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Patient's Perception of Primary Health Care Provision With Respect to Access, Continuity and Coordination—InCept: An International Qualitative Perspective

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ABSTRACT

Health care systems are confronted with an increasing burden of (multi-)morbidity and a shortfall of healthcare providers. Coordination and continuity of care in chronic and multi-morbid patient is especially important. As qualitative patient experience data within care processes is scarce, we aim to increase the understanding of chronically ill patient's perspectives by assessing patient experiences in different health systems while treated in primary care. Patients were recruited via GPs from Germany, Sweden, Switzerland, and the British island of Jersey. To ascertain regular healthcare utilisation, inclusion criteria were either a stroke, and/or a myocardial infarction or heart failure during the past year, and an underlying metabolic syndrome. Identical semi-structured interview-guides were used in the respective language. Transcribed interviews were analysed according to inductive-deductive qualitative content analysis. Based on 22 interviews we derived four main categories (patient centeredness, continuity, coordination, access). Overall, healthcare processes were considered positive if information flow was personal and functional. Non-physician staff seemed to create reassurance. A long-lasting doctor-patient relationship was connected to the context of trust and security. Patients were critical of a perceived lack of time, inducing insufficient counselling and information-flow. This international explorative study suggests that patients' experiences can provide important information about care provision. Patients consistently focused more on relational aspects rather than on structures or functions. This has connotations for healthcare planning; for example, by providing non-physician staff to support patients through their care pathway and to improve the cooperation between providers.

Abbreviations: APN, advanced nurse practitioner; CHE (see citations), Switzerland; CHN, community health nurse; EPR, electronic patient record; GER (see citations), Germany; GP, general practitioner; HF, heart failure; JER (see citations), Jersey; NEHR, national electronic health record; NP, nurse practitioner; OECD, Organisation for Economic Co-operation and Development; PC, primary care; PREMs, patient reported experience measures; SWE (see citations), Sweden; UK, United Kingdom.

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Summary

- Patients preferences were not dependent on the country they were treated in.
- Patients focussed on interpersonal aspects of care (such as adequate time consulting, communication of information and personal interaction) rather than on the function or the structure of the primary care practice.
- Physicians should be complemented (and therefore relieved) by other professions such as case-managers.
- Patients' perceptions of their care processes during and after acute incidents can provide poignant information about their preferences.

1 | Background

Healthcare systems are facing an increasing burden of chronic disease largely due to ageing societies and unhealthy lifestyles, which is compounded by a shortage of healthcare professionals [1, 2].

Primary care includes a generalist, person-centred approach and a broad range of coordinated services offered to a defined population [3].

To cope with future challenges of care, in many countries integrated care solutions with more elements of patient-coordination and process-management are being discussed and implemented [4–6].

Most of these adjustments strategically align with directives to strengthen the role of primary care [7, 8]. In 1978, the Alma Ata declaration laid the groundwork for this very goal. It spelt out the fundamentals of primary care, defining it as the provision of continuous, coordinated, comprehensive, and first-contact care to a population, without discrimination based on gender, age, or medical condition [9]. Starfield et. al. then distilled the fundamentals of primary care in the four C's: *'first-contact access for each new need, long-term person- (not disease) focused care, comprehensive care for most health needs; and coordinated care when it must be sought elsewhere'* [7].

Despite a general theoretical consensus that individualised, patient-centred care is an indispensable element in health care planning, patient preferences towards distinct elements of primary care are still not clearly described and often quantitative endpoints are used to persuade key decision makers [10, 11]. Increasingly however, policy planners and researchers are seeking to include patients' perceptions into healthcare planning, although research organisations are still learning how patients can be involved and contribute to the planning process [12]. One of the goals in engaging patients is to understand the lived experience of patients during his or her contact with the health care system [13]. The aim is to capture what happened and what the perception is, and how it made the person feel; key guidance for quality improvement. The US Agency for Health Care Research and Quality (AHRQ) states that patient experience *'encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities'* [14].

Although quantitative PREMs (Patient Reported Experience Measures) ask patients about their experience of care, they are based on known drivers of a good patient experience [15, 16]. They do not, however, allow for new aspects by considering patient narratives. Care experiences often worsen as care needs become more complex [17]. However, a growing body of evidence suggests that aligning care with the needs and goals of patients and their families leads to better treatment adherence, improved self-management, appropriate use of resources, and overall better care experiences [18].

We postulated that qualitative patient-perceptions of care can reveal aspects of the care structure that they found particularly helpful or harmful. By applying a cross-national approach, patients' experiences within the central structures of an established primary care system, namely of access (e.g., gatekeeping), care coordination, and continuity of care (e.g., team-based care provision, task shifting or additional coordinators) can detect more ubiquitous patient needs and preferences, that hold true across different settings.

Therefore, the goal of this multi-national study was to detect elements of care provision in primary care, which are particularly relevant to patients and can guide healthcare planners.

2 | Methods

2.1 | Study Design

This qualitative international study is based on semi-structured patient interviews. Analysis was performed using descriptive content analysis based on inductive-deductive coding strategy [19].

2.2 | Sampling Participant Selection

Patients were recruited in Germany, Sweden, Switzerland, and Jersey (UK), countries with primary care settings, ranging from single practices to big primary care centre units. GP Practices and local care centres were recruited via established networks of the respective research teams. For each country, at least two primary care sites (with the exception Jersey) were chosen. Participants were recruited face-to-face by their local GP or within their local care centre with a purposive sampling approach. In order to achieve homogeneity in the patient samples, a tracer diagnosis [20] as an inclusion criterion was defined: patients had to have a history of myocardial infarction, heart failure exacerbation or stroke as an acute event within the last year in combination with an underlying chronic condition: metabolic syndrome, consisting of a cluster of cardiovascular risk factors (diabetes, hypertension, lipid metabolism disorder). Individuals with a diagnosed mental illness or younger than 18 years were not eligible.

Sample size was guided by Information Power sampling [21]. In addition, data saturation was considered and discussed within the national research teams after a minimum of three national interviews were carried out.

2.3 | Data Collection

Interviews were performed by local researchers in the respective care setting of the patient (i.e., GP practice, healthcare centre or patient home) in 2019. During the COVID-19 pandemic some interviews were carried out via telephone (Germany only). In cases where the patient was highly dependent on an informal caregiver, he or she was invited to join the interview to ensure cohesiveness in the patient narrative.

In the interview guide, based on the critical incident technique [22, 23], the interviewee was asked to recall a particularly positive and negative situation during the care process. Here this was explicitly related to the acute event (stroke/heart attack, heart failure [HF]). More in-depth questions were then asked to extract information about the process and the assessment of the process from a patient perspective. The same interview guide (see additional material) was used in all settings to achieve interview consistency and homogeneity. Interview duration ranged between 22 and 73 min, on average 44 min.

Interviews were recorded and transcribed.

2.4 | Data Analysis

Main categories were based deductively on the study questions. Additional main categories as well as subcategories were extracted inductively via qualitative content analysis in different steps: Firstly, (due to language restrictions) the German, Swiss (both in German) and Jersey data (in English) were coded and paraphrased by the German team. From this material inductive sub-categories were derived. In a last step, Swedish content was added as paraphrases by the respective national researchers and citations attached in the original language, which were translated to English for the manuscript. Categories were developed inductively by at least two researchers in an incremental and reflexive process going through the data several times. For coding and analyses, MAXQDA Plus 2020 was used.

Ethical approval was granted 8 October 2019 (F-2019-087) by the ethics commission of the district physician chamber ('Landesärztekammer') of Baden Württemberg.

3 | Results

In total, data of 22 patients were collected. In Sweden patients were affiliated to a multi-disciplinary primary care centre, while all other patients were affiliated to single-handed GP practices. Average age was 74 years, 40% were female (Table 1).

3.1 | Categories

Based on Starfield's core dimensions [7] our main preset deductive categories were: Patient centeredness, continuity, coordination of care, and access. Inductively derived subcategories are presented in Table 2 and described in the beginning of each section.

The subcategories of these deductive categories were not always sharply separable: for example, coordination and continuity of care both were connected to the role of personal relations.

3.2 | Patient Centeredness

Patients' reports about especially good or bad experiences revealed that patient-workforce relationship issues were relevant factors they cared about. Secondly, comprehensive communication—with the aspects content and comprehensibility—provided a sense of security (Table 2).

3.2.1 | Patient-Workforce Relationship

Enough time, personal exchange, availability of a contact person, that does not have to be the GP, were grouped into patient-workforce relationship.

The perceived **lack of time** was reflected in interviews from different settings and countries. British, German and Swedish patients complained about a lack of time of staff. Patients (GER3, GER6, GER9, JER1, SWE5) reported that medical staff gave the impression of being under time constraints. GPs not listening to the patient's symptoms or not giving advice because of time constraints was seen as a consequence of lack of time:

TABLE 1 | Patient characteristics.

		Sex			Diagnosis		
Country	Participants	Female	Male	Average age	Stroke	MI	HF
Germany	9	4	5	74.2	2	7	0
Sweden	7	4	3	81.2	0	0	7
Switzerland	3	1	2	64	1	2	0
Jersey	3	0	3	76.6	3	0	0
Total	22	9	13	74	6	9	7

Abbreviations: HF, heart failure; MI, myocardial infarction.

TABLE 2 | Category system.

Main category	Subcategory	
Patient centeredness	Patient workforce relationship	Available time
		Personal exchange
		Availability of contact person
	Comprehensive communication is key for patients	Information content
		Comprehensibility
Continuity of care	Informational continuity	(In-)sufficient information transfer
	Effects of (not) changing health professionals or practices (personal continuity)	Personal GP
		Flexible GP
Coordination of care	Guidance and overall care responsibility	Defined coordinator
		Referrals (gatekeeping)
	Organising care	Structured follow-ups
		Organising appointments
Access to care	Available services	
	Accessibility	

> I think [...] you [medical staff] got pressure on you, you can't read up. [...] you only get 15 minutes in the primary care. And that's a joke, you know?
>
> (JER 1)

> Because these general practitioners don't really twiddle their thumbs [...] The throughput must be right.
>
> (GER 9)

> ... but it has been a bit problematic and messy here at our healthcare centre because two doctors have quit, and one has died, and that naturally causes problems ...
>
> (SWE 5)

By contrast, **offering more time** for personal exchange seemed to have a reassuring effect on patients. This included, the possibility to talk about lifestyle issues, fears and other psychological or personal issues. Especially **non-physician personnel** like specially trained advanced practice nurses (APNs) in Switzerland or Swedish heart failure nurses, the continuous presence of nurses in Jersey or German practice assistants managed to offer the feeling of being cared for, seen and heard.

> Now I have another doctor and he actually took the time to talk through everything. From the first day, [...] we sat there, we actually went through the lock, stock, and barrel, [...], and it gave a little peace and quiet to meet him.
>
> (SWE 7)

> And she [APN] took away my inner fear a little bit and talked to me. What I could change in my life, what I have to pay attention to, what I am allowed to do. She's always looking out for me.
>
> (CHE 1)

> [...] the closest, really the closest, was always Mrs. W. [APN], who talked openly with me about it. And she actually took away my fear of everything. [...] she really helped me and still helps me now, I come here about once a month.
>
> (CHE 1)

> Because there are so many things, I can discuss with her [APN]. I can confide in her almost the same things as I do with a psychological counsellor [...].
>
> (CHE 2)

> The relationship between the patient and the doctor, that also has to be right. Otherwise, everything else is useless. [...] It's the personal thing [...]
>
> (GER 8)

In connection with providing a sense of security in the background, it is particularly important that this person or institution can be reached promptly. For patients a defined **contact person** for emergencies or urgent situations was important. Again, not only physicians could take on this role, depending on the severity of the situation.

> Interviewer: 'And would you rather report to [...GP] or to the [practice assistant]?' Patient: 'So it's more likely to be the [practice assistant]. Unless I really keel over, then I think it's Mr. S. [GP].'
>
> (CHE 1)

> [...] I would like to have the assurance that [...] my doctor [...] is there when I need him.
>
> (SWE 6)

3.2.2 | Comprehensive Communication Is Key for Patients

Overall patients felt well cared for if there was a **good exchange of information** between physicians (or medical staff) and themselves (including relatives). The information content, as well as its comprehensibility, were equally relevant. Independent of the care setting, patients stated a need of information about the disease itself, therapeutic options, follow-up, psychological guidance and preventive advice:

> [...] regular contact with the doctor [...] would be good, then maybe you can feel this way and maybe talk to the doctor if he or she has other ideas, other medications or something like that [...].
>
> (SWE 3)

> [...]And I was expecting not only psychological tips, but also tangible tips, [...] Pay attention to that in the future. That this and that comes, so I continued to have the feeling of being completely at the mercy of this heart attack. [...] Yes! In fact, that would have been the most important thing for me.
>
> (GER 9)

If information was provided, the way HOW it was delivered was not always perceived as helpful. Purely informing about behaviour change was perceived as insufficient:

> Interviewer: '[...] And did you get recommendations on how to change your lifestyle or how to deal with your blood pressure?' Patient: 'Yes, they just said to lose weight. [...] Eat less.'
>
> (GER 1)

> [...] I've got it all, but I don't really look at it, do I?
>
> (JER 1)

> [...] the search to find a cardiac sports group. That was very, very difficult and bad. [I would have liked] someone who could help me a bit [...] and so I just poked around on the internet for hours, until I found something.
>
> (GER 4)

By contrast, being informed in detail about the procedures of inpatient medical examinations could provide a sense of security:

> [...] I was really scared [of the cardiac catheterisation], of course, because I didn't know what they were doing. But they really reassured me, so it all went well. [...] they [the doctors] were also very nice and explained everything. So, there is nothing to say.
>
> (GER 6)

The perceived lack of advice and information about further care, fits with the space a care coordinator would fill; they would offer guidance and help in organising further care.

3.3 | Continuity of Care

The information flow across providers is central to perceived "continuity of care", as one of the two main categories here. Personal continuity on the other hand here refers to the long-standing and ongoing relationship between the physician mainly and the patient.

3.3.1 | Informational Continuity

Insufficient informational continuity was an important topic: Patients were concerned about **missing or inconsistent information**.

While the communication within care structures, such as GP practices was mostly reported to work well in Switzerland and Germany, patients especially in Germany were dissatisfied with the extent to which the GP was informed about the care provided by specialists and hospitals. Almost half of the patients in Germany were responsible to establish the information transfer between hospitals or specialists and the GP, and GPs didn't automatically receive reports of the provided specialist care:

> He [the GP] said it still hasn't arrived and I was at the GPs for a consultation [...]. He [the GP] had to rely [...] on me as a patient, as an unreliable source [...]. Well, that doesn't work!
>
> (GER 9)

Other patients described the cooperation within the primary care team and the communication between their GP and others, such as heart failure nurses, cardiologists, and hospitals, as sufficient.

3.3.2 | Effects of (Not) Changing Health Professionals or Practices (Personal Continuity)

The opportunity to **see the same GP** seemed important to patients from all settings. Patients stated that trust, security, and the feeling of being well cared for, were a result of having the same general practitioner over a longer period of time. This was especially related to the fact, that the practice has long-term information about the patients and their social context:

> So it's [the practice] a big family. That's why you don't change something like that. [...] (GER 5) [Staying with

> the same GP for as long as possible] is actually the most important thing, because he has had my data for 40 years. If he looks in the archive, he has all my data in there. So, he can read from it, and I think that's actually important.

(GER 5)

> One had a personal, a very personal relationship with the family doctor. And above all, he knew the whole family [...]. He knew them and all the problems [...].

(CHE 3)

> It feels safe that I have had the same doctor many times. [...] It is important to have the same doctor because you get the impression that [...] we kind of know each other and [...] with heart failure he has everything under control, I think.

(SWE 2)

In contrast, frequently changing doctors in an organisation tended to unsettle the patient and patients aimed to still keep a personal GP:

> No, there are several doctors in the practice and also two female doctors. And when it comes to important things, then of course only Dr. H. [GP] is an option for me, because he knows the course of my illnesses. Whereas the other doctors first have to deal with it and look up what I had [...].

(GER 8)

> Yes, there are many people. [...] I would like to be sure that this is my doctor, that he'll be there when I need him.

(SWE 6)

As long as a good personal contact and informational continuity could be established and if there was no severe health problem, patients were also **content with other doctors** (JER1, GER1, GER4, GER8):

> If it's something minor, I go to a substitute doctor [in the same practice].

(GER 8)

> Interviewer: 'So the main thing is that you do have a family doctor. It doesn't matter if it's someone else now and then?' Patient: 'That's not so important to me.'

(GER 4)

> But it is clear that it is a bit difficult when there are different doctors and say different things, it can be a bit difficult.

(SWE 6)

3.4 | Coordination of Care

Patients were asked about how their care is organised and how the different caregivers cooperate. The responses could be grouped into (1) guidance or advice about whom to consult or which steps to take and (2) into organising care (referring to the management of appointments and interprofessional cooperation). Those tasks can be provided by one person, but can also be shared.

3.4.1 | Guidance and Overall Care Responsibility

Next to a defined coordinator of care, also the issues of (formal) referrals was raised. There was not always a clearly defined coordinator, when asked, if there was anybody responsible for their care and care planning (GER, JER). If there was a responsible care coordinator, patients felt this should be the GP because GPs were the first point of access, easy to reach, and had a generalist approach. Additionally, patients trusted the competence and diagnostic skills of their GPs.

> [...] normally that [GP practice] is the first port of call, because I think he's competent and I've chosen the GP because I think he's capable.

(GER 9)

> Interviewer: '[the GP] takes on the role of a coordinator for you, who would refer you [...] to other doctors?' Patient: 'Yes, I think so. And he also has an eye, I have the impression, on both of us, on my husband and me [...].'

(GER 3)

> I am satisfied with it. [...] if I need a specialist, for example a cardiologist or a dermatologist [...] then the GP says to me, go there or there or there. [...] And the specialist will then give him a report on what he has done and what he recommends.

(GER 8)

Patients felt uncared for when responsibilities were not clearly defined, for example, between the specialist and the GP:

> If he sends me to the cardiologist, he must do the blood tests first. [...] I was not satisfied. [...] I noticed that he [the cardiologist] was [...] astonished. [...] Dr. O. [GP] should have done that, right? [...].

(GER 4)

> [...] I guess it [the care process] is a bit too compartmentalised, there should be more collaboration [with the neurologist]. [...].

(SWE 6)

Referrals to specialists by GPs were sometimes seen as helpful guidance, on the other hand the gatekeeper function of the GP, when he or she has to issue a formal referral to a specialist like in Jersey, was sometimes perceived as being restrictive or even patronising by patients:

> Yes that worked. He [the GP] immediately referred to the relevant specialist.
>
> (CHE 3)

> I don't know if it [the referral] is necessary, but I feel patronised. [...] I feel incapacitated. [...].
>
> (GER 9)

> That is rather difficult [...] really, because you can't really leave out the middleman [...]. The first man that you see is a doctor. [...] The GP, you can't really leave him out. So what do you do? [...] the system is: they won't look at you unless you're being referred to by a doctor. I couldn't have gone up to ENT [Otorhinolaryngologist] and say: I want to see Mr. DC? [...] You got to see the GP [first].
>
> (JER 1)

3.4.2 | Organising Care

Patients wished for more **structured support** when it comes to care planning after acute incidents, such as stroke or myocardial infarction, and appreciated regular, defined check-ups and active, regular follow-up by GPs or other professionals:

> [...] I have to say that N. [practice assistant] calls me regularly to tell me how I am and whether everything is all right with my tablets and to take blood samples. She calls quite often.
>
> (GER 2)

> ‘I used to have somebody that used to come every two months. A nurse. She used to come and checked over.’ Interviewer: ‘[...] do you think your condition is taken good care of? Do you think there's good support for you after the stroke and rehabilitation [...]?’ Patient: ‘Yeah. To me it was adequate.’
>
> (JER 1)

> He [the GP] used to call me up and send me down for tests and keep an eye on me all the time like [...] every 3 months, sometimes every 14 days [...].
>
> (SWE 7)

Some patients felt comfortable organising their own follow-up or specialist care, while some others preferred having their follow-up or specialist care organised for them.

> ‘He [GP] has already called the hospital I usually go to, and he also makes the appointments [for] colonoscopy.’ Interviewer: ‘And how do you feel about that?’ Patient: ‘No, that's fine. Because they're colleagues, they can do it better together.’
>
> (GER 6)

> I don't really know who I should contact, maybe I could use a little help with that too [...].
>
> (SWE 3)

3.5 | Access to Care

Having access to care is dependent on the regional availability of services in the first place, but also on opening hours, waiting times etc.

3.5.1 | Availability of Services

Patients described circumstances that affected access to different health care institutions. These included the lack of available services in the region...

> Well, it [network of care] leaves a lot to be desired, especially because of fitness and everything. From that point of view, there's nothing up here [Swabian Alb, a rural region in Germany].
>
> (GER 2)

3.5.2 | Barriers in Seeking Care

Other factors influencing access of existing services were distances, technical and financial hurdles or opportunities (e.g., regarding access), opening hours, waiting times.

Patients generally found the **distances** to the GP acceptable if less than 30 min travel time. Depending on the service, longer routes were perceived as difficult and prevented one person from participating in heart sport groups.

Patients in Sweden complained that they couldn't access services due to limited phone opening hours or organisational issues.

> Even if you call at seven in the morning, they may say that it is already busy and, as I don't have a direct number for her [heart failure nurse] either, I must call via the health centre. It has sometimes happened that I can't get there until the afternoon and she is gone home by then.
>
> (SWE 4)

> [It is] very difficult to get through to our health centre because you have to go through [...] and then they wanted all the details and bank ID and all that and I couldn't do that then.
>
> (SWE 5)

While longer **opening hours** were welcomed...

> And if it doesn't work with the normal hours, they also have evening hours. I've already been able to use them.
>
> (CHE 1)

...patients didn't seem to feel well cared for, when opening hours are short or not transparent.

> [...] I had a family doctor, [...] I was with her [...] since the 80s and then she only worked part-time. It was difficult [...] to meet her or to get anything at all within a certain time frame. [...] so that was too much effort. [...] I looked for someone else [...].
>
> (GER 9)

While waiting time to access the GP or emergency services appeared to be acceptable, long waiting times for secondary or tertiary care were consistently a perceived problem.

> It's been a long time since I've been to a doctor in [town]. It's [due to] waiting times.
>
> (SWE 6)

> 'I've got to go to a clinical examination now. It's in August.' Interviewer: '...So it's about six months from now.'
>
> (JER 1)

If the waiting period appears too long, emergency rooms provide a solution:

> If you can call the emergency as well as [the] casualty [department], I think you can get looked at straight away.
>
> (JER 1)

In summary, categories did not show clear national patterns as they regularly contained citations from different countries; answers from patients of one country were often opposing.

4 | Discussion

The goal of this study was to explore patients' experiences with care for similar health conditions in different healthcare systems. Patients' experiences regarding access, care coordination, and continuity of care (e.g., team-based care provision, task shifting or additional coordinators) while being treated in their respective established primary care system, were assessed. This facilitated the focus on perception regarding care structures irrespective of the underlying national healthcare system.

The most important finding is that patients do not seem to differ between countries with respect to what is important to them in the care process. Due to the approach of tracer diagnosis [20] all patients had a chronic condition and in addition an acute event to be cared for, therefore, all presumably had similar needs irrespective of their healthcare setting. Accordingly, experiences reflected individual needs and the local context rather than the patient's country, albeit, of course, experience-based expectations may have played a role too. Thus, emerging categories were regularly built up by data from multiple countries. Indeed, at times, opposing statements were found from within the same country.

Also, patient needs and expectations were interdependent and **categories overlapped** at times. Their preferences were focused on relational aspects of care, such as communication and feeling 'seen and heard'. This reflected patient-centeredness, as the degree of patient-centeredness is influenced by a variety of factors, including the **'flow of information'** [24, 25], the **provision of time capacities** [26, 27], and the active role of **non-physician staff** [28, 29].

Patient centeredness was related to issues with respect to **workforce availability**: For example, patients felt poorly cared for (indicating a lack of patient-centeredness) when staff did not have **enough time**. Participants attributed this to staff shortages. They expressed this directly, for example, as a lack of time for advice, or indirectly by excusing unfulfilled needs as being due to the workload of GPs. GP consultation duration has been shown to correlate with the degree of comprehensive care and patient satisfaction [27]. In Germany, many regions had significant shortages of GPs and consultation times have shortened [26]. Workforce shortage is also related to waiting times [30], and was a recurring complaint with regard to specialist referrals.

For continuity of care, good communication between patients and their doctor or healthcare professional was very important to patients as was the **comprehensibility**. This contributed to a feeling of security and being well cared for. Effective communication includes lay-friendly explanations, informing and educating patients, and their relatives, about treatment options and preventative, health promoting measures [31]. Prioritising communication skills in medical and nursing training [20] could therefore significantly improve the patient experience [25]. **Informational continuity between different health care providers** also contributes to trust and a feeling of security and good, holistic care, especially among chronically ill patients. The lack of informational continuity was criticised and it was one area that did show apparent national traits or groupings in our study. A possible explanation could be the absence of an electronic patient record (EPR), contributing to insufficient information exchange between GPs and specialists. An EPR was (and is still) lacking in Germany, while the Swedish "Nationell patientöversikt" (NPÖ) was introduced in 2009 in Sweden [32]. At the time of our interviews in 2019, Switzerland's EPR ("Elektronisches Patientendossier") was being rolled out [33]. Both countries are pioneering the establishment of national electronic health records (NEHR) in Europe [34]. Swedish health professionals perceived interprofessional communication to be better with EPR and thought that patients received more comprehensive care [35]. Shared electronic health records were able to deliver precisely the benefits that were lacking and, therewith, criticised by some patients in our study.

We were interested in understanding how the **personal relationship** between one individual physician and the patient and his family impacts the patient's experience. Most of this study's patients preferred to see the same doctor due to perceived better information and personal relationships, which created trust and security; this is further evidenced in recent studies [36, 37], while others were not bothered by changing physicians as long as the personal contact and informational continuity was warranted. These results support the recent inception of the term "sustained relationships" by the National Academies of Sciences, and Medicine: "A relationship implies that individuals and their families seeking primary care have identified one or more clinicians in the practice who accepts accountability for their care, health, and wellness and whom they trust and prefer to see." [38] Next to trust, stable physician-patient relationships have been related to better outcomes and lower costs [39].

4.1 | Coordination of Care

Our patients' expectations of the GP as a core coordinator can be deduced from the trust in the GP's competence and diagnostic skills, which were very important for patients. However, patients did not always have a person responsible for their care; a central part of the National Academies' description of high-quality PC. **Non-physician staff** can support guidance, satisfy the patients' wish for a low-threshold, contact person [28], strengthen integrated care [40] and relieve GPs' workload.

The need for guidance depended on the individual situation and on the abilities of the individual patient. Two main issues emerged around coordination: organisation and management of care on the one hand, and guidance and advisory functions on the other. The difference between organisation/management and guidance/advisory functions can be explained using a German example: Even if the organising of a rehabilitation programme worked well, patients found the advice regarding which facility would be suitable to be inadequate or non-existent. The partially poor coordination outcomes reported both in our study and in the OECD report [41], underlines the need of interprofessional (primary) care teams, including nonclinical professionals in order to deliver holistic care that meets the needs of the community or population they serve [38].

In our settings, APNs in Switzerland and heart failure nurses in Sweden were available and participants perceived them as helpful (As there is no uniform definition of terms, we use APNs including CHN, NP or the like) [42]. **APNs** within GP practices have been shown to serve as an accessible, highly trusted contact person [43]. **Health navigators**, practicing independent of GP practices in larger institutions, could assist the patient, providing advice, guidance, and information [44, 45]. Each can play a role, especially in view of the worsening shortage of general practitioners [41]. Although the advantages of additional roles, beyond practice assistants, has been discussed for many years [46], of our nations represented, only in Sweden and the UK are specialised nurses, such as heart failure nurses or diabetes nurses well established [47]. Switzerland is actively working towards this [43] while the implementation of APNs in Germany is still only discussed [46, 48].

4.2 | Limitations

Due to the different native languages of the patients, different interviewers conducted the interviews. By defining disease patterns and using a common interview guide, we sought to achieve best comparability and standardisation [49]. However, different national researchers as well as the need to translate the interviews could have contributed to biases or errors in the data. In addition, due to the pandemic, the planned joint data analyses were substantially restricted. To overcome these limits, the category system was initiated and completed in Germany, then further developed with data from the other sites.

Another limit is the low number of interviews of this explorative study. Sample size therefore was guided by Information Power sampling [21]. This method is explicitly used when sample size is limited by aiming to homogenise samples as much as possible. We used defined conditions in the patients in order to obtain similar experiences and care needs.

5 | Summary

This international study showed that patient preferences are focused on relational aspects of care, which are similar across settings. Our patients' experiences were consistent with well-documented precipitants (positive and negative) of healthcare structures. Patients focused on relational aspects of care (such as enough time, information flow and personal relation), rather than functions or structures. We conclude, that physicians could be relieved by other professions such as APNs, and next to this, prioritising communication skills in medical and nursing training could contribute to better patient experience.

The consistency of such patient experiences—temporally and geographically—underlines the need for the patient experience to play a core role in health policy planning. This is particularly relevant, and its importance amplified, given that patients' experiences have previously been among the least frequently examined parameters in healthcare systems evaluation [50].

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Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.