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Evaluating general practitioners' job satisfaction, a comparison between private and public practice.

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Dedication

To my husband, Matthew, and our children, Beppe, Lucia, Timothy, and Ezequiel.

This work is dedicated to you with all my love

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First and foremost, I thank God for granting me the strength, perseverance, and grace to carry out this work. Without His guidance, none of this would have been possible.

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Abstract

General practitioners (GPs) play a vital role in the effective functioning of primary healthcare systems, yet their job satisfaction is influenced by a complex interplay of personal, professional, and systemic factors. This thesis investigates job satisfaction among GPs in Malta using a triangulated mixed-methods approach, integrating both quantitative and qualitative data to capture a comprehensive picture of the local context.

The study is underpinned by the Social Production Function (SPF) theory, which considers how individuals seek to optimise physical well-being and social approval through goal-oriented activities. A national survey was distributed to 70 GPs working across public and private sectors, examining factors such as workload, autonomy, administrative burden, patient continuity, remuneration, peer support, and opportunities for professional development. These results were further explored through focus group discussions with both public and private GPs, allowing for deeper insight into the lived experiences behind the quantitative patterns.

Findings revealed significant disparities between public and private sector GPs. Public GPs frequently cited issues related to lack of continuity of care, walk-in systems resembling 'shopping counter' dynamics, inadequate administrative support, and limited career progression. Conversely, private GPs reported higher satisfaction correlated to autonomy, long-term patient relationships, and more control over work schedules. Across both sectors, stress and burnout were common themes, compounded by structural and policy-related constraints.

Notably, appointment-based clinics and improved patient registration systems emerged as promising areas for reform, with participants highlighting their potential to enhance patient care, reduce GP stress, and improve professional satisfaction. The study also points to a broader systemic

challenge: the limited responsiveness of primary care policy in Malta to the evolving needs of GPs and patients alike.

This research contributes to the limited literature on GP job satisfaction in Malta and offers practical recommendations for health system leaders. It calls for policy changes that support continuity of care, investment in workforce planning, better recognition of GP roles, and the implementation of more sustainable practice models. Addressing these concerns is essential for retaining a motivated GP workforce and strengthening primary care as the cornerstone of the Maltese health system.

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Chapter 1: Introduction

1.1 Background

Job satisfaction is a critical determinant of the quality of care provided by general practitioners (GPs) and their retention within healthcare systems. When GPs are satisfied with their work, they are more likely to remain in their positions, perform at a higher level, and contribute positively to patient outcomes (Syed & Akhtar, 2014). Various factors influence GP job satisfaction, including work conditions, autonomy, workload, and the availability of resources. GPs in the public sector often experience challenges such as high patient turnover, lack of continuity of care, and shift work, which can lead to increased stress and burnout (Sammut, M. R., 2003). GPs with greater control over their work schedules, patient load, and clinical autonomy, features often associated with private practice, tend to report higher levels of job satisfaction (Stobbe et al., 2021). Autonomy and manageable workloads are key factors contributing to job satisfaction in primary care, and research suggests that these elements play a significant role in reducing physician dissatisfaction and improving healthcare delivery (Cohidon et al., 2020). Thus, ensuring supportive work environments, adequate resources, and better organisational structures is essential for enhancing job satisfaction among GPs and, consequently, improving the overall healthcare system.

Primary healthcare in Malta is delivered through a network of health centres and community clinics, with the primary aim of ensuring accessibility and continuity of care for the population. The public sector is central to healthcare delivery, with three main 24/7 health centres in Mosta, Floriana, and Paola offering walk-in services without patient registration, unlike systems with structured registration (Primary HealthCare Department. (2023)). Smaller centres operate during daytime hours, while peripheral community clinics provide scheduled 20 minute appointments focused on chronic disease management. These clinics play a key role in addressing long-term health needs.

Plans are underway to open the Paola Hub in the Southern region to further expand access (*Primary HealthCare Department. (2023).*).

The Maltese public healthcare system does not merely focus on general services; it extends to specialised care, offering podiatry, physiotherapy, immunisation services, speech therapy, as well as antenatal and postnatal clinics. Diabetes clinics, orthopaedic clinics, and wound management services are also part of the healthcare network, providing patients with the comprehensive care they need for various conditions. This multidisciplinary approach is supported by a diverse healthcare workforce, including general practitioners (GPs), nurses, and other allied health professionals. Moreover, the integration of telemedicine services and national screening programmes further enhances accessibility, ensuring that patients, particularly those in remote areas, benefit from holistic care. The coordination of services across these different levels of care is a cornerstone of the Maltese primary healthcare system, aiming to deliver high-quality care while reducing fragmentation.

In Malta, however, primary care faces a set of challenges that affect both the quality of care and the satisfaction of healthcare providers. One prominent issue is the high patient throughput in public health centres, which strains the workload of general practitioners and compromises their ability to provide continuous, personalised care (Kirsten Schembri, 2016). The absence of a formal patient registration system in the public sector exacerbates these challenges, leading to fragmented care and making it difficult to track patient histories consistently across appointments. This lack of continuity of care can result in delays in treatment, misdiagnoses, and overall reduced patient knowledge, while also limiting the GPs autonomy and negatively impacting their job satisfaction and professional well-being (Sammut, M. R., 2003). These organisational constraints are compounded by inadequate staffing levels and resource limitations, especially given the growing demand for healthcare services due to demographic changes, such as an aging population, and increased patient

expectations (Sammut, D., 2013) (Sammut, M. R., 2003). Malta has experienced consistent population growth in recent years, reaching over 563,000 residents by the end of 2023 (NSO, 2024). Alongside this growth, the country is also facing a significant demographic shift, with the proportion of people aged 65 and over steadily increasing. According to projections, nearly one-third of Malta's population will be over the age of 65 by 2050 (WhosWho.mt, 2024). This dual trend of population growth and ageing presents important social and economic challenges, particularly in areas such as healthcare, social services, and community support systems. In addition, the increasingly multi-ethnic composition of Malta's population- drive by a growing number of foreign residents who primarily access public health centres- introduces further complexity to the provision of equitable and culturally competent care.

On the other hand, GPs in the private sector face a different set of challenges. While they enjoy greater autonomy over their work schedules and are able to manage patient loads more effectively, the pressures of running independent practices introduce financial and administrative burdens that can affect job satisfaction. GPs with greater control over their work schedules, patient load, and clinical autonomy, features often associated with private practice, tend to report higher levels of job satisfaction (Stobbe et al., 2021). However, this also creates disparities in the overall healthcare system, where the availability of care and the quality of the patient experience can differ significantly between the public and private sectors. The divide between public and private practice in Malta, as in other healthcare systems, has led to growing concerns about workforce disparities and equity in access to care, with some patients receiving more attentive care in private practices due to the greater time available for consultations (Kirsten Schembri, 2016).

The QUALICOPC study, which assesses the quality and costs of primary care across Europe, provides a helpful framework for evaluating the satisfaction of GPs within Malta's healthcare system.

According to the study, key factors influencing GP satisfaction include continuity of care, the adequacy of resources, and manageable workloads (Schäfer et al., 2011). These dimensions have

been central to ongoing debates in Malta about how best to reform the healthcare system to meet the needs of both patients and healthcare providers. The OECD's Health at a Glance report also echoes these findings, emphasising the importance of continuity of care and the availability of adequate resources as critical factors that influence the quality of primary care and the job satisfaction of GPs (OECD, 2023).

Moreover, research conducted by the European Federation of Salaried Doctors (FEMS) has highlighted that the structural disparities between public and private practice are a consistent source of dissatisfaction among GPs, with public sector GPs particularly affected by high patient turnover, shift work, and limited autonomy. This is in contrast to the more flexible, albeit financially demanding, private sector. These findings align with research from the Commonwealth Fund, which shows that GP autonomy and control over patient load are key drivers of job satisfaction (Cohidon et al., 2020). As such, addressing these systemic challenges requires comprehensive policy reforms that can bridge the gap between public and private sectors, ensuring that GPs across both spheres can work under conditions that promote job satisfaction, reduce burnout, and enhance the quality of care. These issues will be further addressed in the policy recommendations outlined in chapter 6.

1.2 Rationale of the Study

The role of GPs as primary care providers is pivotal in any healthcare system. In Malta, the dual structure of public and private practice presents unique challenges and opportunities. However, with the increasing demands on the healthcare system due to population growth and changing patient expectations, understanding the factors influencing GP job satisfaction is essential. Studies like those by Kristensen et al. (2005) have emphasised that organisational factors, such as autonomy, workload, and support systems, significantly impact satisfaction levels. These factors are especially

pertinent in Malta, where public sector GPs face constraints such as shift work and high patient turnover, while private sector GPs experience pressures related to managing independent practices. This study also draws on the Social Production Function (SPF) theory, which posits that individuals strive to achieve well-being by optimising physical and social resources to fulfil basic needs (Ormel et al., 1999). The theory provides a valuable lens for understanding job satisfaction, as it highlights the importance of autonomy, competence, and relatedness in achieving professional fulfilment. By integrating the SPF theory with data from the QUALICOPC questionnaire, this study aims to provide a nuanced analysis of the factors influencing GP job satisfaction in Malta.

This study seeks to compare job satisfaction between GPs in the public and private sectors, aiming to identify deficiencies and propose evidence-based recommendations for policy implementation. The lack of continuity of care in the public sector, contrasted with the personalised nature of private practice, further underscores the need for an in-depth examination of these disparities. By addressing this gap, the study contributes to a better understanding of how systemic and organisational factors affect GP satisfaction. Furthermore, it provides insights that can guide policymakers in implementing reforms to enhance working conditions and healthcare delivery in Malta.

1.3 Aims and Objectives

The primary aim of this study is to compare job satisfaction among general practitioners in Malta's public and private sectors. The objectives are as follows:

- To identify key factors influencing job satisfaction in both sectors.
- To analyse the differences in work conditions, autonomy, and patient care between public and private GPs.

- To assess the impact of these factors on the overall well-being and performance of GPs, using the QUALICOPC questionnaire.
- To apply the Social Production Function theory to interpret how job satisfaction is influenced by physical and social resource optimisation.
- To provide evidence-based recommendations for policy improvements aimed at addressing deficiencies in the public and private sectors.

1.4 Contribution to Knowledge

This study makes several contributions to the existing body of knowledge on GP job satisfaction. First, it provides a comprehensive comparison of the public and private sectors within the Maltese context, offering insights into the unique challenges and opportunities within each system. By bridging the gap in local literature, this study incorporates findings from grey literature and contextualises them within current healthcare dynamics. For instance, research highlights the need for improved patient experience and continuity of care in public health centres (Kirsten Schembri, 2016), while other studies advocate for improved continuity of care, which could be supported by a patient registration system (Assenova, 2019) (Sammut, D., 2013).

The integration of the QUALICOPC questionnaire enables a detailed assessment of the factors influencing GP satisfaction, building on international findings (Schäfer et al., 2013). By employing the Social Production Function theory, this study provides a theoretical foundation for understanding how GPs achieve professional well-being through the optimisation of resources (Ormel et al., 1999).

Additionally, the mixed-methods approach of this research strengthens its contribution. By incorporating both quantitative and qualitative methodologies, it addresses the multifaceted nature of job satisfaction. The inclusion of a focus group is particularly significant, as qualitative studies are

essential in healthcare for amplifying the voice of workers. A qualitative research approach was adopted, consistent with Creswell's (2014) emphasis on understanding complex human experiences in context, and aligned with Bhaskar's (2008) critical realist stance that social phenomena require interpretive methods to uncover underlying mechanisms.

Ultimately, this research seeks to promote a more sustainable and effective primary care system in Malta, benefiting healthcare professionals and the communities they serve. By providing a more recent evaluation of GP job satisfaction and comparing it to older studies, this study addresses the gaps in the existing literature, which is relatively outdated. This approach will help identify trends, changes, and persistent issues over time, offering actionable insights to enhance GP job satisfaction and improve healthcare delivery in Malta.

1.5 Overview of the study:

This dissertation is structured into six chapters. Chapter 1 introduces the study, outlining its background, objectives, and significance within the Maltese healthcare context. Chapter 2 provides a literature review, highlighting key theories, existing research, and gaps in knowledge related to GP job satisfaction. Chapter 3 describes the mixed-methods methodology, including quantitative data collection through the QUALICOPC questionnaire and qualitative insights from a focus group. Chapter 4 presents the study's results, while Chapter 5 discusses these findings in relation to the literature and their broader implications. Finally, Chapter 6 concludes with a summary, practical recommendations, and suggestions for future research.

Chapter 2: Literature Review

2.1 Introduction

Job satisfaction among general practitioners (GPs) is an increasingly important issue in healthcare systems worldwide, given its correlation with workforce retention, healthcare quality, and patient outcomes Gjessing et al. (2024). As frontline providers of care, GPs play a critical role in managing the health of populations, particularly in the context of rising chronic conditions and multimorbidity (Fang et al., 2022). Despite this, many healthcare systems face challenges in retaining GPs, as dissatisfaction with their work environment often leads to burnout, attrition, or a shift to private practice.

This study aims to explore and analyse the key factors influencing GP job satisfaction, drawing from both international and local contexts. Current literature identifies multiple determinants, including workload, financial remuneration, organisational support, professional autonomy, and interpersonal relations within the healthcare environment. Additionally, differences between public and private GPs further complicate this landscape, particularly in countries like Malta, where limited resources and systemic challenges impact satisfaction disproportionately. By synthesising findings from recent studies, this research seeks to provide a holistic understanding of GP job satisfaction and offer actionable insights. It aims to identify strategies and interventions that can improve their working conditions and enhance job satisfaction levels, ultimately contributing to better retention rates and improved healthcare delivery.

2.2 Methodology

A literature review is a systematic approach to gathering and synthesising previous research. When executed effectively and thoroughly, a literature review serves as a robust research method that lays a solid groundwork for advancing knowledge and promoting theory development. By putting findings and viewpoints together from numerous empirical studies, a literature review can provide further insight into the subject matter.

Additionally, it can offer a comprehensive overview of areas where research is varied and interdisciplinary. Furthermore, a literature review is an outstanding method for synthesising research findings to present evidence on a meta-level and to identify areas where further research is necessary, which is crucial for developing theoretical frameworks and constructing conceptual models (Snyder, 2019).

2.2.1 Inclusion and exclusion criteria:

The table outlines the criteria for selecting studies on GP job satisfaction. Inclusion criteria include peer-reviewed, full-text English articles from 2019 to 2024. The starting point of 2019 was chosen to ensure the inclusion of recent literature reflecting current challenges and reforms in primary care, including the impact of the COVID-19 pandemic on GP workloads, wellbeing, and job satisfaction. Studies published before 2019 were excluded to avoid outdated findings that may not reflect the present realities of general practice. Eligible studies include systematic reviews, meta-analyses, and various study designs involving General Practitioners (GPs).

Studies must focus on GP job satisfaction. Excluded are non-peer-reviewed works, non-English articles, studies published before 2019, and those not involving GPs or irrelevant to GP job satisfaction. These criteria ensure the research is based on substantial, current, and relevant evidence.

Table 1 Inclusion and exclusion criteria

	Inclusion	Exclusion	Justification
Article	Peer reviewed articles available in full text	Non peer reviewed articles, editorials, commentaries and books.	Substantial peer reviewed evidence
Language	Published in English	Any language other than English.	Using English-language resources streamlines the research process by eliminating the translation step.
Timespan	2019 to 2024	Articles published before 2019.	Up-to-date literature is more relevant to current challenges and trends.
Population	GPs, even when included in studies with secondary care specialists or patients.	Study populations without GPs.	The population aligns with the research question.
Relevance	Analysis of GP job satisfaction, independently or in relation to other doctors or patients.	Anything irrelevant to GP job satisfaction.	Job satisfaction among GPs is a multifaceted factor affecting the overall quality of care.

2.2.2 Search Strategy

To ensure a comprehensive approach to identifying relevant literature, a systematic search strategy was employed following the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. The primary databases utilised in this search were PubMed Central and Scopus, which facilitated the collection of a substantial number of records.

The keywords used for the search included "general practitioner," "job satisfaction," "primary health care," and "private vs public." This combination was aimed at capturing studies that explore the complexities of job satisfaction amongst general practitioners within different healthcare settings.

2.3 Results

The search yielded a total of 2,571 articles across the identified databases. No additional articles were obtained from registers or supplementary sources.

2.3.1 Screening Process

Prior to formal screening, preliminary filters were applied:

- Duplicates: 56 duplicate articles were removed.
- Automation Tools: 2,000 articles were excluded through automation based on:
 - No full-text availability,
 - Articles not peer-reviewed,
 - Articles published before 2019 (date filter).
- Other Reasons: 99 records excluded because they were commentaries, editorials, or books.

After these steps, 416 unique articles remained for manual screening.

During manual screening of titles and abstracts, 52 records were excluded based on specific reasons:

- 20 articles discussed doctors or healthcare professionals in general without specific focus on GPs.
- 12 articles focused on nursing staff or interdisciplinary primary care teams.
- 8 articles were about patient outcomes unrelated to GP satisfaction.
- 7 articles focused on health systems organisation without addressing workforce satisfaction.
- 5 articles were duplicate conference abstracts already represented in full articles.

2.3.2 Articles Sought for Retrieval

From the screened articles, 364 were sought for retrieval.

301 could not be retrieved because:

- 160 studies targeted healthcare workers broadly (nurses, allied health, doctors generally) and did not mention GPs specifically.
- 141 studies lacked full-text availability or were not accessible through institutional subscriptions.

Thus, 63 reports were successfully retrieved.

2.3.3 Assessment for Eligibility

Of the 63 full-text articles assessed:

- 9 articles focused on GP trainees and training programs (excluded due to different study population).
- 10 articles addressed universal health coverage broadly (not directly tied to GP job satisfaction).
- 7 articles explored patient satisfaction rather than practitioner satisfaction.

- 12 articles studied financial models or insurance reimbursement systems not applicable to Malta.

The remaining 25 articles were included for synthesis.

2.3.4 Identification via Other Methods

Citation searching identified an additional 20 articles.

- 17 articles were sought for retrieval, but 4 could not be retrieved because:
 - 2 articles were inaccessible due to subscription/paywall restrictions.
 - 2 articles lacked sufficient detail in abstracts and were unavailable in full-text.

Of the 13 reports retrieved:

- 3 articles were excluded because they focused on health systems fundamentally different from Malta (e.g., healthcare structures in developing countries like India or Bangladesh, where GP roles differ significantly).

This methodology outlines a systematic and transparent approach to literature identification and assessment, adhering to the PRISMA guidelines to ensure a rigorous and comprehensive literature review process. The criteria for inclusion and exclusion were intentionally designed to focus on studies that pertain specifically to the context of job satisfaction among general practitioners within the healthcare landscape of Malta.

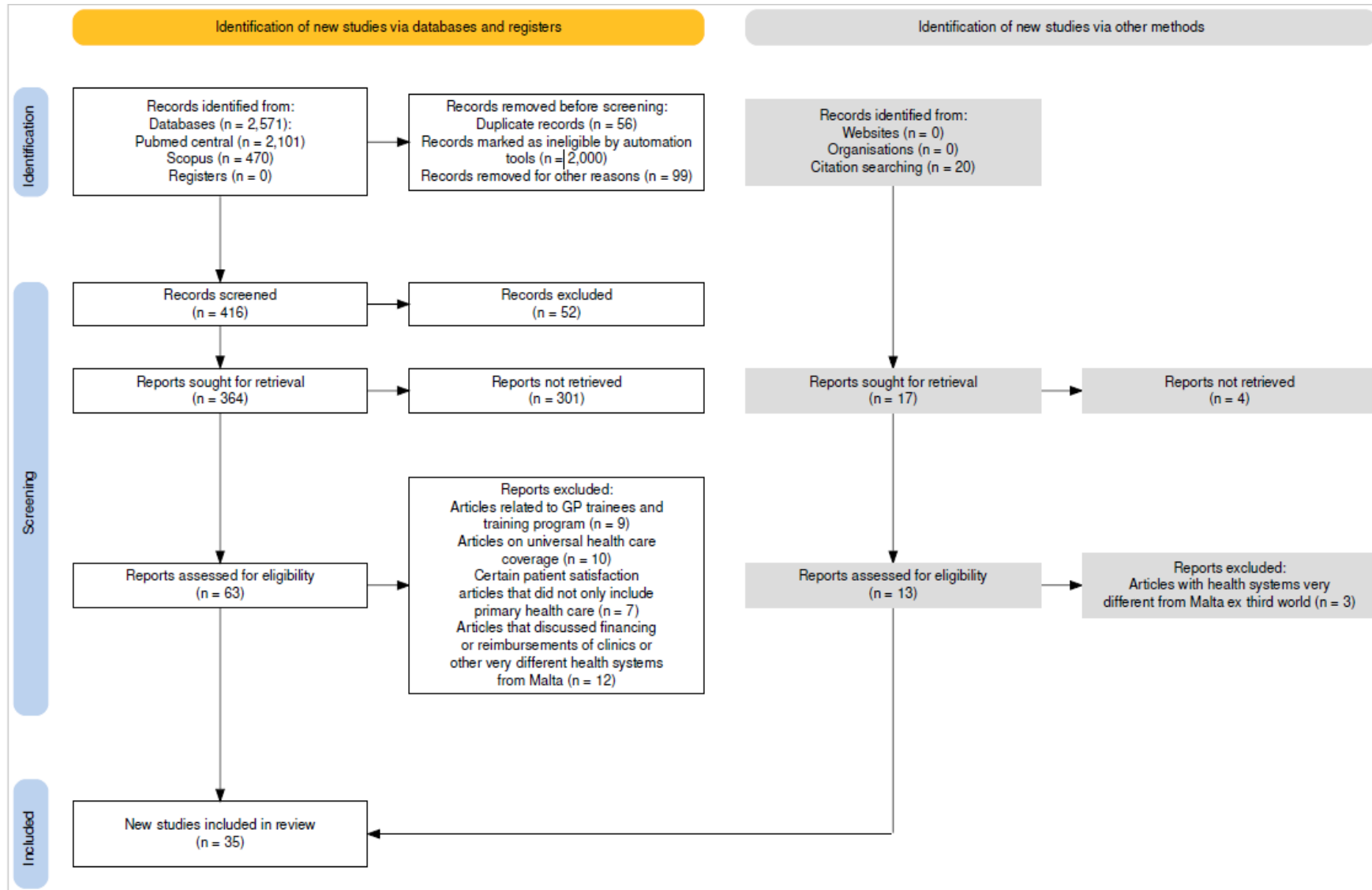


Figure 1 PRISMA flowchart showing study selection process

2.3.5 Study characteristics

In the conducted literature review, a total of 35 articles were analysed, categorised by subjects and data collection methods. The most frequent study type was quantitative, comprising 62.86% of the articles. Systematic reviews and qualitative studies each accounted for 11.43%, while mixed-method studies represented 8.57%. One study (2.86%) combined longitudinal and quantitative approaches. Regarding the subjects addressed, work-life balance and mental health were prominent, appearing in 17.65% and 14.71% of the articles, respectively. Leadership and effort-reward topics appeared in 8.82% of the studies each. Workload, burnout, and multifactorial topics were each explored in 11.76% of the articles. Topics such as remuneration and policy, team implementation, doctor-patient relationship and patient-centred care, organisational climate, patient preference, digital health, and the SPF theory were represented to a lesser extent, with each category making up 5.88% or less of the total articles. This distribution highlights the diverse range of topics covered in the literature, with a particular emphasis on quantitative methodologies.

2.3.6 The local context:

A separate literature review was conducted to explore the local context of GP job satisfaction and patient experiences in Malta. This review aimed to complement the main findings of the study by providing a deeper understanding of sectoral disparities within the Maltese healthcare system. Given that all identified studies were published before 2019, this review did not form part of the PRISMA framework. An exception was made here to include articles from the patients' perspective, as very few published articles and dissertations were identified.

2.4 Findings

2.4.1 The Importance of Job Satisfaction

Job satisfaction among general practitioners (GPs) is a vital determinant of healthcare quality and sustainability. High levels of satisfaction are associated with better patient outcomes, improved continuity of care, and stronger adherence to clinical guidelines (Glenister et al., 2021; Xu et al., 2020). Satisfied doctors engage more deeply with patients, promote trust, and contribute to enhanced communication, critical components of effective primary care (Thomas et al., 2023).

Studies highlight that relational continuity, where patients see the same GP over time, leads to more personalised and proactive care (Glenister et al., 2021). Such continuity is often more easily achieved when practitioners feel valued, autonomous, and supported in their work environments. This link between satisfaction and performance also extends to error prevention. Dissatisfied or overburdened physicians are more prone to mistakes, while satisfied professionals tend to be more focused, productive, and accurate (Xu et al., 2020).

Burnout remains a significant risk, especially in under-resourced or high-pressure environments. In both high- and middle-income countries, burnout correlates with heavy workloads, administrative burden, and limited autonomy (Dutheil et al., 2021; Fang et al., 2022). In rural areas, where GPs often serve large catchments with fewer support services, dissatisfaction can lead to high turnover and gaps in care delivery. Fang et al. (2022) found that job satisfaction was closely linked to staff retention in Singapore, with similar findings reported in Portugal and France (Dutheil et al., 2021; Ferreira et al., 2021).

A stable, satisfied workforce is essential for integrated care. When GPs are content, they coordinate care more effectively across disciplines, particularly for patients with chronic diseases or

multimorbidity (Thomas et al., 2023). As healthcare systems move toward patient-centred, team-based care, GP job satisfaction becomes not just a workforce issue, but a policy priority.

2.4.2 Factors Influencing Job Satisfaction and the SPF Theory

2.4.2.1 Workload and Administrative Burden. Excessive workload and increasing administrative responsibilities are among the most cited factors contributing to low job satisfaction in general practice. These demands often reduce the time available for direct patient care and are associated with emotional exhaustion and burnout (Rosta et al., 2019; He et al., 2020; Stobbe et al., 2021; Weltermann et al., 2020). Administrative tasks such as documentation and regulatory compliance are seen as detracting from the core values of general practice and limiting meaningful patient interaction (Stobbe et al., 2021). The burden of non-clinical work also impairs GPs' sense of professional autonomy and contributes to dissatisfaction (Weltermann et al., 2020).

2.4.2.2 Organisational Structure and Support. The structure and organisation of healthcare systems significantly influence GP satisfaction. Fragmented systems and poor coordination between levels of care are linked to reduced morale and a diminished sense of purpose (Cohidon et al., 2020; Damarell et al., 2020). Inadequate managerial support and lack of involvement in decision-making processes further contribute to a sense of disempowerment (Werdecker & Esch, 2021). These organisational challenges can also affect continuity of care, a core aspect of job satisfaction for many GPs (Damarell et al., 2020).

2.4.2.3 Autonomy and Control. Professional autonomy is a critical factor in job satisfaction, with higher levels of control over clinical decisions and work patterns associated with increased engagement and reduced turnover intentions (Chowhan et al., 2024; Le Floch et al., 2016). According to Social Production Function theory, autonomy helps fulfil basic psychological needs such as behavioural confirmation and status, which are essential for subjective well-being (Stobbe et al., 2021). Constraints on autonomy, such as top-down policies, rigid scheduling, and limited influence over practice management, are strongly linked to dissatisfaction (Le Floch et al., 2016; Stobbe et al., 2021).

2.4.2.4 Leadership and Management. Leadership style plays a fundamental role in shaping workplace culture and professional fulfilment. Transformational leadership, which involves clear communication, shared goals, and emotional support, is positively associated with GP satisfaction (Preiser et al., 2021). The presence of supportive leadership has been shown to promote motivation, improve retention, and mitigate burnout (Schmidt et al., 2023; Thielmann et al., 2024). In contrast, lack of leadership transparency and limited feedback mechanisms often contribute to feelings of undervaluation and disengagement (Preiser et al., 2021; Schmidt et al., 2023).

2.4.2.5 Remuneration and Sector Differences. Remuneration remains a key component of job satisfaction, particularly when income is perceived as fair and reflective of workload. GPs working in private practice often report higher satisfaction, partly due to better financial incentives and greater flexibility in work arrangements (Stobbe et al., 2021; Govender et al., 2021). When remuneration does not align with expectations or workload, especially in public systems, frustration and dissatisfaction may increase (Stobbe et al., 2021).

2.4.2.6 Collegial and Doctor–Patient Relationships. Interpersonal relationships significantly affect GP satisfaction. Strong doctor–patient relationships enhance the sense of professional meaning and trust (Buffel et al., 2023; Grant et al., 2024). Similarly, positive relationships among colleagues and a strong team culture help reduce professional isolation and promote well-being (Kuipers et al., 2021; Thomas et al., 2023). The absence of collegial support is often associated with increased stress and intentions to leave the profession (Kuipers et al., 2021).

2.4.2.7 Work–Life Balance. A healthy work–life balance is closely linked to GP job satisfaction. Inflexible schedules, long hours, and workforce shortages often lead to personal and professional strain (Bodendieck et al., 2022). Dissatisfaction with work–life balance is a key reason cited for career change or early retirement (Gjessing et al., 2024). In contrast, flexible work arrangements and organisational support for personal well-being are associated with higher satisfaction and retention (Göbel et al., 2022).

These factors can be meaningfully interpreted through the lens of Social Production Function (SPF) theory, which suggests that individuals aim to achieve well-being by fulfilling five instrumental goals: stimulation, comfort, status, affection, and behavioural confirmation (Lindenberg, 1996). Taken together, these elements highlight how GP job satisfaction depends not only on external conditions, but on how well these conditions enable practitioners to meet fundamental human needs as described in SPF theory.

2.4.3 Local Context: Malta’s Primary Care Landscape

The Maltese healthcare system presents a set of challenges that, while reflective of broader international patterns, are intensified by local structural constraints. General practitioners (GPs) in the public sector frequently report dissatisfaction due to high patient turnover and administrative

inefficiencies, which contribute to disrupted relational continuity and a fragmented care experience

(Kirsten Schembri, 2016).

Job dissatisfaction among GPs in Malta's public sector has been a long-standing issue. Early research identified poor remuneration, limited opportunities for professional development, and high stress levels as primary factors contributing to low morale and a resulting shortage of doctors in the public system (Sammut, M. R., 2003). More than a decade later, many of these issues remained unresolved. A quantitative assessment confirmed that excessive workload, limited professional autonomy, and minimal structural reform continued to undermine job satisfaction, suggesting that awareness of the problem has not been matched by meaningful systemic change (Debono, 2015). Further compounding the issue, both healthcare providers and patients have expressed dissatisfaction with public primary care. Stress and low job satisfaction among doctors, alongside patients' concerns about poor communication and lack of continuity, indicate a system under strain (Agius, 2009). These concerns are echoed in research on patient experiences, which shows that although public clinics offer broader access, patients attending private sector services report better continuity of care (Pullicino et al., 2015). Continuity has also been directly associated with improved health outcomes, highlighting the importance of stable, ongoing GP-patient relationships (Sammut, D., 2013; Vella et al.).

Structural reforms, such as the establishment of centralised health centres, have been perceived to weaken the traditional model of community-based primary care. This pattern mirrors developments in other European countries, where systemic disruptions to primary care models have contributed to elevated levels of burnout among GPs (Soler et al., 2008). Burnout was found to be closely associated with excessive workloads, lack of institutional support, and systemic inefficiencies, factors that are also prevalent in the Maltese context.

These findings collectively point to the urgent need for targeted reforms in Malta's public primary care system. Key areas for improvement include the introduction of a patient registration system, greater professional autonomy for GPs, and enhanced administrative support, measures that could help alleviate dissatisfaction and strengthen the quality of care.

2.4.4 Public and Private Systems

The disparity between the public and private healthcare sectors in Malta mirrors global trends. Private GPs enjoy higher job satisfaction, attributed to greater clinical autonomy, manageable patient loads, better financial remuneration, and stronger doctor-patient relationships

(Kirsten Schembri, 2016; Pullicino et al., 2014).

Public sector GPs, in contrast, experience systemic barriers such as rigid administrative systems, resource constraints, and heavy patient turnover. Similar patterns are observed internationally: in Malaysia and South Africa, private sector physicians consistently report higher satisfaction levels due to better working conditions and more favourable effort-reward balances (Ab Rahman et al., 2019; Govender et al., 2021).

These disparities suggest that enhancing GP satisfaction within the public sector will require addressing structural barriers, improving clinical autonomy, and offering financial incentives that better reflect workload demands.

2.4.5 Global Perspective on GP Job Satisfaction

Globally, GP job satisfaction varies considerably depending on systemic structures and cultural values. Scandinavian countries such as Denmark are frequently cited as models of high

satisfaction due to equitable healthcare policies, supportive workplace environments, and strong emphasis on work-life balance (Stobbe et al., 2021).

In contrast, countries like Spain and China continue to face challenges with high workloads, fragmented care systems, and limited professional autonomy (Stobbe et al., 2021; Xu et al., 2020). Similar challenges are evident in Malaysia's public sector, where dissatisfaction is driven by bureaucratic obstacles and resource scarcity (Ab Rahman et al., 2019).

The COVID-19 pandemic has further impacted GP satisfaction globally, with many reporting increased stress, feelings of professional vulnerability, and systemic insufficiencies. In Malta, no post-pandemic peer-reviewed studies currently exist, with the last documented analysis dating back to Schembri (2016).

The SPF theory offers a useful explanatory framework across these contexts, emphasising that well-being and job satisfaction are dependent on achieving comfort, stimulation, status, behavioural confirmation, and social approval (Chowhan et al., 2024). Systems that promote organisational justice, shared decision-making, flexible working models, and professional recognition are better positioned to maintain high levels of GP satisfaction (Anderson et al., 2020; Grant et al., 2024).

2.5 Strategies for Enhancing Job Satisfaction

Improving general practitioner (GP) job satisfaction requires comprehensive strategies that address both structural and individual-level challenges. Drawing on the Social Production Function (SPF) theory and empirical studies, several key approaches emerge.

First, leadership development within primary care settings is fundamental. Training GPs in transformational leadership skills, focusing on motivation, support, and promoting inclusive team cultures, has shown to significantly improve engagement and job satisfaction (Degen et al., 2022; Schmidt et al., 2023). Effective leadership strengthens communication, team collaboration, and organisational loyalty, all of which are essential for sustained professional fulfilment.

Streamlining administrative processes is another crucial intervention. Administrative burden consistently appears as a key driver of GP dissatisfaction across various healthcare systems (Grant et al., 2024). Introducing support staff, improving delegation practices, and promoting time management training can substantially reduce bureaucratic overload. In parallel, the careful implementation of digital health technologies can optimise patient record management and facilitate communication, although care must be taken to ensure that technological innovations do not themselves become sources of frustration (Zaresani & Scott, 2020).

Enhancing workplace environments is particularly critical within public sector primary care. Creating supportive and collegial settings, especially through team-based practice models, promotes a stronger sense of professional identity and reduces burnout (Buffel et al., 2023; Thielmann et al., 2024). Group practices, characterised by shared responsibilities and collaborative problem-solving, allow GPs to manage complex patient caseloads more effectively and sustainably (Weinmayr et al., 2020).

Policy reforms addressing financial compensation are also necessary. Financial structures must reflect the complexities of contemporary primary care work, recognising managerial duties, patient complexity, and administrative responsibilities (Deng, Q. et al., 2024; He et al., 2020). Fair and transparent remuneration models are crucial to maintain morale and prevent the attrition of

skilled practitioners. Recognition initiatives, whether through career development opportunities or financial incentives, further reinforce GPs' professional satisfaction (Jackson physician, 2022). Promoting interprofessional collaboration remains a powerful mechanism to enhance job satisfaction. Interdisciplinary teams, where GPs, nurses, social workers, and specialists work together, not only improve patient outcomes but also provide professional support networks that reduce isolation and professional exhaustion (Buffel et al., 2023; Grant et al., 2024; Weinmayr et al., 2020). Interprofessional teamwork also aligns with the SPF framework by supporting GPs' need for behavioural confirmation and social approval (Chowhan et al., 2024).

Lastly, prioritising GPs' psychological well-being is paramount (Villarreal-Zegarra et al., 2022). Initiatives focusing on resilience training, stress management, and time efficiency have demonstrated positive impacts on GP mental health and productivity (Degen et al., 2022; Naehrig et al., 2021). Creating environments that support emotional resilience and allow GPs to maintain meaningful professional and personal relationships directly addresses key elements identified in the SPF theory for sustaining well-being.

By implementing a combination of these strategies, healthcare systems can create the conditions necessary to retain a motivated, resilient, and satisfied primary care workforce, ultimately improving the quality of patient care and system sustainability.

2.6 Conclusion

This review highlights that general practitioner (GP) job satisfaction is shaped by complex interrelated factors, including workload, autonomy, financial recognition, interpersonal relationships, and system structure. Differences between public and private healthcare sectors, both locally and internationally, underscore the importance of supportive organisational environments

and fair policy frameworks. The Social Production Function (SPF) theory offers a useful lens to understand how comfort, stimulation, status, and social approval drive professional well-being.

Strengthening leadership, reducing administrative burdens, promoting interprofessional collaboration, and ensuring equitable remuneration are essential strategies to sustain a motivated and resilient primary care workforce. Future research, particularly within the Maltese context, should prioritise longitudinal studies to evaluate the impact of specific reforms on GP satisfaction and healthcare outcomes

Chapter 3: METHODOLOGY

3.1 Research Questions

This study aims to explore job satisfaction among general practitioners (GPs) in Malta through both quantitative and qualitative research approaches. The quantitative research questions focus on measuring GP job satisfaction levels and identifying the factors influencing their overall satisfaction. Specifically, the study seeks to determine whether there are significant differences in job satisfaction between private and public GPs, how workload, remuneration, administrative burden, and work-life balance impact satisfaction, and whether demographic or professional characteristics play a role in shaping satisfaction levels.

The qualitative research question is designed to gain deeper insights into the lived experiences of GPs regarding job satisfaction. It explores how GPs perceive and describe their professional challenges and rewards, what factors they identify as crucial to job satisfaction, and how systemic or policy-related issues affect their work. Through a focus group discussion, this study aims to capture the nuances of GP job satisfaction and provide context to the statistical findings from the quantitative analysis.

3.2 Research Design and Philosophical Approach

This research employs a mixed-methods approach with an exploratory sequential design to investigate job satisfaction among general practitioners (GPs) in Malta. The study is grounded in a pragmatist paradigm, which allows for the integration of both quantitative and qualitative methodologies to derive a comprehensive understanding of the research problem (Creswell, 2017). Pragmatism focuses on real-world applications and practical solutions, making it particularly suitable for health research where policy implications and stakeholder perspectives play a crucial role.

A key tenet of this study is critical realism, which acknowledges that while an objective reality exists, such as GP job satisfaction levels, our understanding of this reality is influenced by subjective perceptions and contextual factors (Bhaskar, 2008). This approach is beneficial in health research as it allows for an examination of both the structural challenges and the personal experiences that shape job satisfaction among GPs.

3.3 Theoretical Framework: Social Production Function Theory

This study is grounded in the Social Production Function (SPF) theory, which serves as the theoretical framework underpinning the QUALICOPC questionnaire. The SPF theory posits that individuals strive to optimise their well-being through the efficient production of universal goals, which are categorised into physical well-being (e.g., comfort, stimulation) and social well-being (e.g., status, behavioural confirmation, affection). The theory further asserts that well-being is achieved by utilising different instrumental goals such as professional autonomy, financial remuneration, and social recognition (Ormel et al., 1999).

The QUALICOPC questionnaire, which serves as the primary research tool for this study, is structured around SPF principles. It assesses factors that influence GP job satisfaction by evaluating whether GPs can fulfil their professional and personal well-being goals within their work environment (Schäfer et al., 2011). Specifically, the questionnaire captures how GPs derive satisfaction from their roles by analysing job characteristics that enhance or hinder well-being, such as work-life balance, income, administrative workload, and professional recognition (Ormel et al., 1999).

The SPF framework is particularly relevant to job satisfaction research in healthcare as it explains how healthcare professionals balance intrinsic and extrinsic job motivators to maintain

overall well-being. In the case of GPs, job satisfaction is influenced by their ability to achieve autonomy, professional fulfilment, and financial security, which align with the instrumental goals of the SPF model. This relationship is further supported by recent research indicating that healthcare workers' satisfaction is significantly shaped by organisational practices and managerial competence within national health systems (Cantarelli et al., 2023). Additional findings show that distinct facets of job satisfaction, such as communication, supervision, and benefits, reflect the social and instrumental dimensions outlined in SPF theory (Karaferis et al., 2022). By incorporating these insights, this study strengthens its theoretical grounding and highlights critical factors that contribute to or detract from GP job satisfaction and overall well-being.

3.4 Target Population and sampling

The target population consists of fully qualified general practitioners currently practicing in both the public and private sectors in Malta. At the time of writing, in the public sector, there were 161 fully qualified GPs, while in the private sector, around 120 GPs were members of the Association of Private Family Doctors (APFD) and were included in the study. This selection was made because the APFD secretary served as an intermediary who was willing to disseminate the questionnaires via email. The exact number of fully qualified GPs working in the public sector ($n = 161$) was obtained directly from the Human Resources department of the Primary Health Care Services through personal communication with a senior officer. A copy of the email correspondence confirming these figures is included in the appendices to support transparency and traceability of the data. Although there might be more GPs working privately (not registered with APFD), this approach ensured a structured and efficient distribution of the survey, whilst still capturing the vast majority of private GPs. GPs who are registered as specialists with the SAC/ medical council were included to ensure a direct comparison between public and private practitioners. In Malta, doctors in training are not

permitted to work as GP specialists in the private sector, making it essential to compare like with like to ensure valid and meaningful results.

To ensure comprehensive representation and minimise sampling bias, this study employed a census-based approach, targeting the entire population of general practitioners in Malta. Fink and Kosecoff (1999) emphasise that when the population is small and accessible, surveying all eligible individuals is both practical and methodologically sound. Their step-by-step framework outlines how full population surveys can enhance the reliability of findings by eliminating sampling error and ensuring that all relevant subgroups are included. Similarly, Etikan et al. (2016) acknowledge that while non probability sampling is often used due to constraints, surveying the entire population is ideal when feasible, as it avoids the limitations inherent in selective sampling techniques (Etikan et al., 2015; Fink and Kosecoff, 1999) The decision to include all fully qualified public GPs and APFD members in the private sector was thus justified based on the feasibility of reaching the entire population and ensuring robust, representative results.

For the focus group discussion, four fully qualified GPs from each sector (private and public) were selected after an open call for participation. An email was sent by the intermediaries to all GPs in both sectors, inviting those interested to privately message the researcher. From the respondents, four participants from each sector were chosen. A total of eight participants was deemed appropriate for a focus group discussion, as this number allows for diverse viewpoints while maintaining a manageable and interactive discussion environment (Gerger Swartling, 2007). Moreover, Morgan (2025) suggests that small focus groups of 6 to 10 participants are optimal for generating in-depth qualitative insights, making this sampling decision suitable for the study's objectives (Morgan, 2025).

3.5 Quantitative Data Collection

Quantitative research is a structured approach to collecting and analysing numerical data, allowing researchers to identify patterns, correlations, and statistical relationships (Fetters et al., 2013). It is particularly useful for measuring variables such as job satisfaction and determining the influence of different factors on professional experiences. The use of a questionnaire survey ensures a systematic and replicable method of data collection, facilitating objective comparisons across different GP groups.

3.5.1 *Research Tool*

The primary research tool used for data collection was a structured questionnaire based on the QUALICOPC framework, which has been widely used in primary care research. The tool was verified through rigorous methods and validated for primary care research (Schäfer et al., 2011). The questionnaire was adapted to the Maltese context through a pilot study involving four GPs, ensuring linguistic and cultural appropriateness. The final questionnaire contained 55 questions, designed to assess various factors influencing job satisfaction.

The questionnaire consisted predominantly of yes/no or multiple-choice questions, enabling efficient data analysis. The final six questions specifically focused on job satisfaction, utilising a Likert scale to measure levels of satisfaction. The remaining questions addressed factors influencing job satisfaction, including workload, administrative duties, remuneration, work-life balance, and professional autonomy.

The survey was estimated to take approximately 15 minutes to complete, ensuring that respondents could provide comprehensive input without excessive time commitment.

3.5.2 Data Collection Process

The data collection period spanned from July to October, with email reminders sent every 15 days to encourage participation. The reminders continued until a saturation point was reached, ensuring that all willing participants had an opportunity to complete the survey.

To facilitate accessibility and maximise response rates, the survey was administered using SurveyMonkey, an online platform that allows for secure and efficient data collection. The use of an online tool ensured anonymity, streamlined data management, and provided real-time tracking of responses.

3.5.3 Internal Reliability: Cronbach's Alpha

To ensure the internal reliability of the questionnaire in the local context, Cronbach's alpha was used to assess the consistency of responses across the different survey items. While the QUALICOPC questionnaire is a validated international tool, reliability statistics such as Cronbach's alpha are still essential when deploying the instrument in a new setting like Malta, where primary care structures, cultural norms, and health system characteristics may differ from those of countries where the tool was originally tested. Cronbach's alpha helps verify whether grouped items within each construct (e.g., continuity, satisfaction, or workload) consistently measure the same underlying concept within the Maltese context. It is a widely accepted statistical measure for evaluating the internal consistency of a scale, with values above 0.70 generally considered acceptable and values above 0.80 indicating good reliability (Tavakol & Dennick, 2011). The overall Cronbach's alpha score for this study was 0.7, suggesting a high level of internal consistency among the questionnaire items. This result indicates that the survey effectively measured the intended constructs related to GP job satisfaction, ensuring the reliability of the findings.

3.6 Quantitative Data Analysis

collected quantitative data were analysed using Statistical Package for the Social Sciences (SPSS) software, which is widely used for statistical analysis in health research (Pallant, 2020). SPSS was chosen for its robust capabilities in handling survey data, performing reliability tests, and conducting inferential statistical analysis.

The analysis began with descriptive statistics, which provided an overview of the data, including frequencies, means, and standard deviations for key variables related to job satisfaction. This step allowed for a clear understanding of the general trends in the dataset.

To examine differences between private and public GPs, inferential statistical tests were conducted. Mann Whitney U tests were used to compare mean differences in job satisfaction scores between the two groups, while chi-square tests were applied to assess categorical variables related to job satisfaction factors.

The application of SPSS ensured that the findings were statistically sound, replicable, and reliable, providing a strong basis for interpretation and policy recommendations in improving GP job satisfaction.

3.7 Qualitative Data Collection

The qualitative data were collected through a focus group discussion conducted via Zoom, lasting one hour. Online platforms such as Zoom have been increasingly used in qualitative research due to their accessibility, cost-effectiveness, and ability to reach geographically dispersed participants

(Archibald et al., 2019). Conducting the focus group online allowed participants to join from their preferred locations, reducing logistical challenges and increasing participation rates.

However, online focus groups also present challenges. Connectivity issues, participant engagement, and non-verbal communication limitations can affect data quality (Richard et al., 2021). While video conferencing enables real-time interaction, it may also create digital fatigue, reducing participant willingness to engage deeply (Stewart et al., 2025). Despite these drawbacks, online methods were deemed appropriate given the need for convenience and efficiency in recruiting busy medical professionals.

3.8 Qualitative Data Analysis

The qualitative data from the focus group were transcribed verbatim and analysed using thematic analysis following Braun and Clarke's (2006) six-step framework (Braun & and Clarke, 2006). The steps included familiarisation with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final analysis.

Thematic analysis was selected due to its flexibility in identifying patterns and themes within qualitative data, allowing for a rich, detailed interpretation of GP job satisfaction factors (Nowell et al., 2017). Codes were derived inductively, ensuring that themes emerged from the data rather than being pre-imposed.

3.9 Comparison of Quantitative and Qualitative Findings

Following data analysis, the quantitative and qualitative findings were integrated to provide a comprehensive understanding of GP job satisfaction. The quantitative data offered broad trends and statistical significance, while the qualitative data provided context and deeper insights into the lived experiences of GPs.

This mixed-methods approach allowed for triangulation, strengthening the validity of findings by comparing survey results with the focus group narratives (Fetters et al., 2013). For example, statistical correlations between job satisfaction and workload were enriched by qualitative explanations detailing how administrative burdens affect professional autonomy and work-life balance.

3.10 Ethical Considerations

Ethical approval for the study was obtained from FREC (Faculty Research Ethics Committee). Participants were provided with an informed consent form before participation, ensuring they understood the study's objectives, voluntary nature, and confidentiality measures. Anonymity was maintained throughout, and data were securely stored in compliance with General Data Protection Regulation (GDPR) guidelines (European Union, 2018).

Special considerations were made for the online focus group, ensuring that participants were in a private and secure environment when contributing to discussions (Rose Wiles, 2012). Participants were also informed that they could withdraw at any time without consequences.

3.11 Strengths and Limitations of the Method

The triangulated (mixed methods) approach employed in this study offers several strengths. By combining quantitative survey data with qualitative insights from a focus group, it allowed for a more comprehensive exploration of job satisfaction among general practitioners (GPs). The survey provided broad trends and measurable patterns, while the focus group captured nuanced perspectives that enriched and contextualised the quantitative findings. This methodological

integration strengthens the study's internal validity through triangulation, increasing the credibility and depth of interpretation. The focus group, comprising eight participants from both public and private sectors, was of appropriate size for in-depth discussion and ensured a diversity of perspectives within the sample. The use of thematic analysis enabled the identification of key themes grounded in real-world experiences, adding explanatory value beyond numerical data. However, the approach also presents certain limitations. Conducting the focus group via Zoom, while practical and accessible, may have influenced the dynamics of discussion. Virtual environments can affect non-verbal communication, participant engagement, and the spontaneity of interactions compared to in-person settings. Furthermore, while both data sources complemented each other, integrating qualitative and quantitative findings requires careful interpretation, and the process can be complex and subjective. Although every effort was made to ensure rigour, through reflective analysis and transparent coding, there remains a possibility of interpretive bias.

A key limitation lies in the sampling strategy and its implications for generalisability. The focus group sample, though diverse in terms of sector, was relatively small and may not capture the full range of experiences within the wider GP population. Similarly, the response rate for the quantitative survey was low, which may limit the representativeness of the data. This may likely be due to the length of the questionnaire and the absence of monetary or other incentives, both of which may have discouraged participation, especially among time pressured GPs. The self-selecting nature of participants in both components introduces the potential for selection bias, with individuals having stronger views on job satisfaction potentially more inclined to respond.

Nonetheless, the mixed methods design ultimately enhanced the study by offering both statistical generalisability and contextual depth, making it particularly suitable for exploring the multifaceted nature of GP job satisfaction.

3.12 Conclusion

This study employed a mixed-methods approach to investigate GP job satisfaction in Malta, integrating both quantitative survey data and qualitative focus group discussions. The findings provide a nuanced understanding of the factors influencing job satisfaction, highlighting differences between public and private sector GPs.

The use of SPSS for quantitative analysis and thematic analysis for qualitative data ensured a rigorous methodological approach. Ethical considerations were carefully addressed, maintaining participant confidentiality and data integrity.

Future research could expand on this study by exploring longitudinal trends in GP job satisfaction over time. The insights gained from this study contribute to policy discussions aimed at improving working conditions and retention strategies for GPs in Malta.

These methodological considerations provide the foundation for the subsequent analysis and interpretation of the study's findings. The following chapter presents the results derived from both the quantitative survey data and the qualitative focus group discussions, offering an integrated overview of the factors influencing GP job satisfaction.

Chapter 4: RESULTS

4.1 Introduction

This chapter presents the findings from both the quantitative survey and the qualitative focus group discussion, following a triangulated approach to provide a comprehensive analysis of general practitioners' (GPs) job satisfaction in Malta. Out of 133 general practitioners who began the QUALICOPC questionnaire, 70 completed it in full, resulting in a completion rate of 52.6% among respondents and representing approximately 24.7% of the total GP population. While higher response rates are generally desirable, response rates between 20% and 30% are considered acceptable for online surveys, especially within healthcare settings, as noted by Cook, Heath, and Thompson (2000). Additionally, other studies have shown that low response rates do not necessarily compromise the validity or representativeness of survey results (Keeter et al., 2006; Holbrook et al., 2005). The qualitative component consists of a focus group discussion involving eight participants, evenly representing public and private sector GPs. The integration of these two data sources enhances the depth of the analysis, allowing for a more nuanced understanding of statistical trends while incorporating the lived experiences and perspectives that shape them.

The analysis explores key themes that emerged in the dataset, including differences in work-life balance, stress levels, administrative burden, remuneration, and professional recognition. Given the statistically significant differences in job satisfaction scores between public and private GPs, the qualitative findings provide essential context for understanding the reasons behind these variations.

4.2 Overall Job Satisfaction Score

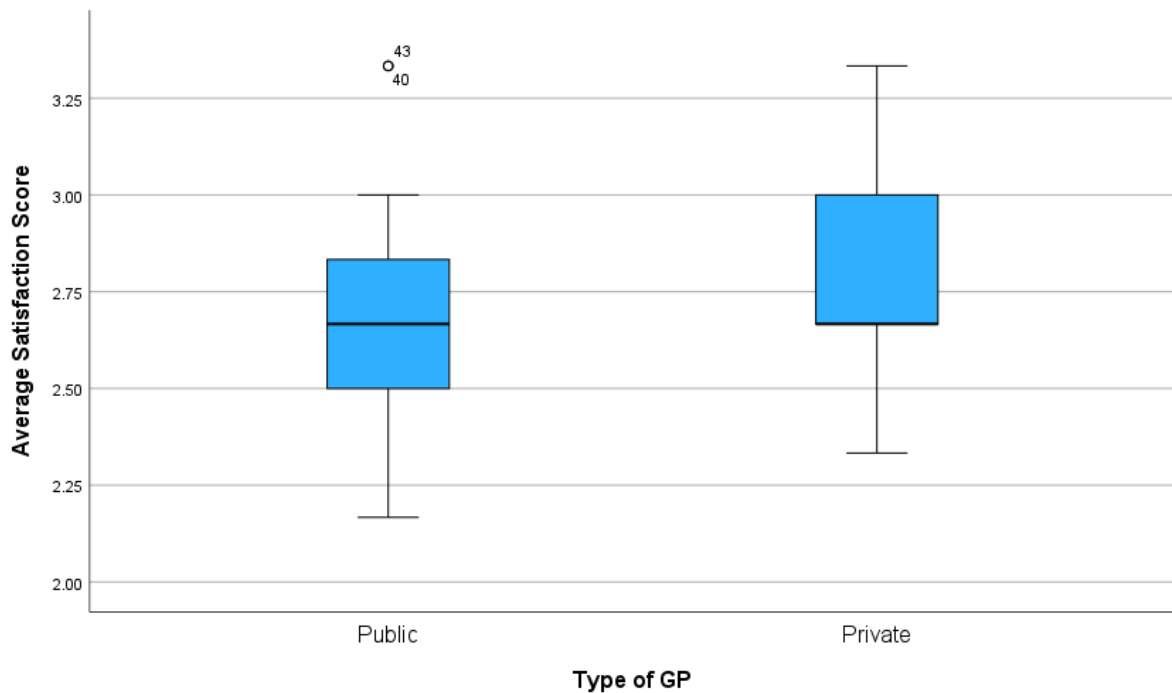


Figure 2 GP Job satisfaction scores across public and private sectors

The average job satisfaction score for private GPs was 2.79 (SD = 0.26), while public GPs reported a slightly lower mean score of 2.64 (SD = 0.29). Although the standard deviations indicate some overlap in individual scores between the two groups, a Mann–Whitney U test, a non-parametric test used to compare differences between two independent groups when data may not be normally distributed, revealed that this difference was statistically significant ($p = 0.034$), indicating that private GPs reported significantly higher levels of job satisfaction compared to their public sector counterparts. These findings show a modest increase in overall GP satisfaction compared to the 2.47 average reported in Malta by Stobbe et al. (2021), who used the same measurement tool with data collected between 2010 and 2012. This score was lower than those reported in countries such as Denmark (2.97) and Canada (2.77), but higher than in Hungary (2.17) and Spain (2.15), placing Malta near the midpoint among the 34 countries surveyed.

The focus group discussion provided valuable insights into why there is a difference between the private and public scores. Private GPs emphasised autonomy in scheduling, financial rewards, and a greater sense of professional respect from their patients, which contributed to their higher satisfaction levels. In contrast, public GPs highlighted challenges such as administrative workload, limited autonomy, and a perceived lack of recognition, all of which were seen as contributing to lower job satisfaction. The discussion that follows explores these findings in greater depth through a thematic analysis, integrating survey results with qualitative narratives.

4.3 Analysis of Job Satisfaction Factors

4.3.1 Job-related stress and Gender Disparities

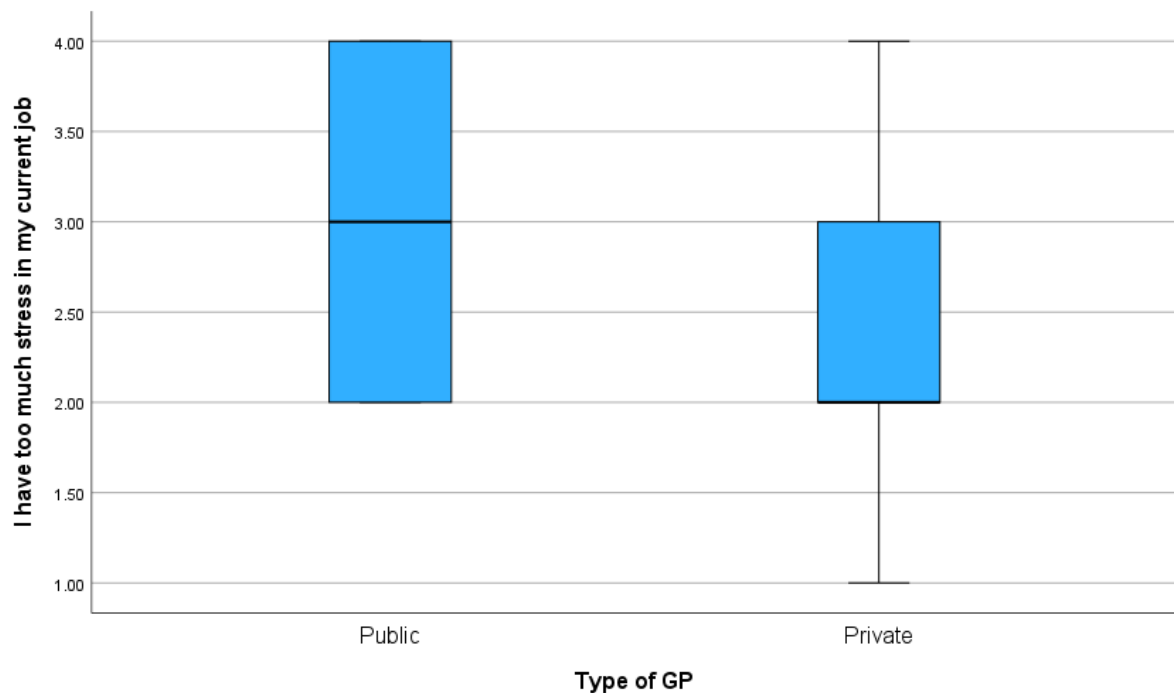


Figure 3 Perceived stress levels among GPs by sector

One of the most pronounced differences between public and private GPs emerged in relation to work-life balance and gender disparities. Survey data indicated that public GPs reported

significantly higher stress levels (Mean = 3.13) compared to private GPs (Mean = 2.53, $p < 0.001$). This difference was statistically significant as determined by the Mann-Whitney U test. The demographic data further revealed that women were more likely to work in the public sector, whereas private GPs were predominantly male.

The focus group discussion elaborated on these findings, particularly in relation to gender-based career choices and the realities of work-life balance in both settings. A female public GP shared her perspective on why she left private practice, stating, "and the reason why I left private practice in the end was because it was so difficult being a female GP in fact to find a balance between family and children and work." This sentiment was echoed by another participant, who noted that "so you have the grace and the ability to work your own hours because you worked so much in the past and you built a reputation for yourself, and you are free to work less" and another one saying "it is easier to just go with the government"

A private GP countered this viewpoint, arguing that autonomy in scheduling ultimately makes private practice more flexible. "I choose my own hours of work, igifieri, the clinic hours I devise them as long as I want." However, another private GP clarified that this level of flexibility is not immediate, stating, "private work is more flexible but it comes later on you don't get it at an early stage" and another stating that "the workload and the trust only happen through a lot and a lot of work in the start"

These insights highlight that work-life balance in private practice is contingent upon experience, whereas public practice provides more immediate stability. The tendency for female GPs to choose public employment may reflect structural challenges in private practice, where early-career flexibility is limited.

4.3.2 Administrative Burden and meaningless of work

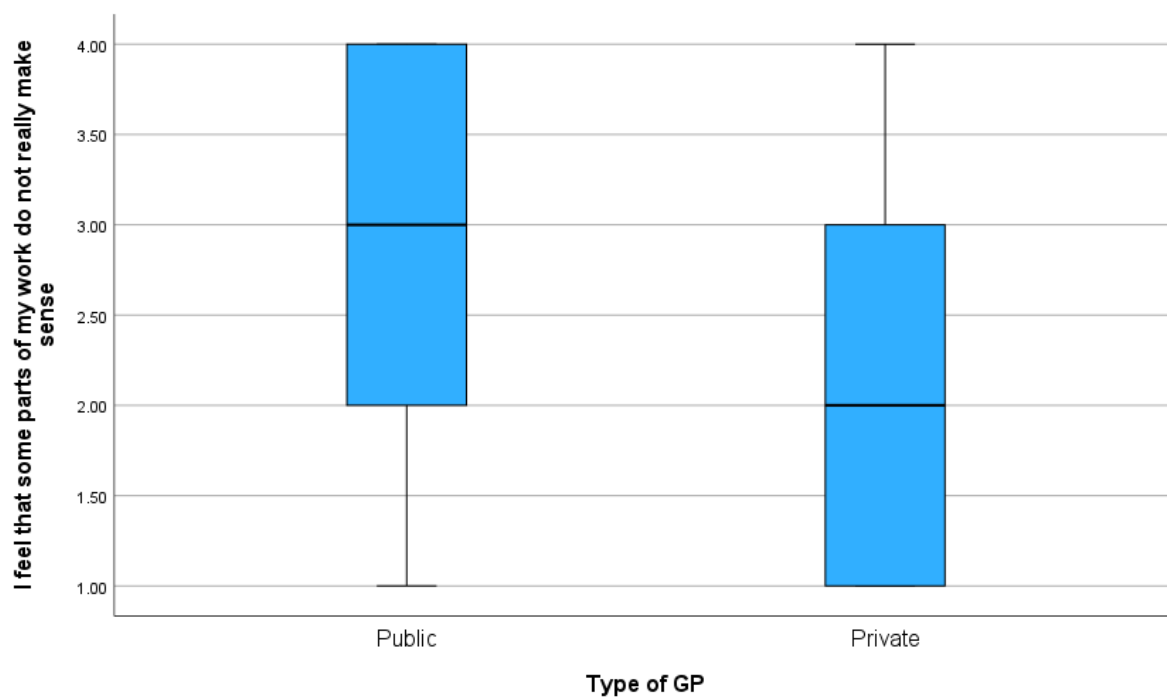


Figure 4 GP agreement with the statement "I feel that some parts of my work do not really make sense"

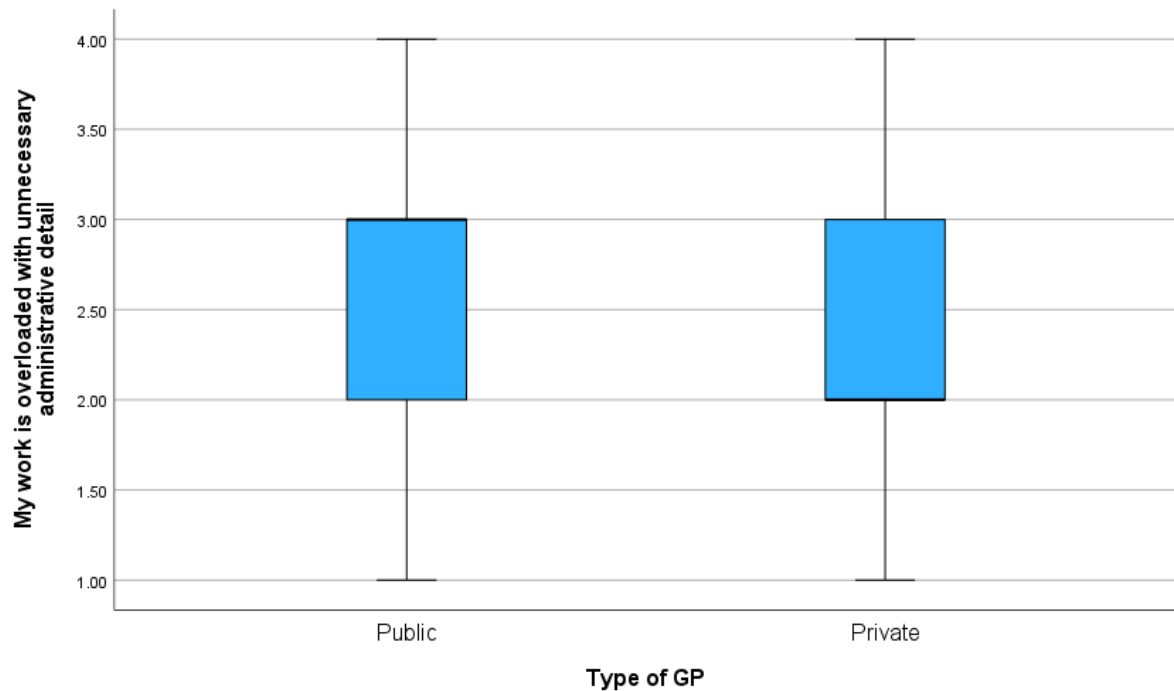


Figure 5 GP agreement with the statement "My work is overloaded with unnecessary administrative detail"

Survey data suggested that public GPs experience greater dissatisfaction with administrative workload (Mean = 2.84) compared to private GPs (Mean = 2.50), although the difference was not statistically significant ($p = 0.052$), as determined by the Mann-Whitney U test. Similarly, perceptions that aspects of their work do not make sense were more common among public GPs, with a statistically significant difference ($p < 0.001$). While the survey did not reveal a strong statistical difference in administrative burden alone, qualitative findings provided deeper insights into how GPs experience this aspect of their work.

During the focus group discussion, public GPs expressed frustration over bureaucratic inefficiencies in documentation procedures, arguing that outdated systems increase workload unnecessarily. One public GP remarked, "I would expect us to adopt certain things (enabling technology) ...it is useless waste of time. I would rather keep seeing patients than putting notes or whatever. Most of the stuff we end up doing is a huge waste of time."

In contrast, private GPs described a different kind of administrative burden, with some noting that they must handle business-related tasks, such as financial management and patient records, without institutional support. A private GP working in a group practice explained, "obvious duty that the private GP has to get insurance. Also, a private GP has finance administration and contributions and it's a big headache... in public service you don't have this stuff."

The discussion also highlighted potential solutions to reduce administrative burden in public healthcare, with some participants advocating for increased use of AI-based documentation systems. One GP suggested, "much of the administrative work can be done by AI. Most of the countries in the EU do so already."

These findings suggest that while administrative burden affects both sectors, its nature differs significantly. Public GPs struggle with systemic inefficiencies, while private GPs must manage their practice as a business. The integration of digital tools in public healthcare could help reduce bureaucratic workload, allowing doctors to spend more time on patient care.

4.3.3 Effort vs. Reward Balance and Income Differences

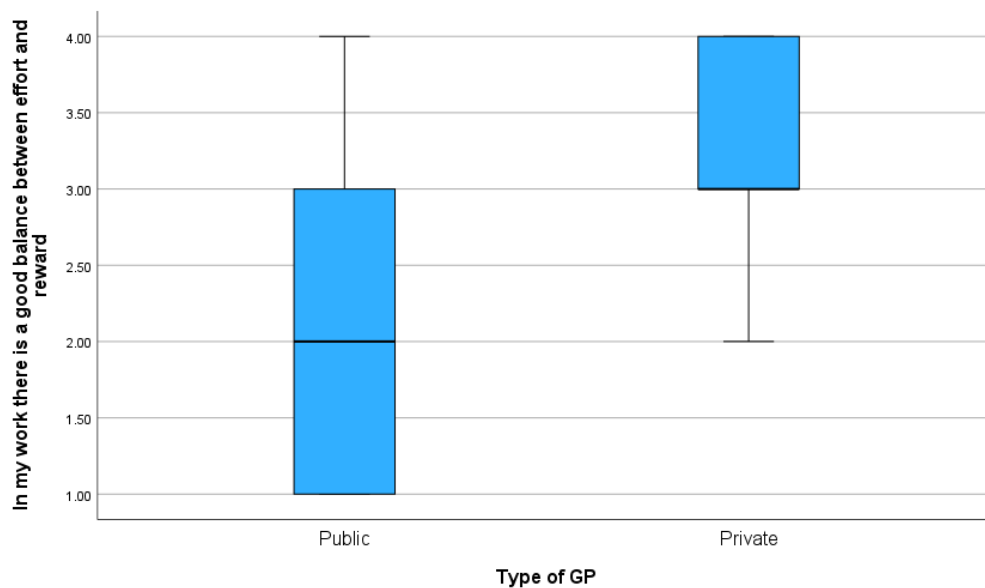


Figure 6 GP agreement with the statement "In my work there is a good balance between effort and reward"

The survey results revealed a significant gap in perceptions of effort versus reward, with private GPs reporting a better return (Mean = 3.13) compared to public GPs (Mean = 2.08, $p < 0.001$), as shown by the Mann-Whitney U test. This finding was reinforced by qualitative data, where financial incentives were repeatedly mentioned as a factor influencing job satisfaction.

Private GPs emphasised the financial benefits of working outside the public sector, with one stating, "the pay is 2 to 3 times better than that of the public GPs." However, some acknowledged that income is directly tied to workload, with one explaining, "however the issue in the private sector is that you really have to work for every penny."

Public GPs, on the other hand, expressed frustration over a lack of financial incentives for extra effort, with one noting, "Whether I see six in an hour or ten the pay is the same whereas in the private sector you are paid per patient."

These findings suggest that private GPs are more satisfied with their financial compensation because their earnings are directly proportional to their effort, while public GPs feel underpaid relative to their workload. The lack of performance-based incentives in the public sector may contribute to lower job satisfaction, as effort is not directly rewarded. This reinforces the broader theme that financial incentives play a crucial role in GP job satisfaction, particularly in balancing workload with rewards.

4.3.4 Respect, Recognition, and Professional Identity

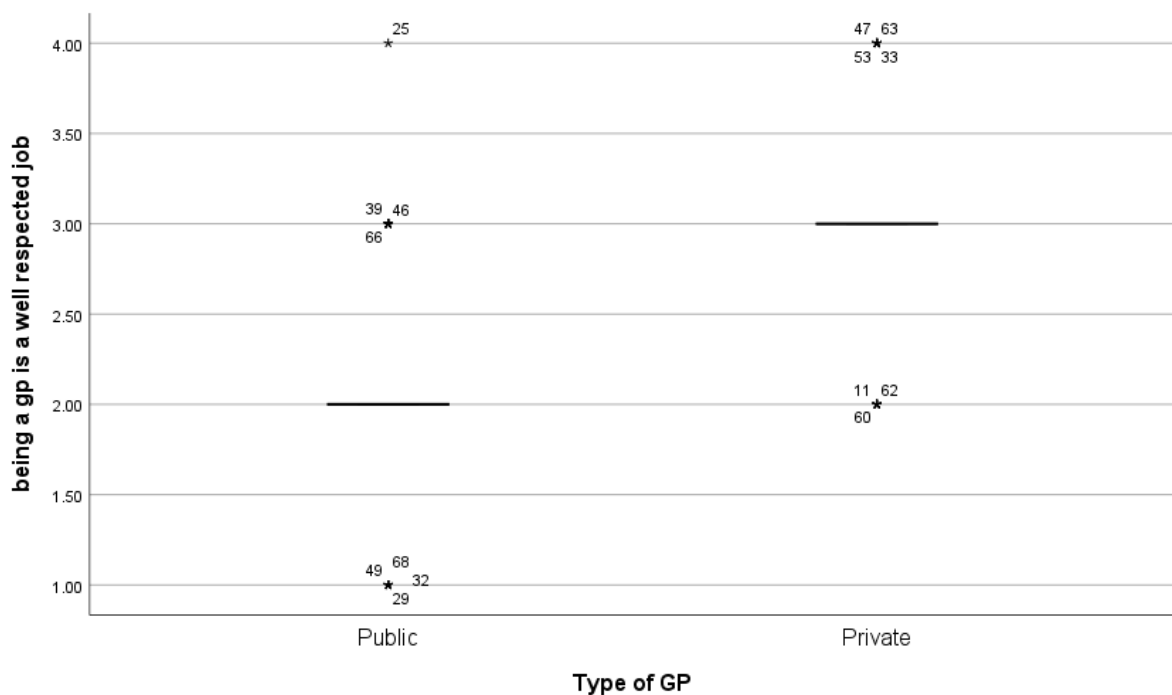


Figure 7 GP agreement with the statement "Being a GP is a well-respected job"

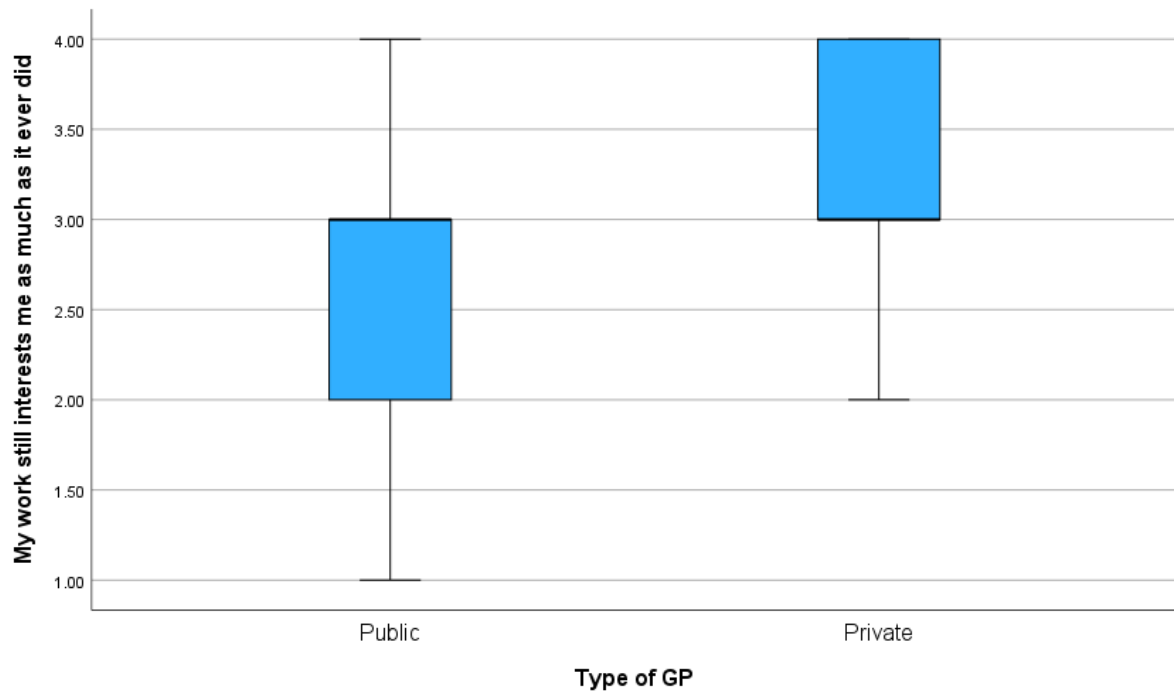


Figure 8 GP agreement with the statement "My work still interests me as much as it ever did"

Survey results indicated that private GPs felt significantly more respected in their profession compared to public GPs ($p < 0.001$). Figure 7 shows that most GPs responded the same with only few outliers. In addition, private GPs reported significantly higher levels of continued interest in their work ($p < 0.001$), as reflected in the item "My work still interests me as much as it ever did." Both cases used Mann Whitney U test as described previously. These two findings appear interrelated and were illuminated further through focus group discussions.

Private GPs emphasised that continuity of care promotes stronger patient-doctor relationships, which in turn leads to greater professional respect. One private GP stated, "they feel they are safe and they can share their true problems which at the health centre they cannot do because each time they find a different doctor." At least one other added "continuity of care is a problem at the health centre."

In contrast, public GPs reported challenges related to patient entitlement and lack of recognition. One public GP remarked, "whenever there were some ideas of reforms in the public sector they

were always about patients' attitude." Another noted the difference in patient attitudes, explaining, "It is a fact that a lot of people have the mentality that they are paying their taxes, so they feel entitled. It is a general disrespect to anyone working with the government." This was echoed by another GP stating that "it is free at the point of retail, so people tend to take that for granted" With improvements in training and specialisation within public healthcare, many GPs strongly believed that it is not the quality of the doctor that attracts people to the private sector but it is continuity of care with almost all speakers agreeing to this.

These findings suggest that professional recognition plays a major role in job satisfaction. The lack of continuity in public healthcare, coupled with patient entitlement, may contribute to feelings of underappreciation. In contrast, private GPs benefit from direct patient relationships, which reinforce a sense of professional identity and respect. The qualitative data reinforce the statistical finding that private GPs feel more respected, which is a key factor in overall satisfaction.

4.3.5 Workload and Patient Contact Patterns

The analysis of working hours found no significant difference in the total number of hours worked per week between public and private GPs ($p = 0.118$). However, significant differences emerged in specific aspects of patient contact and workload distribution. Public GPs reported significantly higher patient call volumes on a normal working day ($p = 0.006$), as well as a greater number of emails from patients ($p < 0.001$). This indicates that public GPs experience higher demands for remote consultations compared to their private counterparts.

Additionally, private GPs reported significantly longer clinic consultation durations ($p = 0.005$), suggesting they spend more time per patient interaction than their public-sector counterparts. The number of house visits per week was also significantly higher for public GPs ($p =$

0.002), highlighting additional time pressures. These workload difference may contribute to varying levels of job satisfaction as heavier patient contact is associated with increased stress and reduced perceived autonomy among GPs.

While the number of hospital-based consultations did not differ significantly ($p = 0.382$), public GPs did not report a higher frequency of patient visits in homes for the elderly ($p = 0.867$) or other institutions ($p = 0.148$), suggesting that their workload is largely concentrated in direct outpatient consultations and remote patient interactions.

4.3.6 On-Call Duties and Work Strain

Significant differences were found in on-call workload, with public GPs reporting substantially higher call duty hours compared to private GPs. Public GPs had significantly more evening ($p < 0.001$), night ($p < 0.001$), and weekend call responsibilities ($p < 0.001$), reinforcing the notion that public sector employment entails greater work strain.

The qualitative data corroborated these findings, with public GPs expressing concerns about the impact of excessive on-call duties on work-life balance and overall job satisfaction. Some GPs emphasised the physical and emotional toll of frequent night shifts, which contributed to burnout and fatigue. Frequent and intensive on call duties increase work strain and reduce work life balance, both of which are key determinants of lower job satisfaction among Gps.

4.3.7 Collaborative work environment

The quantitative results indicate that overall job satisfaction ($p = 0.029$) differs significantly based on whether GPs work alone, in a group, or with other healthcare professionals, with those in collaborative settings reporting higher satisfaction. The focus group findings align with this trend, as GPs working in group practices emphasised greater professional fulfilment, reduced stress, and improved work-life balance. One GP highlighted the benefits of shared responsibilities, stating,

“Working together helps. There is a person you can speak to about your difficulties. Sharing also life experiences. We have been 25 years together now, so we know each other well. We ask opinions not only about work but also about other things as well.” This underscores the importance of peer support in preventing burnout and enhancing engagement.

In contrast, solo private GPs reported feeling isolated despite the autonomy their role provides. One GP admitted, “When you work alone, it’s okay, I can phone my friends or consultants with whom I have confidence. But being in a team setting, you learn from older doctors or younger ones who have just qualified. There is an element of loneliness that tends to affect me.” Another private GP added, “The problem with Maltese doctors is that they don’t trust each other.” These insights reinforce the survey results, highlighting that while solo GPs enjoy independence, they face greater challenges in maintaining engagement and managing workload.

These findings suggest that collaborative work environments contribute to higher GP satisfaction by promoting professional support, reducing stress, and ensuring a more sustainable work-life balance. The qualitative insights reinforce the quantitative trends, underscoring the importance of peer collaboration in sustaining job satisfaction among GPs.

4.3.8 Adherence to guidelines

The adherence to clinical guidelines for heart failure (HF), asthma, and chronic obstructive pulmonary disease (COPD) showed some variation between public and private GPs, with public GPs demonstrating slightly higher adherence to asthma and COPD guidelines ($p = 0.047$), while adherence to HF guidelines was not significantly different ($p = 0.203$). Here Chi Squared test was used for comparing categorical variables.

4.3.9 Feedback

The analysis of feedback mechanisms revealed limited engagement in both external and peer review processes among general practitioners (GPs). Feedback from health authorities or insurers on prescriptions or referrals was reported by only 3 out of 70 GPs. A Chi-Squared test showed no statistically significant difference between public and private GPs in this regard, $p = 0.696$. In contrast, peer feedback through colleague review or practice visitation was somewhat more common, particularly among public GPs (28.2%) compared to those in private practice (12.9%). However, this difference was also not statistically significant, $p = 0.121$. These findings suggest that structured feedback systems remain underutilised in Malta's primary care setting, potentially limiting opportunities for professional development, quality assurance, and reflective practice.

4.3.10 Time off:

Findings suggest that both groups have similar opportunities for continuous professional development, time off, and work flexibility. However, qualitative insights from the focus group provide additional nuances regarding the reasons behind these trends.

One private GP explained that self-directed learning is often preferred over attending conferences, stating, "I don't attend conferences because I study alone at home." This highlights that while formal conference participation may not be widespread among private GPs, alternative learning approaches such as independent study or peer discussions may compensate. Another GP emphasised the value of knowledge-sharing in group practice, stating, "If you work in a group, you're constantly discussing cases with colleagues. That's also learning." This reinforces the idea that structured collaboration can be an alternative to conference attendance.

Regarding vacations, the lack of statistical significance ($p = 0.143$) suggests that both public and private GPs take similar amounts of leave, but the focus group highlighted key differences in flexibility. One public GP noted, “Yes, we have allocated leave, but getting approval when clinics are understaffed is another story.” Conversely, a private GP stated, “In private, if you take time off, you lose income, and patients may go elsewhere.” These comments suggest that while vacation time may be quantitatively similar, the constraints and consequences of taking leave differ between sectors.

Similarly, the results indicate no significant difference in illness-related absences ($p = 0.878$), suggesting that health-related absences are comparable across sectors. However, one public GP noted that illness policies are more structured in the public system, explaining, “At least in public, if you’re sick, you have sick leave. In private, missing work means losing money.”

These findings suggest that while professional development, vacation time, and illness rates do not statistically differ between public and private GPs, the practical realities of these aspects vary. Private GPs experience greater financial constraints when taking leave or attending professional events, whereas public GPs may face bureaucratic hurdles despite having structured policies.

4.3.11 Communication with secondary care providers:

Communication with secondary care was reported to be low, with no statistically significant difference between public and private GPs. The survey data did not reveal a notable discrepancy in referral patterns, suggesting that both groups experience similar levels of interaction with hospital specialists and secondary care providers. The focus group echoed these findings, with participants expressing frustration over the lack of structured communication channels. One GP remarked, “You would expect that referrals would be less than 5%, but now a much higher referral rate is being

pushed. That is not good medicine, and it reduces continuity of care". Another participant added, "I cannot understand how this hasn't been fixed... The system is just not designed for seamless coordination between primary and secondary care". These comments reflect the broader concerns about continuity of care, with GPs feeling that increasing referral rates may be driven by systemic inefficiencies rather than medical necessity.

4.4 The social production function theory:

The findings of this study align with the Social Production Function (SPF) theory, which posits that individuals strive to optimise physical well-being and social well-being through instrumental goals such as comfort, stimulation, status, behavioural confirmation, and affection. The quantitative results indicate that private GPs report higher job satisfaction ($p = 0.034$), largely attributed to greater autonomy, financial incentives, and professional respect: factors that contribute to status and behavioural confirmation within the SPF framework. Conversely, public GPs reported higher stress levels ($p < 0.001$) and dissatisfaction with administrative burden, highlighting constraints on comfort and stimulation due to systemic inefficiencies. The qualitative data further reinforce these patterns, with public GPs expressing frustration over bureaucracy and lack of recognition, whereas private GPs emphasised the rewards of patient continuity and self-determination in practice. Additionally, collaborative work environments were linked to higher satisfaction ($p = 0.029$), aligning with the SPF notion that social interactions and peer support enhance well-being. These results suggest that job satisfaction among GPs is deeply tied to their ability to fulfil core instrumental goals within the SPF model, with private practice offering greater rewards in autonomy and status, while public practice provides more stability but at the cost of increased constraints.

4.5 Conclusion

Overall, the findings show that while both public and private GPs in Malta face shared challenges, their experiences of job satisfaction differ markedly. Private GPs reported greater autonomy,

stronger patient continuity, higher financial rewards, and more professional respect, whereas public GPs valued stability but were hindered by heavier workloads, greater administrative inefficiencies, and higher stress. Collaborative work settings and peer support enhanced satisfaction across both sectors, yet systemic gaps, such as limited feedback mechanisms and weak communication with secondary care, persist. Viewed through the Social Production Function lens, private practice tends to better meet needs for status, behavioural confirmation, and autonomy, while public practice fulfils stability but imposes more constraints on comfort and stimulation.

Chapter 5: DISCUSSION

5.1 Introduction

This chapter critically evaluates the findings of this study in relation to existing theoretical frameworks and literature on general practitioners' (GPs) job satisfaction. Rather than reiterating results, it contextualises them within broader discussions on workforce retention, healthcare policy, and primary health care challenges. The study's findings are examined through the lens of Social Production Function (SPF) theory, which explains job satisfaction as the optimisation of physical and social resources to fulfil instrumental and intrinsic needs (Ormel et al., 1999). Additionally, the discussion assesses how the results align or diverge from previous research on primary care in Malta and international studies on GP job satisfaction.

The primary aim of this study was to compare job satisfaction among GPs in Malta's public and private sectors. The study addressed five key objectives:

1. Identifying key factors influencing job satisfaction in both sectors.
2. Analysing differences in work conditions, autonomy, and patient care between public and private GPs.
3. Assessing the impact of these factors on the overall well-being and performance of GPs, using the QUALICOPC questionnaire.
4. Applying Social Production Function theory to interpret how job satisfaction is influenced by physical and social resource optimisation.
5. Providing evidence-based recommendations for policy improvements to address deficiencies in both sectors.

Through a mixed-methods approach, this study offers a comprehensive perspective on GP job satisfaction, combining survey data with qualitative insights from a focus group discussion. The findings provide evidence of sectoral differences in job satisfaction, with private GPs reporting higher autonomy and financial compensation, while public GPs experience greater job security but lower satisfaction due to administrative burdens and resource constraints. These findings contribute to the ongoing debate on workforce retention and primary care reform in Malta, offering insights for both policymakers and practitioners.

The following sections will critically engage with these findings, linking them to the SPF theory and existing literature, highlighting key differences and similarities, discussing their practical implications, and reflecting on the strengths and limitations of the study.

5.2 Theoretical Interpretation of Findings

This section interprets the study's findings in relation to Social Production Function (SPF) theory (Chowhan et al., 2024), which posits that job satisfaction arises from the optimisation of physical and social resources to fulfil essential needs such as stimulation, comfort, status, behavioural confirmation, and affection. By applying SPF theory, this study provides a structured understanding of how GPs in both public and private sectors experience and evaluate their work environments.

5.2.1 Work Conditions and Job Satisfaction

The study found that workload, administrative burden, and resource availability significantly influence GP job satisfaction. Public sector GPs reported higher stress levels due to excessive administrative tasks and limited resources, which aligns with Sammut (2003), who highlighted that

inefficiencies in Malta's public healthcare system contribute to physician dissatisfaction. These administrative burdens limit GPs' ability to achieve comfort (i.e., reducing physical and mental strain) and stimulation (i.e., maintaining professional engagement) as proposed by SPF theory. International studies similarly highlight how administrative workload negatively affects job satisfaction (Stobbe et al., 2021). Research from Norway and Germany indicates that higher patient loads and bureaucratic inefficiencies increase stress levels among GPs, ultimately leading to burnout and attrition (Rosta et al., 2019; Werdecker & Esch, 2021). Digital health solutions offer potential relief, yet poorly implemented systems can exacerbate administrative burdens rather than alleviating them (Niazkhani et al., 2020; Zaresani & Scott, 2020).

5.2.2 Autonomy and Professional Identity

Autonomy emerged as a key differentiator between public and private GPs. Private GPs valued their ability to set their schedules, make independent clinical decisions, and avoid bureaucratic constraints, leading to higher satisfaction levels. This aligns with Le Floch et al. (2016), who argue that greater autonomy enhances professional fulfilment among primary care doctors. According to SPF theory, autonomy contributes to behavioural confirmation, as it enables GPs to make independent clinical decisions, reinforcing their professional competence and self-efficacy (Chowhan et al., 2024).

However, public sector GPs, despite reporting lower autonomy, found meaning in their role through their responsibility in public healthcare provision, but many were frustrated by the lack of continuity of care. Research indicates that continuity of care is a key driver of GP satisfaction (Kuipers et al., 2021; Thomas et al., 2023). SPF theory explains this as a fulfilment of affection and behavioural confirmation, as GPs benefit from long-term patient relationships and peer validation.

5.2.3 Financial Incentives vs. Intrinsic Rewards

The findings indicate that while financial incentives contribute to GP satisfaction, they are not the sole determinant. Private GPs reported higher financial satisfaction, but public GPs placed greater emphasis on job security from the start, which contributed to status and comfort needs as per SPF theory (Chowhan et al., 2024). This aligns with research by Ab Rahman et al. (2019), which suggests that financial rewards alone do not guarantee job satisfaction but must be complemented by non-monetary incentives such as work-life balance and professional development opportunities. Cross-national comparisons reveal that countries with higher GDP per capita and fair remuneration structures report greater GP job satisfaction (Aiken et al., 2012; Stobbe et al., 2021). However, financial incentives must be balanced with work conditions to prevent burnout and attrition (Deng, G. et al., 2021; Maslach & Leiter, 2016). For instance, the Commonwealth Fund (2022) found that GPs in high-income countries like the Netherlands and Norway, where investment in primary care and work-life balance is prioritised, report higher levels of satisfaction compared to those in systems with lower spending and higher bureaucratic burdens.

5.2.4 Work-Life Balance and Burnout

A major theme emerging from the qualitative discussion was work-life balance. Public GPs, despite having fixed schedules, felt overburdened due to administrative tasks and patient overload, leading to higher burnout levels. This aligns with studies indicating that excessive workload negatively affects job satisfaction and mental health among physicians (Dutheil et al., 2021; Fang et al., 2022). SPF theory suggests that an inability to manage workload disrupts comfort and status needs, contributing to stress and job dissatisfaction.

Conversely, private GPs reported greater flexibility in managing their time, but some expressed concerns about income variability and lack of institutional support, which can offset

financial gains and create professional uncertainty. Research from Portugal and Germany confirms that flexible scheduling is a protective factor against burnout, reinforcing the importance of structural support for GPs (Bodendieck et al., 2022; Göbel et al., 2022).

5.2.5 Continuity of Care: A Major Difference Between Public and Private

Sectors

One of the most striking differences in job satisfaction between public and private GPs in Malta is related to continuity of care. Private GPs reported higher job satisfaction due to their ability to build long-term relationships with patients, whereas public sector GPs were frustrated by the lack of continuity in Malta's free healthcare system.

This aligns with Pullicino et al. (2014), who found that patients in private clinics experienced better continuity of care, whereas public clinics struggled with accessibility issues and frequent changes in assigned doctors. Similar findings were reported in international studies, with continuity of care consistently linked to higher GP satisfaction and improved patient outcomes (Kuipers et al., 2021; Thomas et al., 2023).

From an SPF theory perspective, continuity of care fulfils the affection and behavioural confirmation needs, as GPs derive satisfaction from long-term patient relationships and seeing the impact of their care over time (Chowhan et al., 2024). The absence of continuity in Malta's public sector prevents GPs from achieving this fulfilment, potentially contributing to lower job satisfaction and burnout in the system.

These findings reinforce the need for policy interventions aimed at improving continuity of care in the public healthcare system, which could enhance both GP satisfaction and patient experiences (Kirsten Schembri, 2016).

5.3 Practical Implications

The findings of this study provide valuable insights into the structural and organisational factors influencing GP job satisfaction in Malta's public and private sectors. Addressing these issues is critical for workforce retention, healthcare system sustainability, and patient outcomes. This section discusses the implications for policymakers, healthcare administrators, and practitioners, highlighting key areas for reform and improvement.

5.3.1 Addressing Workload and Administrative Burden

One of the most significant sources of dissatisfaction among public GPs is the excessive administrative burden, which encroaches on clinical time and contributes to burnout. These findings align with international research demonstrating that high administrative workloads negatively impact GP job satisfaction and retention (Stobbe et al., 2021; Rosta et al., 2019). While electronic patient records (EPR) are already in place, focus group discussions have highlighted the potential of AI-assisted documentation as a further step to alleviate administrative pressures.

To address these challenges, several strategies can be implemented. Increasing the availability of clerical and support staff in public clinics would allow GPs to focus more on patient care rather than paperwork (Buffel et al., 2023). Policy reforms aimed at reducing bureaucratic inefficiencies could also enhance operational efficiency, ultimately improving job satisfaction among GPs (Cohidon et al., 2020).

A critical component of addressing administrative burden is the implementation of protected time for documentation. This dedicated time would allow GPs to complete necessary paperwork without compromising patient care or personal well-being. Additionally, focus group participants suggested exploring AI-assisted documentation tools to further streamline administrative tasks. These tools could automate routine documentation processes, improve accuracy, and save time, thereby reducing the cognitive load on GPs.

By combining these strategies: enhanced support staff, policy reforms, protected documentation time, and the integration of AI-assisted tools, public GPs could experience a more manageable workload and improved job satisfaction. This, in turn, would benefit both practitioners and patients, creating a more sustainable healthcare environment.

5.3.2 Improving Continuity of Care in the Public Sector

A key structural issue affecting public GPs' job satisfaction is the lack of continuity of care, which prevents them from building long-term relationships with patients. This contrasts with private GPs, who report greater professional fulfilment due to long-term patient follow-ups (Pullicino et al., 2014). The absence of a patient registration system in the public sector exacerbates this issue, leading to fragmented care and limiting the development of sustained doctor-patient relationships. Implementing a patient registration system in public primary care would enable assigned GPs to follow their patients over time, improving both job satisfaction and patient outcomes (Kuipers et al., 2021).

Patient registration, the formal linking of individuals to a specific general practitioner, is widely regarded as a cornerstone of effective primary care systems. It supports continuity of care,

strengthens the doctor–patient relationship, and enhances the GP’s sense of professional responsibility and job satisfaction. Despite its recognised importance, Malta has repeatedly failed to implement such a system in the public sector.

Attempts to introduce patient registration in Malta date back to the late 1980s, with the Family Doctor Scheme (1987–1993) representing the first structured effort to formalise the doctor–patient relationship (Isabel Stabile and Jean Karl Soler, 2008). This initiative aimed to assign every citizen to a specific GP and bring healthcare delivery closer to the community. However, due to a combination of political shifts, lack of stakeholder buy-in, and systemic inertia, the scheme was eventually abandoned.

A similar initiative, the 'Doctor of Your Choice' scheme launched in 2008, sought to reintroduce patient registration and increase accountability and continuity of care in the public sector. This, too, was short-lived. Although it received some media and professional attention, the reform did not progress to full implementation (Malta Independent, 2008).

A third wave of reform proposals between 2008 and 2010 again placed patient registration on the national agenda. These were part of broader health system strengthening efforts, including chronic disease management and primary care reorganisation. Yet no formal registration system materialised (Cini Sarreo, 2018).

The absence of such a system has contributed to fragmented care, affecting both patient experiences and GP satisfaction. Addressing this longstanding issue remains crucial for improving primary care delivery and ensuring that public GPs can provide more consistent and personalised care. patient registration system, arguing that it would create a sense of responsibility for both

doctors and patients, ensuring more sustainable and structured healthcare services in Malta (Soler et al., 2008).

Findings from the focus group discussion suggest that the introduction of health centres politically contributed to the erosion of the sense of community, affecting both patient experiences and the role of GPs within these settings. The shift from a community-based healthcare model to a centralised health centre system disrupted longstanding relationships between GPs and the populations they served, which may have further contributed to job dissatisfaction. Addressing this concern would require a more localised approach to primary care, encouraging stronger connections between GPs and their patient communities.

One of the key suggestions from the study was the introduction of appointment-based clinics to improve patient flow and reduce the inefficiencies associated with walk-in clinics, which were sometimes perceived as functioning like a shopping counter. The unstructured nature of walk-in clinics may contribute to lower job satisfaction, as GPs have little control over their schedules and encounter high patient turnover with minimal continuity. While appointment-based systems would not replace chronic disease management programs, they could complement existing services by allowing for better patient organisation and reducing overcrowding, ultimately enhancing GP job satisfaction. Additionally, creating a more structured system where patients are encouraged to seek care from assigned providers rather than switching between different doctors within the public system would contribute to a more sustainable and fulfilling primary care environment.

5.3.3 Balancing Autonomy and Standardisation

Autonomy emerged as a key factor in job satisfaction, with public GPs expressing frustration over their lack of control due to the unstructured nature of walk-in clinics and excessive

administrative burdens. Unlike private GPs, who regulate their workload and patient scheduling, public GPs described feeling constrained by unpredictable patient flow, which negatively impacted their efficiency and professional fulfilment. This aligns with research showing that reduced autonomy contributes to stress and dissatisfaction among primary care physicians (Le Floch et al., 2016).

The focus group suggested that introducing appointment-based clinics in the public sector would enhance autonomy by allowing GPs to manage patient flow more effectively. Rather than replacing chronic disease management programs, structured scheduling would create a more organised workflow, addressing inefficiencies associated with walk-in clinics. Studies indicate that such models improve both physician job satisfaction and patient outcomes (Deng, Q. et al., 2024). The findings also highlight how autonomy shapes professional identity. Public GPs felt undervalued due to their limited influence over care delivery, while private GPs found greater satisfaction in long-term patient relationships. SPF theory reinforces that autonomy contributes to professional motivation and fulfilment (Chowhan et al., 2024). Increasing GP autonomy through structured appointment systems and reducing administrative burdens could improve job satisfaction, aligning with research suggesting that greater control over workflow reduces burnout and enhances engagement in patient care (Ab Rahman et al., 2019). Reforming public primary care to provide GPs with greater autonomy would bridge the satisfaction gap between sectors, creating a more sustainable work environment.

5.3.4 Financial Incentives

While private GPs report greater financial satisfaction, remuneration disparities between the public and private sectors may contribute to the migration of GPs to private practice, a trend observed in Malaysia and other healthcare systems (Ab Rahman et al., 2019). Addressing this issue requires a more balanced compensation model that reflects workload demands and professional

responsibilities. Introducing performance-based financial incentives in the public sector could improve retention without compromising job security, ensuring that GPs are rewarded for their contributions (Deng et al., 2024). Aligning public GP salaries with workload intensity would help those handling high patient volumes receive appropriate compensation, making the public sector a more attractive work environment (Kirsten Schembri, 2016).

However, during focus group discussions, concerns were raised about the practicality and fairness of performance-based remuneration models. Two participants expressed difficulty envisioning how such a system could work equitably, particularly in scenarios where GPs are "stuck with one patient" for an extended period, which may not align with performance metrics. This highlights a potential gap between theoretical models proposed in the literature and the practical realities faced by GPs in their daily work.

Beyond salary adjustments, providing additional non-monetary incentives, such as funding for continuous professional development (CPD), could enhance job satisfaction and encourage retention. Studies have shown that professional growth opportunities contribute to long-term career engagement (Weltermann et al., 2020). By addressing both financial and professional development concerns, these reforms could help stabilise the primary care workforce and reduce the shift toward private practice. At an organisational level this requires a cultural shift within public primary care settings, from reactive high throughput environment, to more sustainable, team-based care models. Investment in leadership training for clinical managers, inclusion of GPs in decision making processes, and adoption of digital tools that support rather than obstruct clinical care are all necessary to improve the working environment. Ultimately, aligning organisational structures with the realities of frontline practice is essential for creating a resilient and satisfied GP workforce.

5.3.5 Enhancing Work-Life Balance and Burnout Prevention

Burnout remains a major issue among public GPs, who face high patient loads and administrative burdens. Similar trends have been documented in Portugal, Germany, and France, where burnout significantly affects retention rates (Dutheil et al., 2021; Bodendieck et al., 2022). Introducing flexible scheduling options for public GPs could reduce excessive workload pressures and improve overall job satisfaction (Buffel et al., 2023). Given that a higher proportion of female GPs work in the public sector, offering more adaptable work arrangements, such as part-time roles or job-sharing models, could help prevent physician burnout while ensuring continuity of care (Gobel et al., 2022). Additionally, implementing well-being programs, including mental health support and stress management training, could improve workforce resilience, particularly for public GPs who frequently report high stress and exhaustion due to on-call duties and administrative inefficiencies (Naehrig et al., 2021).

5.4 Practical implications

Numerous structural barriers have consistently affected GP job satisfaction in Malta, particularly within the public sector. These challenges are not only long-standing but often interrelated, reflecting gaps in policy implementation, organisational design, and resource allocation. This table summarises the most pressing issues as highlighted in both international literature and local reports, their implications for workforce wellbeing and patient care, and evidence-based recommendations for reform.

Table 2 Issues and recommendations

Issue	Implication	Recommended Solutions
Administrative Burden	Reduces clinical time, increases stress	Digital health tools, more support staff, policy reforms
Lack of Continuity of Care	Lowers GP satisfaction and affects patient care	Patient registration system, chronic care models
Limited GP Autonomy	Decreases motivation and job fulfilment	Flexible care models, peer-led governance
Financial Disparities	Contributes to migration to private practice	Performance-based incentives, CPD funding
Burnout & Work-Life Balance	Leads to low retention and poor mental health	Flexible scheduling, job-sharing, mental health support

5.5 Researcher's Reflexivity and Insider Status

As the researcher conducting this study is also a practicing GP in Malta, this insider status offers both unique advantages and potential limitations. On the one hand, it allowed for deeper contextual understanding of the challenges faced by GPs, facilitating more relevant survey design and meaningful interpretation of nuanced qualitative insights. This familiarity likely encouraged openness and trust during the focus group discussion potentially enriching the data. However, being an insider, also presents risks of bias. There is a possibility that personal experiences or assumptions may have unconsciously shaped the interpretation of the data or the framing of

survey items. Efforts were made to mitigate these biases through transparent coding processes, reflective journaling, and triangulation of data sources. Nonetheless complete objectivity is not possible, and the findings must be interpreted with this positionality in mind. A more detached researcher may have emphasised different themes or drawn alternative conclusions.

Future research could benefit from collaborative approaches that include both insider and outsider perspectives, strengthening the rigour and balance of interpretation.

5.6 Conclusion

This study provides a comprehensive analysis of job satisfaction among general practitioners (GPs) in Malta's public and private sectors, using a triangulated approach that integrates quantitative survey data with qualitative focus group insights. By applying Social Production Function (SPF) theory, this research examines how job satisfaction is influenced by the optimisation of physical and social resources, shedding light on key structural and organisational factors that shape GP experiences.

The findings highlight that while private GPs report higher satisfaction due to greater autonomy, financial stability, and continuity of care, public GPs experience greater job security but struggle with administrative burdens, high patient loads, and the lack of a patient registration system, which limits continuity of care. The absence of patient continuity in the public sector emerges as a major issue, reinforcing existing concerns about fragmented healthcare delivery and its impact on both GP well-being and patient outcomes. These results align with existing literature on workforce retention and job satisfaction in primary care, particularly regarding the role of professional autonomy, workload, and remuneration in shaping job fulfilment.

By linking these findings to international research, this study demonstrates that the challenges faced by Maltese GPs are not unique but rather reflective of broader trends observed in

healthcare systems with public-private dynamics. The evidence suggests that addressing key issues such as administrative inefficiencies, workload distribution, and remuneration disparities could enhance GP satisfaction, thereby improving retention and overall healthcare delivery. The need for reforms, particularly in the public sector, is critical to ensuring a sustainable and motivated primary care workforce.

The practical implications of these findings extend beyond academic discourse and offer concrete policy recommendations. Reducing administrative burdens through digital health solutions and additional support staff would allow public GPs to focus on patient care. Implementing a patient registration system in public primary care could enhance continuity of care, encouraging stronger physician-patient relationships and improving job satisfaction. Financial incentives, aligned with workload and performance, could help retain public sector GPs, mitigating the ongoing shift toward private practice. Furthermore, promoting flexible work arrangements and mental health support programs could alleviate burnout and improve overall well-being.

While this study contributes valuable insights to the discourse on GP job satisfaction, it also highlights areas for further research. The cross-sectional nature of the study limits the ability to track long-term trends in job satisfaction, highlighting the need for longitudinal research. Additionally, incorporating patient perspectives in future studies could provide a more holistic understanding of how GP satisfaction influences patient outcomes. Comparative analyses with similar healthcare systems could further contextualise the findings and inform evidence-based policy decisions. In conclusion, this study reinforces the urgent need for primary care reforms in Malta, particularly in addressing the deficiencies of the public healthcare system. Ensuring that GPs have the necessary resources, autonomy, and support to perform their roles effectively is crucial for sustaining a strong and resilient healthcare workforce. By implementing targeted policy interventions, Malta can bridge the satisfaction gap between public and private GPs, creating a more equitable and sustainable primary care system that benefits both practitioners and patients alike.

Building on these findings, the following chapter (Chapter 6) offers an in-depth discussion and interpretation of the results. It situates them within the broader context of existing literature, theoretical frameworks, particularly the Social Production Function theory, and relevant policy implications. The discussion also explores how these insights can inform practical strategies to enhance job satisfaction and support the sustainability of primary care in Malta.

Chapter 6: CONCLUSION AND RECOMMENDATIONS

6.1 Summary of Findings

This study aimed to compare job satisfaction among GPs in Malta's public and private sectors, addressing five key objectives: identifying factors influencing satisfaction, analysing differences in work conditions, assessing their impact on GP well-being, applying Social Production Function (SPF) theory, and providing policy recommendations.

The findings indicate significant differences in GP job satisfaction, with private GPs reporting higher satisfaction ($p = 0.034$) due to greater autonomy, financial rewards, and professional recognition, while public GPs faced higher stress levels ($p < 0.001$), administrative burdens, and on-call workload pressures. Differences in work-life balance, collaboration, and adherence to clinical guidelines further shaped satisfaction, with public GPs demonstrating stricter adherence to protocols ($p = 0.047$), while private GPs valued clinical flexibility.

The SPF theory provided a useful framework for interpreting these results, illustrating how financial security, autonomy, social interactions, and professional recognition contribute to GP well-being. Notably, collaborative work environments were linked to higher satisfaction ($p = 0.029$), reinforcing the importance of peer support and teamwork in preventing burnout.

6.2 Key Insights from the Study

This study provides a comprehensive analysis of GP job satisfaction in Malta, revealing distinct differences between public and private practice. The findings highlight key factors influencing job satisfaction, including autonomy, financial incentives, workload, administrative

burden, and professional recognition, all of which shape GPs' professional well-being and long-term engagement in the healthcare system.

The results indicate that public GPs experience higher job-related stress, often attributed to administrative workload, rigid scheduling, and excessive on-call duties. In contrast, private GPs report greater satisfaction due to financial autonomy, flexibility, and stronger continuity of care. Unlike the public sector, which lacks a structured patient registration system, private GPs build long-term relationships with patients, reinforcing professional fulfilment and trust. This aligns with existing literature on the role of continuity of care in strengthening GP satisfaction and patient outcomes.

The study also provides insight into peer interaction and professional collaboration, particularly among public GPs, who rely more heavily on peer discussions and shared clinical experiences. While private GPs enjoy greater independence, they also work in more isolated settings, whereas public GPs benefit from a collaborative work environment, offering informal support systems that help them navigate professional challenges. These findings reflect the importance of team-based support in mitigating stress and maintaining professional engagement. Furthermore, the application of Social Production Function (SPF) theory offers a meaningful interpretation of these findings. The study illustrates how GPs optimise well-being through autonomy, financial stability, peer relationships, and professional recognition. Private GPs, with greater control over their workload and patient base, find satisfaction in continuity of care and financial incentives, whereas public GPs, despite bureaucratic hurdles, derive fulfilment from professional collaboration and structured healthcare delivery.

Ultimately, these findings inform evidence-based recommendations aimed at enhancing GP job satisfaction, reducing burnout, and improving workforce retention. Addressing key challenges,

such as administrative inefficiencies, financial disparities, and the need for better integration between primary and secondary care, is critical to fostering a more sustainable and fulfilling work environment for GPs in Malta. Improving continuity of care within the public sector may also enhance patient trust and professional satisfaction, reducing frustration caused by fragmented care delivery.

6.3 Policy recommendations

The study highlights systemic and structural barriers impacting GP satisfaction in Malta. The following targeted recommendations aim to address these challenges and support a more sustainable, equitable, and fulfilling primary care environment.

Policy 1 - Introduce Flexible Work Models Across Sectors

Improve work-life balance and maternity support for GPs in Malta's dual healthcare system, tailored approaches are needed for each sector. Public GPs would benefit from increased flexibility within their structured hours, such as job-sharing and part-time options, to better accommodate family needs. For private GPs, who operate independently and often lack formal benefits, policies such as government-supported maternity insurance schemes and locum networks could provide financial stability and cover during maternity leave. These sector-specific measures would promote gender equity, enhance retention, and support sustainable careers for female GPs in both public and private practice.

Policy 2 - Reduce Administrative Burden Through Digital and Structural Reform

Administrative overload reduces clinical efficiency and contributes to stress in both sectors. Public GPs are hampered by bureaucratic systems; private GPs face business-related paperwork. Solutions include AI assisted record keeping and introducing an off-site allowance for public GPs to

complete paperwork outside clinic hours. In private practice, subsidised clerical support and simplified insurance systems could ease administrative strain.

Policy 3 - Establish a Structured Career Progression Framework for Public GPs

Public GPs report limited career advancement compared to hospital specialists. A structured progression model should include experience-based pay increments, incentives for additional responsibilities (e.g., chronic disease management), and opportunities for sub-specialisation. This would enhance professional motivation and long-term retention.

Policy 4 - Implement Patient Registration to Improve Continuity of Care

The absence of a formal patient registration system undermines continuity and weakens GP–patient relationships in the public sector. Reviving and implementing this long-stalled reform would improve accountability, clinical outcomes, and job satisfaction, aligning Malta with international best practices in primary care delivery.

Policy 5 - Enhance Professional Recognition and Public Understanding of GPs' Role

Public GPs often feel undervalued compared to private counterparts. Awareness campaigns highlighting the expertise and central role of GPs in the health system, coupled with greater decision-making autonomy and inclusion in health planning, could strengthen their professional standing and morale.

Policy 6 - Promote Team-Based and Peer-Support Models

Peer collaboration helps protect against burnout, especially in the private sector where professional isolation can be high. Encouraging multidisciplinary teams, peer-led governance, and regular knowledge-sharing can strengthen collegiality. Additionally, creating opportunities for interaction and collaboration between private and public GPs could enhance mutual learning, share

best practices, and build a more cohesive primary care community across Malta's dual healthcare system.

Policy 7 - Improve Communication Between Primary and Secondary Care

Fragmented communication with specialists impairs patient care and GP satisfaction.

Establishing dedicated consultation channels, such as direct contact lines, joint case discussions, or interdisciplinary meetings, would improve care coordination, reduce unnecessary referrals, and enhance interprofessional trust.

6.4 Recommendations for Future Research

While this study provides critical insights into GP job satisfaction in Malta, further research is necessary to deepen the understanding of workforce dynamics and inform future policy decisions. One important avenue for future research is the examination of long-term job satisfaction trends among GPs, particularly in response to policy changes and systemic healthcare reforms. Given that GP job satisfaction is influenced by structural and organisational factors, a longitudinal approach could offer valuable insights into how these changes impact workforce retention, stress levels, and career satisfaction over time.

Comparative research is also essential in positioning Malta's primary care system within a broader European context. Investigating how GP job satisfaction in Malta compares to that of other European countries would allow for the identification of best practices in workforce management, financial incentives, and administrative support. Countries with similar healthcare structures or workforce challenges may offer models that could be adapted to the Maltese setting, helping policymakers develop strategies that enhance both job satisfaction and patient outcomes.

Another area that warrants further study is the gender-specific challenges faced by GPs, particularly the reasons why female doctors are more likely to work in the public sector. While this study suggests that stability and structured work schedules play a key role in this trend, further research could explore how policies can better support career progression and work-life balance for female GPs, particularly in the private sector where maternity leave and sick leave remain limited. Understanding how gendered career trajectories impact long-term retention and professional satisfaction could provide the basis for more equitable workforce policies.

With the increasing reliance on technology in healthcare, future studies should also assess the impact of digital transformation on GP workload and job satisfaction. The integration of AI-based documentation systems and telemedicine has the potential to reduce administrative burden and streamline patient management, yet its effectiveness and impact on GP well-being remain underexplored in the Maltese context. Investigating how these innovations influence consultation time, administrative workload, and doctor-patient relationships would provide valuable insights into whether digitalisation enhances or detracts from GP satisfaction.

Finally, while this study focused on the perspectives of GPs, future research should incorporate patient perspectives on GP job satisfaction and service quality. Understanding how patients perceive primary care services and their interactions with GPs could offer a more comprehensive view of the strengths and limitations of the healthcare system. Examining whether patient satisfaction aligns with GP job satisfaction, or whether certain workforce challenges affect patient care experiences, could help inform workforce planning that balances both provider well-being and patient expectations.

Further research in these areas would not only build on the findings of this study but also contribute to evidence-based policymaking aimed at strengthening Malta's primary care system. By

addressing workforce challenges, improving gender equity in career progression, and evaluating the role of digital transformation, future studies could support the development of policies that enhance both GP job satisfaction and the quality of healthcare delivery.

6.5 Implications for Practice and Education

The findings of this study have several important implications for primary care workforce planning, medical education, and professional development. Addressing GP job satisfaction requires a holistic approach that not only improves working conditions but also ensures that GPs are equipped with the necessary skills and support to navigate the challenges of their profession effectively.

One key implication for medical education is the need to integrate training on workload management and burnout prevention into GP training programs. Given that public-sector GPs, in particular, face high administrative burdens and stress due to heavy patient loads and bureaucratic inefficiencies, future primary care physicians should be better prepared to manage these pressures. Training on time management, resilience-building, and stress reduction techniques could help mitigate the risk of burnout early in their careers. Additionally, teaching GPs how to navigate administrative tasks more efficiently could ensure that they are not overwhelmed by non-clinical responsibilities.

Continuing professional development (CPD) programs should also place greater emphasis on interdisciplinary collaboration, ensuring that GPs develop strong communication channels with specialists. The study highlighted a lack of direct verbal communication between primary and secondary care providers, which often results in fragmented care and inefficiencies in referrals. By

incorporating interdisciplinary training and structured case discussions between GPs and specialists, CPD programs could improve coordination between different levels of healthcare, leading to more effective patient management and better professional relationships.

6.6 Strengths and Limitations

Every research study has strengths and limitations that influence its interpretation and generalisability. This section evaluates the robustness of the study while acknowledging areas that may require further research.

6.6.1 Strengths of the Study

A key strength of this study is its triangulated methodology, which integrates quantitative survey data with qualitative focus group insights. This approach provides a nuanced understanding of GP job satisfaction, capturing both statistical trends and personal experiences. The quantitative component offers generalisable findings about GP satisfaction levels across public and private sectors, while the qualitative focus group adds depth by exploring the lived experiences and underlying motivations influencing job satisfaction. The combination of these methods ensures a balanced interpretation of factors affecting GP well-being.

This study addresses a major gap in local literature regarding GP job satisfaction in Malta, providing empirical evidence that can inform policy and workforce planning. Unlike many international studies that examine GP satisfaction broadly, this research specifically compares public and private GPs in the Maltese healthcare system. It highlights structural challenges unique to Malta, particularly the lack of continuity of care in the public sector, which is a key issue affecting both GPs and patient outcomes.

Another strength of this study is its application of Social Production Function (SPF) theory to interpret job satisfaction through resource optimisation. This theoretical model enhances the depth of interpretation, moving beyond a descriptive analysis to a conceptual understanding of GP job satisfaction. SPF theory helps explain why private GPs report higher satisfaction due to greater autonomy and continuity of care, while public GPs experience frustration due to structural inefficiencies.

The findings of this study are also highly relevant to policy reforms, particularly in areas such as reducing administrative burdens for public GPs, improving continuity of care through patient registration systems, and introducing financial incentives to improve public sector GP retention. By providing evidence-based recommendations, this study contributes to the ongoing policy discourse on primary care reform in Malta.

6.6.2 Limitations of the Study

While the study gathered responses from 133 GPs, only 70 fully completed the survey, representing 24.7% of the total population of 41 public and 29 private GPs. Although this response rate falls within acceptable ranges for online surveys, it may still limit generalisability. There is a potential for response bias, as GPs experiencing greater dissatisfaction or burnout may have been less likely to participate, affecting representativeness.

This study provides a cross-sectional snapshot of GP job satisfaction at a single point in time. Longitudinal studies tracking changes over time would offer a richer understanding of job satisfaction trends, especially as policy changes or workforce conditions evolve. Future research

could incorporate pre- and post-policy evaluations to assess the impact of reforms on GP satisfaction.

The qualitative component was based on a focus group of eight participants, evenly split between public and private GPs. While this provided valuable in-depth insights, the sample size remains limited. Some subgroups, such as newly qualified versus experienced GPs or urban versus rural settings, may have had different experiences that were not fully captured. Expanding qualitative research through additional focus groups or interviews would strengthen the understanding of GP satisfaction across different demographics.

While this study focuses on GP job satisfaction, patient experiences were not directly examined. Given that continuity of care in the private sector is a key satisfaction driver, future research could incorporate patient perspectives to explore how GP satisfaction and patient outcomes are interconnected.

The findings are highly relevant to Malta but may not be directly transferable to other healthcare systems with different structural setups. Countries with universal GP registration systems may not face the same continuity of care issues seen in Malta. However, the findings could still be informative for small healthcare systems with similar public-private dynamics. Comparative studies with healthcare systems that share structural similarities with Malta could further validate the findings.

6.6.3 Addressing Limitations in Future Research

Future research could improve upon the sample size and response rate by conducting larger-scale surveys with incentives for participation. Longitudinal studies would be beneficial in tracking

job satisfaction trends over time, particularly in response to healthcare reforms. Expanding the qualitative component through additional focus groups or one-on-one interviews could provide a deeper understanding of GP experiences. Including patient perspectives in future research would also offer a more comprehensive analysis of how GP satisfaction influences healthcare outcomes. Lastly, comparing findings with similar small healthcare systems would provide valuable insights into whether the trends observed in Malta are consistent with other settings facing comparable challenges.

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Appendices

Appendix A: Full approval from primary health care department



FRN 1940

PRIMARY HEALTHCARE

7 Harper Lane,
Floriana
FRN 1940

Website: <http://www.health.gov.mt>

Telephone: + 356 21239993
Telefax: + 356 21222856

16th July 2024

Juanita Camilleri Casingena
60, Triq Taltas, Zejtun

Re: Your request to carry out a study within the Primary HealthCare Department

Dear Dr Camilleri Casingena,

I am pleased to inform you that your request to carry out the research within the department has been **fully approved**.

May I inform you that as we have to abide to the Data Protection Law, **we cannot provide you with a list of data subjects' (clients/patients/staff) personal contact details.*** The data subjects also have to sign an informed consent form that also includes a data protection statement (unless it is an anonymous questionnaire) prior to participating (see E below). Any modifications of this approach would have to be first discussed with the data protection officer. Where statistics are involved, only data in terms of age, sex etc can be forwarded to you but not names of individuals.

May I bring to your attention that the researcher is obliged to apply necessary safeguards as a condition for carrying out this research, namely -

- A. The personal data (of data subjects) accessed or given are only to be used for that specific purpose to conduct the research and for no other purpose;
- B. At the end of the research, all personal data should be destroyed;
- C. All references to personal data should be omitted in the report unless an informed consent is specifically obtained from the person being identified in the research report;
- D. Participation in the research being conducted should be at the discretion of the individual, and they can refuse any participation whatsoever if they so wish;
- E. If data subjects (patients/staff) are going to be interviewed, video recorded or given a non-anonymous questionnaire to fill, an informed consent form should be signed by the participating data subject and a privacy policy statement read to them; Faces should be hidden or digitally modified as to conceal identity;
- F. Any other measure deemed fit by the respective Head, depending on the research to be carried out.

I sincerely wish you every success in your studies.

Yours truly,

Dr Glenn Garzia,
f/Data Protection Officer, Primary HealthCare

** May I suggest that you offer the invitation for participation through any officer in charge (e.g. Nursing officer/Senior GP/service provider)*

Appendix B: Number of GPs working in public sector email from HR



Mizzi Sandra at Health-Primary Health Care <sandra.mizzi@gov.mt>

to me ▾

Dear Dr Camilleri Casingena

Kindly find below the totals of doctors working in Primary HealthCare.

- GP Trainee - 97
- GP – 61
- SGP – 76
- PGP – 24

Kind Regards

Sandra

Sandra Mizzi

Principal | Head Office

Human Resources Section

Health - Primary HealthCare

MINISTRY FOR HEALTH



t +356 25576107 e sandra.mizzi@gov.mt

www.primaryhealthcare.gov.mt

Kindly consider your environmental responsibility before printing this email



MCAA
SH EN ISO 9001:2015

Appendix C: Focus group participants consent form



L-Università
ta' Malta

Focus Group Participants Consent Form

***Research Title – Evaluating general practitioner job satisfaction:
a comparison between public and private practice***

I, the undersigned, give my consent to take part in the study conducted by Juanita Camilleri Casingena. This consent form specifies the terms of my participation in this research study.

- 1) I have been given written and/ or verbal information about the purpose of the study; I have had the opportunity to ask questions and any questions that I had were answered fully and to my satisfaction.
- 2) I also understand that I am free to accept to participate, or to refuse, or to stop participation at any time without giving any reason and without any penalty. Should I choose to participate I may choose to decline to answer any questions asked. In the event that I choose to withdraw from the study, any data collected from me will be erased as long as this is technically possible (before it is published), unless erasing of the data will render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymous form.
- 3) I understand that I have been invited to participate in the focus group in which the researcher will discuss the results collected from a survey questionnaire about job satisfaction in general practice. This is so that the researcher will get deeper insight of the results. I am aware that the focus group discussion will take approximately 1 hour. I understand that the focus group will be conducted online and at a time that is convenient for me.
- 4) I understand that my participation does not entail any known or anticipated risks.
- 5) I understand that there are no direct benefits to me from participating in this study.

- 6) I understand that, under the Data Protection Regulation (GDPR) and national legislation, I have the right to access, rectify, and where applicable, ask for the data concerning me to be erased.
- 7) I understand that all the data collected will be erased on completion of the study and publication of results that is by June 2025.
- 8) I have been provided with a copy of the information letter and I understand that I will also be given a copy of this consent form.

I have read and understood the above statements and agree to participate in this study.

Participant Name : _____

Signature : _____ **Date :** _____

Researcher:



Juanita Camilleri Casingena

Email Address – juanita.camilleri-casingena.06@um.edu.mt

Contact Number – +356 7931 5232

Supervisor:



Dr Kenneth Grech

Email Address - kenneth.grech@um.edu.mt

Contact Number – +356 2545 6886

Appendix D: Questionnaire consent form



**L-Università
ta' Malta**

Questionnaire Consent Form – Anonymous Data Collection

***Research Title – Evaluating general practitioner job satisfaction:
a comparison between public and private practice***

My name is Juanita Camilleri Casingena, and I am currently reading for a Masters in Health Systems Management and Leadership at the University of Malta.

I am currently conducting research that aims to explore and evaluate the positive factors supporting the satisfaction of GP in primary health care. The survey that you have been invited to complete forms part of this study. This will take you approximately 20 minutes to complete. Any data collected from this survey will be used solely for purposes of this study. There are no direct benefits or anticipated risks in taking part.

Participation is entirely voluntary, i.e., you are free to accept or refuse to participate. At no point will you be asked to provide your name or any other personal data that may lead to you being identified. Furthermore, you may skip over any questions that you do not wish to answer.

If you wish to participate in this study, please click the button that says "I agree to participate". If not, please close the browser or click "I do not wish to participate".

Should you have any questions or concerns, you may contact myself or my supervisor on the details provided below.

DECLARATION BY RESPONDENT:

I hereby confirm that I am 18 years of age or older. I am aware that completing and submitting this anonymous questionnaire implies that I am participating voluntarily and with full informed consent on the conditions listed above.

- I agree to participate – Begin Survey
- I do not wish to participate – Exit The Survey

Sincerely,

Researcher:

Juanita Camilleri Casingena

Email Address – juanita.camilleri-casingena.06@um.edu.mt

Contact Number – +356 7931 5232

Supervisor:

Dr Kenneth Grech

Email Address - kenneth.grech@um.edu.mt

Contact Number – +356 2545 6886

Appendix D: Information Letter



L-Università
ta' Malta

Information Letter

***Research Title – Evaluating general practitioner job satisfaction:
a comparison between public and private practice***

Dear Doctor,

My name is Juanita Camilleri Casingena and I am a student at the University of Malta, presently reading for a Masters in Health Systems Management and Leadership. I am presently conducting a research study for my dissertation titled Evaluating general practitioner job satisfaction: a comparison between private and public practice. This letter is an invitation to participate in this study. Below you will find information about the study and about what your involvement would entail, should you decide to take part.

The aim of my study is to Explore the factors influencing the satisfaction of GP in primary care in Malta. Your participation in this study would help contribute to a better understanding of what improves and what hinders job satisfaction in general practice. Both sectors will provide insight to each other. Any data collected from this research will be used solely for purposes of this study.

Should you choose to participate, you will be asked to fill in an anonymous questionnaire of 55 questions majority with a yes or no answer or a choice of best answer. The last question, which is subdivided into 6 are on a Likert scale and are about job satisfaction. This would take an average of 20 minutes to complete. Data collected will be anonymous and only I and my supervisor will have access to it.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you.

If you choose to participate, please note that there are no direct benefits to you but management benefits will be to the whole GP community. Your participation does not entail any known or anticipated risks.

All data collected will be erased at the end of the study and following publication that is by June 2025.

A copy of this information sheet is being provided for you to keep and for future reference. Thank you for your time and consideration. Should you have any questions or concerns please do not hesitate to contact me or my supervisor.

Sincerely,

Researcher:



Juanita Camilleri Casingena

Email Address - juanita.camilleri-casingena.06@um.edu.mt

Contact Number - +356 7931 5232

Supervisor:



Dr Kenneth Grech

Email Address - kenneth.grech@um.edu.mt

Contact Number - +356 2545 6886

Appendix E: Communication with APFD secretary



Jason J. Bonnici <secretary@apfd.info>
to me ▾

Wed, 22 Nov 2023, 20:51

Dear Juanita

The APFD will distribute your survey to its members, provided that a feedback session is organised once results are available

Regards
Jason

Dr Jason Bonnici MD FMCFD Dipl. Fam. Pract. (MCFD)
Honorary Secretary
Association of Private Family Doctors
E: secretary@apfd.info
A: The Professional Centre, Triq tas-Sliema, Gżira. GŻR 1633
W: apfd.eu



Juanita Camilleri Casingena <juanita.camilleri-casingena.06@um.edu.mt>
to Jason ▾

23 Nov 2023, 08:50

Yes thank you will be happy to give you feedback. Questionnaires will be anonymous and focus group recording will be destroyed after data collection and analysis.

Regards,

Juanita

...

---- On Wed, 22 Nov 2023 14:43:27 +0100 **Dr Kenneth Vassallo** <drkvassallo@gmail.com> wrote ---

No Objection

From: Jason J. Bonnici <secretary@apfd.info>
Sent: Tuesday, November 21, 2023 10:04 PM
To: Kunsill <kunsill@apfd.info>
Subject: Fwd: Permission for study on private Gps

dear all

I find no objection, do you?

regards
jason

Dr Jason Bonnici MD FMCFD Dipl. Fam. Pract. (MCFD)
Honorary Secretary
Association of Private Family Doctors
E: secretary@apfd.info
A: The Professional Centre, Triq tas-Sliema, Gżira. GŻR 1633
W: apfd.eu

Appendix E: Permission to Use Questionnaire and Online Usage

Approval

J **Juanita Camilleri Casingena** <juanita.camilleri-casingena.06@um.edu.mt>
to w.schafer@nivel.nl ▾ Wed, 15 Nov 2023, 10:23 ☆ ↶ ⋮

Dear Admin,

I am a General Practitioner and a student of the Masters in HealthSystems Management and Leadership with the University of Malta. I am doing my dissertation on GP Job Satisfaction in the private and the public sector. I am planning to do this in a mixed method approach.

During my literature review I came across the study of Primary Care in 34 countries: perspective of General Practitioners and Their patients. There is also the questionnaire of the GPs and their satisfaction at the end with the appendix. Dr Philip Sciortino also recommended this questionnaire to me. He was involved in QUALICOPC from Malta.

I would be grateful if you would kindly give me permission to use this Questionnaire for my study. It is very exhaustive and very useful.

Thanks and regards,

Dr Juanita Camilleri MD MRCGP MMCFD

i **Willemijn Schäfer** <W.Schafer@nivel.nl>
to me ▾ Thu, 16 Nov 2023, 09:11 ☆ ↶ ⋮

Dear Juanita,
Yes, please go ahead and use this questionnaire!
Kind regards
Willemijn

Van: Juanita Camilleri Casingena <juanita.camilleri-casingena.06@um.edu.mt>
Verzonden: woensdag 15 november 2023 10:23
Aan: Willemijn Schäfer <W.Schafer@nivel.nl>
Onderwerp: Permission to use Questionnaire

J **Juanita Camilleri Casingena** <juanita.camilleri-casingena.06@um.edu.mt>
to Willemijn ▾ Sat, 2 Dec 2023, 23:22

Dear willemijn,

I hope this email finds you well.

This is following your permission to use the questionnaire of the primary care in 34 countries study.

By any chance was the questionnaire filled by GPs online? If so would it be possible to send me the software that was used at the time?

If not can I have your permission to convert it to an online version?

Thanks and regards,

Juanita

⋮

W **Willemijn Schäfer** <W.Schafer@nivel.nl>
to me ▾ Tue, 5 Dec 2023, 11:08

Hi Juanita,
The questionnaires were completed on paper only. Feel free to convert it to an electronic version.
Kind regards,

⋮

Appendix F: Request for intermediary

Request for intermediary External Inbox x ↕ 📄 🔗

J **Juanita Camilleri Casingena** Fri, 2 Feb 2024, 18:16 📧
Dear Dr Garzia and Ms Cassar, I hope this message finds you well. As part of my ongoing efforts in finalizing my proposal for my Masters program in Health System

G **Garzia Glenn at Health-Primary Health Care** <glenn.garzia@gov.mt> Mon, 5 Feb 2024, 07:52 ★ ↶ ⋮
to me, Cassar ▾


Hi Juanita,

We can distribute the link through the official admin channel.

Regards,

Glenn Garzia
MD, MMCFD, MRCPGP(int)
PG Cert (Healthcare Management)

Principal General Practitioner
Assistant Data Protection Officer
Health - Primary HealthCare
t +356 25576110 e glenn.garzia@gov.mt
www.gov.mt | www.publicservice.gov.mt | fb.com/servizzpubbliku



MINISTRY FOR HEALTH AND ACTIVE AGEING
PRIMARY HEALTHCARE, 7, HARPER LANE, FLORIANA, MALTA

Kindly consider your environmental responsibility before printing this e-mail

Appendix G: Focus group transcript

Me: good afternoon, so first of all I am going to use the English language. This is a focus gp aimed at analysing job satisfaction in GPs and we are going to be 4 in public and 4 in private, so I am going to present my data analysis from the questionnaire for further discussion and insight and to gain insight from each other as well. It is a comparative analysis between private and public GPs.... Introducing them as one by one as requested by the. It is going to take an hour and it is going to be recorded. It will be deleted when it is no longer needed. I am going to start by demographic data. One of the first questions answered by 133 GPs. As you can see there is a tendency for females to work in the public setting there is male predominance in the private setting. There is a tendency for private GPs to be older as well. I would like to present this question based on this: how easy or difficult do you find it to work in the private sector particularly as a woman or as a younger GP. Whoever would like to answer can just answer.

Speaker 1 public female: I wouldn't mind answering this question. First of all I would like to point out that although now I am working in public, I worked for about three years in the private sector. And the reason why I left private practice in the end was because it was so difficult being a female GP in fact to find a balance between family and children and work. So I would feel that public makes it easy for female gps especially those who have children and a family.

Speaker 2 private male: Nista nghaddi kumment jekk joghgbok.. mela emm bl ingliz jew bil malti... hawnekk I have to disagree first of all emm inselli ghalikom kollha. I disagree with what Charlene said. In fact my point of view is quite the opposite that Charlene said. That in public service you get more work life balance than the private. In private practice, I have written down a few points because I scribbled them just a few minutes before. Jlen awnekk ezempju I am my own boss. Igifieri jekk jien ma rridx naghmel nights ma naghmilx nights. Issa veru li hemm xi nies li they might be exempt from it in the public imma most GPs in the private don't do night and it s the same this fr

weekends and for public holidays. I choose my own hours of work igifieri the clinic hours I devise them as long as I want and if for example up to 6 7 years ago I used to work with very full clinics everyday but now for example I took out a few days every week and also I reduced the times of the clinics igifieri a private gp he can devise his own hours of clinic. If you want to work the afternoon you can work and if you want to take it off you can load as much work as you sort of feel kemm tiflah than you actually can take because then you can burn yourself out. There are some people in the private sector who are part timers perzempju. In fact my number of hours are less than before and they are less than the number of hours that the health centre obliges you with contact a to work and the pay in the private is much better because first of all you can.. ok there is no tariffs as yet.. but everybody sets his own which I wish we all agree that we settle this as a group by the associations, but anyway with the tariffs that you can set the pay is 2- 3 times better than that of the public GPs. As an hourly rate and if you charge the correct amount of money igifieri you don't have low tariffs have the higher end. And there is more respect from the patients e ovjament.

Speaker 3 private male: Nista nghaddi kumment please, I understand that private work gives flexibility and that it feels prima facie that it gives more work life balance.. it is an occupation that is a business built upon your presence being there and reputation. So you have the grace and the ability to work your own hours because you worked so much in the pas and you built a reputation for yourself and you are free to work less. For a GP who has worked 3 years in private practice and for a woman who wants to have success in carrier and success for her being a mother she wasn't given that flexibility. So in her case it would have been easier to work or stagger out a deal with the gov to work stable hours to complement her lifestyle with her kids. Currently I work as a private doctor. I ve been working privately ever since I got my registration number. Currently I work full time and its always been going uphill thank god but it has been like this because I sacrifices a lot and I have missed days watching my kids and there were times when I didn't see them at all especially during the time where I've been working with the gov and private at the same time. I have presently

opted to work in private because I'm in a state where I can play with hours now because I see that private work has been gaining momentum and obviously it is a competition as well. You have to be there. It is useless to be a good GP but then not be present. Of course it is my largest commitment. It takes most of my time. I understand your point that in private work is more flexible but it comes later on you don't get it at the early stage

Speaker 2: hes right .i mean jiena initially I used to work very hard and I used to have to work on undays and in the evenings but eventually when sort of you get the reputation, when people get to know you jien I came here in my district in Fgura and Zejtun. I came from Gzira. I came here without a single person knowing who I am, within 16 years I got such a good reputation that I managed even to get elected in the Maltese parliament not just once but even twice in a row. It takes hard work yes then obviously when the age starts coming in there are some people that continue working. And actually, I intend to keep on working until I die or until my health allows me to but if I feel that I need to reduce the number of hours again. For example, I can work morning only. There is this notion that a gp has to be available all the time for a patient this is I think ok it is very ethical and professional but one has to consider also that a human being is a human being, the doctors at the health centre when you are out of the health centre you're sort of at home alone and you are free. If you are a private GP and you leave your mobile switched on and maybe your conscience doesn't allow you to switch it off you have to be stand by for calls 24/ 7 and you are going to be destroyed by that unless you go into a gp practice group. A group practice. If you are alone then we. Once I heard doctor Balzan say that the private gps have learnt to live together with the health centres. Which basically means that sort of during the night hours when private gps sleep because everybody has to sleep the doctors at the health centres will see to the needs of the patients during the nights and after hours. But you are right about the need to work in the beginning. But I was speaking to Jason Bonnici that right now the private sector actually there is nuqqas ta GPs. The population of private gps is ageing and many new ones are going to the contract a. if the GP skips days in private or example a

woman needs few months of maternity leave she can do that without harming her practice. Because I mean some people say that if you are missing for few months patients might leave, you might lose clients which is I don't think it is really that true. It is something which many private doctors hear but it is not so true. Jena when I did an operation myself and skipped 2 months I actually returned and found more people than before. I don't know why. But igifieri, it is not a true fact that if you take some days off you will be ruined. Ok for the patients it is better that you are available unless you serve them for 24/7. But one has to consider that a human being is a human being. If you are a solo GP you have to take care of your own health and have to take your breaks, manage your time and make sure that your hours are the hours that you can tolerate without creating fatigue and burnout.

Speaker 1: about the maternity issue.. because when you think about it taking 2 months off when you have a baby is not enough. The gov gives you plenty more time to recover and go on with your life and then return back to work as opposed to the scenario of the private practice so I still feel that it is easier for male doctors to go into private practice rather than female ones.

Speaker 4 male public: I definitely agree with Charlene. I mean there are pros and cons for both private and public. There is something for everyone. I would agree that females, especially mothers are at a disadvantage when they go into private practice. The gov with all its faults, has its own benefits for mothers. They are released and sick leave and you still get paid. Because maybe you wont loose patients if you leave for a few months but you will definitely loose money. Your income. so that is important for your family as well. So at least with the maternity leave you are getting something back. I think you are much more protected than if you are working in the private.

Speaker 2: but the pay is not that high

Speaker 4: but at least you are getting something I mean it is better than nothing

Speaker 5 female public: you also have to remember that we have a biological clock I mean first you postpone having children because of the training then you decide to start a private practice it takes

time. There isn't much years to play around with. It is easier to just go with the gov and you are a qualified gp.

Speaker 6 private male: if I may add something so it is true what has been said. In a private setting you can choose your working hours but the workload and the trust only happens thru a lot and a lot of work in the start. so the trust will come with time. Starting de novo in a private practice is not going to be easy. The more available you are the more they will come to you. Working in a group practice it is better because there is always someone else that can cover during the time that you are not at work and that is a bonus. But you have to work for that as well. It doesn't come without any sacrifices to work in a group, to be able to work in a group and to achieve the commodities which a group can afford.

Me: so the last 6 questions in the questionnaire were related to job satisfaction. They were on a likert scale, a score of 1- 4. One being strongly disagree to 4 being strongly agree. These questions these 2 are about administrative burden. As a reminder from the survey they were I feel that some parts of my work do not really make sense and my work is overloaded with unnecessary administrative detail. Now do you think that public gps, because for public gps there was a little higher dissatisfaction since the questions are negatively worded. Do you really think public gps face more administrative tasks and how do these factors impact job satisfaction?

Speaker 3: honestly my background is actually nursing, I have been a nurse in the past as some of you might already know, in KGH basically. There is a saying that KGH huwa sptar tal- karti so everything you do you have to document. I truly believe in documentation and litigation has been on the increase. Medical practice has its own administration. You have to take notes. Also obvious duty that the private gp has to get insurance. Also a private gp has finance administration and contributions and it is a big headache. I mean you have to deal with accountants etc. in public service you don't have this staff because it is being taken care for you but I recall that most times I found a mistake so I used to work with that questions mark. Like I work like a dog and I'm not being

paid for it. Do I have to check. It is a minor thing for some but I used to care. Because the clinical work has always been my fantasy I did accept my duty of administration and it is something I embrace.

Me: so no effect on job satisfaction you think?

Speaker 3: I mean no one likes doing house visits but it is part of the job. I mean at the end of the day it has to be done. It doesn't effect satisfaction for me.

Me: anyone else would like to share something. Do you think it's a burden in the public sector rather than in the private? Anyone else?

Speaker 4: some necessary admin work. I mean obviously electronic medical records are necessary and need to be done it is our duty. But the new scheme which is not innovative. I mean much of the administrative work can be done by the AI. Its not something I just came up with. Most of the countries in the eu do so already. Most of the work that used to be done by gps it is being done now by AI/ you have to check but it far more efficient. Especially in this era we are sort of in this digital health era. I would accept us to adopt certain things. These schemes. It is useless waste of time. I would rather keep seeing patients than putting notes or whatever. Most of the staff we end up doing is a huge waste of time.

Speaker 2: yes hopefully with AI note taking, typing etc ,can be replaced by vocal input and things can become more efficient. I want to comment about DR Johnathan's (speaker 4). Yes note taking takes time and once the president of the APFD told me that it takes him one hour extra just to take notes to put notes in order. Obviously who is going to pay for this? That's why I like the gov should do reforms about the pay of gps working in the public. The tariffs of private gps should. All the private doctors, which are apparently decreasing ux because you didn't give us the numbers exactly. GPs are decreasing. They should come together to set their tariffs and to make sure that whatever they work for they get paid. Their tariff will cover the dana. Otherwise we come in a situation that there are some doctors who charge 10 others who charge 20, those who charge 30. And because of

competition. Today there is free market mentality but it shouldn't be like that for doctors. They should agree through an association. Everybody has to stick to it. Of course there is no standard thing because a visit might take 5 minutes other visits might take more. But yes the doctors should come together and agree to make sure that whatever they work for whether they are seeing patients, studying, cpd, they get paid. Pero one other thing li nixtieq ngħid li the thing that I miss in the HC is working with colleagues. When you work alone is ok I can phone my friends or consultants with whom I have confidence. I don't attend conferences because I study alone at home. But yes being in a setting of team work. You will learn from the older doctors you will learn from the younger just qualified. You can learn from other and there is the element that instead of being alone. Loneliness is something that tends to affect me.

Me : there was a question in fact. Because in Malta the majority of private gps are lone gps and it is known according to literature that the fact that working alone is related to a lower job satisfaction as opposed to working in a group. It is more common abroad for private gs to work in groups.

Speaker 2: it is not easy to work in a group. Speaker 6 can tell us and probably also soler works in a group. In Malta this thing that people tend to want a particular doctor and not another might be able to break this culture mentality of the Maltese public in the future. Just like covid has significantly changes changed certain mentalities like having to take antibiotics for every cold and some covid change was a break through in certain things. Telemedicine gained popularity although telemedicine has its own drawbacks. It is not the subject of today pero kif ghidna it is something that we have to discuss.

Speaker 6: working together helps there is a person you can speak to about your difficulties. Sharing also life experiences. We have been 25 years together now so we know each other well. We ask opinions not only about work but also about other things as well. The problems with Maltese

doctors is that they don't trust each other it's a major problem. Solo gps work as solo because they.. I'm not saying that everybody here is the same. In the past we have searched for doctors to work with us and they actually refuse because they don't, everybody wants to work in his own environment and doesn't want other to know what they are doing. It's I think it is more a question of trust rather than the patient. The patient will eventually share the doctor. They are ready to do that. If they don't find one doctor they will go to the other one. They do that. Everybody has his own patients but if they don't find you, if you are abroad or you're sick they will go to the other. That's how it works.

Me: the next satisfaction question was about interest in work. As a reminder from the survey, it was worded as my work still interests me as much as it ever did. So the private GPs scored a bit higher than the public GPs over here. Why do private GPs feel more interested in their work and what contributes to keeping you engaged at work?

Speaker 6: the most important thing is continuity of care they can come to you with one problem and then they will come to you with another problem, and they feel they are safe and they can share their true problems which at a health centre they cannot do because each time they find a different doctor. So you don't get the same doctor seeing you for the same condition, so they don't open up about certain things which they do with us. They confide in us we get to know them personally.

Speaker 2: and this gives us more respect from the patients e you feel the appreciation. In the health centre for example when I was at the health centre. In private people tend to respect you more. In my time at the health centre there used to be people they come in hawn xi tabib, there used to be certain arrogance. If they don't get their way they threaten to report to admin or politicians. I think private there is more satisfaction because of appreciation. Not having your own group of patients which come to know you and you become... as speaker 6 said there is continuity of care.

Speaker 4: continuity of care is a problem in the health centre. You get these reports reporting to minister and so on. There might have been a small diminishment in this regard, but it is still a

problem. Another issue we are being take for granted. It is free at the point of retail, so people tend to take that for granted. The major factor that is shooting the attitude a little bit is the training, and I think we can all agree on that. Now people know that the doctor they will find at the health centre is a top-notch doctor. There is medical training and that helps that makes a difference e. our patients do feel that there has been a shift in service, in quality of service. So again, I'm not comparing it to the private aspect.

Speaker 2: Igifieri are you insinuating. Are you saying that private doctors are not up to it?

Speaker 4: no no no no, that why I said I am not making comparison first of all one of us at the moment is in private after undergoing the training. So providing good quality service in the private.

Speaker 7: I have never been part of actually.... Excuse me I have a phone call

Speaker 4: and there are 5 other doctors who have done the same and all of them are top notch doctors. But besides those, my own trainer was a private GP when I was still a trainee. An that is the reason why I have also given my training by private GPs. I am not making any comparisons. So, this is just my perspective of what's being given in the public service alone.

Speaker 2: actually, the impression is the opposite e that even the people say it ghax now that you have made a suggestion, and I hop that you clarify yourself that private GPs people tend to prefer private GPs because they are better doctors and more experienced doctors than the younger ones who are top notch. Of they were top notch people would want them so much that they would probably flood them with requests to serve them personally.

Speaker 1: if I may add something here, I think the issue with patients with choosing a private doctor is the continuity of care because many a times we are in the clinic for example and patients ask you do you see patients privately. So, the point is not the quality, I think. I think it is the continuity of care. Being able to see the same doctor gives patients reassurance that they know their history and they know things about them. So, I think the crucial thing is the continuity of care. Patients like the continuity of care.

Speaker 4: I have never been against private doctors, I've been a private GP myself, I know them most of them are my friends and I am president of the Malta college of family doctors which represents both private and public so I know exactly what level they have.

Speaker 2: but you are not saying that the level of private GPs, just because they are the older generation and not the ones who are bearing the MRCGP and etc etc they are of less knowledge than the younger ones.

Speaker 4: no no no at no point did I make such a comparison. Absolutely not. I would never say that. Because it doesn't make sense. After all there also elderly GPs in the public service as well.

Me: there are yes.

Speaker 4: and there are younger ones in the private service.

Me: the situation will change in the future I think everyone will be the same sooner or later.

Speaker 4: it is not a question of quality I can assure you. There are GPs who work in the schools and in homes. There are exceptional gps everywhere. The continuity is the main thing. The only

comparison I made was between the past and the present in the public service. So, it was... there are still issues with reports and so on and we are still taken for granted but there is a slight shift. I would say actually a significant shift really because in time patients are realizing that the GPs in the public service are qualified. They're not merely doctors that did not know what to do with their lives. So there is training and there is a difference. So that is the only comparison I made.

Speaker 2: do you agree with the pay?

Speaker 4: we get good pay I can't really complain but obviously not everyone would agree with me. But I would say that the only issue I would have with the pay is that we are at disadvantage compared to other specialists. So, we still get good pay but when comparing equal grades, we get less pay which is obviously discriminatory and that is another crusade we are working on.

Me: so not comparing between private and public but to other specialists

Speaker 4: exactly which is another issue.

Speaker 1: and I think comparing the pay between private and public of course in private you get to earn more and as I said in the beginning I work in the private practice and I did earn more. However the issue with the private practice is that you really need to work for every penny. In the health centre whether I see 6 in an hour or 10 I earn the same pay whereas in the private sector you are paid per patient. So there is also that element I think about the pay.

Speaker 2: and sorry to ask ta imma in the public service does everybody work to the same degree or there are some doctors who earn more because they work harder.

Me: no there are no remunerations

Speaker 4: this is obvious

Me: you are not paid according to workload in the public

Speaker 1: it boils down to the individual, but we are paid at an hourly rate and also sometimes we are stuck with a case for an hour and there are other instances where you see 10 patients in an hour. It depends on what the case is. But yes, it depends on the individuals. some are faster some are slower. But it is what it is I mean

Me: what do you think about compensations and remunerations? Since there are some countries that have it. The doctor is compensated more depending on the workload that he or she does. But in Malta we don't have this

Speaker 5: this is controversial I think because then you might be stuck with the same patient or be unlucky enough to get more than one consecutive psychiatric patients. Would that be fair for you to be paid less. So, its hard to remunerate and I don't think it would be fair.

Me: I'm going to move on to the last 2 questions of satisfaction scores because they had the highest significance. With regards to respect and recognition so this was found to have a strong correlation to the overall job satisfaction score. So, it is important for the GPs. The question was worded as being a GP is a well-respected job. Obviously, as you said already, that in the private sector this score higher than in the public. What factors contribute to the fact that in the public sector there are more GPs that feel less respected?

Speaker 5: it is the fact that a lot of people have the mentality that they are paying their taxes, so they feel entitled. It is a general disrespect to everyone working with the gov not only in health.

General disrespect to teachers etc etc. I mean no appreciation at all. But it is in general across the board. Everyone is busy, no has time to wait and I don't know. I don't know if you get any complaints in the private sector about waiting etc but maybe in the private sector at least it is your own choice whereas in the public sector it is not

Speaker 3: I think that in the public sector the thing which effects doctors' satisfaction the most, is not the clinical case, because I understand that maybe a GP people have to come to me for primary education so even for blood pressure. So, I wasn't frustrated because of the quality of cases seen but a lot of GPs agree with this. Whenever there were some ideas of reforms or whatever in the public sector they were always about patient attitude and a lot of the blame was actually on the securities who are actually. insomma whatever

Speaker 7: can I say something. because maybe I have an idea about this, I published a study of burnout in 13 European countries. And I actually looked at it.. again, because now it's been a while since I did the study. It was published in 2008 including studies on Maltese GPs. And I mean I hear all of this about people's personal experiences, that's fine obviously pero the actual correlations which we found are different with what is being said. We looked at burn out not job satisfaction, principally, the principal outcome, was burnout. Job satisfaction was one of the factors we looked at. And one of the things which people have looked at job satisfaction was found to be most important predictors is locus of control. So, if you feel that you have control on your place of work what you do what you cant do, your hours of work can they change, can you easily take leave, are you in control of your own professional but also your personal or is there someone else who takes over that for you. So authoritarian. So, if I understand because you did not explain the Likert score.

Me: ehe because you were not here it is from 1- 4, 1 being strongly disagree and 4 strongly agree

Speaker 7: so higher scores say there is more stress in public practice. So that correlates. I would expect that there is less job satisfaction in public practice

Me: yes

Speaker 7: and probably...

Me: so, these were the administrative burden, the interest in work

Speaker7: because it was a bit difficult to get involved

Me: yes ok

Speaker 7: so basically, what you are seeing is what we found, I mean did you read my study the one I published in 2008 because we looked at a large number of variables and we found a large number of factors. We do actually suggestions for further studies and policies. I mean in wonder whether you were aware of my study yourself because what you are seeing here is basically a repeat of that it is basically you have higher satisfaction in private practice; you have more stress in public, you feel less accomplishment in public. These things were already looked into

Speaker 5: this study was in 2008 e

Speaker 7: yes, but then if you already know it and you are doing a new study you try to find things that you didn't have answers for new answers, so the usual approach is to do a qualitative approach to understand and explore the variables and then you measure them with a questionnaire. This is in some way the other way round. But maybe you should look at my study because you are finding things. We looked at the three dimensions of burnout emotional exhaustion, autonomy and

personal accomplishment and you tend to have more of a feeling of personal accomplishment in the private practice so that what you are doing is useful but then on the their hand you tend to have more of an emotional burden and that is maybe you tend to get more involved with patients and the personalisation I believe was yeah feeling detached from patients. For example, one of the predictors for that was actually years in practice. So, there is a lot of data which came out from that study and which also, I also did the literature review at the time myself. So maybe looking at that you will also get some information about the correlation. But what I'm seeing here is more or less what I picked up around 20 years ago. Im not much less said. Gifieri jiena I don't want to give personal experiences of what I thought and how I feel I mean the administrative burden in a sense is greater in the private practice because you have to pay for the things youre using, you have to purchase the things you are using, you have to fill in a tax sheet. Jiena I have a clinic to run, you have to take care of a business but at the end of the da what's the purpose. I hear people how much they earn and not loosing patients. I mean that's fine if that's your only source of income and you're in the private practice, you are in competition with others you don't want to lose patients. On the other hand, what's the purpose of this exercise. I mean in my opinion its giving people what they want. The customer comes with a request, and you give them what they want. At the same time, you have to take care of your own life. These days I work evenings twice a week; I work mornings 4-5 times a week and weekends are free. In the past I used to work 80 hours a week. You can't keep that up. So at the end of the day, I have no problems not being available 24/ 7 for patients but when they want an opinion they will come to me as a specialist in family medicine and to help them understand and to help them organise advice they have been given or else seeing a new condition and maybe you come to a diagnosis and management. But the fact that I am my own boss is helpful, and I think that is one of the things that really helped me to feel better at what I do. I hope that's useful.

Me: yes, thank you. The last satisfaction question was in fact about effort and reward balance with public GPs having a lower satisfaction score and so the last question from my end is how does imbalance between effort and reward effect satisfaction especially in the public practice and how can this be improved?

Speaker 4: one of the issues we continue mentioning is continuity and that is something annoys most of us. Annoys patients and it does bother us. In fact, one of the proposals that we are working on is the gp appointment clinics which solves part of the problem and remove walk in clinics. At the moment is like everyone going to the grocer coming b the health centre and saying ah I need to check my blood pressure. So that is what is happening at the moment. The go appointment clinics won't save the world but at least they help regulate some of the problem and it will even help with satisfaction. That will solve part of the problem. More or less, what is happening in the community clinics. Most of you work in community clinics and you know what happens. Patients start asking for you and you like it. Again and again, there is a sort of continuity. Ideally that will be all around in the health centres. It is one of the main pushes.

Speaker 8: yes, I work quite frequently in the community clinics. And the satisfaction that I get from working there. I mean the patients start getting used to you. Because if you're in the health centre seeing one after the other. The fact that that in these clinics you get to know the, I mean I have had a patient frequently that have an appointment, realize that it is not me and schedule another appointment just to see me again so they want to see the same doctor . they really appreciate this. Abroad there is g registration so that is something that we can look into in the future.

Speaker 7: I'm a bit surprised I mean the pillars have been known since the 70s in primary care you have the first contact and longitudinal continuity and coordination between riary and secondary. They come back to you and comprehensiveness. So the more you can do in primary care the better. You would expect that referral would be less that 5%. But now a much higher referral rat. People are

being pushed to refer. That is not good medicine. And it reduced the continuity of care because who can give. I cannot understand how politicians how this hasn't been fixed. And the reason is that when they originally set up in the private practice. Not that I want to be political but I'm not afraid neither. Moving on from the district medical officer who was actually a doctor by the gov. this a system from the knights. So they got its right in the medieval period. But instead, it was changed by implementing health centres and the community has been destroyed. I don't know whether the politicians doing these decisions know any science and the science is clear. I am not surprised we are all deteriorating in this country.

Me: thanks a lot an hour has passed. Thanks a lot for you input.

Appendix H: Key Tables from Dataset

Nonparametric Tests

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig. ^{a,b}	Decision
1	The distribution of I feel that some parts of my work do not really make sense is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	<.001	Reject the null hypothesis.
2	The distribution of My work still interests me as much as it ever did is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	<.001	Reject the null hypothesis.
3	The distribution of My work is overloaded with unnecessary administrative detail is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.052	Retain the null hypothesis.
4	The distribution of I have too much stress in my current job is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.007	Reject the null hypothesis.
5	The distribution of being a GP is a well respected job	Independent-Samples Mann-Whitney U Test	<.001	Reject the null hypothesis.
6	The distribution of In my work there is a good balance between effort and reward is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	<.001	Reject the null hypothesis.
7	The distribution of Average Satisfaction Score is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.034	Reject the null hypothesis.

a. The significance level is .050.

b. Asymptotic significance is displayed.

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig. ^{a,b}	Decision
1	The distribution of How many hours per week do you work as a GP? is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.118	Retain the null hypothesis.
2	The distribution of How many of these hours do you spend on direct patient care (consultations, home visits, telemedicine) (Hours) is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.220	Retain the null hypothesis.
3	The distribution of How many face to face patient contacts do you have on a normal working day? is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.378	Retain the null hypothesis.
4	The distribution of How many patients call you on a normal working day? is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.006	Reject the null hypothesis.
5	The distribution of How many patients send you an email on a normal working day? is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	<.001	Reject the null hypothesis.
6	The distribution of How long does a regular clinic consultation normally take? (Minutes) is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.005	Reject the null hypothesis.
7	The distribution of Number of house visits per week is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.002	Reject the null hypothesis.
8	The distribution of Number of patients seen in hospital per week is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.382	Retain the null hypothesis.
9	The distribution of Number of patients seen in homes for the elderly is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.867	Retain the null hypothesis.
10	The distribution of Number of patients seen in outhor institutions or settings per week is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	.148	Retain the null hypothesis.
11	The distribution of Call duties evenings (hours) is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	<.001	Reject the null hypothesis.
12	The distribution of Call duties nights (hours) is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	<.001	Reject the null hypothesis.
13	The distribution of Call duties weekends (hours) is the same across categories of Type of GP.	Independent-Samples Mann-Whitney U Test	<.001	Reject the null hypothesis.

a. The significance level is .050.

b. Asymptotic significance is displayed.

Case Processing Summary

	Type of GP	Cases					
		Valid		Missing		Total	
		N	Percent	N	Percent	N	Percent
I feel that some parts of my work do not really make sense	Public	38	97.4%	1	2.6%	39	100.0%
	Private	30	96.8%	1	3.2%	31	100.0%
My work still interests me as much as it ever did	Public	38	97.4%	1	2.6%	39	100.0%
	Private	30	96.8%	1	3.2%	31	100.0%
My work is overloaded with unnecessary administrative detail	Public	38	97.4%	1	2.6%	39	100.0%
	Private	30	96.8%	1	3.2%	31	100.0%
I have too much stress in my current job	Public	38	97.4%	1	2.6%	39	100.0%
	Private	30	96.8%	1	3.2%	31	100.0%
Being a G is a well respected job	Public	38	97.4%	1	2.6%	39	100.0%
	Private	30	96.8%	1	3.2%	31	100.0%
In my work there is a good balance between effort and reward	Public	38	97.4%	1	2.6%	39	100.0%
	Private	30	96.8%	1	3.2%	31	100.0%
Average Satisfaction Score	Public	38	97.4%	1	2.6%	39	100.0%
	Private	30	96.8%	1	3.2%	31	100.0%

Appendix H: Overview of Articles in Literature Review

Article (Year)	Subject(s)	Data Collection Method
Deng et al (2024)	Remuneration, Policy	Systematic Review and Meta-analysis
Thielmann et al (2024)	Leadership, Workload	Quantitative
Gjessing et al (2024)	Workload, Work Life Balance	Quantitative
Grant et al (2024)	Team Implementation	Literature Review
Thomas et al (2023)	Doctor-Patient Relationship, Patient-Centered Care	Mixed
Schmidt et al (2023)	Leadership	Quantitative
Buffel et al (2023)	Team Implementation, Workload	Quantitative
Bodendieck et al (2022)	Work Life Balance, Burnout	Quantitative
Bodendieck et al (2022)	Work Life Balance	Quantitative
Jackson Physician (2022)	Effort Reward, Finance, Work Life Balance	Quantitative
Fang et al (2022)	Effort Reward, Retention	Quantitative
Gobel et al (2022)	Work Life Balance	Quantitative
Villarreal et al (2022)	Workload, Burnout, Mental Health	Quantitative
Dutheil et al (2021)	Burnout, Mental Health	Quantitative

Preiser et al (2021)	Leadership	Quantitative
Govender et al (2021)	Patient Preference	Qualitative
Naehrig et al (2021)	Mental Health	Systematic Review
Werdecker et al (2021)	Burnout	Quantitative
Ferreira et al (2021)	Burnout	Quantitative
Kuipers et al (2021)	Patient-Centered Care	Mixed
Glenister et al (2021)	Patient Preference	Qualitative
Zaresani et al (2020)	Digital Health	Quantitative
Anderson et al (2020)	Work Place Climate, autonomy	Qualitative
He Rongxin et al (2020)	Policy, Effort Reward, Work Life Balance	Systematic Review
Weinmayr et al (2020)	Team	Qualitative
Xu et al (2020)	Mental Health	Quantitative
Niazkhan et al (2020)	Digital Health	Systematic Review
Damarell et al (2020)	Patient-Centered Care	Qualitative
Weltermann et al (2020)	Mental Health, Work Life Balance	Quantitative
Cohidon et al (2020)	Organisational Climate, Mental Health	Quantitative
Ab Rahman et al (2019)	Multifactorial	Quantitative
Rosta et al (2019)	Multifactorial	Longitudinal and Quantitative
Stobbe et al (2019)	Multifactorial, SPF Theory	Mixed
Chowhan James et al (2024)	SPF Theory	Quantitative
Le floch et al 2019	Autonomy	Qualitative

Appendix I: QUALICOPC questionnaire for general practitioners:

QUALICOPC questionnaire for general practitioners:

1) Are you male or female?

- Male Female

2) What is your age group?

- 25 - 35 36 - 45 46-55 56+

3) Are you a private or public GP?

- Private Public

4) For private GPs:

What is the size of your practice population in private practice? (an estimate is enough)

If you do not have a formal list please estimate the number of people that normally rely on you for primary medical care

5) To what extent do you think your practice population compares to the average national level with respect to the following categories?

Elderly people (over 70)

- Below Average Average Above Average Don't Know

Socially disadvantaged people

- Below Average Average Above Average Don't Know

Ethnic minority people

- Below Average Average Above Average Don't Know

6) To what extent do you think that practice turn over compares to other practices in Malta:

Below Average Average Above Average Don't Know

7) How many hours per week do you work as a GP?

8) How many of these hours do you spend on direct patient care (consultations, home visits, telemedicine)

_____ (hours)

9) How many patient contacts do you have on a normal working day?

Face to face (*per day*) _____

By telephone (*per day*) _____

By email (*per day*) _____

10) How long does a regular clinic consultation normally take?

_____ (minutes)

11) In a normal working week how many patients do you see?

At home visits (per week) _____

In hospital (per week) _____

In homes for the elderly (per week) _____

In other institutions or settings (per week) _____

12) In the past 3 working months, how often and for how long did you have on call duties during evenings, nights, or weekends?

During evenings (*total hours*) _____

During nights (*total hours*) _____

During weekends (*total hours*) _____

13) Besides your work as a GP do you have any other paid professional activities?
(multiple answers possible)

- No
- Yes as a physician in private practice (contract B)
- Yes as a company doctor
- Yes in teaching medical students or trainee
- Yes/ other

14) For each of the following components please estimate whether they contribute to your income as a GP, and if so up to what percentage?

Salary (*percent*) _____

Capitation payments (*a fixed sum of payment per patient for a certain period of time*) (*percent*) _____

Fee for service from third party payer (*percent*) _____

Out of pocket payments from patients (*percent*) _____

Performance payments (for instance related to targets) (*percent*) _____

Other sources (*percent*) _____

15) Can you receive an extra financial incentive of bonus for:

- | | | |
|--|------------------------------|-----------------------------|
| Management of patients with diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Management of patients with HT | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Achievement of targets for screening of prevention | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Referral rates below a certain level | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Having disadvantaged patients in your practice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

16) Do you work alone or in a group? Or other health care professionals?

- Alone
- In group with other GPs
- Other healthcare professionals

17) Which of the following disciplines are working in your practice/ center?

- Receptionist
- Practice Nurse
- Community Nurse
- Psychiatric Nurse
- Nurse Practitioner
- Lab Assistant
- Manager of the Center or Practice
- Midwife
- Physiotherapist
- Dentist
- Pharmacist
- Social Worker

18) Do you use clinical guidelines for the treatment of the following?

- | | | |
|----------|------------------------------|-----------------------------|
| HF | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| COPD | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

19) In the past 12 months have you been involved in a disease management program for patients with the following chronic conditions? (such programs are multidisciplinary approaches across practices, often based on protocols)

- | | | |
|------------|------------------------------|-----------------------------|
| Chronic HF | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| COPD | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

20) In the past 12 months has the following occurred in your practice/ health center?

Feedback on your prescriptions or referrals by health authority or insurer

- Yes No

Feedback by colleague GP (peer review or practice visitation)

- Yes No

Investigation into the satisfaction of your patients

- Yes No

21) In cases of referral who usually decides where the patient is referred to?

- I do The patient does It is a shared decision

22) In cases of referral, to what extent do you take into account the following considerations?

The patient's preference where to go

Always Sometimes Average

Your previous experiences with the medical specialist

Always Sometimes Average

Comparative performance information on medical specialists

Always Sometimes Average

Waiting time for the patient

Always Sometimes Average

Cost for the patient

Always Sometimes Average

23) Please tick the equipment used in your practice/ health center by yourself or your staff:

Laboratory

- Haemoglobinometer
- Any blood glucose tests set
- Any cholesterol meters
- Blood cell counter

Imaging

- Ophthalmoscope
- Proctoscope
- Otoscope
- Gastroscope
- Sigmoidoscope
- X ray
- Ultrasound
- Microscope

Functions

- Audiometer
- Peak flow
- Spirometer
- ECG
- BP monitor
- Infusion set

Other

- Urine catheter
- Set for minor surgery
- Suture set
- Defibrillator
- Disposable syringes
- Cryogen
- Refrigerator for medicines
- Resuscitation equipment

24) What access do you have to lab facilities? Within the practice, easy access outside, difficult access

- Within the practice Easy access outside Difficult access

25) What access do you have to X-Ray? Within the practice, easy access outside, difficult access

- Within the practice Easy access outside Difficult access

26) How many hours on average is your practice/center open for patient care?

_____ (hours)

27) Is it possible to visit your practice?

After 6pm

- Yes No

On a weekend day

- Yes No

28) During evenings and nights on weekdays what access do your patients have to non-emergency medical services

- I am not available
 I am always available
 I am available on a rota basis with the gp group
 I am not available but other GPs in my group are
 Other arrangements are available

29) On Saturdays and Sundays, what access do your patients have to non-emergency medical services

- I am not available
- I am always available
- I am available on a rota basis with the gp group
- I am not available but other GPs in my group are
- Other arrangements are available

30) What percentage of your patient consultation are by appointment (public GPs to consider community and subspecialty clinics)

_____ (percentage)

31) In the past 12 months have you ever done the following to reduce the financial burden on the patients?

Provide free samples of medications.

- Yes No

Prescribe the cheapest equivalent.

- Yes No

Not charge the patient

- Yes No

32) In the past 12 months how often do you notice that patients delay their visit for financial reasons?

- Frequently Occasionally Never

33) If new patients enter your practice do you receive their medical records from their previous doctor?

- Yes Always Occasionally Rarely or Never

34) Which restrictions do you apply to accepting new patients?

- No Restrictions
- No new patients are taken above a maximum number
- No new patients are taken above a certain age
- No new patients are taken outside my geographic area
- I use a wait period for new patients
- Acceptance depends on patient's medical history
- Acceptance depends on patient's insurance status.

35) Do your medical records normally include the following information?

- Living situation
- Ethnicity
- Patients' family history
- Patients' weight and height
- Smoking status
- Blood pressure.
- Reason for encounter
- Diagnosis
- Prescribed medications
- Test results.

36) How do you keep patients' medical records?

- I keep records except for minor or trivial complaints
- I only keep records for regularly attending patients
- I keep records unless I am too busy
- I keep records routinely for all patient contacts
- Don't know

37) In the past 2 years have you used your medical records to list a selection of patients on the basis of age, diagnosis or risk?

- No
- Yes, by age.
- Yes, by diagnosis or health risk
- Yes, by medications they take, yes to send reminders for follow up

38) For which of the following do you use computer in your practice?

- Not applicable (I don't use a computer)
- Making appointments
- Issuing drug prescriptions
- Keeping records
- Sending referral letters to medical specialists
- Storing diagnostic test results
- Searching medical information on the internet
- Sending prescriptions to the pharmacy

39) How often do you meet face to face with the following professionals: (*per month*)

- Other GP
- Practice nurse
- Ambulatory medical specialists
- Hospital medical specialists
- Pharmacist
- Home care nurse
- Midwife
- Physiotherapist
- Social worker
- Dietician

40) How often do you ask for advice from the following specialists?

- Paediatrician
- Internist
- Gynaecologist
- Surgeon
- Neurologist
- Dermatologist
- Geriatrician
- Psychiatrist
- Radiologist

41) Does your practice nurse or assistant independently provide?

Immunization.

Yes No

Health promotion.

Yes No

Routine checks in chronic diseases.

Yes No

Minor procedures (like ear syringing and wound treatment)

Yes No

42) To what extent do you use referral letters when you refer patients to other specialists?

- For all patients that I refer,
- For most patients that I refer,
- For a minority of patient,
- Seldom or never

43) To what extent do specialists inform you after they finished the treatment or diagnosis of your patients?

Always Usually Occasionally Seldom

44) After a patient has been discharge how long does it usually take to receive a discharge summary or report?

- 1- 4 days
- 5- 14 days
- 15- 30 days
- More than 30 days
- I have to look it up

45) For the following health problems, to what extent will patients in your practice population/ health center contact you or present at your clinic as the first health care provider? (this is only about the first contact not about further diagnosis or treatment)

Child with severe cough.

- Always Usually Occasionally Seldom

Child aged 8 with hearing problems.

- Always Usually Occasionally Seldom

Woman aged 18 asking for OCP.

- Always Usually Occasionally Seldom

Man aged 24 with stomach pain.

- Always Usually Occasionally Seldom

Man aged 45 with chest pain.

- Always Usually Occasionally Seldom

Woman aged 50 with a lump in her breast.

- Always Usually Occasionally Seldom

Woman aged 60 with deteriorating vision.

- Always Usually Occasionally Seldom

Woman aged 60 with polyuria.

Always Usually Occasionally Seldom

Woman aged 60 with acute symptoms of paralysis/ paresis.

Always Usually Occasionally Seldom

Man aged 70 with joint pain.

Always Usually Occasionally Seldom

Woman aged 75 with moderate memory loss.

Always Usually Occasionally Seldom

Man aged 55 with sprained ankle.

Always Usually Occasionally Seldom

Man aged 28 with a first convulsion.

Always Usually Occasionally Seldom

Anxious man aged 45.

Always Usually Occasionally Seldom

Physically abused child aged 13.

Always Usually Occasionally Seldom

Couple with relationship problems

Always Usually Occasionally Seldom

Woman aged 50 with psychosocial problems.

Always Usually Occasionally Seldom

Man aged 32 with sexual problems.

Always Usually Occasionally Seldom

Man aged 52 with alcohol addiction problems.

Always Usually Occasionally Seldom

46) To what extent are you involved in treatment and follow up of patients in your practice population with the following diagnoses (practice population means people who normally apply to you for primary medical care)

Chronic bronchitis/ COPD

Always Usually Occasionally Seldom

Hordeolum

Always Usually Occasionally Seldom

Peptic ulcer

Always Usually Occasionally Seldom

Herniated disc lesion

Always Usually Occasionally Seldom

Congestive heart failure

Always Usually Occasionally Seldom

Pneumonia

Always Usually Occasionally Seldom

Peritonsillar abscess

Always Usually Occasionally Seldom

Parkinsons disease

Always Usually Occasionally Seldom

Uncomplicated diabetes type 2

Always Usually Occasionally Seldom

Rheumatoid arthritis

Always Usually Occasionally Seldom

Depression

Always Usually Occasionally Seldom

Myocardial infarction

Always Usually Occasionally Seldom

47) To what extent are the following activities carried out in your practice population by you or your staff and not by medical specialists (for example If fundoscopy is always or almost always done by you tick that box)

Wedge resection of ingrowing toenail

Always Usually Occasionally Seldom

Removal of sebaceous cyst from the hairy scalp

Always Usually Occasionally Seldom

Wound suturing

Always Usually Occasionally Seldom

Excision of warts

Always Usually Occasionally Seldom

Insertion of IUD

Always Usually Occasionally Seldom

Fundoscopy

Always Usually Occasionally Seldom

Joint injection

Always Usually Occasionally Seldom

Strapping an ankle

Always Usually Occasionally Seldom

Cryotherapy

Always Usually Occasionally Seldom

Setting up an intravenous infusion

Always Usually Occasionally Seldom

48) When do you or your staff measure blood pressure? (more than one answer can be given)

- In connection with relevant clinical conditions
- On request
- Routinely in clinic contacts for adults regardless of their reason for visit
- In adults invited for such purpose

49) When do you or your staff measure blood cholesterol levels? (more than one answer can be given)

- In connection with relevant clinical conditions
- On request
- Routinely
- In adults invited for this purpose
- No such measures

50) To what extent are you involved in health education on the following topics? (more than one answer can be given)

- Not involved in connection with normal patient contacts in gp sessions
- Smoking
- Diet
- Problematic use of alcohol
- Physical exercise

51) Are you or your medical staff involved in the following activities? (not medical specialists)

- Routine antenatal care
- Immunization of children (as part of the program)
- Pediatric surveillance in children under 4 years
- Influenza vaccination as part of the program
- Palliative care

52) In the past 12 months have you offered special sessions or clinics to the following groups?

- | | | |
|---------------------|------------------------------|-----------------------------|
| <u>Diabetes</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <u>Hypertension</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <u>Pregnant</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <u>Elderly</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

53) If you were confronted through your patients' contacts with the following occurrences, would you report this (for example to the authority)?

- Repeated accidents in an industrial setting
- Frequent respiratory problems in patients living near certain industry
- Repeated cases of food poisoning

54) In the past 12 months about how many weeks altogether have you been away from your practice / clinic due to.

- Attending conferences or other educational activities
- Research activities
- Vacations
- Illness

55) To what extent do you agree with the following statements?

I feel that some parts of my work do not really make sense

- Strongly Agree Agree Disagree Strongly Disagree

My work still interests me as much as it ever did

- Strongly Agree Agree Disagree Strongly Disagree

My work is overloaded with unnecessary administrative detail

- Strongly Agree Agree Disagree Strongly Disagree

I have too much stress in my current job

Strongly Agree Agree Disagree Strongly Disagree

Being a GP is a well-respected job

Strongly Agree Agree Disagree Strongly Disagree

In my work there is a good balance between effort and reward

Strongly Agree Agree Disagree Strongly Disagree