturation, defined in this study as the lack of any new theme raised during three consecutive interviews. Oral consent was systematically sought from the patient before each interview both by the patient's attending GP and by the interviewer. The participants were informed that the interview could be interrupted at any time. The participants were not compensated.

Interviews

Interviews were conducted individually by two residents (interns in general medicine) and took place at patients' homes between March and July 2013. The resident-interviewers were not involved in any way in the care of the participating patients. Both interviewers used the same interview guide (Appendix 1), which was compiled by a multidisciplinary team of four researchers (a health services researcher, an economist, and the two residents). A literature review was performed to identify appropriate topics and questions. The interview guide was then tested through four exploratory interviews with interviewees who did not know what pay for performance was. The guidelines were modified according to the answers and the feedback of the interviewers.

A standard description of the French pay-for-performance scheme was, in principle, agreed on by the research team. Each patient was also told the indicators in diabetes and hypertension domains as examples of the type of care they may experience. Interviews were digitally recorded and transcribed in full.

Data analysis

Analysis was conducted in parallel with the interviews. Several steps were necessary to perform an inductive analysis of thematic

content that was in line with the modified grounded theory.[24] Thematic categories were identified in initial interviews and then explored in subsequent interviews. Differences in views were actively sought and disconfirming evidence was used to modify emerging themes. The main categories were then compared across interviews and reintegrated into common themes. The identified themes were a cluster of connected categories. The primary purpose of this analysis is to allow research findings to rise from the frequent, dominant, or significant themes inherent in the raw data.

The investigators' triangulation involved two different researchers who read, annotated, and categorised the interview transcripts independently. Each researcher used the same method to analyse the data and each evaluator's findings were compared to optimise the data conformity. The classification was later analysed independently by a senior lecturer with more qualitative research experience, and by a sociologist. When disagreements occurred, the data were discussed by the whole research team. Because this study was explorative rather than theoretical, open coding was used rather than axial or selective coding.

RESULTS

Twenty of the 42 GPs contacted agreed to take part. They had all accepted a pay-for-performance contract and each of them included two patients in the study. Participants' mean age was 56 years (standard deviation [SD] ±22, range 22–90 years) and included 24 females and 16 males (Table 1). The average interview duration was 21 minutes (SD ±9, range 9–41 minutes).

Table 1. Patient characteristics

Sex, *n* (%)	
Male,	16 (40)
Female	24 (60)
Place of residence, *n* (%)	
Rural	15 (38)
Urban	25 (62)
Diabetes, *n* (%)	
Yes	8 (20)
No	32 (80)
Hypertension, *n* (%)	
Yes	16 (40)
No	24 (60)
Mean age, years (SD, range)	56 (±22, 22–90)
Duration, minutes (SD, range)	21.3 (±9, 9–41)

SD = standard deviation

Five key themes relevant to the aims and objectives of this study were identified. The answers were quite similar whether or not patients were concerned by a pay-for-performance indicator.

Abbreviations following participants' quotes are as follows: DM = diabetes mellitus, HTA = hypertension, P = participant.

Knowledge of the system

Few patients had heard of pay for performance prior to the interview and those who had, had only a vague notion of the scheme:

'I heard about it, but I can't tell you exactly what it consists of.' (P35: 34-year-old male urban patient, no DM/HTA)

None knew the details of the system, but some were informed about the objectives of the Public Fund, (social security system) such as a decrease in the volume of prescriptions written, or the prescription of generic medications to reduce health expenses:

'I think that the GPs are paid if they do not prescribe a lot of certain medications, for instance antibiotics.' (P9: 60-year-old female, urban patient, no DM/HTA)

Most patients had not noticed any changes in the structure or process of care following the introduction of pay for performance, whether or not they had diabetes and/or hypertension.

Lack of information

Some patients were disappointed by the lack of information regarding pay for performance and would have preferred to have been better informed by their GPs or via posters. Concerning the indicators, older patients who had known their GPs for several years were not interested in these indicator results:

'I don't think so, I trust my GP. I have had the same GP for years. He will never let me down, and this is more important to me than his results regarding these criteria.' (P8: 90-year-old female urban patient, HTA no DM)

Some feared that having access to the indicator results would change their point of

view regarding their GP that they had so far trusted. However, they may be interested in knowing the results if they happened to move or choose another GP:

'Perhaps, [we would look at GPs' indicators] *if necessary, when moving and having to change GPs.'* (P21: 52-year-old female urban patient, no DM/HTA)

Potential beneficial effects

Although they had not previously noticed any tangible modifications, some participants believed that pay for performance could improve the follow-up of patients, and the prevention of certain pathologies, particularly some cancers:

'Concerning the patients' follow-up, it seems to be on the right path, the follow-up is more regular and more rigorous.' (P35: 34-year-old male urban patient, no DM/HTA)

This system could also counteract one of the downfalls of the fee for services system, which results in numerous short consultations to maximise profits, sometimes to the detriment of listening to patients' inherent needs:

'Perhaps, thanks to this bonus, they will not try as much to pile up quick consultations, but they will authorise themselves to spend time with their patients.' (P20: 28-year-old female urban patient, no DM/HTA)

Pay for performance could lead to health savings in three ways: increasing screening and prevention; a reduction in the prescription of some medications such as antibiotics; and encouraging the prescription of generic medications:

'For instance, the vaccine against the flu which allows cutting expenses when the patient suffers from it.' [that is, the vaccination should prevent the disease] (P22: 77-year-old female urban patient, HTA no DM)

'For instance, for antibiotics, it is a good thing if the GPs' prescriptions are checked' (P9: 60-year-old female urban patient, no DM/HTA)

Potential adverse effects

Although most of the patients interviewed had not noticed any adverse effect on their care, many highlighted the risk of overprescription of unnecessary and costly examinations:

'It is going to lead to examinations which would not have been performed before, without any benefit to patient care.' (P30: 60-year-old female rural patient, HTA no DM)

Some patients also worried that this system would encourage GPs to give preferential treatment to the patients meeting the pay-for-performance criteria to the detriment of others:

'There may be a selection of the patients. I would not be one of his priorities: I am young, without any chronic disease.' (P19: 27-year-old female urban patient, no DM/HTA)

Several patients thought that this system could lead to GPs changing their behaviour according to profit maximisation, while forgetting the patient's main complaint:

'The risk is for the GPs to do what the National Health Insurance wants them to do rather than doing what the patients really need at a given time.' (P5: 36-year-old female urban patient, no DM/HTA)

There were concerns that consultations could become routine and driven exclusively by performance indicators, leading to a loss of personalised patient care. GPs could become more interested in their bonus than in their patients' care:

'I always fear that if the National Health Insurance is the GPs' ordering institution, it is more economically driven than patients' interests driven.' (P22: 60-year-old female urban patient, HTA no DM)

Some patients also thought that it was an extremely costly system. However, these fears were put into perspective by the patients' awareness of the fact that pay for performance formed only a small part of the GPs' income:

'This pay is a plus but is not determining regarding the GPs' global pay.' (P24: 66-year-old male urban patient, HTA no DM)

Participants also widely expressed trust in their GPs' ethics in terms of fighting against performance-induced pressure.

Divided opinions

Some patients were fully in favour of the principle of pay for performance, explaining that a bonus was an efficient financial

motivation to improve performance, in any field:

'I think that it can motivate the GPs even if it is a vocation, they must earn their living, and money counts.' (P11: 39-year-old female rural patient, no DM/HTA)

Others were sceptical and considered it was more like a windfall effect for GPs, considering they already had good results:

'The pay for performance is a means to congratulate the GPs who are already good performers in their work.' (P28: 83-year-old female urban patient, DM and HTA)

A third category of patients was resistant to the pay system, which they said was unsound. They were comparing the pay-for-performance system in the medical sector to bonuses used in other sectors such as the banking system. To these participants, the idea of performance did not seem appropriate to the medical field. These patients seemed puzzled to hear that the GPs were paid for simple things that were part of their normal assignment:

'It makes me think of the banks with their objectives system.' (P10: 84-year-old female rural patient, HTA no DM)

'In the medical field, it is difficult to ask the GP systematically for results.' (P12: 30-year-old male urban patient, no DM/HTA)

'It is a pity that for GPs to perform their work well, there is such a need for a lure of profit.' (P19: 27-year-old female urban patient, no DM/HTA)

A proposal to integrate the patients' satisfaction as an indicator was reported several times:
'For my part, I would prefer a patient's satisfaction rate regarding their GP and their relationship with him, in a general way.' (P16: 35-year-old male rural patient, no DM/HTA)

DISCUSSION

Summary

Pay for performance was implemented with the aim of improving quality of care. Patients' opinions about the system were very much divided. Some of them considered that awarding a bonus could improve certain practices, while others were fundamentally hostile to the principle, which, they believed, went against the naturally compassionate and caring values of GPs.

If some patients had heard of pay for performance before the study, very few of them declared they had noticed any change in their GPs' behaviour since the implementation of the system.

Strengths and limitations

This is the first study in France and the second worldwide to question patients directly about their views on pay for performance.[22] The interviewed patients' panel was broad and diversified regarding sex, age, place of residence (urban or semi-rural), and socioeconomic level, allowing for the widest range of perceptions and feelings.

However, it is a specific sample for several reasons. First, the study was exclusively performed in the Île-de-France area, where patients have relatively easy access to their GPs, and where there are high socioeconomic levels. Second, GPs were asked to randomly select patients among certain categories of patients but were not provided with any methodology or software to help them with randomisation. It is possible that some GPs may have unconsciously selected patients with whom they had a good relationship. Third, both researchers were introduced to the patients by the GP as residents. Hence, this status could generate some goodwill from the patients and consequently accrue more favourable answers towards the medical profession.

The average duration of the interviews was quite short for in-depth interviews. This may result from the fact that pay for performance, which has been fairly recently introduced in France, was for doctors and did not lead to much press interest or public debate. No information campaign has targeted patients. Moreover, this is in accordance with other research in a French context where patients seem to have limited involvement in the healthcare system.[25]

Comparison with existing literature

The only study performed so far, dealing with patients' point of view about pay for performance, took place in the UK in 2011.[22] Some results were similar in both studies. First, interviewed patients, as a whole, declared that they trust their GPs. Both English and French patients were surprised to see that their GPs were paid for simple tasks, which according to them, were part

of their GP's everyday activity. Similarly, in both studies, certain patients declared themselves to be reassured by incentivising measures, while others felt that pay for performance is a system ill adapted to the medical field. The main concern expressed by patients seemed identical in both studies: the risk that GPs may focus only on the indicators, (the diseases measured by indicators) at the expense of other types of care such as listening to patients' most salient needs.

Some patients in the UK have noticed modifications in their experience with GPs, particularly regarding the use of computers. The UK pay-for-performance system obliges GPs to devote more of their time to using a computer, resulting in a tendency to listen less to patients, while aiming for a better follow-up. No patients in France mentioned the use of computers. Also, some patients in the UK thought that GPs not performing well should be sanctioned, in contrast to French patients.

A selection of French GPs were interviewed in 2011.[19] The pay for performance-related problems they raised were also frequently mentioned by the patients in the current study. New conflicts have arisen for GPs, who are now split between the interests of the National Health Insurance (social security system) and the interests of patients. Consequently, there is a risk of a subsequent decrease in patient autonomy and the return of the 'doctor knows best' mentality.

Implications for practice and research

The patients interviewed did not think of the GP payments as being comparable with those of an ordinary service (other than health administration, for instance). Their words revealed the omnipresence of an idealised image of GPs, with concepts such as 'vocation' and professional ethics, contrasting with the idea of 'pay for performance'. A personalised care expectation can contradict the care standardisation implied by the logic of pay for performance. This is in accordance with observations made through interviews with UK GPs showing that pay for performance could be associated with a shift of the dominant institutional logic in the field of primary medical care away from patient-centred care towards a logic of 'population-based' medicine.[26] The patient's point of view was not previously sought in the implementation of pay for performance. In the future, patient representatives could be involved in setting the definition of performance indicators so that these take patients' expectations into account, particularly regarding the quality of the doctor–patient relationship and the importance paid to individual care needs.

Funding

The project was not externally funded.

Ethical approval

Not applicable.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Acknowledgements

The authors would like to thank the Prospere team and Christian Herve for their useful contributions, as well as Erin Rainey and Evelyne Lefebvre.

Discuss this article

Contribute and read comments about this article: **bjgp.org/letters**

REFERENCES

1. Rosenthal MB, Dudley RA. Pay-for-performance: will the latest payment trend improve care? *JAMA* 2007; **297(7):** 740–744.
2. Doran T, Fullwood C, Gravelle H, *et al.* Pay-for-performance programs in family practices in the United Kingdom. *N Engl J Med* 2006; **355(4):** 375–384.
3. Endsley S, Baker G, Kershner BA, Curtin K. What family physicians need to know about pay for performance. *Fam Pract Manag* 2006; **13(7):** 69–74.
4. Pham HH, Schrag D, O'Malley AS, *et al.* Care patterns in Medicare and their implications for pay for performance. *N Engl J Med* 2007; **356:** 1130–1139.
5. Saint-Lary O, Bernard E, Sicsic J, *et al.* Why did most French GPs choose not to join the voluntary national pay-for-performance program? *PLoS One* 2013; **8(9):** e72684.
6. Mannion R, Davies HT. Payment for performance in health care. *BMJ* 2008; **336(7639):** 306–308.
7. Ryan AM. Has pay-for-performance decreased access for minority patients? *Health Serv Res* 2010; **45(1):** 6–23.
8. Woolhandler S, Ariely D, Himmelstein DU. Why pay for performance may be incompatible with quality improvement. *BMJ* 2012; **345:** e5015.
9. Maynard A. The powers and pitfalls of payment for performance. *Health Econ* 2012; **21(1):** 3–12.
10. Jha AK. Time to get serious about pay for performance. *JAMA* 2013; **309(4):** 347–348.
11. Eijkenaar F, Emmert M, Scheppach M, Schöffski O. Effects of pay for performance in health care: a systematic review of systematic reviews. *Health Policy* 2013; **110(2-3):** 115–130.
12. Scott A, Sivey P, Ait Ouakrim D, *et al.* The effect of financial incentives on the quality of health care provided by primary care physicians. *Cochrane Database Syst Rev* 2011; **(9):** CD008451.
13. Campbell SM, Reeves D, Kontopantelis E, *et al.* Effects of pay for performance on the quality of primary care in England. *N Engl J Med* 2009; **361:** 368–378.
14. Ryan AM, Doran T. The effect of improving processes of care on patient outcomes: evidence from the United Kingdom's quality and outcomes framework. *Med Care* 2012; **50(3):** 191–199.
15. Cheng SH, Lee TT, Chen CC. A longitudinal examination of a pay-for-performance program for diabetes care: evidence from a natural experiment. *Med Care* 2012; **50(2):** 109–116.
16. Bloy G, Schweyer FX. *Singuliers généralistes. Sociologie de la médecine générale.* [Singular GPs. Sociology of general medicine]. Rennes: Presses de l'EHESP, 2010.
17. Lester HE, Hannon KL, Campbell SM. Identifying unintended consequences of quality indicators: a qualitative study. *BMJ Qual Saf* 2011; **20(10):** 1057–1061.
18. McDonald R, Roland M. Pay for performance in primary care in England and California: comparison of unintended consequences. *Ann Fam Med* 2009; **7(2):** 121–127.
19. Saint-Lary O, Plu I, Naiditch M. Ethical issues raised by the introduction of payment for performance in France. *J Med Ethics* 2012; **38(8):** 485–491.
20. Cheraghi-Sohi S, Hole AR, Mead N, *et al.* What patients want from primary care consultations: a discrete choice experiment to identify patients' priorities. *Ann Fam Med* 2008; **6(2):** 107–115.
21. Krucien N, Le Vaillant M, Pelletier-Fleury N. Do the organizational reforms of general practice care meet users' concerns? The contribution of the Delphi method. *Health Expectations* 2013; **16(1):** 3–13.
22. Hannon KL, Lester HE, Campbell SM. Patients' views of pay for performance in primary care: a qualitative study. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X641438.
23. Mays N, Pope C. Qualitative research in health care. Assessing quality in qualitative research. *BMJ* 2000; **320(7226):** 50–52.
24. Strauss A, Corbin JM. *Basics of qualitative research: techniques and procedures for developing grounded theory.* 4th edn. Thousand Oaks, CA: Sage Publications, 2015.
25. Ghadi V, Naiditch M. Comment construire la légitimité de la participation des usagers à des problématiques de santé? [How to build the legitimacy of the participation of users in health issues?] *Santé Publique* 2006; **18(2):** 171–186.
26. McDonald R, Cheraghi-Sohi S, Bayes S, *et al.* Competing and coexisting logics in the changing field of English general medical practice. *Soc Sci Med* 2013; **93:** 47–54.

Appendix 1. Interview guide

A thesis is to be achieved in order to study the patients' point of view about the way a GP is paid.

1. Do you know how your GP is paid?
2. Do you know the other ways GPs are paid, in France and worldwide?
3. Do you know the payment for performance, and if you know it, can you explain what it is? And what do you think of it?

Now, we are going to tell you how the French GPs are paid:

a) *The most widely spread way of payment is fee for services: GPs are paid by their patients for each consultation (€23 per consultation according to Sécurité Sociale rate), therefore the more consultations there are the higher the remuneration is.*

b) *A new way of payment is spreading: payment for performance. This system lies on the achievement of objectives aiming at encouraging GPs to improve the quality of care. For instance, the GP receives a certain amount of money at the end of the year if he regularly prescribes a dosage of HbA1c (a marker monitoring the quantity of sugar in the blood) to his diabetic patients, or if he verifies that the patient has had every year an eye fundus (ophthalmic examination required for the follow-up of patients with diabetes).*

Within this contract, GPs can be evaluated according to 29 different points. This type of remuneration fulfils one of the three pre-existing (payment per care, payment per capitation, or wage system).

4. According to these explanations, do you think that the payment for performance could have an impact on the quality of care and how?
5. In 2009, there was an optional form of Contrat d'Amélioration des Pratiques Individuelles (CAPI). Do you know if your GP had signed it, and do you think you would have liked to know about it?
6. Did you know that since 2012 this adhesion to pay for performance has been compulsory?
7. Have you noticed any differences regarding your GP's care since 1 January 2012?
8. Would you like to have access to your GP's results markers?
9. If you are ≥50, have you noticed any modification in your GP's attitude regarding cancer screening?
10. If you are diabetic, have you noticed any modification in your GP's attitude regarding your diabetes? (If they are unable to answer the question, please give precise questions about: the frequency of the biological follow-up, the clinical examination, the frequency of consultation at the cardiologist and the ophthalmologist).
11. Do you think that this system of payment for performance could create drifts?