3 THE RELATIONSHIP BETWEEN STATE AND PRIVATE PRIMARY CARE

DR. PIERRE MALLIA, M.D., M.PHIL.

In Malta there is no uniform Healthcare system. There are government services divided primarily in State hospitals and health centres in the community; and there are private doctors – from primary to tertiary level. Although the system works somehow, it is by no means perfect and is confusing to the person trying to make use of both. Government doctors have on their contracts that they may work privately - this is one reason why many believe salaries have been kept quite low. Those who opt to work only in the private sector have a choice of making use of government services or using only private institutions for investigations etc. In primary care, it is impossible to always refer people privately for tests and specialist consultations. The private General Practitioner thus usually discusses with the patient whether she wishes to be investigated at hospital or privately and explains the pros and cons of each.

Invariably, many opt to be referred to hospital for further investigations. Since medical insurance is still in its infancy in Malta, and since they by no means gives comprehensive unlimited coverage to the insured, many who have tests done privately pay for them personally. In this respect the health centres have offered a number of tests which the GP may avail herself of and which will thus save the patient some money.

Tests offered by the department of health

Recently it was announced that GPs may order a limited amount of blood tests either through health centres or by taking blood themselves and handing it personally to the hospital laboratory. This was definitely a step in the right direction as not all people can afford to have tests done privately, and it thus saves a considerable amount of patient and staff time by avoiding unnecessary referrals for basic blood tests.

However the generosity stops here. For other specific tests doctors must refer either through a hospital firm or, rather unprofessionally, through another health centre doctor. For example, if I want to order a simple Chest X-ray I may send the patient to the health centre; but I must do this through another doctor, I do not get a copy of the X-ray (unless I am prepared to wait for about three months – I have tried this and till now have never managed to get hold of a copy), and it is only at the other doctor's discretion whether he will send me a note. The fact is that by referring the patient to the health centre, I have had to send the patient to another doctor who then decided whether that Chest X-ray was to be done. Although these are rarely refused, it is rather unprofessional that another doctor – usually junior to onself decides about my patients.

Co-operation with Health Centres

Patients are not registered with a doctor under our system. Yet when asked who their doctor is many will give you the name of their private GP. This occurs for example when someone unfortunately dies and the family calls in the health centre doctor. To avoid having to issue a death certificate for someone they have never seen before, the doctor asks the family who their doctor is. They are then instructed to call him or her – even if in reality he may not have seen the deceased for months or even years. Nevertheless, if the private GP is good enough to be involved in such situations, should he or she not be good enough to informed about the patient's history and visits to the health centres? It is definitely not in the interest of patients to have two files – one at the polyclinic and one at their private GP; both files having information which the other lacks.

Inter-professional co-operation and communication is something we owe our patients and is a requirement by any code of ethics. To date our ethical codes approved by the Medical Council do not stipulate such co-operation because in reality health centres and private doctors

owe nothing to each other and it is only at their discretion to co-operate. In effect health centres take away from the private GP his or her everyday bread and butter so it would seem ironic to many to co-operate at all. Nevertheless if we are to make a health system which provides optimal care, the government has to realise that it is only the private family doctor who provides a true family service and who provides continuity of care that no doctor in a health centre can provide. It is thus in the interest of everybody that the private GP should be helped and not hindered.

The role of the GP in hospital

Let us now tackle the relation between primary and secondary care. To date there is no protocol governing how the hospital team should deal with the family doctor. Indeed, even in discharge letters, although there is a space for the name of the family doctor being addressed, this is left unfilled even if the family doctor referred the patient to hospital. Patients may be seen again at Out Patients Departments and finally they are discharged. There is never any continuity of care, however, and I often get patients complaining that they have been ignored or abandoned, not realising that their private GP or the health centre is to take care of their continuing medical needs. Sometimes patients are told that they now have to continue seeing their doctor; or if the patient asks he is granted a note for his GP.

What should happen is that there should be continuity of care throughout the process, both as in-patients and as out-patients. There is a role for the family doctor to be included in the treatment plan of the patient throughout; and the least one can do is to have a good system of communication with the GP. As it is, it is at the discretion of the GP to chase the hospital doctors for information about his or her patients; and even in hospital the nurses may be reluctant to allow this stranger claiming to be the patients' GP to see the file. Who can blame them? They are responsible for the confidentiality of files.

Follow-up after hospital

Diabetic patients are often referred to the Diabetes Clinic for instruction and further tests. Once patients finish the secondary-care treatment of diabetes, they are never referred to their primary care doctor. Instead they are referred to the health centres in the community. I think this is the most unethical practice in our health care system. We are giving our patients the message that diabetes is something to be followed up by a specialist who works in the health centre, or in some instances, privately. But in an emergency, it is the GP who is called in, and who then must make sense out of a situation which he not only has not been following, but, in the case of a patient he has not seen for some time, may be unaware of.

Diabetes is to be looked after by the family doctor – unless the doctor feels he needs to share the care of the patient with a specialist. It is not only unethical for any doctors working in the diabetes clinic to take on patients without ever communicating with the family doctor, it is unprofessional for the government to lure people into thinking that they will not be entitled to free insulin unless they attend the polyclinic.

Conclusion

The government should seek to explore further possibilities of co-operation with doctors at primary care level – be they health centre doctors or private doctor. Only private doctors provide true Family Medicine Without them the government would have to invest more. People attend health centres; but only their family doctor provides them with an on-going security. If we want this to remain the government must not only stop competing with the family practitioners providing patients with services which only give a false sense of security, but it should seek to promote the family doctor who knows you from birth through to the age when you yourself have children.

Moreover, the government should commit itself to provide post-graduate education to doctors. I recently sought the help of the Department of

Radiology to learn ultrasound screening – a process which has started in Family Medicine abroad. Ultrasound screening is recommended as part of the general physical examination. It is cheap, it is easy and it can detect conditions, which are otherwise silent, much before patients present with symptoms. I was turned down. If anything this should increase referrals to radiologists for confirmation; but the point is, once the government does not provide ultrasound screening and once international standards suggest ultrasound for primary care, government should provide the training. Unless we are to scrap either private care or State care, the only road left is co-operation between the two. Professionally we owe this to our patients.