

The Content of General Practice in Malta

A pilot study comparing Health Centre and Private practice in Malta with each other and with General Practice (as reported for other countries)

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The effective planning of a system and the training of personnel to run it requires accurate data regarding the use to be made of the system. For a health care system such data, apart from actual numbers of patients, will include age/sex distribution, patient requests and expectations, and common presenting symptoms and diagnoses. Studies have been conducted in various countries to collect such data¹ and while they have demonstrated general similarities among countries, they have also shown important regional differences.

The present study arose as a result of discussions during a course on Family Medicine held by the University of Malta attended by ten doctors working in Government Health Centres, as it was noted that no such information has been published for Malta.

- The main objectives of the study were to:
1. determine the content of general practice in Malta;
 2. compare general practice experience in Government Health Centres and in private practice;
 3. determine and compare referral rates in Government Health Centres and in private practice.

METHOD

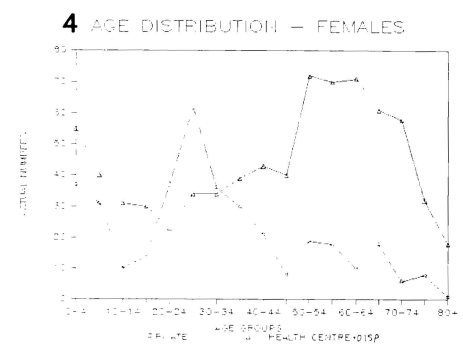
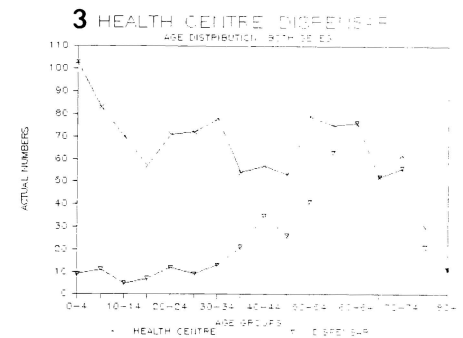
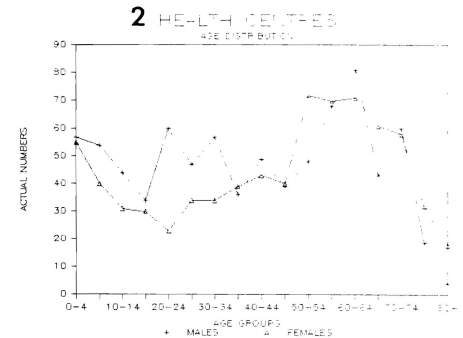
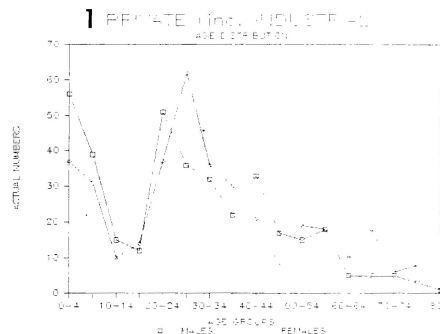
Physicians taking part in the Family Medicine course were asked to document each of their encounters with patients, both at Health Centres and in their private practices starting at 08.00 on Monday 25 January and ending at 08.00 on Monday 8 February 1988. Eight physicians took part in the study and the encounters were recorded on a purposely designed form. The data thus collected were entered into a computerised database. Diagnoses were coded according to the International Classification of Health Problems in Primary Care (ICHPPC-2)² and the codes also entered in the database. Specific counts of the data were then carried out.

The participating physicians were working full time in Government-run Health Centres staffed for twenty four hours a day and they saw patients in the office, in the satellite

dispensaries, "Bereg", (open for one or two hours on most mornings), in the clinic treatment room and at home. During the time of the study, they were also attending a course on Family Medicine for three mornings every week. Private practice varied considerably due to doctor preferences and differences in time off from Government duty. It included a number of home visits to industrial workers consisting mostly of sickness certification and verification and was mainly carried out in the afternoons and evenings. The short time during which the encounters were recorded and the physician factors noted above may have introduced certain biases but we believe that the overall picture presented is accurate.

RESULTS AGE DISTRIBUTION OF PATIENTS (Fig. 1-5)

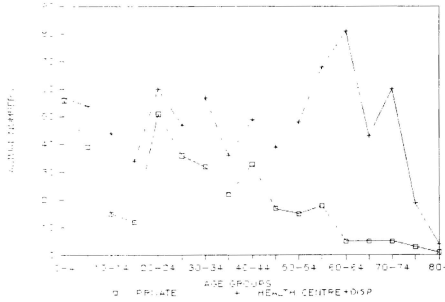
For private practice the male/female distribution is very similar (fig. 1). The industrial patients were all in the 20-44 age group with one female under 20 and one male over 45. Total numbers were small however. The Health Centres (and not the dispensaries) show a small excess of males over females in the 20-34 year age group possibly related to work injuries that present there most often but otherwise there is also a uniform distribution (fig. 2). In fact, injuries appear more often for males than for females. The dispensaries show a marked excess of older patients, both male and female, compared to the Health Centres (fig. 3). This may reflect in part the high number of patients suffering from chronic conditions attending dispensaries mostly for renewal of regular prescriptions. Less patients in this group were seen in private



practice. A peak was observed for private female patients in the 20-34 year age group (fig. 4). This may partly be accounted for by the number of Antenatal Care visits which, in the Health Centres, are done by visiting specialists.

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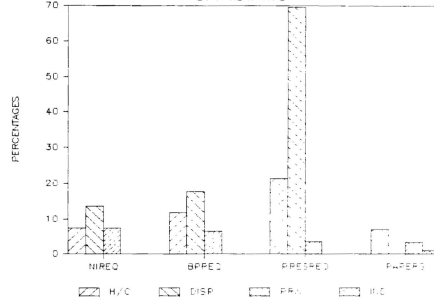
5 AGE DISTRIBUTION - MALES



PATIENT REQUESTS (Fig. 6)

The large section of patients attending health centres and dispensaries asking for prescriptions for free drugs, mostly on form DH46, represents a considerable amount of clerical work. This seems to be particularly so for the dispensaries where around 70% of the encounters were of this nature. For such paperwork as passport and driving licence applications and similar forms, many more patients attend the health centres. The number of requests for blood pressure check, while consuming a large part of the doctor's time, perhaps reflects low public understanding of their health and interest in preventive health care; the first to be corrected and the second to be fostered. A specific search of 468 encounters in the dispensaries showed that *only 28 patients (6%) did NOT request a blood pressure check, repeat prescription or a national insurance certificate.*

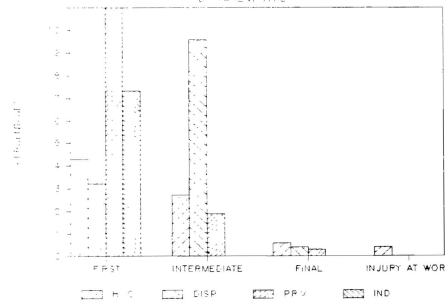
6 PATIENT REQUESTS BY PATIENT TYPE



NATIONAL INSURANCE CERTIFICATION (Fig. 7)

A group of patients with very chronic disabling diseases attend at their local dispensary for their intermediate national insurance certificates, which have to be renewed weekly, rather than at the main health centres or at private clinics. Patients requiring NI30 certificates for injuries sustained at work presented solely at the health centres during the study.

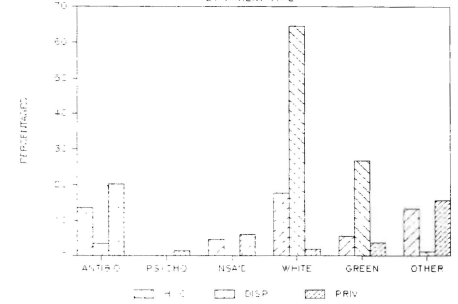
7 NATIONAL INSURANCE CERTIFICATES DONE BY PATIENT TYPE



PRESCRIPTIONS AND PAPERWORK (Fig. 8)

This histogram (fig. 8) shows the relative numbers of patients receiving prescriptions for antibiotics, psychotropic agents, and non steroidal anti inflammatory agents. It also shows the amount of patients receiving a "white" form (DH46) for medicines supplied free by Government, and "green" form (DH129) for narcotic and psychotropic medications. The "other" section includes investigation forms, drug control card renewal, income tax relief forms, etc.

8 PRESCRIPTIONS AND PAPERS BY PATIENT TYPE



COMMON DIAGNOSIS (Fig. 9-10)

Diagnoses were recorded in open language by the participating physicians but were then coded according to the ICHPPC-2(2). This system was chosen because of its suitability for coding of problems in general practice many of which are often not

TOP FIVE

FIG. 9 - ANALYSIS OF COMMON REASONS FOR CONSULTATION (with relative percentages to allow comparison)

	Grand Total	Health Centres	Bereg	Govt. Total	Private	Company Work	Non-Govt. Total
Total No. of Patients	2282	1083	468	1551	635	96	731
		% of h.c. total	% of Bereg total		% of priv. total	% of indus. total	
Top Five reasons for consultation:							
1. V680 (pure paperwork)	604	21.1%	71.2%	561	6.8%	0.0%	43
2. 460 (acute URTI)	272	10.9%	2.4%	129	18.9%	24.0%	143
3. V70 (preventive exam)	156	9.0%	3.8%	115	6.5%	0.0%	41
4. 401/7962 (raised BP)	118	2.4%	15.2%	97	3.3%	0.0%	21
5. 463 (ac. tonsillitis)	63	3.1%	0.9%	38	3.5%	3.1%	25
All other reasons	1069	53.5%	6.5%	611	61.0%	72.9%	

FIG. 10 – COMMONEST REASONS FOR CONSULTATION IN SPECIFIC GROUPS OF PATIENTS (ICHPPC – 2 codes, ranked in descending order)

GOVERNMENT OFFICE-VISITS		GOVERNMENT HOME-VISITS	
MALE	FEMALE	MALE	FEMALE
1. V680 – pure paper work (266)	V680 – pure paper work (286)	460 – acute URTI (28)	460 – acute URTI (13)
2. V70 – preventive exam (53)	V70 – preventive exam (59)	463 – tonsillitis (10)	464 – tonsillitis (11)
3. 460 – acute URTI (46)	401 – hypertension (48)	536 – stomach disorders (5)	V70 – preventive medical exam (4)
4. 401 – hypertension (42)	460 – acute URTI (42)	558 – diarrhoea, non-infectious (4)	466 – ac. bronchitis (3)
5. V999 – unclassifiable (30)	V999 – unclassifiable (20)	7873 – gas problems/wind (4)	536 – stomach disorders (3)
PRIVATE OFFICE-VISITS		PRIVATE HOME-VISITS	
MALE	FEMALE	MALE	FEMALE
V680 – pure paper work (22)	460 – acute URTI (22)	460 – acute URTI (39)	460 – acute URTI (19)
460 – acute URTI (20)	V680 – pure paper work (18)	463 – tonsillitis (14)	V70 – preventive medical exam (8)
V70 – preventive exam (12)	V70 – preventive exam (17)	558 – diarrhoea, non-infectious (6)	558 – diarrhoea, non-infect. (7)
401 – hypertension (7)	V220 – antenatal care (4)		250 – diabetes mellitus (5)
COMPANY HOME-VISITS			
1. 460 – acute URTI (11)	460 – acute URTI (12)		

NOTE: The numbers in brackets are the numbers of patients seen in each category.

classifiable by the International Classification of Diseases version 9 (ICD-9)³. This choice was subsequently justified by the fact that almost 65% of problems seen in Government practice and almost 48% of problems seen in private practice were in these categories. The timing of the survey in winter probably accounts for the large number of respiratory system conditions encountered. Of interest is the relatively greater number of bronchitics as well as diabetics and hypertensives seen in private practice. Trauma was met more often in the main Health Centres. Also of note is the more varied medical “diet” that was met by doctors in private practice where less time was spent on routine form filling (6.8% in private practice and 71.2% in dispensaries) and more on a large group of less common conditions (61.0% in private practice, 53.5% in the Health Centres and 6.5% in the dispensaries). (Fig. 9).

We also have some data regarding selected prescribing habits that appear to show that relatively more patients in private practice receive prescriptions for antibiotics, psychotropic and non steroidal anti-inflammatory drugs. This is an arguable conclusion when the different proportions of acute and non-acute conditions seen in private and government practice are considered.

REFERRAL RATES (Fig. 11)

The referral rate from Government practice was 3.7% overall, while that from private

practice was 2.5%, 18 of the 57 referrals in Government practice were to the ophthalmology service. These are mostly patient generated requests for “eye-sight check” for various reasons. Taking this into account, referral rates in government and private practice are comparable in our study.

FIG. 11 – REFERRAL OF PATIENTS

Government:	Private:
18 Ophthalmic	4 Casualty
9 Casualty	4 Orthopaedic
5 Dermatology	2 MOP
5 Dental	2 SOP
4 Podology	2 Dental
3 E.N.T.	1 Psychiatric
3 Schedule V	1 E.N.T.
2 MOP	1 Family planning
2 Orthopaedic	1 Podology
1 SOP	
1 Psychiatric	
1 Labour ward	
3 Unspecified	
Total: 57 referrals	Total: 18 referrals
No. of patients seen: 1551	No. of patients seen: 731
Referral Rate: 3.7%	Referral Rate: 2.5%
(Excl. Ophthalmic referrals):	Government practice referral rate: 39/1551: 2.5%
	Private practice referral rate: 18/731: 2.5%

CONCLUSION

This was a pilot study carried out between regular work and study sessions and we can only claim to have partly quantified general practice in Malta.

We have confirmed that a larger part of Health Centre work is devoted to what is mainly routine clerical work. In fact, clerical work is the only feature in which the content of general practice in Malta differs significantly from what we have seen reported for other countries¹.

Diagnoses encountered in private practice tend to be more varied and therefore more likely to maintain physician interest and motivation.

It is felt that this limited study has been useful and has already led to other work aimed at improving data collection and analysis in primary care, that could form the basis of a more comprehensive study in the future.

SUGGESTIONS

The results of this study suggest that an effort could be made to reduce the General Practitioner's clerical workload as this would leave more time available for clinical

work. Ways of achieving this could include revision of existing policies regarding prescription and certification, revision of the relevant stationery, and/or by delegation of part of the work to paramedical personnel or even to machines. This could apply to prescription for Schedule V, intermediate National Insurance certification, and to the "Pink card" system for free medicinals.

Expansion of form DH46 (the "white prescription") to accept more than three drugs would result in an immediate saving of time and effort. A "repeat previous prescription" option for Schedule V could also be considered. Computer aided repeat prescribing, as already carried out in some countries, could be a desirable and attainable goal.

Implementation of continuity-of-care at the Health Centres would place the family physician in a position to take fuller responsibility for patient management and would make for better liaison with hospital staff. This would lead to a reduction in unreasonable patient demands, which are difficult to control in the present situation.

Another point worth considering is the setting up of specific blood pressure clinics. These could have a protocol for screening and monitoring of blood pressure, perhaps by trained nurses, and periodic review of patients by the physician.

Patient education, preferably through the mass media, could take us a long way towards achieving better utilisation of our human resources (e.g. doctors and nurses) and material resources (e.g. drugs and clinic facilities) especially when these are provided free of charge.

ACKNOWLEDGEMENTS

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