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Short Report

Comparison of patients' experiences in public and private primary care clinics in Malta

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Demographic changes, technological developments and rising expectations require the analysis of public–private primary care (PC) service provision to inform policy makers. We conducted a descriptive, cross-sectional study using the dataset of the Maltese arm of the QUALICOPC Project to compare the PC patients' experiences provided by public-funded and private (independent) general practitioners in Malta. Seven hundred patients from 70 clinics completed a self-administered questionnaire. Direct logistic regression showed that patients visiting the private sector experienced better continuity of care with more difficulty in accessing out-of-hours care. Such findings help to improve (primary) healthcare service provision and resource allocation.

Introduction

Several international studies have shown the beneficial effect of primary care (PC) on controlling costs and reducing health disparities.^{1,2} However, the findings of these studies have included a limited number of EU countries.¹ There are no easy solutions to create healthcare sustainability across and beyond Europe.³ One option is maintaining high-quality PC.¹

In Malta, PC is provided by the state health service and by private general practitioners (GPs). The public service is free of charge at the point of use, accessible from government Health Centres, 24 h a day and 7 days a week. Private GPs work in their own offices or within community pharmacies.

This study was conducted to compare the public against the private PC patients' experiences in Malta using a validated tool to evaluate the delivery and outcomes of primary healthcare.

Methods

The target population were all patients attending PC clinics. Seventy GPs divided equally between each sector were recruited. GPs were selected randomly from the Malta Medical Council Family Medicine

register after systematically removing GPs who were retired, not practicing or practicing abroad/in another area. A small remuneration was offered to the GPs.

Using convenience sampling, 10 patients aged 18 years and older were invited to participate voluntarily, before they visited the GP. Patients filled in the questionnaire about their experience with the GP they had just visited, after the consultation. This minimized recall and information bias. Each patient's responded questionnaire was linked to the GP's questionnaire using an anonymous coding system. Exclusion criteria included attending for solely an administrative procedure and being too sick.

The survey was conducted over 8 weeks between 8 am and 9 pm to capture the whole range of service users. This enabled a quasi-random sampling procedure. The fieldworkers who were medical doctors underwent a training session to limit inter-observer bias. Using an online sample size calculator Pi-face for a confidence interval around a proportion, we considered the worst-case scenario and 50% proportion. With a sample of 700 patients, the confidence interval was $\pm 3.7\%$.

A descriptive, cross-sectional study design was applied using the QUALICOPC GP and Patients Experiences Questionnaire. These tools were developed by the QUALICOPC Consortium to evaluate

the European PC systems on quality, equity and costs.¹ The English version was translated into Maltese. A professional translator made an independent back-translation. A pilot study was performed amongst 50 PC patients. Further analysis indicated good test–retest reliability. The patients' questionnaires collected data at the process and outcome level, based on Donabedian's framework.¹ The PC process was conceptualized on four dimensions including access, coordination, comprehensiveness and continuity of care. Quality care formulated the outcome of the system.¹

The χ^2 test was used to test for differences in socio-demographic and PC dimensions scores. Logistic regression analysis was conducted to examine the association between private/public sectors, sociodemographic characteristics and PC dimensions.¹ The data was analysed using the Statistical Package for Social Sciences (SPSS) Version 20.

Results

The response rates amongst the public and the private GPs were 94.3 and 82.9%, respectively. The patients' response rate in this study was 73%. Reasons for patients' non-participation included literacy issues, being too busy, disinterested or impatient.

The majority of the participants were females (61.9%, $n = 386$). The sample population had an age distribution of 18–88 years with a mean of 48.2 ± 17.6 years. Eight-eight percentage ($n = 545$) of the population claimed that they had their own doctor. Private PC patients were more likely to be female with higher national average income. Students, homemakers and the unemployed tended to use the public service.

Direct logistic regression was performed to assess the impact of these patient-reported experiences in the PC dimensions on the likelihood that these occur in the private sector as opposed to the public sector (table 1). The full model containing all predictors was statistically significant, $\chi^2 (4, N = 626) = 312.56, P < 0.001$. Unadjusted scores indicated that patients who had just visited the private GP reported better experiences in 'Continuity of Care' and 'Comprehensiveness of Care' with a poorer experience in 'Access'. Adjustment for age, income, education level, socioeconomic status, gender and geographical areas, attenuated the difference although those visiting the private GP still scored significantly better for providing continuity of care and for applying a biopsychosocial approach with significantly poorer scores in accessing out-of-hours care. After adjusting for age, income, education level, socioeconomic status, gender and geographical areas, there was no significant difference in the reported health improvement between the public and the private sectors.

Discussion

Consistent with other studies, the majority of respondents were females.⁴ The low-income participants, the younger and the older age categories tended to use the public service. This finding might be hinting at the ideas that younger patients do not value or need continuity of care as their healthcare needs are mostly for acute conditions. The low-income patients are more likely to represent

the elderly patients who are less affluent and can afford to wait longer for the service although they may have more healthcare needs.

In Britain, the use of public GPs is greatest in the highest socio-economic group.⁵ The opposite occurred in Spain.^{5,6} This study showed that there was no significant difference in the socioeconomic pattern in the use of private GPs, probably due to the relatively low fee charged by private GPs. An international comparative study showed that access and continuity of PC in Malta are weak.⁷ Similarly, lack of equity of access to healthcare has long been described in studies from other Southern European countries.^{6,8}

Similar to the findings of a telephone survey conducted in Hong Kong, this study showed that the private sector offered greater continuity of care and better doctor–patient relationship.⁴ There are indications that group practice might enhance informational continuity of care through the use of health information technology.⁹ It is worthwhile to consider incentivising 24-h private care provision.

A US-based study showed that disparities in healthcare process were associated with inequalities in outcomes.¹⁰ Conversely, this study showed that there was no significant difference between patients' self-reported health improvement in the public and the private sector. Although there is no patient registration system in Malta, 88% of the population claimed that they had their own doctor. This showed that public patients also use private GP services and *vice versa*. Due to historical and cultural reasons, the concepts under study could have been understood in a different way.

Due to time and resource constraints, this study did not capture general practice activities performed by other healthcare professionals, in private hospitals and during home visits and by practitioners not registered in the Malta Medical Council Family Medicine specialist register including hospital-based specialists and private independent community-based specialists.

Participants' recall bias, 'halo effect' and 'Hawthorne effect' could have occurred. Frequent users of PC services might have been overrepresented. This study did not assess whether these services were cost-effective and grounded in evidence-based medicine. Future research can address these limitations.

Conclusions

In summary, the findings of this study showed that there is room for further development in both sectors. Unmet needs particularly for the vulnerable population can be addressed by improving access, continuity of care and by adopting a bio-psycho-social approach.

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Table 1 Logistic regression predicting likelihood of different factors occurring in private primary care sector as opposed to the public sector as reported by patients

Patients' experience	Unadjusted		Adjusted	
	Odds ratio	P value	Odds ratio	P value
Patients' gender	1.56	0.007	2.17	0.027
GP knowing living situation	16.59	<0.001	2.6	<0.001
Patients visiting own doctor	71.61	<0.001	61.02	<0.001
Patients coping better with health problem after visit	3.36	0.004	0.87	0.85
Difficulty to see a GP during weekends, evenings and nights	1.61	0.012	2.564	0.008

Conflicts of interest: None declared.

Key points

- This study showed that there was no significant difference in the socioeconomic pattern in the use of private GPs.
- No significant difference occurred in patients' self-reported health improvement between the public and the private primary care sector.
- The public sector offered better access to out-of-hours care whilst the private sector corresponded better to the main goals of primary care to apply a bio-psycho-social approach in clinical practice and to provide longitudinal and relational continuity of care.
- There is considerable overlap between the two systems, that is, public patients also use private GP services and vice versa.
- There is a role for strengthening and supporting both the public and the private sector in delivering primary healthcare to help improve patients' outcomes, particularly for the at-risk or vulnerable population.

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Short Report

Unregulated access to health-care services is associated with overutilization—lessons from Austria

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The Austrian health-care system is characterized by free provider choice and uncontrolled access to all levels of care. Using primary data, the ECOHCARE study shows that hospitalization rates for the secondary and tertiary care levels in Austria are both 4.4 times higher than those reported from the USA using a similar methodology. At the same time, essential functions of the primary care sector are weak. We propose that regulating access to secondary and tertiary care and restricting free provider choice to the primary care level would both reverse overutilization and strengthen the primary care sector.

Introduction

The Austrian health-care system is characterized by universal health coverage and free provider choice. At the same time, the functions of the primary care sector are weak when compared with countries with similar socioeconomic conditions. Especially, the performance of primary care in the areas of continuity of care and coordination of care is suboptimal.^{1,2} Austria ranked only 10th

among 14 countries on a primary care development scale and thus was classified as a 'low primary care' country.³ Hospital admission rates are very high and the secondary and tertiary care levels suffer from overutilization.⁴

The Austrian health-care system is based on the Bismarck Model and is largely financed by sickness funds which draw on mandatory contributions from both employers and employees. Today, 99% of the Austrian population have health insurance. In 2010, total health