

Do the experiences of patients of state-employed family physicians and concessionaires in Slovenia differ?

Ali se izkušnje bolnikov z zdravniki družinske medicine, zaposlenimi v javnih zavodih, in s koncesionarji v Sloveniji razlikujejo?

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Izvleček

Izhodišče: Družinsko medicino v Sloveniji izvajajo zdravniki, ki so zaposleni v javnih zavodih, in koncesionarji. Oboji delujejo v okviru pogodbe z Zavodom za zdravstveno zavarovanje. Ta študija se osredinja na primerjavo izkušenj bolnikov z zdravniki, zaposlenimi v javnem zdravstvu, in s koncesionarji.

Metode: Uporabili smo podatke presečne raziskave o izkušnjah bolnikov, ki je kot del mednarodne raziskave QUALICOPC potekala od septembra 2011 do aprila 2012. V njeno slovensko vejo je bilo vključenih 1.962 bolnikov, ki so obiskali ambulante družinske medicine. Bolniki so vprašalnike izpolnili takoj po opravljenem obisku. Podatki, uporabljeni v analizi, vključujejo 76 spremenljivk: 18 socialno-ekonomskih in 58 spremenljivk, povezanih z bolnikovimi izkušnjami.

Rezultati: Analiza je pokazala nekaj razlik med koncesionarji in zdravniki v javnih zavodih. V primerjavi z bolniki, ki so obiskali zdravnike družinske medicine, zaposlene v javnem zdravstvu, so se bolniki koncesionarjev manjkrat naročili na pregled (19,8 % v primerjavi z 29,2 %), na splošno so koncesionarja tudi pogosteje obiskali (43,7 % v primerjavi s 50,7 %) in pogosteje menili, da je obratovalni čas preveč omejen (25,7 % v primerjavi s 31,9 %). Bolniki koncesionarjev so pogosteje menili, da so zdravniki vredni zaupanja (40,1 % v primerjavi s 47,1 %). Manjši odstotek bolnikov, ki so obiskali koncesionarje, je povedal, da so bili poleg obravnave medicinskih deležni tudi obravnave svojih osebnih težav (61,9 % v primerjavi s 54,7 %).

Zaključki: Obstaja nekaj razlik v izkušnjah bolnikov, ki so obiskali zdravnike družinske medicine, zaposlene v javnem zdravstvu, in koncesionarje. Slovenski bolniki imajo na splošno pozitivne izkušnje z družinsko medicino ne glede na status

družinskega zdravnika. Načrti za organizacijske spremembe v zdravstvenem sektorju bi morali vključevati izkušnje bolnikov.

Abstract

Background: Family practice healthcare in Slovenia is provided by state-employed family physicians as well as concessionaires. However, both work under a contract with the National Health Insurance Institute. This study focuses on comparing patients' experiences with Slovenian concessionaires and state-employed physicians.

Methods: We performed analyses using survey data from a cross-sectional study on patient experiences, which took place from September 2011 to April 2012 as a part of the international QUALICOPC study. The Slovenian branch of this study included 1,962 patients visiting family practices. Patients were classified into two groups with respect to the registered status of their family physician. They completed the questionnaires immediately after visiting their family physicians. Data used in the analyses included 76 variables: 18 socio-economic and 58 variables linked to the patient's experience.

Results: The analyses showed few differences between concessionaires and state-employed family physicians. In comparison with patients of state-employed family physicians, patients of concessionaires were less likely to make an appointment for a visit (19.8 % vs. 29.2 %), were generally more frequent visitors (43.7 % vs. 50.7 %), and more often felt that opening hours were too restricted (25.7 % vs. 31.9 %). Patients of concessionaires believed more often that in general, doctors can be trusted (40.1 % vs. 47.1 %). A smaller percentage of patients of concessionaires felt that their physician had the capacity to deal with personal problems as well as to provide medical care (61.9 % vs. 54.7 %).

Conclusions: There are few differences in patients' experiences of state-employed family physicians and concessionaires. Slovenian patients have a generally positive experience with family

practice services regardless of the family physicians' status. Plans for organizational change of the health sector should include patients' perceptions of services.

Background

The current situation of how family medicine is organized is extremely heterogeneous in Europe.¹ Some family physicians (FPs) work as independent contractors (concessionaires), while others are salaried employees of health-care institutions (state-employed physicians). It is possible in some countries to have a family medical practice that is entirely private². But this is rare. Although solo practices are still the dominant form, there is also a trend in some European countries towards group practices, with physicians working in partnership.³

The proportion of group practices is less than 20% in Italy⁴. In Bulgaria, the Czech Republic, Estonia, Hungary, Romania, and Slovakia, family physicians are (mostly) concessionaires, whereas in Lithuania, Poland, and Croatia they can choose to be either state-employed or concessionaires. Physicians are exclusively state-employed only in Russia⁵. Private group practice has become the predominant mode of primary medical-care delivery in countries such as Australia, Canada, Denmark, the Netherlands, New Zealand, and the UK.⁶

The reason for the great variety of systems is historical. The "Semashko system" was in place in the former communist countries. This model was hierarchical, structured with exclusive power for authority, excluding the private service providers. Variations of the "Beveridge model" prevail in the UK, Mediterranean countries, and Scandinavia. Private providers have an opportunity to either contract with the health system or to work in private practice, parallel to the system. Healthcare in Germany, Austria, the Netherlands, France, Belgium, and Luxembourg is rooted in the "Bismarck model". The provision of care has mostly been left to private providers and institutions.¹

Various forms of organizing health-care delivery are largely related to the health-care

financing system.⁷ The Beveridge model is characterized by the provision of healthcare for all citizens and is financed by the government through tax payments. The Semashko model was completely state-financed and state-operated. The Bismarck model has health insurance, financed through social insurance paid at the place of employment, with a sick fund paying for the services of private medical practice and nongovernmental hospitals.⁸

All three models are undergoing reforms with similar aims expressed. These reforms are addressing quality and efficiency problems, reducing fragmentation in the pooling of funds, restructuring excess capacity, improving transparency by balancing available resources with expected costs, reducing rigidities and the lack of control by the budgetary system. They also promote equity and financial protection for disadvantaged groups.⁹

Contractual obligations have their benefits and limitations. The prevailing payment system may influence FP activities to a certain extent. State-employed FPs may provide better quality of care due to a lack of administrative duties or the financial incentives to increase their patient list and reduce the number of patient consultations. State-employment also imparts other advantages, such as income stability and no financial stake in practice ownership. Disadvantages include lower income and perceived lower status.¹⁰

Central and eastern European countries and newly independent states faced a new, challenging environment, not only in terms of overall funding for healthcare, but also the efficiency of their health-care services in using available funds and in developing sufficient government and technical capabilities.¹¹ Studies show that Lithuanian FPs in 2004 seemed much busier than ten years

earlier. Not only did they report seeing 60 % more patients, but the range of services provided also increased.¹²

Determined by political will, the introduction of concessionaires in Slovenia has been a gradual process. The idea of changing the existing health-care system stems from rigidity, uneconomical practice, and the impersonal nature of large health centers. The term concessionaire is still relatively new to Slovenian healthcare.¹³⁻¹⁵ The number of concessionaires has increased since Slovenian independence in 1991. It now involves 30 % of primary-care providers (FPs, pediatricians, and specialists in school medicine), almost 60 % of dental providers, and about 20 % of out-patient specialty-care providers.¹³ There are 6,449 physicians registered with the Medical Chamber of Slovenia¹⁶. At the primary level, there are 1,057 FPs working at health centers who are state-employed and salaried, and around 343 who are concessionaires. In 2011, the Health Insurance Institute of Slovenia (HIIS) signed contracts with 224 public institutions and 1,560 concessionaires.¹⁷

The introduction of concessionaires also raised fears about negative consequences. The Court of Auditors carried out an audit drawing attention to potential risks. They emphasized the need for precise organization of emergency services and emergency medical services. They stressed the need to regulate health-care providers, despite their different organizational forms and regular professional supervision.¹⁸ The prevailing belief concerning concessionaires was that they could provide unrestricted services to their patients. But in reality, the same rules apply to state—employed family physicians and concessionaires. The contract agreement, which applies to both, is under state monopoly and this defines the organization of the health sector.¹⁹

With the opportunity to introduce changes to the health-care system, the question arose about which type of medical-care delivery worked better. Heated discussions were held, usually taking into account the position of physicians. So far, no analyses have examined the perspective of the payer or the users (i.e., patients). Only limited data allow

a more thorough comparison between state-employed family physicians and concessionaires, especially with regards to patient satisfaction. This study seeks to address this inadequacy by examining a sample of family practice users and providing empirically-based recommendations for primary health-care policy development in Slovenia.

Methods

Design

We used survey data from a cross-sectional study of patient experience, which took place from September 2011 to April 2012. This was part of a larger international QUALICOPC study evaluating quality, costs, and equity in primary care. A detailed study protocol has already been published.¹⁹ The study assessed the quality and costs of primary healthcare in relation to patient and physician experiences. Part of the study questionnaire related to the organizational form of medical practices, and so it is possible to compare patient experience for the two types of practices, i.e., state-employed family physicians and concessionaires. The research protocol was approved by the Medical Ethics Committee of the Republic of Slovenia, decision number 144/07/11, on August 11, 2011.

Setting and participants

The patient survey in the Slovenian part of the study included 1,962 patients visiting family practices. Respondents were divided into two mutually exclusive groups using the FP's registered status as either state-employed or concessionaire. In the survey, patients who had just visited their FP were approached in the waiting room by a fieldworker who asked them to complete a questionnaire. Questionnaires were handed to consecutive patients coming from the physician until nine patients had consented to fill in the answers. The completed questionnaires were then collected.

Measures

The data used in this analysis were collected in the EU-wide QUALICOPC project in thirty-one European countries and in three non-European countries: Australia, New Zealand, and Canada. Details about the study protocol and questionnaire development have been published elsewhere.^{19,20} Patients were asked various questions about family

practice: patient accessibility, the appointment system, skill profile, disease prevention and health promotion, their reasons for visiting emergency care instead of FPs, coordination of care by FPs, patient communication, level of trust, ethical evaluation (any disrespect by the physician or members of the team towards the patient) and expected benefits and importance of the FP visit.

Table 1: Socio-demographic characteristics of patients visiting a concessionaire and a state-employed family physician (N = 1521)¹

Socio-demographic characteristics of patients		Visit of a concessionaire (N = 386)	Visit of a state-employed family physician (N = 1135)
Gender	Male	154 (40.7 %)	460 (41.0 %)
	Female	224 (59.3 %)	663 (59.0 %)
Age group	Under 65 years	300 (80.6 %)	891 (79.8 %)
	65 years and more	72 (19.4 %)	225 (20.2 %)
	Median	48.0 years	47.5 years
Education level	Primary or less	128 (34.0 %)	340 (30.5 %)
	Upper secondary	157 (41.6 %)	515 (46.1 %)
	Post-secondary or higher	92 (24.4 %)	261 (23.4 %)
Place of birth	Slovenia	329 (87.0 %)	1008 (89.8 %)
	Another country	49 (13.0 %)	114 (10.2 %)
Mother's place of birth	Slovenia	320 (84.4 %)	932 (82.9 %)
	Another country	59 (15.6 %)	192 (17.1 %)
Language proficiency	Fluent/native	347 (92.0 %)	1045 (93.3 %)
	Sufficient or less	30 (8.0 %)	75 (6.7 %)
Household income	Below average	104 (27.6 %)	384 (34.3 %)
	Around average	235 (62.3 %)	643 (57.4 %)
	Above average	38 (10.1 %)	93 (8.3 %)
Employment status	Employed	190 (50.1 %)	510 (45.6 %)
	Self-employed	23 (6.1 %)	83 (7.4 %)
	Student	19 (5.0 %)	76 (6.8 %)
	Unemployed	23 (6.1 %)	79 (7.1 %)
	Unable to work	7 (1.8 %)	40 (3.6 %)
	Retired	116 (30.6 %)	339 (30.3 %)
	Homemaker	12 (3.2 %)	22 (2.0 %)
Household living type	With other adults	294 (78.0 %)	890 (79.5 %)
	With any children (under 18)	144 (38.1 %)	382 (34.1 %)

¹ Proportions are calculated considering only valid values (not taking into account the missing or other invalid answers to a given question).

Statistical analysis

Patients' answers were compared using 76 variables: 18 socioeconomic and 58 involving patients' experience. Data were analyzed using the SPSS version 20.0 statistical package. The Pearson chi-square (χ^2) test of independence was used to identify significant differences about various aspects of the patient experience and perception of primary care. To identify which category produced a significant difference, standardized residuals between the observed and expected frequencies were examined. The limit of statistical significance was set at $p = 0.05$.

Results

The final analysis included 1,521 patients, of which 386 (25.4 %) were of concessionaires and 1,135 (74.6 %) were patients of state-employed FPs. Their mean age was 48.6 years ($SD = 17.1$). The socio-demographic background of patients was measured by 9 characteristics (Table 1), but only one of them proved to be statistically significant – household income ($p = 0.048$) (Table 2). Differences regarding patient's gender, age group, education level, place of birth, mother's place of birth, language proficiency, employment status, and household type were not confirmed as statistically significant. Based on the QUALICOPC sample, the results show that patients visiting concessionaires and state-employed family physicians had similar socio-demographic profiles, with greater numbers of females, age younger than 65, upper secondary education, born in Slovenia, fluent in the Slovenian language, employed, and living with other adults.

Differences in primary-care traits

Analyses of the 76 variables showed the majority of correlations were not significant. However, bivariate analyses did show a few significant differences between the experiences of patients registered with concessionaires vs. state-employed FPs regarding appointments, number of consultations in the previous six months, opening hours of the practice, provision of personal care, ge-

neral trust of FPs, and having a chosen FP (Table 2) ($p \leq 0.05$).

The first statistically significant difference related to patients not making an appointment (the proportion visiting concessionaire without an appointment was 29.2 %; for state-employed FPs it was 19.8 %). A second important difference related to patients categorized as either non-frequent or frequent visitors. Compared to patients visiting concessionaires, a significantly higher proportion of patients visiting state-employed FPs answered that they had seen the physician only once in the past six months. Concessionaires had a higher proportion of patients reporting five or more visits in the past six months. A third significant difference was associated with patients' experience concerning opening hours, expressed in the statement that they were too restrictive. A higher percentage of patients in the concessionaire group compared to the state-employed group felt that opening hours were too restrictive (31.9 % vs. 25.7 %). A fourth significant difference concerned FP's capability to deal with patients' personal problems, in addition to their medical problems. Less patients visiting concessionaires vs. state-employed FPs answered that they received help with personal issues (54.7 % vs. 61.9 %). A fifth difference was found regarding general trust of physicians. A significantly higher percentage of patients visiting concessionaires, compared to those visiting state-employed FPs, believed that doctors can generally be trusted (47.1 % vs. 40.1 %). The final difference related to patients who had not yet decided on a chosen physician. The proportion of patients visiting an office without the formal selection of a chosen physician was significantly higher among the concessionaire group compared to the state-employed FP group (1.3 % vs. 0.4 %).

Discussion

Concessionaires have about the same patient profile as state-employed FPs. This finding was quite surprising. Based on media reports, we expected the patient population of concessionaires to be mainly young, wealthy, and healthy, which essentially was

not the case. Our results confirmed only that patients of concessionaires had a higher household income in comparison to the national average and reported a better material status than patients of state-employed FPs. The reasons for this finding should be investigated in future research.

Patient experiences

Results showed that both patient populations had a generally positive experience with FPs. The similarities between the two groups of FPs were striking, considering their patient socio-demographic profile. Similar findings were found in another recent

Slovenian study of self-perceived competencies of Slovenian FPs. It showed no significant differences between concessionaires and state-employed FPs.²² A study from Poland, however, indicated that patients perceived family physicians in non-public practices to be of higher quality.²³

Concessionaires in Slovenia more often received visits from patients without an appointment, something that might have positive consequences. Representatives of patients' rights often emphasize the growing number of complaints from patients who cannot get an appointment. They complain that their right to the free choice of a doctor and medical institution is being violated.²⁴

Table 2: Comparison of experiences of patients visiting a concessionaire and a state-employed family physician (N = 1521)¹

Patients' experiences		Concessionaire (N = 386)	State-employed family physician (N = 1135)	X ² _(df)	p
Did you make an appointment for the visit?	Yes	70.8 %	80.2 %	14.516 ₍₁₎	0.000**
	No	29.2 %	19.8 %		
How often have you visited or consulted your FP in the last 6 months?	First visit	24.0 %	26.3 %	10.284 ₍₃₎	0.016*
	Once	25.3 %	30.0 %		
	2 to 4 times	33.6 %	32.4 %		
	5 times and more	17.1 %	11.3 %		
The business hours are too restricted.	Yes	31.9 %	25.7 %	4.886 ₍₁₎	0.027*
	No	68.1 %	74.2 %		
My FP does not just deal with medical problems but can also help with personal problems.	Yes	54.7 %	61.9 %	4.628 ₍₁₎	0.031*
	No	45.3 %	38.1 %		
In general, doctors can be trusted.	Strongly agree	47.1 %	40.1 %	8.537 ₍₃₎	0.036*
	Agree	48.4 %	54.1 %		
	Disagree	3.2 %	5.2 %		
	Strongly disagree	1.3 %	0.7 %		
Do you have your own doctor that you normally consult first?	Yes	98.7 %	99.6 %	4.374 ₍₁₎	0.037*
	No	1.3 %	0.4 %		
Compared to the national average, your household income is:	Below average	27.6 %	34.3 %	6.066 ₍₂₎	0.048*
	Around average	62.3 %	57.4 %		
	Above average	10.1 %	8.3 %		
	No	4.5 %	2.6 %		

¹ Proportions are calculated considering only valid values (not taking into account the missing or other invalid answers to a given question).

X² = chi-square test; df = degrees of freedom; * = p < 0.05; ** = p < 0.01; n.s. = not significant

The same problem was addressed by Buetow et al. who found five barriers in the accessibility of FP care: limited opening hours, traditional appointment systems, intolerance of missed appointments, long waiting times at the doctor's office, and inadequate time spent with the doctor.²⁵

Patients rate timely access as one of the most important elements in primary care.²⁵ To achieve timely appointments, various appointment-booking models are being employed by family practices. Same-day scheduling, also known as advanced access and open access, typically requires practices to do "today's work today" by offering the vast majority of patients the opportunity to book their appointments the same day they call, regardless of the reason.²⁶ On the other hand, the lack of an appointment means a greater chance of a long wait and may point to less efficient practice management.

Although the European Health Consumer Index suggests that access and waiting time in Slovenia are problematic and restrictive²⁷, our study showed that 68.1 % of patients visiting concessionaires and 74.2 % of patients visiting state-employed physicians responded that opening hours are not too restrictive. Despite this favourable figure the difference in opening hours was statistically significant according to the response of patients. This can be explained by the fact that concessionaires generally work in solo practices or in small-group practices where they are more limited in planning their time schedule. State-employed FPs working in public health centres are certainly in a better position in terms of opening hours. They have more staff and are usually open 24 hours a day in order to accommodate round-the-clock healthcare. On the other hand, problems in offering rapid access to patients are also reported by physicians from other countries.²⁷

The difference in the number of appointments in the past six months is not very relevant because it is mainly based on patients' backgrounds and not the result of the appointment system.

The difference in comprehensive/holistic care (the fourth difference) may be due to better teamwork availability at public he-

alth centres. They regularly employ other workers such as psychologists and physiotherapists, who are usually members of the FP team and can provide non-medical care to patients.²⁹ Similarly, the study from Poland²³ reported that patients of state-employed physicians are more satisfied in terms of comprehensive/holistic care.

Measuring patient trust (the fifth difference) is helpful for informing public policy deliberations and for balancing market forces. Studies have established that patient trust predicts instrumental variables, such as the use of preventive services, adherence, and continued enrolment, at least as well as satisfaction does.³⁰ Although trust is important, this might be influenced by experiences with other medical specialists and by the media. This may also reflect concessionaires' financial dependence on patient visits and therefore greater efforts to communicate and build trust.

There was only a minimal difference in answers to the question, "Do you have your own doctor with whom you normally consult first?" Almost all patients from both groups had their own physician. Apparently, continuity of primary care is not diminished by concessionaires.

Finally, it is appropriate to ask to what extent both groups of FPs met expectations. Has the Slovenian health-care system yielded the expected results, or is it still too early to judge? Generally, in terms of the measures of this study, both groups of FPs are doing well. There are only a few differences and these may even contribute to increased competition and improvement of quality. A future question for health policy is whether public medical centres have successfully adapted to rapid social change and how concessionaires can better benefit the health sector during these changes.

Methodology

One limitation of this study stemmed from confounding elements that may have been present when patients were asked to report on things that had happened to them. They may have offered subjective assessments.³¹

Conclusions

Patients' experiences with both types of family physicians were positive. In comparison to patients of state-employed FPs, patients of concessionaires made appointments less frequently, visited their FP more often, and were more critical about restrictions in opening hours. Fewer patients visiting concessionaires vs. state-employed FPs answered that they received help with personal issues. A significantly higher percentage of patients visiting concessionaires believed that doctors in general can be trusted. Further studies might focus on other quali-

ty-of-care measures between the two groups of doctors.

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