VALIDATION OF THE MALTESE VERSION OF THE EUROPEP INSTRUMENT FOR PATIENT EVALUATION OF GENERAL PRACTICE CARE.

A thesis submitted in partial fulfillment of the requirements for the degree of

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I the undersigned declare that this dissertation is my own original work and was carried out under the guidance and supervision of

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Summary

It is now accepted, both by the medical profession and by government and non-government organisations dealing with health care, that patient evaluations can make an important contribution towards the improvement of health care services. EUROPEP is an internationally validated 23-item questionnaire that has been used successfully throughout Europe in national, regional and local surveys for measuring patient evaluations in primary health care.

The aim of this thesis is the validation of the Maltese version of the EUROPEP instrument for patient evaluation of general practice care. It will attempt to measure patient satisfaction using a methodology that has been specifically developed for this purpose. This is the first such study in Malta.

In addition, the thesis aims to establish a reliable, verifiable and unambiguous Maltese text of the 23-item questionnaire of the EUROPEP instrument. It will also seek to establish the validity of the translation and the reliability of the EUROPEP questionnaire when applied to Maltese patients by conducting a pilot study for this purpose. Finally, the thesis will attempt to prove the reliability and consistency of the Maltese version of the EUROPEP instrument by comparing the results obtained from its application in Malta with those obtained from EUROPEP's application in other European countries. This comparison is extended to the results obtained by the European Health Interview Survey carried out in Malta in 2008.
The EUROPEP questionnaire was translated, forward and backward, by two independent professional translators. The Maltese version was then tested for possible ambiguities and misunderstandings using a pilot group of fifteen persons. The final Maltese version was agreed and validation of the translation was completed.

The reliability of the Maltese EUROPEP questionnaire was tested using the Intra Class Correlation Coefficient test. All questions scored 0.8 or more on this scale. The reliability of the Maltese EUROPEP was also tested with a group of twenty-three persons. These were interviewed by telephone individually, on two occasions with an interval of four weeks between each interview. Transcripts of the replies to both interviews were compared and found to correspond perfectly.

Taking into account the objectives of the study and various statistical assumptions, the sample population was established at 239 randomly selected Maltese nationals over the age of eighteen. The sample was obtained from the latest edition of the Maltese electoral register.

Telephone interviews were carried out by five professionally trained public relations officers, who were especially trained over a three-week period to conduct telephone interviews, and who had the objectives and contents of the EUROPEP instrument clearly explained to them.

In addition to the 23-item questionnaire of EUROPEP, those interviewed were
asked 9 additional questions concerning gender, age, health status, chronic illnesses, location and frequency of visits to general practitioner, in order to facilitate the analysis of the results.

Once all the interviews were carried out, the results of the EUROPEP were pooled together and compared using the Cronbach α (alpha). This revealed internal consistency of the scales. The response rate was 74.45%, which compares well with the response rates obtained by EUROPEP in various European countries, and with the response rate of the European Health Interview Survey that was carried out in Malta between June and August 2008.

The gender distribution of the respondents, their educational attainment, their perceived health status, their chronic condition, and the distribution by general health care provider, were analysed. The results obtained by the Maltese version of EUROPEP were found to tally with corresponding distributions in the Health Interview Survey 2008. There was also a high level of correlation between these results and those obtain by EUROPEP in ten other European countries. These results confirmed the reliability of the Maltese version of EUROPEP.

The scores obtained by the Maltese version of EUROPEP for patient evaluation in the five dimensions of primary health care covered by the EUROPEP questionnaire could be confirmed by comparisons with the scores for similar dimensions in ten European countries where the EUROPEP questionnaire was used. These results could also be
confirmed by comparisons with the statistics provided by the Health Interview Survey 2008. Thus the study confirmed the validation of the Maltese version of EUROPEP.
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Introduction

The debate on the reform of the primary health care system in Malta has been going on for some time. Recently various proposals on reforming primary care came from both the medical profession, in particular the Malta College of Family Doctors, and the Department of Primary Health Care and in particular the Patient Registration Task Force that has been set up by government in August 2008. However, patients have also been contributing substantially to this debate. As patients become more educated, and quite knowledgeable in managerial skills, they do not hesitate to voice their opinion on how the primary health care sector can be better managed in order to increase efficiency and patient satisfaction.

Comments from patients and laymen are sometimes spurious and may result from a lack of knowledge of medical exigencies; however, they also indicate the areas of the general practice where patients and the general public express most dissatisfaction, and which are those in the most urgent need of reform. The objective of this thesis is the validation of the Maltese version of the EUROPEP which is an instrument to measure patient evaluation of general practice care. This is the first study that looks at patient evaluation into general practice in Malta, using an internationally validated and standardised instrument.

In order to achieve this objective this thesis will first attempt to establish a reliable and unambiguous Maltese text of the 23-item EUROPEP questionnaire. As part of the preparatory research two pilot studies were conducted, one to test the clarity of the translated text, and the other to check the validity of the questionnaire when applied
to Maltese patients. In a parallel study, the thesis will also seek to prove the reliability and consistency of the Maltese version of the EUROPEP instrument by comparing the results obtained in Malta with those obtained by EUROPEP in other European countries, and with the results of other surveys on primary health care in Malta, in particular the European Health Interview Survey 2008.

Ultimately the health system to be accepted by its users has to reflect and respond to their needs be they perceived or otherwise. Patients' observations and comments are fundamental. Patients sometimes express a high level of satisfaction for the care they receive. This points to elements in the primary care practice where the profession is in the right direction and is providing a valuable and appreciated service. On the other hand, patients sometimes express dissatisfaction. The medical profession and the government providing the service should not take this criticism too badly and interpret it as a sign of lack of gratitude or understanding from the recipients of care. One should look positively at these signs of dissatisfaction and try to identify their causes.

The EUROPEP instrument has been translated and adopted into Maltese. It is a valid scientific instrument used for measuring patient evaluation of primary health care. This measurement is conducted through a set of 23 validating and internationally standardised questions. The research is based on the patient response to these 23 items. EUROPEP's standardized questions have been translated into Maltese by accredited translators following clearance from EUROPEP authorizing the use of its questionnaire. The patients' response has been gathered by means of a phone interview with randomly selected individuals.
Following a detailed analysis of the information thus collected, the thesis will identify aspects of the general practice which have been positively evaluated by patients and those where patient appreciation is not so positive. Based on this patient evaluation the thesis will conclude by making suggestions for amendments and improvements to the general practice system in Malta.

For the objective of this thesis, it is important to provide background information on the primary health care sector in Malta and on the concept of patient satisfaction in general practice. With regard to the first of these items the thesis will begin by providing the salient features of the Maltese geographical, social and economic environment in which the general practitioner/family doctor has to function. The thesis will then describe the characteristics of the two systems of general/family practice in Malta, namely the public and the private systems, and how they complement and supplement one another in covering the health needs of the population.

In the second section the thesis will deal with the search for a definition of patient satisfaction and will attempt to present what is the most widely accepted concept of patient satisfaction. In doing so it is important to start with the definition of general practice and with an account of the core duties of the general practitioner. An analysis of how the carrying out of these duties meets the expectation of patients will lead to the definition of the concept of patient satisfaction. It is important to get this analysis right because on it is built the questionnaire that is intended to measure patient evaluation of the general practice. The patient's perspective is paramount to the validity of the conclusions of this research.
Section three will consist of a literature review of the most important research that has been carried out, particularly over the last decade, leading to the development of a reliable instrument for measuring patient evaluation of primary health care.

In sections four and five, the thesis will proceed with a presentation of the methodology used for this research. As already indicated it will make use of the EUROPEP instrument, and therefore section four gives a description of this instrument highlighting its validity and international acceptance. Then section five will present a description of the methodology used to adapt the instrument to the Maltese context, in particular the specificities of the typical Maltese patient. This will be followed by a detailed description of how the actual research was carried out, how the items of the questionnaire were validated and tested for internal reliability, the sample of population interviewed and the conditions under which the interviews took place. The safeguards taken in order to ensure the objectivity and the validity of the replies given will also be described.

Section six of the thesis will deal with the results of the research. The replies from patients will be sorted and sifted to gather the relevant points put forward by those interviewed. These points will be analyzed and related to actual situations of the general practice in Malta.

Section seven will conclude with a detailed description and analysis of the above results and their interpretation. A set of recommendations for adaptations or improvements of the general practice system in Malta will be drawn. It is hoped that these recommendations will make a valid contribution to the current debate on how to
reform the primary health care sector in Malta.
Section 1

General/Family Practice in Malta

Background

The Maltese archipelago is made up of three main islands, Malta, Gozo and Comino. The total population of the Maltese Islands, according to the latest population census (2005) is 404,962. Malta with a population of 373,955, is the largest of the three inhabited islands. The Maltese Islands occupy an area of 316 square km. This gives the Islands a population density of 1,250 per square km., one of the highest country population densities in the world. (Malta population census 2005)

Malta scores high on the Human Development Index with a life expectancy of 76 years for males and 80 years for females, which compare well with the EU average of 75.5 for men and 82 for females. The infant mortality rate is 6.1 per 1000 live births. The birth rate has been steadily declining and is currently 11.6 live births per 1000 population, one of the lowest among Mediterranean countries, and slightly higher than the EU average, which are 10.7 live births per 1000 population. The death rate is 7.6 per 1000 (NSO Statistics 2007) the male to female ratio is 0.98. The dependency ratio is 44.7 per cent. (WHO Regional Statistics Databases 2009)

Circulatory diseases are the major causes of mortality and morbidity, accounting for 46 % of all deaths and 8 % of hospital admissions. Within this category the major killers are ischemic heart disease, which causes 25 % of all deaths, and cerebrovascular
diseases, which cause 11% of deaths. Cancer (malignant neoplasm) is the second cause of mortality, accounting for 25% of deaths. However, overall, the incidence of cancer in Malta is lower than the EU average. Diabetes is a significant national problem with a prevalence of 10.3% in adults over the age of 35 years old. Infectious and parasitic diseases account for 5.6 deaths per 100,000 population. In total non communicable diseases account for 89% of deaths and 87% of the disease burden. (WHO Regional Statistics Databases 2009)

Health risks in Malta are primarily related to life style. Smoking related deaths are estimated at 302 per 100,000 each year, compared to 229 EU average. However, smoking is on the whole decreasing as a result of intensive campaigns by the health public authorities and of legislation prohibiting smoking in all public places, including cafes and restaurants. Obesity poses a significant health risk among the Maltese population, with 34 per cent of women and 22 per cent of men being classified as obese. About 72,200 persons have been identified as suffering from long term illnesses or health conditions. In addition about 23,800 persons suffer from a long term disability, with sight impairment being the highest form of disability. (Health Information Survey summary statistics 2008)

The total expenditure on health in Malta amounts to 8.8% of GDP, which roughly equal the EU average. (Malta Government budget 2008) Just over 68% of this total expenditure is financed from public funds, with only about 31.5% coming from voluntary health insurances and out-of-pocket fees. Recurrent public health expenditure amounts to nearly 13% of total Government expenditure. In the 2009 Budget €333696000 are earmarked for the health sector. It is to be noted that expenditure on
health has been steadily rising and the public system for financing health services has to deal with problems of insufficient funding as both demand and costs continue to increase.

The health sector is one of Malta's largest employer, employing 11,360 persons, that is about 7% of the total workforce. Hospital beds amount to 496 per 100,000 of population. Ward admission reaches nearly 90,000 per year, about 54% of which are new patients. Surgical operations performed in the principal state hospital amount to nearly 34,000 each year. More than 110,000 visit the emergency department each year, of which only about 20% normally require hospital treatment. Most of those visiting the emergency department, about 72%, are self referred patients. Less than 27% are referred by their GP. (Ministry of Health, the Elderly and Community Care annual report 2006)

The number of registered practitioners is about 1,150, that is, about 287 per 100,000 population. This compares well with the EU average. This includes about 60 foreign physicians/surgeons engaged by government. 81% of registered medical doctors are male and 19% are females; however, the number of female practitioners is increasing rapidly. Nearly 40% have a post graduate qualification. About 600 of registered practitioners are employed by government, the rest are either in private practice or retired. It is estimated that about 270 full-time and 30 part-time medical doctors are engaged in general practice/family medicine. Of these 95 are employed by the Department of Primary Health Care, while the rest practice as solo private practitioners. (Sciortino Ph. MCFD website, accessed on the 14th April 2009)
Public primary health care system

In Malta primary health care is provided by the state health service and by private general practitioners. These two systems of general practice function independently of one another. It has recently been estimated that private practice amounts to about two-thirds of the workload in primary health care. (Health information Survey summary statistics 2008) General practitioners working in the public service are allowed to carry out private practice. This dual system, providing a rich mix of the public and the private sectors, is well accepted by the Maltese.

Until recently General practitioners are granted a warrant to work on a private basis after completing training in Medicine and Surgery during a five-year university course and after working under supervision for two years as house-physician/surgeon in the government hospital. Vocational or specialist training in general practice/family medicine has only just started and is not a requirement for the local practice of family medicine. However the Malta College of Family Doctors organises regular continued medical education (CME) activities to brief and update current practitioners on the new developments in their specialty. (MCFD website accessed on the 14th April 2009)

The state primary health care system covers general practice, community care, immunization and the school health care service.

Primary health care is offered free of charge at the point of use from government health centres to all the population. This free service is carried out by 50 general practitioners employed by the Department of Primary Health Care. They are available in
8 health centres, which are open 24 hours a day, seven days a week, and 45 village clinics, open for one or two hours on weekdays. They may be visited without any prior appointment on a first-come-first-served basis. There is little to discourage patients from attending for trivialities. The village clinics are mostly attended by patients needing routine prescriptions or sickness certificates. The general practitioners on duty in health centres also carry out domiciliary visits from these health centres, though after 20.00 hours house-calls are restricted to urgent cases only.

Within this system, patients are not registered with their own general practitioner and are seen by the doctor who happens to be on duty at that particular time. This lack of registration leads to a lack of continuity of care and is not conducive to a sound patient-doctor relationship which is one of the fundamental aspects of primary care. Although medical histories are available in the health centres, a substantial number of patients attend for trivialities with entries not always being made in the files. This leads to dissatisfaction for both patients and doctors. The current system is oriented towards curative and episodic care rather than preventative care. Doctors at health centres are facing an ever increasing workload in addition to this unlimited access by patients. Furthermore, most of their workload consists of writing prescriptions, often repeat prescriptions, verifying sick leave and treating minor injuries.

Another consequence of the absence of a patient registration system in primary care is that hospital specialists find it more difficult to discharge patients from their outpatient clinics. Patients therefore tend to be followed up at hospital outpatient clinics rather than in the primary care level. There are plans to set up a single computerized medical record for all patients. Once completed this would not only ensure continuity in
primary health care, but would provide an invaluable epidemiological tool.

In addition to primary care and family doctor service, health centres provide free specialist services in internal medicine, diabetes, psychiatry, ophthalmology, obstetrics, gynaecology, paediatrics and dentistry. They also provide paramedical services such as nursing, midwifery, pharmacy, radiography, podology, speech therapy, and laboratory services. Health clinics also carry out preventive medicine services such as immunization, well-baby clinics, ante-natal care, cervical smears, glaucoma screening, smoking cessation clinics and weight loss clinics.

The 50 - odd general practitioners/family doctors working in primary health centres are directly employed by government and paid on a salaried basis. Nearly all general practitioners working in the public primary health service also carry out their own private practice. Because of their inadequate salary most of them feel it necessary to engage in private practice or as company medical officers while off duty in an effort to supplement their income. This means that they have to work a substantial number of extra hours per week in addition to the time they work at health centres. Amongst junior doctors a placement at a health centre is often viewed as a stepping stone and as an aid to building up a private practice. Indeed, the full complement of health centre doctors is rarely reached because the system is not able to retain them. It will be difficult to replenish this shortage of government general practitioners since the private sector continues to offer more professional satisfaction and better remuneration. However, doctors at health centres appear to be willing to give up their private practice and work exclusively for the public sector if the public system were to be changed to provide job satisfaction and adequate remuneration.
Private primary health care

The proportion of private primary health care has been estimated to be two-thirds of the primary health care workload. Private primary care is provided by general practitioners mostly working in single handed practice. There are about 170 self-employed solo general practitioners, together with a good number of the government employed general practitioners working on a part-time basis. Private General Practitioners rely exclusively on fees for items of service paid directly by the patients. They charge relatively modest fees and the private primary health care service is affordable to the majority of the population. The well established general practitioners have their own private clinics whilst other general practitioners work in clinics/offices based within retail pharmacies which they attend according to specific time tables. Most of the private general practitioners run their service single handedly, without any secretarial or nursing support. A few firms are being established which are specifically contracted by large employers to cover their employees, mostly for purposes of sick leave verification.

The service provided by the private system is perceived to be superior from the point of view of continuity of care. (Health Information Survey – summary statistics 2008) Although there is no formal registration, and record-keeping is not compulsory, private general practitioners have a core of patients who consult them most of the time for all their health needs with satisfactory continuity of care and doctor-patient relationships.

In spite of existing limitations private general practitioners provide their patients with an easily accessible, continuous, person oriented health care which integrates
curative and rehabilitative care, health promotion and disease prevention. They get to know the whole family and provide a more holistic type of care from the physical, psychological and social perspectives. Private General Practitioners do not form part of a multidisciplinary team, and yet they assume responsibility for coordinating referrals to specialists and hospital when the need arises, and become the patient's advocate on all health matters. Within the private system it is easier for general practitioners to act as gatekeepers and to take responsibility for managing all health problems of patients either at primary care level or by referral to specialists or hospitals. However, since patients have direct access to all specialists, especially in private practice, this is not always the case.

Private General Practitioners tend to be well respected in their communities and are still considered as popular personalities in their town or village. This is can be seen from election results for those general practitioners who choose to contest general or local elections.

_On-going proposals for improving General Practice/Family Medicine_

The status of general practice/family medicine in Malta is still lagging behind the standing that it enjoys in most European countries. In many respects general practice/family medicine in Malta remains the Cinderella of medicine and its development lags behind what has been achieved by other traditional medical disciplines. The present state of affairs is largely the result of the insufficient attention given by successive governments and the University of Malta to the evolving needs of family practice. (Sammut M. 1999)
In an attempt to remedy this situation the Malta College of Family Doctors was founded in 1989, with the aim of providing initiatives to upgrade the standards of family practice in Malta. The MCFD is an academic body concerned with improving the status of family doctors and acting as a pressure group to influence the development of undergraduate, post-graduate and continuing education in the area of family medicine. It also aims at promoting quality assurance and research in this area.

In May 1988, the MCFD published a policy document which drew attention to the lack of patient registration, systematic record keeping, teamwork and a cost-effective referral system within well-organised practices. These are all essential to guarantee continuity of care and a strong doctor-patient relationship. The College also stressed the need for a computerised medical records data base, which it helped to prepare and which was launched in 1999.

Besides promoting quality assurance and research in Family Medicine, the MCFD was instrumental in the introduction of education in Family Medicine both at undergraduate and at postgraduate level. In April 2004, the College adopted a policy document on the Specialty of Family Medicine in Malta in which it defined Family Medicine and the requirements for inclusion in the Specialist Register for Family Medicine (SRFM), either through past experience or through accredited training. It also defined the requirement of a Vocational Training Programme for Family Medicine. A distinctive achievement of the College has been the establishment of the Department of Family Medicine at the University of Malta, under the auspices of which a two-year postgraduate course in Family Medicine is being held.
The MCFD is certainly making a most valuable contribution towards upgrading the standards of general/family practice in Malta. However, a holistic approach towards reforming primary health care, which would bring together the government, the University, and representatives of the medical profession, is needed. An analysis of primary health care in Malta reveals a number of gaps in the system that need to be addressed to meet the aspirations of the population for a preventive and curative health care throughout one's lifetime. A major gap is the lack of continuity of care and a weak doctor-patient relationship. Duplication of resources, the lack of a robust and reliable patient record and IT system, limited access by family doctors to state facilities, the lack of a multidisciplinary approach to primary care, insufficient investment in the sector and client abuse of the system are a few other discrepancies that need to be addressed.

Basic to an in-depth reform of Malta's primary health care system is no doubt patient registration. There exists an acute awareness of this need almost among all members of the medical profession and government. An important step in this direction has been the appointment of a Patient Registration Task Force, which has been commissioned to make proposals for a Personal Health System in Malta.

A stronger doctor-patient relationship and continuity of care should also be among the major objectives of a reform of the primary health care sector. A longstanding relationship between the family doctor and his patient and the patient's family is basic to a seamless process of care for the patient. It is also necessary that the envisaged reforms will lead to a stronger gate-keeping role of the family doctor.

Family doctors in Malta are mostly solo practitioners and accustomed to
function in this way. Group practice has its advantages especially when it includes multidisciplinary teams. It may therefore prove beneficial to the provision of health care if conditions are created that will encourage the formation of group practices.

While reforming the primary health care system in Malta one cannot ignore the growing financial deficit and the escalating costs in the provision of primary health care. However, one should also not ignore the well established fact that a sound and efficient primary health care provides long term benefits to the health system. It would certainly be beneficial to avoid duplication of resources, eliminate wastage, ensure cost effectiveness in the use of equipment and restrict patient abuse of the system. However, any underinvestment in the primary health care system can lead to a serious dislocation in the health system as a whole.
Section 2

Definition of Primary Health Care

Definition

The term “Primary Health Care” gained widespread currency following the 1978 International Conference on Primary Health Care held by the WHO and UNICEF at Alma Ata. Since that time primary health care came to mean many different things to different people. However, while recognising this complexity, it is possible to draw from the Alma Ata definition, the principle characteristics of Primary Health Care that have become universally acknowledged.

The Declaration defines Primary Health Care in detail as: “...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community though their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.” (WHO & UNICEF 1978)
Definition of general practice/family practice

Over the years there have been many definitions of the general practitioner/family doctor. One which is very frequently quoted is that of Lueewenhorst from 1974, which reads, “The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families and a practice population irrespective of age, sex and illness. It is the synthesis of these functions which is unique.” Other definitions also focus on the patient as an individual in a family and cultural context, on continuity of care and on the sustained doctor – patient relationship. Most of these definitions describe the particulars of the general practitioner in terms of working methods, such as continuity, comprehensiveness, work in a society, a family approach and good communication.

Olesen (BMJ February 2000) questions such definitions since they do not really differentiate between those doctors who are general practitioners and those who are not.

These considerations lead Olesen to attempt the following definition of general practice: “The general practitioner is a specialist trained to work in the front line of a health care system and to take the initial steps to provide care for any health problem(s) that patients may have. The general practitioner takes care of individuals in a society, irrespective of the patient's type of disease or other personal and social characteristics, and organises the resources available in the health care system to the best advantage of the patients. The general practitioner works with autonomous individuals across the fields of prevention, diagnosis, cure, care and palliation, using and integrating the sciences of biomedicine, medical psychology and medical sociology.” (Olesen, BMJ
Olesen's definition naturally leads to the definition of general practice/ family medicine developed in 2005, by the European Academy of Teachers in General Practice (EURACT) on behalf of WONCA Europe – the European branch of the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians: “General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will always have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in assessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care”.
Section 3

Literature Review

It is important to conduct a brief review of the literature describing the research that has already taken place in the area of patient satisfaction and patient’s evaluation of general practice care. This review will help in the identification of lessons to be learned from past research in order to improve the methodology and conclusions of the present research.

Concept of patient satisfaction

Virtually every organization is concerned with satisfying the users of its products or services, whether these users are clients, customers, consumers or patients. The subject of satisfaction has been extensively studied in the fields of sociology, psychology, marketing and health care management, and though there are differences of approach, depending on the discipline, common themes exist, and current theories of consumer satisfaction could benefit research on patient satisfaction, though one cannot expect marketing theories to apply fully to an evaluation of patient satisfaction. Consumer satisfaction is at the core of modern marketing techniques and its importance is based on the notion that organisations survive and prosper through meeting the needs of their customers.

Consumer satisfaction with health care has become widely recognized as a measure of quality, especially since the publication of the 1983 NHS Management Inquiry and its appeal for the collection and analysis of patients’ opinion. (Department
of Health and Social Security, London 1984). Moreover, there has been a growing tendency for greater involvement of the consumer in health care. With particular reference to health care provision a link has been demonstrated between satisfaction and patient compliance in areas such as appointment keeping, intention to comply with recommended treatment and medication use. (Wilson P., Mc Namara J.1982). Since high quality clinical outcome is dependent on patient compliance, which in turn is dependent on patient satisfaction, the latter has come to be seen as a legitimate health care goal and therefore a prerequisite of quality care. “Put simply, one cannot be high quality unless the patient is satisfied’. (Vuori H. 1987) Therefore satisfying patients is fundamental to health care, and an understanding of the nature of patient satisfaction is needed if health care providers are to deliver quality care.

Consumer satisfaction from the marketing perspective has been examined from two aspects. The first sees consumer satisfaction as the outcome resulting from the consumption. “The buyer's cognitive state of being adequately or inadequately rewarded for the sacrifices he has undergone.” (Howard J., Sheth J. 1967) The second aspect sees satisfaction as a complex evaluative process. “An evaluation rendered that the consumption experience was at least as good as it was supposed to be.’ (Hunt H 1977). This latter approach is now more widely followed since, compared to the outcome-oriented approach, it takes into account the socio-psychological determinants of satisfaction, such as perceptions, evaluations and comparisons that precede the evaluation.

The conceptual model of consumer satisfaction that is most widely accepted is based on a comparison between the individual's pre-purchase expectations and the
actual performance of the product or service. This quality assessment as far as services are concerned comprises consumer perceptions of a number of service attributes, such as:

- reliability: the ability to perform the promised service dependably and accurately
- responsiveness: willingness to help customers and provide prompt service
- assurance: provider's knowledge and courtesy, and ability to inspire trust and confidence
- empathy: caring, individualised attention given to customers
- tangibles: appearance of physical facilities, equipment, personnel, and appearance.

The terms satisfaction and quality assessment are often used interchangeably; however, satisfaction is generally seen as the wider concept. Satisfaction can be viewed either at the level of a single service or at a global level, encompassing one's assessment of one's experiences with an organization or a system. And it is important to stress that the assessment/comparison relates to perceived qualities of the service rendered. Indeed the notion of objective performance is an indefinable state in most cases. “All attribute performance will be judged by the service user in perceptual terms. Even with an apparently objective measure, such a waiting time, it is not so much the absolute time but the evaluation of it, as being long/short, or acceptable/unacceptable, which will always be subjective, dependent on the evaluator” (Thompson A., Sunol R. 1995)

Therefore satisfaction/dissatisfaction results from the comparison between the perception of the quality/performance of the service and the expectation of that quality/performance. The higher one's expectations the less likely it is that they can be
met by the quality/performance of the service, resulting in reduced satisfaction. On the other hand, the lower one's expectations, the more likely that they can be met by the quality/performance of the service. Conversely, the higher one's perception of the quality/performance, the more likely that one's expectations from the service are met, and the lower one's perception of the quality/performance, the less likely it will be that expectations are met. This balance between expectation and perception underlines the subjective nature of the concept of satisfaction and the difficulties involved in measuring and evaluating satisfaction. Hence the attempt by researchers to explain fully the terms expectation and perception.

Researchers are taking a broader view of the term “expectations”. Consumers can hold several different views of expectation, and these can be held within a range of levels rather than at a single level. With regard to services, it is useful to distinguish between three types of expectation. The first is “desired service” which is the level of service the customer hopes to receive. This wished for level of performance results from what the customer believes can be done and should be done. The second type of expectation is described as “adequate service”, which is a lower level of expectation, and it results from the customer's belief that it is not always possible to have the best possible service and his/her acceptance of a lower level of performance. It represents the minimum level of tolerable expectation. The third type of expectation is described as “predicted service” and it is based on the level of service that the customer believes he/she is likely to get. It implies some objective calculation of the probability of performance. (Zeithaml and Bitner 1996)

Together with these three notions of expectation is tied that of the “zone of
tolerance”. Customers recognise that the level of performance can vary, and the extent to which they are willing to accept this variation is referred to as the zone of tolerance. The zone of tolerance is the range within which customers do not particularly notice or comment about the service performance. When, however, performance falls outside this range, either very high or very low, the customer expresses satisfaction or dissatisfaction. Customer tolerance zones vary for different service attributes, and the more important the factor, the narrower the zone of tolerance is likely to be. For example the zone of tolerance with regard to waiting time varies according to the level of discomfort or pain the patient is experiencing and the emergency of the medical assistance that is needed. (Parasuraman A, Berry I, Zeithaml V. 1991)

This analysis of the terms “expectation” and “zone of tolerance” that are tied up to the concept of satisfaction further confirms the subjective nature of the elements that led to satisfaction or dissatisfaction. The variables that can influence the final assessment of the customer are practically limitless, ranging from the personal social and psychological characteristics of the customer/patient to the specific circumstances of the moment in which the service is performed.

Moreover, in addition to expectation other themes have been suggested as determinants of satisfaction. The social equity theory is particularly relevant to satisfaction with services. It suggests that individuals compare their gains, the balance of what they put in and what they get out, with those of other consumers and with those of the service providers. Satisfaction is expressed when the customer perceives that the outcome to input ratios are fair. The equity theory manifests itself mostly with relation to waiting and pricing. Inequitable waiting and pricing are perceived as detrimental to
the consumer and lead to dissatisfaction, while equitable timing and pricing, seen as fair by the consumer, lead to satisfaction. (Fisk R., Young C. 1985)

The concept of equity relates to another suggested determinant of satisfaction, that of social comparison. The theory of social comparison suggests that social comparisons influence the formation and evaluation of opinions. People compare themselves to others in order to support their own conclusions. Comparison with others is often invoked in one's evaluation of a service received. A perceived preference extended to others in service performance leads to dissatisfaction.

Another explanation of dissatisfaction, known as the attribution theory, comes into play when the service fails to meet consumer expectations. This theory assumes that in such cases both the customer and the service provider search for reasons, and usually consumer and service provider refer to different and conflicting reasons. This will result in further dissatisfaction.

Whatever theory is put forward to explain the causes of satisfaction, it is clear that the concept of satisfaction involves both cognitive and affective processes. Perception, including beliefs, are cognitive in nature, that is, processes of knowing and thinking, and represent the information the consumer has at his/her disposal and his/her assessment of it. However, affective processes, such as attitudes and emotions, also play a part in the consumer's assessment. As far as satisfaction is concerned, the expectation process, the comparison of performance to expectations or desires, the judgments based on equity and attribution, are mostly conscious activities and therefore primarily cognitive in nature. The role of the affective components of evaluation and satisfaction
cannot be so clearly defined; however, it is accepted that a variety of emotional responses, such as, joy, excitement, pride, anger, sadness and guilt, play a significant role in determining satisfaction. Indeed, in some cases satisfaction or dissatisfaction can be purely an emotive response.

The concept of consumer satisfaction as developed in marketing theory is no doubt helpful for the development and understanding of a conceptual model of patient satisfaction. However, a growing number of researchers are of the opinion that patient satisfaction and consumer satisfaction are not identical concepts. The marketing-oriented conceptual model does not easily fit and is sometimes inappropriate to the common medical scenario. For example, the comparison between expectation and perceived performance, what is most commonly called in marketing as the disconfirmation theory, is a central component of the process of consumer satisfaction. However, the health care situation is more complex than a simple transaction between a customer and a salesman, or between a consumer and a service provider.

The work of Linder-Peltz (1982) has been particularly influential on the interaction between expectations and perceptions in health care. Data concerning patients' health care values, expectations and sense of entitlement to care were collected for 125 first-time patients at a primary health clinic, immediately before seeing a physician. Post-visit satisfaction with a number of dimensions of care were recorded. This study provided little evidence to suggest that satisfaction is largely the result of fulfilled expectation and values, although expectation was shown to be an important psychological variable in the evaluation of patient satisfaction.
Another important conclusion from the research conducted by Linder-Peltz is that expectations have an effect on patient satisfaction independent of other variables, that is, irrespective of their fulfilment. This suggests that beliefs about doctor conduct prior to the visit/treatment play a significant role in determining subsequent evaluations of the doctor conduct. This finding is relevant to any patient evaluation research since it suggests that knowledge of patients' expectations can tell a great deal on how they would rate a visit/treatment. This does not mean that expressions of satisfaction have little to do with the qualities of the care provided, but it does challenge the assumption that satisfaction is entirely the result of a patient's evaluation of care.

Zeithaml et al (1990) noted that while consumers ultimately judge the quality of the service on their perception of the technical outcome of the service, many professional services are highly complex and a clear outcome is not always evident. This is certainly true of many health care scenarios where the technical quality of the service, that is, the actual competence of the provider and the effectiveness of the outcome, is not easy to judge. The patient may never know for sure whether the service was performed correctly or even whether it was needed in the first place. Moreover, as Williams (1992) has suggested, the more complex the technical nature of the treatment the more likely it is that the patient will not consider himself/herself competent to evaluate the treatment and is likely to adopt a "doctor knows best" attitude. With medical treatment becoming more and more sophisticated and technically complex, patients may more and more be expecting a paternalistic approach from their doctor, while adopting a passive attitude with regard to the evaluation of the treatment. In this case the patient's satisfaction is based almost entirely on this psychological variable.
Another important point to consider in conducting research in patient evaluation of health care is that in situations where the patient cannot judge the technical quality of the treatment, he/she will base his/her judgment on dimensions related to the treatment such as the physical setting of the clinic, the doctor's ability to empathise, time-keeping, courtesy of staff and so on. This implies that patient satisfaction is related to the context, as well as to knowledge about the treatment, to expectations and to outcome. The context has to be taken into consideration in order to arrive at a more correct interpretation of the patient's level of satisfaction.

The zone of tolerance concept as developed in marketing theory seems to be particularly applicable to the health care setting and to developing a conceptual model of patient satisfaction. An indication whether the care provided has been within the zone of tolerance can be seen from the patient's post care attitude. A good surprise experienced by the patient indicates that the care has been above the level of the desired care, while a bad surprise would indicate that the care has been below the level of adequate care. No reaction means that the quality of the care provided was within the zone of tolerance. It is accepted that the zone of tolerance will differ both with the individual and the occasion. The majority of patients would probably show roughly the same zone of tolerance for the same treatment given under similar conditions. However, psychological, social and temperamental variables may narrow or extend the zone of tolerance. The zone of tolerance will obviously differ in the same individual depending on the severity of the condition and the emergency of the need for treatment.

At first sight the notion of patient satisfaction may seem unproblematic to define, but as yet there is still no common and unifying definition of the concept.
Marketing literature dealing with consumer satisfaction does provide clues, especially the roles of expectation and perception and the process of comparing them. However, this does not fully explain the whole evaluation process involved in patient satisfaction with health care. Clearly health care evaluation is not homogeneous. It is a distinctive complex mixture of tangible and intangible variables, and its evaluation cannot be viewed in the same light as that for a consumer product or service. Much seems to depend on the way patients perceive themselves in relation to the health care system, and it is also possible that some patients might simply remain passive and not evaluate the care provided.

The description, given in this section of the study, of attempted definitions of primary health care, of the core competences of the family doctor, and finally of patient satisfaction, reveals the complexity of any research which has patient evaluation as its object. The literature review on patient's evaluation that follows further highlights this complexity and describes the various attempts for dealing with it. The review strongly points to the need for developing an evaluation instrument which deals with all the complex variables involved in patient satisfaction.

*Measuring patient evaluation of General Practice care*

In the many efforts that are being undertaken to improve the quality of primary health care, the contribution of patients is being given more and more attention. There is still much uncertainty about how this information about patient satisfaction can be obtained. Methods for conducting satisfaction research need to be developed and assessed, and a literature review will help immensely in arriving at the right
A comprehensive analysis of the literature on quality judgments by patients on primary health care was carried out by Michel Wensing et al in 1994. The authors suggest that much experience has been gathered in this field; however, there are still plenty of unanswered questions. From this literature survey it is not yet clear which aspects of health care are to be presented to patients for judgment. It is also unclear what method of research is the most appropriate one. In addition the link between patient judgment and the quality of care can be established in various different ways. Patient satisfaction can (a) be a means for achieving quality care, (b) it can be the outcome of the care provided, (c) can be an indicator of those aspects of care that can be improved, in the case of dissatisfaction, and (d) can be used for evaluating the quality of care by means of previously set target values.

Wensing et al argue that if the patient report is conducted with the aim of evaluating the quality of the care, special attention should be paid to the motivation of both physicians and patients. Both have to accept the patient report, not only where the choice of aspects is concerned but also with regard to the method that is used. This acceptance is essential to have the necessary cooperation in implementing the patient report, and also to increase the chances that the results will actually be put into use. Of course the method that is used should yield reliable and valid data.

Within the framework of these four conditions, namely, acceptability, reliability, validity and feasibility; Wensing et al conducted a review of the methods of patient reporting in general practice care. Their aim was to contribute to the development of
patient report as a method for quality assurance in general practice care. By means of their review they tried to answer two important questions: (a) to which aspects of general practice can patient evaluation be applied, and (b) what methods for measuring patient evaluation have been applied and how can they be rated.

With regard to the first question the review examined which aspects of care were included so far in patient report in general practice and if and how the patients were involved in selecting these aspects. The review also examined whether the aspects involved on patient report in general practice were different from those occurring in patient report in health care in general.

Forty selected publications which deal with research in patient report of general practice care were checked to find out which aspects of general practice care were dealt with in the interviews on which the studies were based. For this analysis of the aspects of care Wensing et al made use of the aspect approach as developed by the Dutch National Council of Public Health. A further question they examined was whether there was any difference between the aspects that came up in reporting on general practice care and those that featured in patient reporting on health care in general. In order to be able to compare the two they took as reference a review by Hall and Doman (1988) on patient report on health care in general, though they admit that the list proposed by Hall and Doman was limited and did not include all the aspect of care used in their literature analysis.

With regard to the methods applied in the patient reports they reviewed, Wensing et al paid special attention to four points, namely. (a) sample characteristics, (b)
measurement characteristics, (c) discrimination, meaning the highest and lowest percentages of dissatisfied respondents per aspect, and (d) non-response percentage.

The results of this analysis of literature on patient evaluation in the field of general practice care conducted by Wensing et al indicate that patients were relatively often asked to assess aspects like accuracy, humaneness, informativeness and availability. In about half of the surveys patients were requested to give an overall assessment. Aspects like professional competence, indication, empathy, and accommodation were included less frequently. And some aspects hardly occurred at all. These included:

- effectiveness,
- suitability, safety, hygiene, nutrition, and technical aspects of care,
- prevention of superfluous care, and burden on the patient, though these can be regarded as aspects of accuracy,
- mutual trust and cooperation, aspects concerning the relationship between the general practitioner and the patient, which can be regarded as aspects of humaneness,
- accountability and autonomy, aspects concerning the patient's responsibility for his own life,
- continuity, efficiency, integrated care, material privacy, physical and financial accessibility, aspects concerning the organisation of care.

Wensing et al noted that the overall picture resulting from their review of the forty surveys on patient judgement in the field of general practice care corresponds to a large extent with the picture given by research into patient judgements on health care in
general. Notable exceptions are, on the one hand professional competence, which occurred less frequently in surveys on general practice care, and on the other hand aspects such as continuity, availability and empathy, which occurred more frequently in surveys on general practice care.

Wensing et al also noted that in most studies researchers seemed to have decided themselves which aspects to include. Not more than five out of the forty studies reviewed stated that patients had been involved in selecting the aspects of care that were to be examined. In these studies exploratory preliminary research took place beforehand through discussions with patients and patient groups. It is interesting to note that the five surveys that involved patients in the selection of aspects, in general dealt with the same aspects as the total collection of the forty surveys.

Of all the aspects of measurement, Wensing et al concluded that the kind of question asked seemed to exercise most influence on dissatisfaction percentages.

When non-response was examined it was found that taking all studies and all items together it varied from 0 to 58%. On average it amounted to 23.3%. It appeared that oral or written interviews produced similar non-response figures; however, interviews conducted by mail usually produced a higher non-response. Questioning patients before or after a visit usually produced similar non-response figures; however, questioning patients independent of a visit to a physician lead to a higher non-response figure. The place of questioning had little effect. Overall, whether an interview was conducted by mail seemed to exert the greatest influence on non-response, as did questioning conducted independently of a visit to a physician or health centre.
Wensing et al conducted their review of studies on patient evaluation in general practice care with the aim of contributing to the development of a feasible, reliable, valid and acceptable form of patient report, which might prove useful for quality assurance and quality improvement in general practice care. Their central conclusion was that in the area of general practice care relatively little progress had been achieved in the development of patient report as a methodology for quality improvement. Their conclusion is supported by several important findings both with regard to the aspects of care involved and with the research methods applied.

The review showed that patients of general practice were mainly questioned on accuracy in the professional performance of the practitioner, humaneness, informativeness, and availability. The overall picture was that the aspects involved in research on patient satisfaction in general practice care was consistent with those involved in research in health care in general.

Wensing et al ask why a large number of aspects of general practice care were included less frequently in some studies, or were left out altogether in others. Perhaps it was assumed that patients were not competent to pass meaningful judgements on certain aspects. This might be true for certain medical and technical aspects, but could not be true for organisational aspects of care, which could certainly benefit from quality assessment by patients. In this connection it is also worth recording that often the researchers selected the aspects on which patients were to be questioned without involving patients. In view of the need for acceptance of patient report, it is important that patients as well as physicians are involved in the selection process.
Wensing et al draw some important conclusions on the research methods applied. First they consider sample size. From their review they conclude that it is unclear how many patients per general practice have to be interviewed in order to obtain a valid picture of the care provided. Among other things this depends on the homogeneity of the patient population and the provided care. Secondly, with regard to questioning procedures, it seems plausible to conclude that the choice of a particular procedure can seriously affect the acceptance of a survey. Thirdly, the review concludes that there has been hardly any standardisation with regard to the nature and length of the questionnaires. Fourthly, with regard to attempts to reduce discrimination, the review concludes that answers in terms of agree/disagree seem to be the most discriminative. With regard to the moment of the interview, the review concludes that the most favourable moment from the point of view of limiting non-response and optimising discrimination, seems to be prior to the visit to the physician. As for the method of interview, the most attractive from the point of view of optimising discrimination though it is less attractive from the viewpoint of non-response, is the interview conducted by mail. Oral interviews have similar non-response figures as written interviews, and a better score on discrimination. Unfortunately, because of the expenditure and organisation involved, they are less suitable for large-scale and continuous quality assurance.

This Wensing et al review was published in 1994. It points to the inexperience that prevailed at the time in the area of research in patient evaluation of general practice care. Most importantly, it underlines a number of much needed improvements both with regard to the aspects of general practice care that are to be covered by the research, as well as the methodology to be followed to ensure acceptability and validity.
Another systematic literature analysis on patients' opinions and priorities in primary health care was undertaken in 1998 (Wensing M, Jung HP, Mainz J et al. 1998). A systematic search was conducted using electronic and manual searches. Data extraction was performed by two researchers, followed by systematic analyses of study features. 57 studies were included. The analysis showed that these 57 different studies focused largely on different aspects of care, many addressing only one or two aspects. Aspects most often included were "informativeness", "humaneness" and "competence/accuracy". Based on a detailed analysis of 19 studies that were able to rank different aspects of care, the following aspects were seen by patients as most important in at least 50% of the studies: humaneness, competency/accuracy, patient involvement in decisions, time for care provision, availability/accessibility, informativeness, exploring patient needs, and availability of special services. The analysis concluded that a good survey study, addressing a wide variety of all aspects of general practice care, was actually needed.

Another important survey examined which aspects of general practitioners' behaviour determine patients' evaluation of care (Jung H.P, Van Horne F, Wensing M et al. 1998). This qualitative study explored those behaviours of general practitioners which were used by patients in their evaluation of 14 aspects of general practice care. The study also attempted to explore whether patients differentiate between different aspects of care. The results showed that when patients' evaluated aspects of general practice that appeared to be predominantly task oriented they particularly referred to task oriented behaviour of the general practitioner, or they stated that they could not judge these aspects. However, when they evaluated aspects that appeared to be
predominantly affect oriented they referred to both affective behaviour and task behaviour, although the latter to a lesser extent. In general patients did differentiate between tasks and affective oriented aspects.

In order to establish which aspects of primary health care are to be included in a standardised instrument for research on patient evaluation, it is important to examine the relationship between specific characteristics of patients and their priorities with respect to general practice care. This analysis was performed by H. P. Jung in an unpublished report in 1999 (quoted by Wensing M. 2000). The analysis reviewed 33 studies with 687 relations between a particular patient feature (e.g. age, sex, health status, economic status) on the one hand and a patient priority on the other. For more than 200 relations a difference was found between groups of patients with different characteristics. Particularly, younger patients showed to have different priorities from older patients in such areas as being involved in decisions and the provision of medical care. Again, patients with a poor health status showed to have different priorities from patients with a higher health statues, for instance with regard to preventive services and decision involvement. Significant differences were also found between groups with different economic status and with different education level. Wensing et al stress the importance of an awareness of such differences in different populations of the practice so that family doctors and staff can meet patient's expectations well. Knowing such differences will facilitate effective communication with patients as well as an effective response to the patient's problems.

Similarly it is important to examine the differences in the evaluations of patients coming from different population groups. One such large scale comprehensive and
systematic study was carried out by Campell, L.J., Ramsey J., and Green J. (2001), which examined variations in assessments of primary care between group of patients defined by age, gender, socioeconomic and ethnic status.

Significant differences between age groups were evident for all except one (referral) of the GPAQ scales. Older patients rated care more favourably than younger patients. The association between age and favourable evaluation of primary health care is reported in other surveys. (Phillips D., Brooks F. 1998; Baker R. 1996; Cartwright A., Anderson R. 1981). Some think that this finding reflects cultural differences between young and old concerning the willingness to report unfavourable assessments. However, the authors of this report found that the actual differences between the youngest and the oldest population groups were the most substantial, and the trend was evident in practically all dimensions for primary health care. The most likely explanation is that older people because of their higher morbidity and higher consultation rates have more direct contact with primary care, and have more opportunity to be favourably influenced by the care they receive.

The study under review found that differences between men and women in GPAQ scale scores were generally small, and attained statistical significance for none of the 13 aspects examined. This may be surprising considering that consultation rates are much higher among women

The study also found that differences in socioeconomic status accounted for a relatively small variation. Differences in scores between ethnic groups were evident in eight out of the thirteen GPAQ scales examined. White respondents consistently


reported more favourable scores in each of the domains examined than respondents from other ethnic groups. Respondents from black ethnic groups tended to give intermediate responses, while those from Indian, Pakistani, or Bangladeshi communities tended to give the lowest scores. The differences were most significant in relation to performance of reception staff, accessibility of care, and trust between doctor and patient.

The authors of this study concluded that there are significant differences between people of different age groups and between people of different ethnic groups with regard to their assessment of primary health care. The study provides evidence that primary care services are evaluated less positively by younger patients and by patients from ethnic minorities. However, in regression analysis age and ethnicity were independent predictors of patients' assessment of primary care. Differences in patient evaluation of primary health care were less marked between people of varying socioeconomic status, and were negligible for patient groups defined by gender.

The authors, Campell J.L., et al, mention three potential explanations for these differences in assessment of care between subgroups in the population. The first is that differences in reported assessments reflect actual differences in the quality or appropriateness of primary care delivery. The second is that differences in reported assessments reflect cultural differences between and within population groups in willingness to report unfavourable assessments. The third explanation is that differences in reported assessments reflect variations in expectations of or needs for primary care between and within population groups. Therefore further work is needed to relate these assessments of primary health care to aspects of actual service provision and to
expectations or needs of patients. In addition primary care providers need to ensure that services provided are appropriate for all patient groups within their communities.

In order to develop an instrument for measuring patient evaluation of care that is internationally recognised, one also has to consider the impact of national health care systems on patient evaluations of general practice. Such a study was carried out by Wensing M., Baker R. et al in 2003. The study examined associations between patient evaluations of general practice care and characteristics of national health care systems. An international comparative study in 17 countries was carried out using international patient survey data and data-bases for health care system characteristics. The characteristics examined were: GP density, physician density, fee for service reimbursement, gatekeeper role, and first contact role. The study did not identify significant associations between patient satisfaction with general practice care and characteristics of national health care systems. In all countries a majority of patients was highly satisfied with general practice. The conclusion is that patients can be highly satisfied with their general practice care in different national health care systems. The mean percentage of patients who used the two most positive answering categories varied across countries between 64% and 91%, with seven countries scoring more than 80% and only three countries scoring less than 70%.

Though none of the associations between patient evaluation and the characteristics of national health care systems were statistically significant, a few hypotheses could be drawn from the data collected. For example, the countries with the highest patient satisfaction scores had a higher density of general practitioners and practicing physicians than those countries with middle or lowest scores. Again, fee-for-
service reimbursement systems may be associated with more favourable patient views. Three of the countries with the highest patient satisfaction scores had a fee-for-service system, while three others in this same category had a mixed reimbursement system which contained components of fee-for-service system. The hypothesis could be made that a higher density of practicing physicians, in particular a higher density of general practitioners, as well as a fee-for-service reimbursement system were associated with more positive patient evaluations in general practice.

In some health systems general practitioners are gatekeepers to specialised care. These systems protect patients from over-treatment and limit the overall costs for the health care services. In the study under review some association could be traced between patient satisfaction and the gatekeeper role of general practitioners, though the statistical information is far from conclusive. Four of the seven countries with the highest patient satisfaction scores did not have a formal gatekeeper role function. Only one of the countries in the middle category did not have such function, and none of the three countries with the lowest patient satisfaction scores had a gatekeeper system. Various reasons have been put forward why patients may prefer not to have a gatekeeper. They may perceive that this reduces their choice of the primary care provider and limits their access to specialist care providers.

The study also explored the association between patient satisfaction and the role of the general practitioner as the first contact for health problems. Once again the data collected did not support any definite conclusion. Countries that reported the most positive patient views had lower scores on the first-contact scale compared to countries in the middle category. The former had a mean score of 3.0 on the first-contact scale,
while the latter had a mean score of 3.3. However, countries with the least positive patient satisfaction score also scored lowest on the first-contact scale.

The authors of this study expected that patient evaluations of general practice care would be most positive in countries where the general practitioner did not have a formal gatekeeper role, but still had a strong first-contact role. Upon examination of the data collected this co-relation remains hypothetical. (Wensing M., Beker R., et al 2003)

Another hypothesis put forward is that competition between primary care providers has a positive impact on patient satisfaction with primary health care. A high physician density and an absence of formal gatekeeper role lead to more competition between primary care providers. Indications from this study that a higher physician density and a lower gatekeeper role are associated with a more positive patient evaluation of primary health care seem to support this hypothesis. However, as the authors themselves stress, the study did not provide a direct indication of this association (Wensing M., Baker R. et al 2003)

Another important survey that has been carried out concerned the importance attributed by patients to the various aspects of general practice care. The survey study was conducted in 8 European countries (Norway, Sweden, Denmark, the United Kingdom, the Netherlands, Germany, Portugal and Israel) (Grol R. 1999) A questionnaire was developed consisting of a structured list of 38 relevant aspects of general practice care, divided into five sections: medical-technical care, doctor-patient relationship, information and support, availability and accessibility and organisation of services. Patients were asked to rate their opinion on the relative importance of each
aspect and to rank the aspects according to importance. The survey was conducted in a consecutive sample of 60 patients visiting their GP from at least 12 practices per country. The response rate was 55%. The result of this survey helped in the identification of those aspects of general practice care that are most highly valued by patients in all 8 countries. The five aspects ranked most highly by patients were: getting enough time during consultations, quick service in case of emergency, confidentiality of information on patients, telling patients all they want to know about their illness, and making patients feel free to talk about their problems. Among the aspects that were ranked relatively low by patients were waiting time before consultation, GPs helping patients deal with emotional problems and convenient facilities in the practice. The overall picture given by the survey is that there are many similarities among patients in different countries on what constitutes optimal general primary care.

Since the organisation of primary care varies from country to country, for example with regard to the gatekeeper role of the general practitioner, it may be that differences in the priorities of patients on general practice are related to specific characteristics of the health care system. The results of a survey on the impact of national health care systems on patient evaluation of primary health care have been described earlier in this section, and the general conclusion of the authors was that this study did not identify significant associations between patient satisfaction with general practice care and the characteristics of national health systems. (Wensing M. Baker R. et al. 2003). A survey conducted earlier (Wensing M 1998) on differences in opinion on the importance of various aspects of general practice care among patients from countries with different health care systems, did not provide a clear picture either.
Another area that has been researched is whether the views of patients and general practitioners on good primary health care differ. Family doctors are expected to respond to patients' expectations and needs. However, doctors and patients may have different views on what constitutes good primary care. A study was conducted in the Netherlands (Jung H.P. 1999) to examine which aspects of general practice care are ranked differently by general practitioners and patients. The study included three different independent samples: a group of patients was asked to rate the importance of each of 38 relevant aspects of primary health care; a group of general practitioners completed the same questionnaire and gave their personal opinion on the importance of the 38 aspects of primary health care; finally a group of different general practitioners was asked to give their estimate of how important each of the 38 aspects would be for patients. This study showed that there is a high correlation between the priorities of patients and of doctors, and furthermore that doctors are able to estimate the priorities of patients with a high level of accuracy. However, some important differences were found, among them that general practitioners seem to underestimate the importance that patients attach to discussing critically the need for and usefulness of investigations, medications and referrals, while they overestimated the priority given by patients to showing a personal interest in the patient's life. (Jung H.P. 1999)

A substantial amount of research has also taken place to examine the reliability of patients' evaluation of primary health care.

A study carried out by Rao M, Clarke A. et al published in 2006, investigates the relation between older patients' assessments of the quality of the primary care they receive and measures of good clinical practice on the basis of data from administrative
and clinical records. The study covered all patients aged 65 or more registered in 19 general practices in Basildon, a medium sized town in the South of England, with fairly typical demography and quite representative to the rest of the United Kingdom with regard to socioeconomic conditions. Patients identified by their doctors as too ill were excluded. The General Practice Assessment Questionnaire was used to test the assessment of these patients of the technical quality of their care. The GPAQ covers nine domains of patients' assessment of the quality of primary care. One of these domains is the technical quality domain, which includes such items as medical knowledge, thoroughness of examination, arrangements of tests when needed, making the right diagnosis, and prescribing the right treatment. The research team used a postal version of the survey. The questionnaires were bar coded and anonymised. The response rate was 76% (3487/4563). Scores for technical care assessment were worked out for each of the 19 general practices.

The study chose three indicators of the technical quality of clinical care: the monitoring of hypertension, the control of hypertension, and vaccination against influenza. The first two were based on adherence to the British Hypertension Society Guidelines. The third was based on the guideline which recommended influenza vaccination to all persons over 75 years of age. These three indicators were chosen for three reasons: firstly because clinical guidelines were available on the care that should be provided to older people based on evidence of benefit; secondly because adherence to guidelines could be determined from patients' records; and thirdly because the conditions are sufficiently common for differences to be detected between practices in adherence to guidelines. Case notes and vaccination records were retrieved pertaining to the respondents and investigated.
The results of this study showed that older patients in primary care did not
distinguish between technical quality of care and other aspects of doctor quality. The
study showed poor correlation between the scores of patients' assessment of the
technical quality of care based on the General Practice Assessment Questionnaire and
the records based measures for the three indicators of the quality of clinical care
(hypertension monitoring, hypertension control and influenza vaccination).

These results are supported by an earlier study conducted by Jung H.P et al 1998
which has already been reviewed in this study. Jung et al carried out a qualitative study
to explore that behaviour of a general practitioner which was used by patients in their
evaluation of 14 aspects of general practice care. The results showed that patients
reported using task oriented behaviour when they evaluated task oriented aspects;
however, when they evaluated affective aspects they reported using both affective
behaviours and task behaviours, though the latter to a lesser extent.

The significance of the findings should be examined further. One possible
explanation is that the patients are correct in their evaluation of and technical quality of
care offered by general practitioners is closely related to the communications skills,
interpersonal skills and trustworthiness skills of the general practitioner. However, it
seems more likely that when patients are asked about technical quality they base their
judgment on those aspects of care that they feel able to judge. These may be only
weakly related to recognised standards of clinical care. The authors therefore conclude
that their study does not provide sufficient evidence for relying only on patients'
evaluation for assessing the quality of primary care. Patients' own assessments of
technical quality are not closely related to independently ascertained records based
measures of technical quality. This leads to the conclusion that assessment of technical quality of primary care should not rely on patient based assessments alone.

Primary health care is provided by teams. Teamwork is characterised by interaction between professionals who are working towards a common goal, and show task interdependence, that is, they recognise the need to develop a shared understanding of their tasks. (Andersen N., West M., 1998) Moreover, the association between effective teamwork and high quality primary care has led researchers to explore the social-psychological processes that operate at the level of primary care teams. Two terms that are important at this level are organisational "climate" and "culture". Culture and climate represent shared beliefs and values that may influence the quality of care provided by health care teams. This association can be manipulated to improve the quality of primary health care.

A study to explore the association between culture, climate and quality of care in primary health care teams was carried out by Hann M., Bower B., et al 2006. For the purpose of this study organisational climate can be defined as a team's shared perceptions of organisational policies, practices and procedures. (Andersen N, West M., et al 1998) A widely used definition of culture is that it represents 'a pattern of shared basic assumptions – invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration" (Schein E. 1985) It is not clear whether climate and culture represent distinct concepts. Measurement of climate may represent a deeper organisational culture. The relationship between the two concepts has more than theoretical significance since both have been found to be associated with outcomes such as team functioning and morale, which are conducive to
high quality in primary health care. If the concepts are distinct it is important to find out which is the better predictor of high quality care. The study by Hann, Bower et al uses data from a large quality of care study in primary care to explore (a) the association between two common self-report measures of climate and culture, and (b) the association between measures of climate/culture and quality of care.

The data was derived from a cross-sectional survey of 492 professionals in 42 general practices in England. Self-report measures of culture (the Competing Values Framework) and climate (the Team Climate Inventory) were used, together with validated measures of quality of care from medical records and self-report. The study found that the majority of practices could be characterised as “clan” culture type. Practices with a dominant clan culture scored higher on climate for participation and teamwork. There were no associations between culture and quality of care, and only limited evidence of associations between climate and culture.

The authors concluded that their analysis would not support the hypothesis that culture and climate were important predictors of quality of care in primary care. However, they acknowledged a number of limitations of their study, including the small sample size which limited the power of the study to detect associations. Moreover, measuring any complex psychological construct, such as organisational climate and culture in teamwork, poses significant methodological challenges which may not yet have been fully addressed. Therefore, the authors add that further research may be required into the interaction of culture and climate with other determinants of behaviour such as internal and external incentives.

Patient feedback surveys are increasingly seen as a key component of
monitoring and improving the quality of health care. Yet, according to Evans RG, Edwards a et al 2006, the theoretical and empirical base for such patient assessment is not clear, and it is important to assess the science underpinning the instruments that are used to obtain these assessments. To substantiate their claim Evans, Edwards et al sought to identify and evaluate the instruments that are designed to assess patients' experiences with an individual practicing physician, and to provide performance feedback at the individual level. In their study they evaluate the development of these instruments, their validity and reliability, as well as their potential to identify poor performance of the individual doctor for and suggest improvement.

The research team searched nine electronic databases with no language restrictions. The initial search was conducted in July 2004 and again in November 2005. They included in their review the instruments that (a) were completed by patients, (b) assess practicing doctors, c) have the capacity to assess individual doctors for performance feedback, and (d) have been used for individual performance feedback. The research team identified 3476 studies from the search strategy on the nine databases. The abstracts of these studies were read, and most were found not to fulfil the inclusion criteria. Only 119 studies were kept for full text assessment. Of these 55 were excluded for not describing an instrument. From the remaining 64 studies, 25 potential instruments were identified, and only 6 were found to fulfil all the inclusion criteria. Most of the instruments were excluded for not focusing on individual performance, or for not being used for individual performance feedback.

The six selected instruments for detailed investigation were: Consultation Satisfaction Questionnaire (CSQ), Chronically Ill Patients Evaluate General Practice
The first conclusion that is drawn by the authors is that none clearly state an aim to use patient assessment of individual doctors to provide direct summative judgment against a standard, though there is usually an implied use for formative or developmental performance improvement. How the feedback is conducted, by whom, to whom, and in what setting are not specified. These instruments seem to assume that normative comparisons will motivate change in the performance of general practitioners because they are sensitive to patients' views about their practice. However, this assumption is not supported by evidence. Clinicians' reaction to the feedback of patients' assessment has not been positive, and there is evidence that clinicians can be defensive and resistant, unless feedback is provided early during the training phase. (Wensing M., Vingerhoets E, et al 2003; Greco M., Brownlea A., et al 2001; Greco M., Francis W., et al 1998).

A second conclusion of the authors is that, with the exception of the CSQ, the remaining five attempts to evaluate both the organisational and the individual level in a single instrument. This can lead to lack of clarity as to whether the patients are evaluating the organisation or the individual clinician. Another cause of potential confusion is the variation between different methods of implementation, such as immediate post-consultation use and postal use, which can lead to variations in scores. Sometimes, as is the case with EUROPEP, more than one implementation method is used for the same instrument. According to the authors of this research, Evans R.,
Edwards A et al, different implementation gives rise to different evaluations, which can undermine benchmarking and comparative feedback.

A third conclusion of the review of instruments by Evans, Edwards et al is that the six instruments under review provide very little data on how patient scores correlate with other assessments of a practicing physician. This suggests a need for more work on construct validity.

The overall conclusion of this research is that the six validated instruments meet the criteria for patient assessment of their experience with an individual physician and have been used for feedback to individual physicians. However, there is no clear statement of purpose for each instrument as a formative or summative assessment. All have been developed in primary care or outpatient setting, and appear to have the potential for identifying poorly performing doctors. However, there may be difficulties in interpreting the findings because the instruments have varying implementation methods and sometimes the distinction between evaluations at the organisation and at the individual levels are not made sufficiently clear to patients.

Moreover, the authors stress that the purpose of assessing must be made clear, and that if the instruments are to be used for decision making, the science underpinning them needs to be more robust, and the construct validity in terms of correlation with other assessment perspectives needs further research.

With regard to evidence of the effect of feedback on practicing physicians, the authors point out that so far there is insufficient evidence regarding this issue, and that
this would not allow more comment except that the feedback could be equivocal or negative. Not everybody agrees with this conclusion. For instance, Angela Countier (Coultier A. 2006) after examining the potential of patients to assess care, concludes that simply giving doctors the results of patients' feedback is not likely to instigate change; however recent practice in the US of integrating patients' feedback into educational programmes and making the results available to the public has yielded improvements in doctors' performance.

It is useful to find out about the priorities, needs and expectations of patients; however, it is also important to gather information on the experiences of patients with actual primary health care. Measuring patient evaluation of care is usually done by written or oral questionnaires completed/given by patients before or after a visit. However, measuring patient evaluation of care is not without problems. Wensing, Grol et al give a list of such potential problems (Wensing M., Grol R., et al 2000) It is useful to know these problems in order to find ways to overcome them.

To begin with there is the theoretical debate about the concepts of satisfaction and evaluation. This thesis has already gone into a fairly detailed discussion of these concepts and presented views about the cognitive and affective aspects of the concepts and how they are related to patient needs, expectations and perceptions. Different definitions have been put forward; however, for the purpose of measuring patient opinion of general practice care, it would be preferable, as Wensing et al propose, to use the concept of “patient evaluation” as “the subjective assessment of different aspects of care provision in positive and negative terms” (Wensing M. 1997 and Jung H.P. 1999). It is assumed that this approach will be based more on a cognitive reaction on the part of
the patient in the process of evaluating care, rather than on an emotional reaction which
is often associated with the process of expressing satisfaction.

A second problem highlighted by Wensing et al, is that many of the instruments
used to measure satisfaction/evaluation of care are not validated by scientific research.

A third problem is that such instruments are usually developed by professional
researchers and clinicians without including the opinions of patients.

Wensing et al further point out that an instrument developed within one cultural,
regional or national group of patients will not necessarily be suitable for use in another
group, and instruments cannot be transferred from one setting to another without the
necessary precautions being taken to ensure that the questions will have the same
meaning to patients and that the answers given by patient have the same meaning for
researchers.

Another important problem considered by Wensing et al is that it is not yet clear
whether patients can give a good evaluation of care in general practice. It is assumed
that patients can make a good judgment about different aspects of care, but in reality
they cannot provide a good assessment because they lack an understanding of some
decisions and processes in general practice. Wensing et al refer to a survey, already
described in this section, conducted by Jung et al in 1998, which shows that although
patients are able to give some specific evaluation to concrete and task oriented
behaviour of their doctor, they have difficulties in evaluating other aspects of their
doctor's behaviour which are not so concrete and task oriented, such as, “The GP
understands what I want”, or “being involved in decisions”.

There is also the question of whether the costs in time and money of collecting information on patient evaluation of care are justified. In a study conducted by Vingerhoets in 2000 (unpublished report cited by Wensing et al 2000) the author concluded that feedback on patients' evaluations alone is not enough to induce change and that a more comprehensive approach to improve care is needed. Available experience shows that patient evaluations should be integrated within a more comprehensive plan for improving care. (Wensing et al 2000).

Experience also shows that it is unclear which is the best method to organise a survey. Should the questionnaire be handed to patients visiting the practice or sent by post to a random sample of patients related to the practice. A study by Wensing (Wensing 1996) showed that the response was higher in hand distributed questionnaires, but the results were the same for the two methods as far as assessments were concerned.

The conclusion reached by Wensing et al from this overview of potential problems in using patients' surveys for gathering evaluations of general practice care, is that this area of study is still underdeveloped, and that valid, reliable, feasible and acceptable instruments are required to deal with these problems. In particular, one needs instruments that are validated in, and can be used in, different countries and cultural settings.
Section 4

The EUROPEP instrument and its application

Development of EUROPEP

It is a challenging task to undertake a research on patient evaluation that would meet the criteria of acceptability, validity and applicability. Nonetheless, such research is necessary especially since there is a growing awareness of the need of improving the response to patients' needs and expectations from primary health care. Patient evaluation of care is increasingly seen by practitioners, administrators, policy makers, and patients themselves as a judgment of quality, a variable outcome in itself, next to outcomes such as morbidity, mortality, and quality of life and health care costs. (Grol R., Wensing M., et al. 2000) A systematic gathering of information on patients' needs and experiences, using methodologically sound instruments such as validated questionnaires, should become an integral part of routine care. (Grol R, Wensing M, et al 2000)

Therefore the next important task for researchers in patient evaluation was to develop an internationally standardised instrument that will enable international comparisons of general practice that will help policy makers to improve national health care systems. The instrument should also be able to provide educational feedback to general practitioners, general practices and patient organisations which would stimulate them to improve specific aspects of their professional performance and organisation of care.
The aim of the developers of EUROPEP was that it should include the aspects of general practice care that reflect first and foremost the patients' priorities. To achieve this, a survey was carried out in 8 countries in order to identify patients' priorities. The researchers also carried out a systematic review of the literature in this area. The research team adopted a structured procedure to make a preliminary selection of items that reflect patients' priorities and also cover the main dimensions of general practice care, using the results of the surveys on patients' priorities.

Specific items were then formulated by the core group of co-coordinating researchers and sent for comments to the EUROPEP working group in the countries involved. About fifty published patient satisfaction questionnaires were used during this process. The core group revised the items on the basis of the comments received and developed a draft questionnaire.

This draft questionnaire was tested in a small qualitative study. The study was conducted in the UK and its aim was to construct an English source questionnaire that is clear, understandable for patients and that uses appropriate English. The result was used to improve on the questionnaire.

A quantitative pilot study was carried out next. The aim was to assess the variation of scores across patients, to determine the item response, and to test the feasibility of procedures for recruiting patients in different countries. The study questioned about 50 patients from 2-4 practices in 5 countries. This study raised some
fundamental questions that were discussed by the EUROPEP working team and a new version of the questionnaire was made comprising 44 items.

Since EUROPEP was to be developed as an international instrument formal translation procedures had to be followed. The English source version of the revised questionnaire was forward translated to the national language by three independently working individuals, including researchers in general practice and a professional translator. Following a consensus meeting the forward translation version was established. This was then backward translated by two other individuals, both professional translators and kept unaware of the interest and concepts of the study. After a consensus meeting between the backward translators and the EUROPEP researchers the final version was agreed.

A validation study was then carried out with the aim of assessing the relevance of the questions to individual patients as well as their sensitiveness to variations across patients. More than 1000 patients responded from 8 different countries. On the basis of these results a structured item selection procedure was the next step. A qualitative analysis that was carried on the revised questionnaire gave a wide range of comments and suggestions but did not identify needs for major changes in the questions.

The aim of the researchers was to make the final selection in a way that was systematic and repeatable. Absolute and relative criteria were established for the selection. Scores on the absolute criteria had a direct consequence on inclusion or exclusion, while scores on the relative criteria contributed to the total score reached. It
It was decided that out of the 44 items in the revised draft questionnaire not more than 25 would be selected for the final questionnaire. Criteria were established at the level of aspects of care and at the level of individual questions. With regard to aspects of care, an absolute criterion was that at least two items should be included for each of the following dimension of general practice care: relation and communication; medical care; information and support; continuity and cooperation; facilities, availability and accessibility. Another absolute criterion concerned the importance to patients. All aspects of care that were ranked in the top-10 of patients’ priorities in at least at least 4 out of the 8 countries were included in the questionnaire. Aspects of care that ranked among the top-10 in at least one country got a positive score for importance, thus fulfilling a relative criterion.

With regard to the level of individual questions, an absolute criteria was that questions were excluded if the item-response was lower than 30% in more than one country. A relative criterion was that questions that had an item-response higher than 80% in at least 4 countries got a positive score for item-response.

Another absolute criterion concerned language and meant that items were excluded if a serious ambiguity or translation problem was found in at least 2 countries.

Finally a relative criterion was set with regard to discrimination which meant that items where less than 65% used the highest answering category in at least 4 countries got a positive score for discrimination.
The application of these criteria resulted in the selection of 23 items, out of the 44, which were included in the final questionnaire of the EUROPEP instrument.

The 23-item questionnaire was submitted to a final validation test, using a psychometric study. The study aimed to assess the psychometric characteristics of these 23 items with regards to content validity (item response) and reliability (internal consistency). 16 European countries reflecting a variety of primary health systems were included. The sample of practices was stratified according to practice size and urbanisation in each country to reflect the national situation as closely as possible. The patient population consisted of individuals who had recently visited their general practitioner. The item response rate in the total sample of respondents varied between 73% and 98%. The internal consistency of the aggregated scores on two dimensions was good. The reliability coefficients were 0.96 for clinical behaviour (items 1 – 16) and 0.87 for organisation of care (items 17 – 23).

One may conclude that the EUROPEP instrument was developed in a series of studies, which included qualitative research and small scale quantitative surveys in all participating countries. Questions were changed or dropped in accordance with the results of these studies and following extensive discussions in the EUROPEP working group. Items were selected following structured procedures, and structured procedures were also followed for the formal translation and for the assessment of the psychometric characteristics of the instrument. Therefore, the EURORPEP instrument is indeed a standardised validated instrument for measuring patients' evaluations of general practice care in Europe. (Grol R. Wensing M. et al 2000)
The EUROPEP instrument was revised in 2006. There were various reasons to revise the instrument. Experiences with the instrument in various countries had led to the identification of problems, needs and ideas for a revision of the instrument. It was felt that it would be useful to collect these ideas, examine them and see whether changes to the instrument were needed. It was also felt that the EUROPEP questionnaire might not cover some specific new aspect of general practice care which had developed substantially during the last ten years. Furthermore, the need was felt to develop a short form or core set of the EUROPEP questionnaire, especially for use as part of a larger questionnaire. Finally, since the beginnings of EUROPEP a number of other questionnaires on patient evaluation had entered into use, and it would be useful to examine whether some valid components of these new instruments could be included into EUROPEP. The revision did not lead to any substantial change to the 23 item questionnaire. Only the wording of some questions was slightly changed. This revised version was the one for the Maltese application of the instrument. The text of the 23 item questionnaire together with the Maltese version is given in the appendix.

Application of EUROPEP in ten European countries

In order to complete this description of the EUROPEP instrument it would be useful to present an account of the main results of the first application of the instrument in various European countries. This account can serve as background with which to compare the results obtained from the application of the instrument in Malta which will constitute the substantive conclusion of this thesis.

Grol R., Wensing M. et al published a study in 2000, in which they carried out
an international comparison of patients' evaluation of general practice care using the EUROPEP instrument. Their aim was to identify aspects of general practice care that are generally evaluated positively by patients, and to compare opinion of patients in different European countries on actual care provision in general practice.

EUROPEP's internationally validated questionnaire was distributed and completed by a large number of patients in 10 European countries, namely, Belgium (Flanders), Denmark, Germany, Iceland, the Netherlands, Norway, Slovenia, Sweden, Switzerland, and the U.K. In each country a stratified sample of 36 practices was recruited. The recruitment procedure was left in the hands of the research teams in the participating countries; however, practice size and urbanisation had to be used as stratified variables in the selection of practices in order to reflect as much as possible the national situation. The actual number of patients approached varied between 45 and 80 per practice, depending on the expected response rate in the country concerned based on past experiences. The study population consisted of patients aged 18 or older who had recent experience of general practice, and who could understand the national language.

The written procedure was used. Questionnaires were handed by doctors to all eligible patients consecutively visiting their practice after a chosen starting date. The patients were asked to complete the questionnaire at home and return it on a pre-paid envelope to the research unit. Reminders were sent to non-respondents after three weeks. The core of the questionnaire was the EUROPEP set of 23 questions on evaluation of different aspects of care, using a five-point answering scale with the extremes labelled as “poor” and “excellent”, as set out in the EUROPEP instrument.
Data entry was coordinated by the research units in the different countries, while further analysis was carried out in the coordinating centre. Frequency distributions were used to describe the patient samples. For the description of the patients' views the research team used the percentages of patients who used the two most positive answering categories (4 or 5) of all patients who answered the question. The researchers also calculated a rank score based on these percentages within each country, and compared these in different countries.

The patients sample included 17,391 patients in 10 different countries. The average response rate was 79%, and ranged from 67% in Iceland and almost 90% in Norway. In all countries about two-thirds of the respondents were women. Average age was approximately 50 years, except in Sweden where it was 57 years. The mean number of visits in the preceding year varied considerable in different countries, from 3.6 in Sweden to 12.3 in Germany. (Grol R. Wensing M. et al 2000) The desired number of 1080 patients from 36 practices per country was almost achieved. The following table summarises these results:

Table 1. Response percentages and characteristical of patients in the study.

<table>
<thead>
<tr>
<th>Country</th>
<th>n</th>
<th>Response (%)</th>
<th>Female (%)</th>
<th>Age in years (mean)</th>
<th>Overall health status (% poor/fair)</th>
<th>Mean number of visits to GP in last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium (Flanders)</td>
<td>2530</td>
<td>81.1</td>
<td>64.3</td>
<td>49.6</td>
<td>23.7</td>
<td>9.7</td>
</tr>
<tr>
<td>Denmark</td>
<td>1307</td>
<td>63.7</td>
<td>73.7</td>
<td>46.0</td>
<td>28.8</td>
<td>5.5</td>
</tr>
<tr>
<td>Germany</td>
<td>2224</td>
<td>77.7</td>
<td>62.5</td>
<td>63.7</td>
<td>35.8</td>
<td>12.3</td>
</tr>
<tr>
<td>Iceland</td>
<td>1058</td>
<td>87.2</td>
<td>69.1</td>
<td>47.4</td>
<td>32.7</td>
<td>7.1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1772</td>
<td>87.6</td>
<td>67.7</td>
<td>47.6</td>
<td>33.0</td>
<td>6.5</td>
</tr>
<tr>
<td>Norway</td>
<td>1609</td>
<td>89.0</td>
<td>70.3</td>
<td>50.7</td>
<td>33.3</td>
<td>5.5</td>
</tr>
<tr>
<td>Slovacia</td>
<td>1808</td>
<td>83.7</td>
<td>65.9</td>
<td>48.3</td>
<td>32.5</td>
<td>6.8</td>
</tr>
<tr>
<td>Sweden</td>
<td>1652</td>
<td>53.4</td>
<td>62.6</td>
<td>57.1</td>
<td>40.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1497</td>
<td>60.3</td>
<td>53.4</td>
<td>59.4</td>
<td>28.4</td>
<td>5.7</td>
</tr>
<tr>
<td>UK</td>
<td>1934</td>
<td>72.7</td>
<td>57.6</td>
<td>51.3</td>
<td>34.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Total</td>
<td>17391</td>
<td>73.5</td>
<td>55.8</td>
<td>50.7</td>
<td>32.0</td>
<td>7.5</td>
</tr>
</tbody>
</table>

(British Journal of General Practice November 2000)
Table 2. Evaluations of patients on general practice care in different countries.

<table>
<thead>
<tr>
<th></th>
<th>Belgium (Flanders)</th>
<th>Denmark</th>
<th>Germany</th>
<th>Iceland</th>
<th>Netherlands</th>
<th>Norway</th>
<th>Slovenia</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>UK</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keeping your records and data confidential (A8)</td>
<td>97</td>
<td>96</td>
<td>94</td>
<td>97</td>
<td>95</td>
<td>91</td>
<td>97</td>
<td>88</td>
<td>95</td>
<td>91</td>
<td>94</td>
</tr>
<tr>
<td>Listening to you (A5)</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making you feel you had time during consultations (A1)</td>
<td>92</td>
<td>75</td>
<td>90</td>
<td>33</td>
<td>88</td>
<td>78</td>
<td>92</td>
<td>85</td>
<td>94</td>
<td>60</td>
<td>87</td>
</tr>
<tr>
<td>Providing quick services for urgent health problems (A23)</td>
<td>93</td>
<td>81</td>
<td>95</td>
<td>96</td>
<td>85</td>
<td>83</td>
<td>99</td>
<td>84</td>
<td>96</td>
<td>71</td>
<td>87</td>
</tr>
<tr>
<td>Telling you what you wanted to know about your symptoms and illness (A13)</td>
<td>90</td>
<td>74</td>
<td>90</td>
<td>89</td>
<td>83</td>
<td>78</td>
<td>92</td>
<td>81</td>
<td>93</td>
<td>79</td>
<td>85</td>
</tr>
<tr>
<td>Thoroughness (A9)</td>
<td>89</td>
<td>80</td>
<td>91</td>
<td>85</td>
<td>81</td>
<td>82</td>
<td>92</td>
<td>83</td>
<td>90</td>
<td>76</td>
<td>85</td>
</tr>
<tr>
<td>Explaining the purpose of tests and treatments (A12)</td>
<td>9</td>
<td>7</td>
<td>10</td>
<td>5</td>
<td>7</td>
<td>15</td>
<td>0</td>
<td>8</td>
<td>10</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>The helpfulness of the staff (other than the doctor) (A18)</td>
<td>83</td>
<td>79</td>
<td>92</td>
<td>81</td>
<td>84</td>
<td>83</td>
<td>88</td>
<td>87</td>
<td>93</td>
<td>70</td>
<td>84</td>
</tr>
<tr>
<td>Making it easy for you to tell him or her about your problems (A3)</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>16</td>
<td>5</td>
<td>4</td>
<td>15</td>
<td>2</td>
<td>11</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Interest in your personal situation (A2)</td>
<td>90</td>
<td>79</td>
<td>93</td>
<td>78</td>
<td>89</td>
<td>84</td>
<td>79</td>
<td>77</td>
<td>95</td>
<td>78</td>
<td>84</td>
</tr>
<tr>
<td>Helping you to feel well so that you can perform your normal daily activities (A9)</td>
<td>88</td>
<td>74</td>
<td>88</td>
<td>90</td>
<td>79</td>
<td>83</td>
<td>93</td>
<td>77</td>
<td>91</td>
<td>69</td>
<td>84</td>
</tr>
<tr>
<td>Helping you understand the importance of following his or her advice (A15)</td>
<td>88</td>
<td>80</td>
<td>88</td>
<td>83</td>
<td>80</td>
<td>76</td>
<td>91</td>
<td>80</td>
<td>89</td>
<td>76</td>
<td>83</td>
</tr>
<tr>
<td>Involved you in decisions about medical care (A4)</td>
<td>16</td>
<td>4</td>
<td>17</td>
<td>12</td>
<td>13</td>
<td>10</td>
<td>10</td>
<td>18</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting an appointment to suit you (A19)</td>
<td>88</td>
<td>72</td>
<td>93</td>
<td>78</td>
<td>78</td>
<td>78</td>
<td>95</td>
<td>83</td>
<td>97</td>
<td>82</td>
<td>82</td>
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<tr>
<td>Quick relief of your symptoms (A7)</td>
<td>94</td>
<td>73</td>
<td>85</td>
<td>81</td>
<td>78</td>
<td>75</td>
<td>90</td>
<td>89</td>
<td>72</td>
<td>81</td>
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<tr>
<td>Knowing what he had done or told you during previous contacts (A10)</td>
<td>94</td>
<td>73</td>
<td>85</td>
<td>81</td>
<td>78</td>
<td>75</td>
<td>90</td>
<td>89</td>
<td>72</td>
<td>81</td>
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</tbody>
</table>

1: percentage of patients who scored 4-5 on the scale; II: rank order within the country based on percentages of patients who scored 4-5 on the scale (1 = most positive).
### Table 2. (continued). Evaluations of patients on general practice care in different countries.

<table>
<thead>
<tr>
<th></th>
<th>Belgium (Flanders)</th>
<th>Denmark</th>
<th>Germany</th>
<th>Iceland</th>
<th>Netherlands</th>
<th>Norway</th>
<th>Slovenia</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>UK</th>
<th>Total</th>
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<tr>
<td>Preparing you for what to expect from specialists or hospital care (A17)</td>
<td>I 85 68 85 82 75 71 88 72 88 72 79</td>
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<td>Help in dealing with emotional problems related to your health status (A14)</td>
<td>I 85 68 85 76 76 69 87 71 90 71 79</td>
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<td>Offering you services for preventing diseases (e.g. screening, health checks, immunisations) (A11)</td>
<td>I 77 68 85 74 76 67 85 75 84 74 77</td>
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<tr>
<td>Getting through to the practice on the phone (A20)</td>
<td>I 93 53 95 75 71 55 92 67 90 62 72</td>
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<td>II 4 23 1 22 22 0 21 6 21 6 21</td>
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<tr>
<td>Being able to speak to the GP on the telephone (A21)</td>
<td>I 90 50 67 72 72 54 83 65 91 51 75</td>
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<tr>
<td>Waiting time in the waiting room (A22)</td>
<td>I 68 59 70 70 61 57 69 65 79 50 63</td>
<td></td>
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</table>

1: Percentage of patients who scored 4–5 on the scale; II: rank order within the country based on percentages of patients who scored 4–5 on the scale (1 = most positive).
The results show that in general patients in Europe visiting their general practitioner are very positive about the care provided. For most of the 23 selected aspects more than 80% of the patients described the care as good or excellent. Most of the positive evaluations were for keeping patient records confidential, the GP listening to patients, time during consultation, and quick service in case of urgent problems. Relatively negative evaluations were made for waiting times in the waiting room, speaking to GP on the phone, getting through to the practice by telephone, and preventive services offered by the practice. More than 20% of the patients thought that care was less than good in these areas. (Grol R. Wensing M. et al. 2000)

Considering the evaluation scores of all the 17 391 patients on the 23 items, the research team found that older patients had more positive evaluations of general practice care than younger patients. No differences were found for sex and overall health status. Frequent visitors to general practitioners had more positive evaluations than others. (Grol R., Wensing M. et al. 2000)

The research team could detect differences in overall assessment between countries. A tendency towards more positive evaluation was found in Switzerland, Germany and Belgium, all three with a fee-for-service system and no gatekeeper role for the GP. A tendency for less positive evaluation was found in the UK and Scandinavian countries. (Grol R., Wensing M. et al 2000).

The evaluations of patients in different countries on the rankings of aspects of care were largely similar. However, the research team could detect interesting
differences. Preventive services were given a high ranking in the UK, information and explanation in the UK and the Netherlands, the helpfulness of the staff in Norway and Denmark, quick relief of symptoms in Slovenia, and getting an appointment by phone in Switzerland, Germany and Belgium. Relatively negative evaluations were given for the time for consultation in Norway and Denmark, quick service in the case of emergencies in the UK and Slovenia, thoroughness in performance in Switzerland, and interest in the patient's personal situation in Slovenia. (Grol R., Wensing M. et al 2000). The researchers drew up a multidimensional scaling to help visualise the similarities and differences in patients' evaluation of general practice care across the 10 countries under study:

![Figure 1. Similarities and dissimilarities in evaluations of patients receiving general practice care in different countries (multidimensional scaling; Euclidean distance model; den = Denmark; nor = Norway; swe = Sweden; net = Netherlands; uk = United Kingdom; swi = Switzerland; ger = Germany; bel = Belgium; ice = Iceland; slo = Slovenia).](image)

These results show that patients' evaluations of general practice care in Germany, Switzerland and Belgium, whose patients have free access to specialist and hospital care, were largely similar and differed from evaluations in the Scandinavian countries and the Netherlands. They also differed from patients' evaluations in the U.K and
Slovenia, countries with centralised national health systems. (Grol R. Wensing M. et al 2000)

The research team of this first international comparison based on the application of the EUROPEP instrument drew a number of important conclusions. It is useful to go over these conclusions so that at a later stage in this thesis one will be able to see whether similar conclusions can be drawn from the application of the instrument to the situation of general practice care in Malta.

The first conclusion from this international comparison is that patients in Europe are generally very positive about the general practice care they receive. They are particularly positive about the time they get for a consultation, the way the GP listens to their problems, the confidentiality of records, and the speed of services in urgent situations. It is relevant to recall that in an earlier study by the EUROPEP group these aspects were found to be the most important from the patients' point of view (Wensing M. Jung H.P. Et al 1998). It is also interesting to see which aspects received relatively negative evaluations. Among these are waiting times, accessibility and organisation of preventive services. It is relevant to recall that these aspects are related to practices management, which can be improved. (Grol R. Wensing M. et al 2000)

Another conclusion is that the evaluations of patients in different counties of general practice care are to a large extent similar. Aspects that are positively evaluated in one country are evaluated in a similar way in another country. However, it is possible to detect that some countries on the whole gave more positive assessments than others. The multidimensional scaling shown above shows how patients in Switzerland,
Germany and Belgium generally gave more positive opinions than Scandinavian countries and the Netherlands. It is relevant to recall that the first three countries have a fee-for-service system and no gatekeeper role for their GP, while the latter group focuses on the central gatekeeper role of the GP. (Grol R. Wensing M. et al 2000).

There are different views about the gatekeeper role. As described earlier in this thesis, Wensing et alia present the hypothesis that the absence of a gatekeeper role, combined with a high GP density, create conditions for more competition among the providers of primary care, and that this in turn will lead to a better service and higher patient satisfaction.

Wensing et al also argue that in a fee-for-service system the general practice will operate in a more consumer friendly environment because of competing market conditions. They add that evaluation by patients probably represents a balance between expectations and experiences. In countries where the national health service offers too much, there may be a crisis of expectations because raised expectations can lead to increased disappointment. A fee-for-service system may follow expectations more closely as it is more flexible in reacting to these expectations and to increased consumerism. (Grol R. Wensing M. et al 2000)

This international comparison presents some other interesting concrete differences in patients' evaluation between countries. For instance, preventive services and information giving were very positively evaluated in the UK, where recently a lot of attention had been given to these two aspects. Accessibility aspects, such as appointment getting was highly evaluated in Germany and Switzerland. This may reflect the need for general practices to give more attention to keeping their patients
satisfied since patients are free to go directly to the medical specialist. (Grol R. Wensing M et al 2000).

There may be some cultural and other natural bias in this international comparison. However, the data was gathered from a large number of patients in a large number of countries with high response rates in all countries. The researchers used the well-designed and systematically tested EUROPEP questionnaire. This international comparison confirmed the validity and the reliability of the EUROPEP instrument, and one can expect that the results provide a valid picture of the opinions of patients visiting general practices in Europe.
Section 5

Methodology

The EUROPEP Questionnaire

The EUROPEP instrument is a 23 – item validated and internationally standardized measure of patient evaluations of general practice care. An international consortium of researchers and general practitioners developed the EUROPEP instrument in the years 1995 - 1998.

It was developed from the beginning as an international instrument for patient evaluations, using rigorous translation and validation procedures. It was aimed at use for educational purposes in practices and regions as well as nationwide surveys and international comparisons. A series of studies were performed for its development, including an international study on patient priorities and studies to examine proto-versions of the questionnaire. The questionnaire is focused on evaluations of specific aspects of care not priorities, wishes, reports, experiences, satisfaction, utilities, etc... Specific criteria were used for the final selection of items, which focused on coverage of domains of general practice, importance to patients, item-response, language problems, and discrimination (specific quantitative criteria were formulated). Providing effective feedback on EUROPEP data was not explicitly addressed, but some countries have developed elaborated feedback procedures.

Since its development, the EUROPEP instrument has been used in many local, regional and national projects. It was also part of new international projects, such as the
EPA project on practice management (2002 - 2005). The instrument has been used in about 20 countries and is available in Dutch, Danish, English, French, German, Hebrew, Italian, Norwegian, Portuguese, Swedish, Slovenish, and Turkish.

The EUROPEP instrument is based on a number of specific assumptions, which have guided the different studies during the development of the project. It is important to recall these assumptions in order to define the scope and objectives of the instrument. These assumptions are listed in Grol, Wensing et al 2000.

The first assumption concerns the concept. The instrument focuses on patients' evaluations of specific aspects of general practice care. The aim is to obtain straightforward evaluations from patients, rather than their affective/emotional responses or accounts of actual experiences with general practice care. This issue of concept remains a problem because it will always be difficult to distinguish to what extent a response from a patient is a straightforward evaluation rather than an emotive reaction. Nonetheless, the researchers of EUROPEP did their best to formulate the questionnaire in such a way as to elicit as little emotive reaction as possible. Therefore the basic assumption of the instrument is that it is measuring patient evaluation rather then patient satisfaction.

Another basic assumption was made with regard to patient population that is the sample population. The instrument focuses on patients who have recently visited their general practitioner because these patients are the ones most likely to provide evaluations based on actual experiences with general practice care rather than on general attitudes and feelings towards primary health care in general.
With regard to the aspects of care, the researchers assumed that the instrument should reflect patients' priorities regarding the main areas of general practice care. The aspects of care should be relevant to patients in the sense that most patients would have had actual experiences regarding the particular aspect of care. EUROPEP, since it is intended to be used as an international instrument, had to pay particular attention to the relevance of aspects in different countries and cultures. The selection of the aspects to be included in the questionnaire was based on these assumptions.

The researchers aimed to make EUROPEP as reliable as possible in the sense that it could be tested for reliability. Each EUROPEP question has its own specific content and is not just an indicator of an underlying dimension of general practice care. While developing the instrument the researchers took care that questions that are indicators of the same dimension would be consistent, and that the dimension could be empirically confirmed. This made possible an assessment of the psychometric characteristics of the instrument as seen below-

- **Doctor-patient-relationship** (Question 1-6).
- **Medical care** (Question 7-11).
- **Information and support** (Question 12-15).
- **Organization of care** (Question 16-17).
- **Accessibility** (Question 18-23).

The EUROPEP instrument is intended to identify relevant variations in patient
evaluations of general practice care across different countries. Ideally the instrument should also indicate variations across different general practitioners and practices; however, researchers found that it would be difficult to combine these two criteria since it would require consistency within countries, which is not always the case. EUROPEP should in principle identify variations over time; however, not enough time has passed to test this.

The validity of the instrument is also important in the sense that it should yield data on patients' evaluation of specific aspects of care in the various countries that is positively related to patients' overall appreciation of general practice care.

Finally it is important that the instrument be validated in the sense that the measurements obtained should relate to other measurements in a way that can be predicted beforehand. For instance, it should, in line with most studies already undertaken, show that older people have more positive evaluations than younger people. While developing the instrument EUROPEP researchers assessed such relationship in different studies.

The hallmark of the EUROPEP instrument is its validity and reliability. To achieve this, a number of studies were undertaken by the working groups of researchers and general practitioners.
**Why was EUROPEP chosen**

This is the first study of its kind to be carried out in Malta. It is the first time that an attempt has been made to use an internationally validated instrument to measure patient evaluation of primary health care in Malta. The EUROPEP instrument has been selected because since its introduction in 2000, it has been used in many local, regional and national surveys on patient satisfaction throughout Europe, in particular in Belgium (Flanders) Denmark, Germany, Iceland, Netherlands, Norway, Slovenia, Sweden, Switzerland, and the UK. It was developed over a four year period (1995 – 1998) during which extensive research was carried out to test its reliability, consistency and validity. In addition, the developers of EUROPEP adopted rigorous translation procedures which made it a valid international instrument. By following these translation procedures it has been possible to develop a validated Maltese version of the instrument. Furthermore, following the revision of EUROPEP in 2006, its authors also developed a user manual. By following this manual, the Maltese version of EUROPEP could be applied to the Maltese Islands with the assurance that its reliability and validity will still stand.

Finally, in a review conducted by Richard G Evans, Adrian Edwards *et al* in 2007, which has been described earlier in this study, the authors identified EUROPEP, together with only five other instruments, as having been used for individual performance feedback.
Translation of the EUROPEP into the Maltese language

Permission was sought from the EUROPEP Group Coordination, Dr. Michael Wensing, to allow the author of this thesis to use the EUROPEP instrument. Full permission was granted by Dr. Wensing, and valuable help and guidance on how to translate and validate the EUROPEP into Maltese was obtained.

Two professional translators, who were totally independent from each other, were brought on board to carry out such a task. Initially the English version of the EUROPEP questionnaire was translated by one of the translators into the Maltese language. Afterwards the Maltese version of the EUROPEP was translated back into the English language by the other translator who was not aware of the English version. This back translation was done in order to ascertain that no alteration was done to the initial EUROPEP version. The go ahead to use the Maltese version of the EUROPEP was given once a consensus was reached between the two translators.

Pilot testing and validity testing

A group of fifteen individuals made up of lay people varying in age, gender and different educational background, were selected. Each individual was contacted and interviewed via telephone and a run through of the Maltese version of the EUROPEP was carried out. During each and every phone interview, notes were taken regarding any queries, misunderstandings or any difficulty these individuals were having in understanding the questions they were being asked. Once all the interviews were carried out, the professional translators were once again approached and those questions which
were proving problematic to people, were re worded such that they could be easily understood by laymen. Once the Maltese EUROPEP instrument had been corrected and validity testing carried out, it was ready to be used on a large scale.

*Testing for reliability*

Twenty three individual were selected for such a process. These participants included family members and friends. Such a population was selected because these individuals had to be interviewed twice, so choosing family members and friends guaranteed acceptance and cooperation. Each individual was called via telephone and the new Maltese EUROPEP questionnaire was carried out and each response was noted and corresponded. After four weeks each and every individual was recalled. They were asked the Maltese EUROPEP questionnaire. The results obtained from each individual was inputted, cleaned, cross checked, and analysed by means of SPSS with the corresponding individual’s previous results. This laborious process was carried out in order to be able to test the questionnaire’s reliability.

The term reliability implies "repeatability" and "consistency". A measure is considered reliable if it gives the same result over and over again assuming that what is being measured is constant. The main types of reliability testing are: Correlation test, Paired T test, and Intra class correlation coefficient tests. In statistics, the latter is considered to be the gold standard since it is a descriptive statistic that can be used when quantitative measurements are made on units that are organized into groups. It describes how strongly units in the same group resemble each other. While it is viewed as a type of correlation, unlike most other correlation measures, the intra class correlation
coefficient operates on data structured as groups, rather than data structured as paired observations. Another prominent application is the assessment of consistency or reproducibility of quantitative measurements made by different observers measuring the same quantity. For these reasons, the intra class correlation coefficient test was chosen to check test re test reliability of the Maltese version of the EUROPEP questionnaire. All the questions reached a score of \((0.8)\) or higher. This meant that the questionnaire was reliable and could be used on a large scale.

**Sample size estimation**

It was assumed that in a worse case scenario one can get 50% of respondents answering in one way as against another 50% in the opposite way. The confidence interval was assumed to be not more than 18%, and using the percentage of MISCO for response rate of telephone interviews was also taken into consideration. Taking account of these assumptions, it was calculated that the number of participants needed to satisfy the above criteria was 239. In order to obtain the sample population, the electoral registry was approached and requested to help in generating a list of randomly selected individuals by using a computer programme the electoral registry has developed for random sample selection of the Maltese electorate. The use of the latest electoral register, reflecting the situation as on 1st October 2008, carried other advantages. It ensured that most of the phone numbers forwarded by the electoral registry were actually still in use, and that all participants were above eighteen years of age, they were Maltese citizens and that most individuals were still alive.
Method chosen to carry out the interview

At the design phase it was decided that phone interviews were the chosen method to carry out the Maltese EUROPEP questionnaire. In addition one had to consider the specific attitude of most Maltese towards questionnaires. Most Maltese do not usually follow up written requests to complete written questionnaires, and many would be reluctant to speak openly during personal interviews, especially if it concerns their doctor. Even though the EUROPEP has never been attempted as a telephone interview, as can be seen from the results section, the individuals questioned were mostly compliant and response rate obtained was very similar to that obtained in other European Union Countries where the written questionnaire or personal interview was used.

A group of five highly skilled persons, who are all experienced in telephone based interviews, were selected and trained for three consecutive weeks on how to carry out the telephone interviews. The aim of the questionnaire as well as the questionnaire itself was explained in great detail and all queries were clarified. The consent form was clearly explained to these interviewers so that they could in turn clearly explain its contents to those individuals being interviewed. During the interviewing period, meetings were regularly held with the team conducting the interviews in order to check whether everything was running smoothly and if any problems arose, it were tackled there and then.

Most health surveys in Malta, including the European Health Interview Survey 2008, have been conducted through personal interviews. The EUROPEP questionnaire
has been carried out in other European countries using written interviews. Therefore the
decision to use the telephone interview for this study calls for some explanation. To
begin with, Malta is a small country, highly overpopulated, with a high level of social
interaction among the population. In Malta, not only in small villages, but also in
towns, everybody knows everybody else, and people find it easy to talk to one another
and to exchange views on almost anything, from the next Super Five lottery draw to the
Archbishop's stand on abortion. The warm climate makes it easier for people to spend
long time outdoors and loiter around for chatting and gossiping. In this specific Maltese
context the author of this study felt that the telephone interview was the interviewing
method which guaranteed the highest possible level of anonymity and objectivity, and
the least possible level of emotional input into the response given. Upon considering the
psychological and social characteristics of the target population it was decided that the
personal interview would have allowed more space for an emotive and affective
response and less space for a clear, succinct and objective reply from those interviewed.
Indeed, the objective of this thesis requires that patients give a straightforward
evaluation of primary health care rather than an emotive reaction to the care they have
received. In the judgment of the author of this study, the telephone interview offered a
better way than the personal interview for eliciting as little emotive reaction as possible
from the study population. In addition the author believed that the telephone interview
would not only yield a more candid response but also a higher response rate than the
personal interview. The author seems to have been proved right since the response rate
of the Health Interview Survey 2008 was 72% compared to 74.45% obtained from this
study.

As already indicted the decision not to use the written interview was taken early
in the preparation for this research. This was an easier decision than that of choosing between the telephone and personal interview. The EUROPEP application in other European countries was done using the written procedure. Questionnaires were handed by doctors to all eligible patients consecutively visiting their practice after a chosen starting date. They were asked to fill in the questionnaire at home and return it in a prepaid envelope to the research unit. The author of this thesis decided that this procedure would not work in Malta and that it would give a very low response rate, and possibly many insincere replies. In Malta most people find it easier to talk about something than to write about it. In all probability, had the written procedure been used, patients would have simply taken the questionnaire with them and never replied. Furthermore, suspecting that the replies would be seen by their doctor, they would probably not have given an honest reply. The response rate obtained in the various European countries where the EUROPEP instrument was used varied considerably from one country to another, ranging from 67% in Iceland to 90% in Norway. This variation indicated that the behaviour habits of the study population, especially those that determine the extent to which respondents would be prepared to allocate about thirty minutes of their free time to reply to a written questionnaire, should be taken into account when deciding the interview procedure. In the judgment of the author of this research the behaviour patterns and educational background of most Maltese patients did not predispose them to look favourably at written questionnaires.

Following these considerations the decision was taken to use the telephone interview, which lead to the satisfactory response rate of 74.45%.
Inclusion / exclusion criteria for the interview

The sample population was, eighteen years of age or older and had to be fluent in the Maltese language. To ensure these criteria, the randomly selected sample of 239 phone numbers was obtained from the last electoral register (2008). This ensured that most of the phone numbers forwarded was actually still in use, and that all participants were above eighteen years of age, were Maltese citizens and that most of them were still living in Malta and were still alive. Anyone who did not fit these selection criteria was excluded from the sample list and replaced by eligible participant selected from a reserve list.

Consent form

For the purpose of this questionnaire a consent form was drawn up. This was read to each and every interviewed individual prior to the commencement of the EUROPEP questionnaire. The consent form was simple to read and follow. It explained the aim of study and highlighted the benefits to general practice care in Malta that could be gained from the results of this research. The approximate duration of the interview was explained to the participants prior to its commencement so that if they were not ready to participate or if this was not a good time, they could stop the interview and could be contacted later at a more convenient time. People were reassured that their participation was on a voluntary basis and that the phone interview was strictly confidential and their replies were untraceable.
Questionnaire and testing for internal consistency

The duration of the questionnaire was approximately ten minutes. The interview consisted of the 23 EUROPEP questions and a further nine questions were added to obtain additional information about the participants and help in the analysis of the results. These additional questions dealt with gender, age, educational level, perceived health status, chronic illness, number of chronic illnesses, and location from where the participants obtained their primary health care and the number of times they visited their general practitioner over the past four months. Once all the interviews were carried out, the results of the EUROPEP were pooled together and compared using the Cronbach $\alpha$ (alpha). This revealed internal consistency of the scales.

Response Rate

The total number of calls made was 239. From these 22 individuals were not interested in participating. 38 never picked up the phone or had changed their phone line and 1 individual had an automated answering machine. This gave an overall response rate of 74.45% which satisfied the purpose for this study. This response rate compared well with that obtained by most patient evaluation surveys. When one considers the general mistrust towards questionnaires prevalent among the Maltese population, such a high participation rate could only be obtained by the highly professional approach of the interviewers and by the clear and unambiguous nature of the questionnaire itself.
Most telephone based surveys show a preponderance of female respondents. EUROPEP's results in ten European countries also showed that almost two-thirds of respondents were female. Important for interpretation of results.
Fig 2: This distribution according to educational attainment is nearly identical to that obtained by the HIS 2008 Survey. One can say that this distribution reflects that of the overall population in the Maltese Islands. (NSO Population Census 2005). Therefore it is not apparent that better educated patients responded more readily to the questionnaire.

Fig 3: This distribution by self-perceived health status is very close to that obtained by
the HIS 2008 Survey, though the categories are named differently. The categories for the HIS 2008 Survey run from very bad to bad, fair, good and very good. The results of the two surveys with regard to the two lowest categories (very poor/very bad and poor/bad) are identical. The other categories roughly correspond. Once again this distribution is very close to that for the population as a whole, and therefore, one cannot conclude that people with a self-perceived health status of good or excellent are more willing than those with a self-perceived health status of poor or very poor to give their evaluation of the general practice care they receive.

Fig 4: Nearly 40% of respondents reported one or more chronic condition. It is probable that most, if not all, respondents reported their condition in accordance with the diagnosis they had received from their general practitioner. In other words it is unlikely that respondents would “invent” a chronic condition. Therefore, one should expect this result to tally with the rates for chronic diseases given in other sources. In fact it tallies
with figures for chronic conditions given in the HIS 2008 Survey and NSO survey. Once again this distribution reflects the normal distribution across the whole population, and one cannot conclude from this result that this variable influenced response rate.

**Distribution of Primary Health Care provision.**

![Distribution Chart]

<table>
<thead>
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<th>Private HC</th>
<th>Public HC</th>
<th>Both</th>
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<td>70</td>
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<td>20</td>
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Fig 5: This result is consistent with the findings of the HIS 2008 Survey, which concludes that the private sector roughly accounts for two-thirds of primary health care provision. It also shows the readiness of patients to avail themselves of both sectors. It is important to keep this result in mind when one comes to consider patient evaluation of general practice care. Nearly 60% of respondents would be reporting on their experience with private general practice care.
Fig 6: This result is consistent with that represented in Figure 5 in that respondents who said they had visited a private family doctor outnumber those who visited a public family doctor by 3:1. However, there is an important conclusion to be drawn from comparing these two figures. It shows that most of the respondents, who say that they may consult both private and public general practitioners, are the ones who reported not having seen a family doctor during the previous four months.
Mean score by dimension.

Doctor patient relationship dimension.
Medical Care
Information and support
Organisation of Care
Accessibility

Figure 7: Global mean satisfaction score and 95% confidence interval for the five dimensions of the general practitioner service that are covered by the 23-items in the EUROPEP questionnaire.

Highest overall score was in doctor – patient relationship; medical care and organisation of care are level at 4.30; information and support scored 4.00 and the lowest score was in accessibility.

It is important to point out that there is a high correlation between this score and that obtained by EUROPEP in other European countries. European respondents gave their most positive appreciation to keeping medical records confidential, listening to patients, giving sufficient time for consultation and providing quick service in urgent cases. All
these are aspects of doctor – patient relationship. On the other hand the most negative judgements concern waiting time and getting through to the practice, which are aspects related to accessibility.

Figure 8: This chart shows the total scores for the five dimensions of care and their distribution by gender. It shows that the mean score for all dimensions, with the exception of information and support, where the scores are nearly level, women expressed a more positive evaluation of primary health care than men. The difference is most marked in the dimension for doctor – patient relationship, followed by the dimension on organisation of care, then that on access to care and that on medical care. This difference between genders in the appreciation of general practice care calls for an explanation, which will be given in the discussion of results. An independent t-test was carried out for each item of the questionnaire. Questions 1, 7, 8, 16 showed a significant difference between the sexes.
Mean score for dimensions by type of care provider.

Figure 9: This chart represents the distribution of scores for the evaluation of general practice care according to service provider. In all five dimensions the private general practice care scored higher, with the most significant difference in the dimension for accessibility. It is followed by that of doctor – patient relationship and that of medical care. The differences for the dimensions of information and support and organisation of care are less pronounced. This clear result in favour of the private general care needs an explanation, which will be given in the discussion of results.
<table>
<thead>
<tr>
<th></th>
<th>Educational attainment</th>
<th>Health Status</th>
<th>Chronic Disease</th>
<th>Private / Public / Both</th>
<th>Family Doctor</th>
<th>Doctor in last 4 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.67</td>
<td>0.07</td>
<td>0.98</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>2</td>
<td>0.39</td>
<td>0.09</td>
<td>0.96</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>3</td>
<td>0.64</td>
<td><strong>0.03</strong></td>
<td>0.74</td>
<td><strong>0.03</strong></td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>4</td>
<td>0.10</td>
<td>0.24</td>
<td>0.11</td>
<td><strong>0.00</strong></td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>5</td>
<td>0.84</td>
<td>0.11</td>
<td>0.49</td>
<td><strong>0.02</strong></td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>6</td>
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<td>0.10</td>
<td>0.94</td>
<td><strong>0.00</strong></td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>7</td>
<td>0.28</td>
<td>0.21</td>
<td>0.18</td>
<td>0.29</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>8</td>
<td>0.10</td>
<td>0.39</td>
<td>0.59</td>
<td><strong>0.00</strong></td>
<td>0.00</td>
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<td>9</td>
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<td>0.22</td>
<td>0.65</td>
<td><strong>0.00</strong></td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>10</td>
<td>0.31</td>
<td>0.51</td>
<td>0.32</td>
<td><strong>0.00</strong></td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>11</td>
<td>0.87</td>
<td>0.66</td>
<td>0.96</td>
<td><strong>0.05</strong></td>
<td>0.16</td>
<td>0.00</td>
</tr>
<tr>
<td>12</td>
<td>0.30</td>
<td><strong>0.02</strong></td>
<td>0.85</td>
<td>0.68</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>13</td>
<td>0.17</td>
<td><strong>0.04</strong></td>
<td>0.29</td>
<td><strong>0.07</strong></td>
<td>0.01</td>
<td>0.00</td>
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<tr>
<td>14</td>
<td>0.83</td>
<td>0.28</td>
<td>0.40</td>
<td><strong>0.01</strong></td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>15</td>
<td>0.77</td>
<td>0.29</td>
<td>0.77</td>
<td>0.58</td>
<td>0.97</td>
<td>0.00</td>
</tr>
<tr>
<td>16</td>
<td>0.34</td>
<td>0.11</td>
<td>0.23</td>
<td>0.17</td>
<td>0.21</td>
<td>0.00</td>
</tr>
<tr>
<td>17</td>
<td>0.91</td>
<td>0.31</td>
<td>0.44</td>
<td>0.32</td>
<td>0.22</td>
<td>0.00</td>
</tr>
<tr>
<td>18</td>
<td>0.82</td>
<td><strong>0.05</strong></td>
<td>0.77</td>
<td>0.26</td>
<td>0.14</td>
<td>0.00</td>
</tr>
<tr>
<td>19</td>
<td>0.14</td>
<td>0.61</td>
<td>0.92</td>
<td><strong>0.03</strong></td>
<td>0.01</td>
<td>0.00</td>
</tr>
<tr>
<td>20</td>
<td><strong>0.01</strong></td>
<td>0.11</td>
<td>0.10</td>
<td><strong>0.00</strong></td>
<td>0.00</td>
<td>0.00</td>
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<td>21</td>
<td><strong>0.01</strong></td>
<td>0.17</td>
<td>0.16</td>
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<td>22</td>
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<td><strong>0.00</strong></td>
<td>0.01</td>
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<tr>
<td>23</td>
<td><strong>0.01</strong></td>
<td>0.18</td>
<td>0.08</td>
<td><strong>0.00</strong></td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Table 1: This table gives the ANOVA analysis for significance of differences in mean score for each item on the EUROPEP questionnaire according to the five independent variables (educational attainment, health status, chronic disease, family doctor:
private/public/both, and family doctor utilisation in the last four months) that are deemed to help in the evaluation of general practice care. The table clearly shows that the two variables which mostly influenced the respondents' evaluation of general practice are those which involve contact with general practitioners; that is, whether the respondent made use of the private or public general practice, and the number of visits the respondent had during the last four months. It seems that educational attainment, health status and chronic condition of respondents did not greatly influenced their overall assessment of general practice care.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>No of Items in dimension</th>
<th>Chronbach Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor patient relationship.</td>
<td>6</td>
<td>0.874</td>
</tr>
<tr>
<td>Medical Care</td>
<td>5</td>
<td>0.840</td>
</tr>
<tr>
<td>Information and support</td>
<td>4</td>
<td>0.732</td>
</tr>
<tr>
<td>Organisation of Care</td>
<td>2</td>
<td>0.601</td>
</tr>
<tr>
<td>Accessibility</td>
<td>6</td>
<td>0.748</td>
</tr>
</tbody>
</table>

Table 2: This table shows the internal consistency in all dimensions of general practice except for Organisation of care, which is covered by questions 16 and17. This can probably be explained by the fact that only 2 items are tested.
### Correlation between dimension mean score and age.

(\(^*\). Correlation is significant at the 0.01 level (2-tailed).)

<table>
<thead>
<tr>
<th>Dimension of care</th>
<th>Age</th>
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<tbody>
<tr>
<td>Doctor Patient relationship</td>
<td>0.069</td>
</tr>
<tr>
<td>(NS) Sig. (2-tailed)</td>
<td>0.363</td>
</tr>
<tr>
<td>N</td>
<td>178</td>
</tr>
<tr>
<td>Medical care (NS)</td>
<td>0.016</td>
</tr>
<tr>
<td>Pearson</td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>0.828</td>
</tr>
<tr>
<td>N</td>
<td>178</td>
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<tr>
<td>Information and support</td>
<td>0.005</td>
</tr>
<tr>
<td>(NS) Sig. (2-tailed)</td>
<td>0.951</td>
</tr>
<tr>
<td>N</td>
<td>178</td>
</tr>
<tr>
<td>Organisation of care. (NS)</td>
<td>0.023</td>
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<tr>
<td>Pearson</td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>0.765</td>
</tr>
<tr>
<td>N</td>
<td>178</td>
</tr>
<tr>
<td>Accessibility (Sig)</td>
<td>0.198((^*))</td>
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<tr>
<td>Pearson</td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>0.008</td>
</tr>
<tr>
<td>N</td>
<td>178</td>
</tr>
</tbody>
</table>

Table 3: This table represents correlation between the mean scores for each dimension of general practice care and the age of respondents. The only statistically significant correlation appears in the last six questions which relate to accessibility. This may be due to the fact that since most general practitioners work solo, accessibility for younger and working patients may not be too good.
ANOVA for the differences in mean score according to reported health status and the dimensions of the EUROPEP instrument.

<table>
<thead>
<tr>
<th>ANOVA</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
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<tbody>
<tr>
<td>Doctor patient relationship</td>
<td>5.295</td>
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<td>1.324</td>
<td>2.601</td>
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<tr>
<td>Within</td>
<td>88.036</td>
<td>173</td>
<td>0.509</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
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<td>177</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical care</td>
<td>2.931</td>
<td>4</td>
<td>0.733</td>
<td>1.339</td>
<td>0.257</td>
</tr>
<tr>
<td>Between</td>
<td>94.682</td>
<td>173</td>
<td>0.547</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within</td>
<td>97.613</td>
<td>177</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total</td>
<td>94.331</td>
<td>177</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informational support</td>
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<td>1.270</td>
<td>2.995</td>
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<tr>
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<tr>
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<td>177</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>78.437</td>
<td>177</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Organisation of care</td>
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<td>0.445</td>
<td>0.852</td>
<td>0.494</td>
</tr>
<tr>
<td>Between</td>
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<td>173</td>
<td>0.522</td>
<td></td>
<td></td>
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<tr>
<td>Within</td>
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<td>177</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>92.118</td>
<td>177</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>3.814</td>
<td>4</td>
<td>0.954</td>
<td>1.826</td>
<td>0.126</td>
</tr>
<tr>
<td>Between</td>
<td>90.322</td>
<td>173</td>
<td>0.522</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within</td>
<td>94.136</td>
<td>177</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: This table represents the differences in the mean score for the five dimensions of general practice care resulting from the respondents' health status. Only the dimensions of doctor – patient relationship and of information and support show statistically significant differences according to the reported health status.
Table 5: This table represents the differences in the mean scores of the five dimensions of general practice care according to educational attainment. The level of education of respondents made a statistically significant difference in the mean score only for the dimension of accessibility. Age and level of education are highly correlated in Maltese society, where the younger generation had much better opportunities for achieving a high level of education. This result reflects the findings of table 3 where age is also shown to have a significant impact on the evaluation of accessibility. This can be explained by younger (working) patients who also have a higher educational attainment reporting greater problems with access.
Table 6: This table represents equality of means according to reported presence of chronic disease for the EUROPEP instrument dimensions. In none of the five scales was there any statistically significant difference. This may be due to the fact that general practitioners are not addressing chronic disease patients. This result is quite worrying since general practitioners should be the ones addressing chronic illness on a
day to day basis. International surveys also report a significance decrease in the evaluation of care scores from patients suffering from chronic illness.
Section 7

Discussion and Conclusion

Why was EUROPEP chosen

This is the first study of its kind to be carried out in Malta. It is the first time that an attempt has been made to use an internationally validated instrument to measure patient satisfaction with primary health care in Malta. The EUROPEP instrument has been selected because since its introduction in 2000, it has been used in many local, regional and national surveys on patient satisfaction throughout Europe, in particular in Belgium (Flanders) Denmark, Germany, Iceland, Netherlands, Norway, Slovenia, Sweden, Switzerland, and the UK. It was developed over a four year period (1995 – 1998) during which extensive research was carried out to test its reliability, consistency and validity. In addition, the developers of EUROPEP adopted rigorous translation procedures which made it a valid international instrument. By following these translation procedures it has been possible to develop a validated Maltese version of the instrument. Furthermore, following the revision of EUROPEP in 2006, its authors also developed a user manual. By following this manual, the Maltese version of EUROPEP could be applied to the Maltese Islands with the assurance that its reliability and validity will still stand.

Finally, in a review conducted by Richard G Evans, Adrian Edwards et al in 2007, which has been described earlier in this study, the authors identified EUROPEP, together with only five other instruments, as having been used for individual performance feedback. This is important from the point of view of this thesis, because
the ultimate aim of the study is to make suggestions for the improvement of the general practice in Malta.

**Sample size**

The study decided on a sample size of 239 patients. This decision was based on a number of statistical assumptions, and other considerations. One important consideration was the homogeneity of the patient population and of general practice in the Maltese Islands. This made a larger number unnecessary for reaching the objective of the study. In addition, financial and time considerations had also to be taken into account. Moreover, the chosen sample size compares well with the samples taken for using the EUROPEP instrument in other European countries. For example, in Germany with a population of 80 million, the sample size was 2224, in the UK with a population of about 60 million, it was 1934, and in the Netherlands with a population of around 13 million it was 1772. (Grol R., Wensing M., et al 2000)

Strictly objective criteria were used in the selection of the sample population. The telephone numbers of the individuals to be interviewed were provided by the Electoral Registry. The principle of random selection was in line with the methodology required by the EUROPEP instrument.

**Procedures**

The study used the telephone interview for collecting replies to the EUROPEP questionnaire. This is not typical of EUROPEP, which uses the postal return or waiting
room completion procedures. However, in the case of the Maltese Islands it was felt that the postal return procedure would obtain a low response rate, and completion in the doctor's waiting room would jeopardise the objectivity of the response. It is important to note that specially trained professionals in public relations carried out the interviews, and every precaution was taken to obtain the most candid replies possible. The results obtained indicate that the decision on procedure was indeed the right one.

**Response rate**

The response rate was 74.45%. This rate compares well with that obtained by the European Health Interview Survey that was conducted in the Maltese Islands in June – August 2008. This survey obtained a response rate of 72%. (HIS Survey 2008). This survey had a sample of 5500 adults and was carried out by means of personal interviews at a place chosen by the participant, usually at home or at the Department of Health Information and Research.

The response rate of 74.45% also compares well with that obtained when EUROPEP was used in other European countries. This ranged from 67.2% in the Netherlands and 83.7% in Denmark. (Grol R. Wensing M., et al 2000) One should note that out of the 239 telephone calls made, only 22 individuals were not interested to be interviewed, and in 38 cases there was no telephone reply. Had they been contacted there was a good chance that the majority would have agreed to be interviewed. This would have rendered the response rate even higher.

The high response rate obtained from the application of the EUROPEP
instrument in Malta points to a high level of interest on the part of patients to participate in the assessment of the health care they receive. Patient involvement in the formulation of health care reforms is nowadays being seriously considered because it is recognised that patients have an important contribution to make, and the readiness of patients to come forward with their evaluation of primary health care should be recommended. The Department of Primary Health Care and the medical profession should encourage patients to express their views on the various aspects of the care they receive and be prepared to make use of the feedback obtained. Perhaps, as pointed out by Angela Coultier (Coultier A. 2006), the best way to make use of patients' feedback is to integrated it into educational programmes for medical students and young doctors.

**Sample characteristics**

Of the 178 individuals who accepted to be interviewed, 64 were males and 114 females. (Figure 1 gives the percentage gender distribution of respondents). This male–female ratio among respondents is somewhat lower than that obtained by the HIS 2008 survey. In this case the male participants were 46.6% and female participant were 53.40%. However, in this respect the result obtained by the Maltese application of EUROPEP follows the same trend as the results obtained by the use of EUROPEP in other European countries, where in almost all countries two-thirds of the respondents were female. (Grol R. Wensing M., et al 2000)

This higher female response rate, which is evident not only in the application of EUROPEP but also in other surveys, clearly points to a higher interest by females in the care they receive. This view is corroborated by the higher frequency of visits by
females to their general practitioner. It provides sufficient proof that males show less interest in their health and are more reluctant to visit a doctor when they have a problem. This conclusion points to the urgent need for the Health authorities and the Medical profession to encourage male patients to look after their health better and to convince them of the value of regular check ups and of preventive medicine. In Malta an important start in this respect has been the publicity campaign to promote male awareness of prostate cancer, the hidden killer, and the campaign to promote a healthy lifestyle and regular check ups to control cardiovascular problems.

The study worked out the distribution of participants by educational attainment (Figure 2). This result very much reflects the situation among the Maltese population at large, where the percentage of those having received no education is very low, and where the percentage of those having received a secondary education approaches the 50%. (NSO population census 2005). The result is also consistent with that obtained by the HIS 2008 survey, where the percentage of respondents having received only a primary education was 23.7% (compared to 26% in the present study), those having had a secondary education was 43.6% (compared to 45% in the present study), those having had post secondary education was 19.3% (compared to 18% in the present study), and those having had tertiary education was 13.8% (10% in the present study).

Educational attainment does not seem to have much influence on patients' evaluation of general practice care. Table 5, which represents the difference in the mean scores for the five dimensions of the EUROPEP instrument, showed a statistically significant difference only for accessibility. According to this study the level of education of respondents has influenced their evaluation of accessibility. One possible
explanation is that better educated patients usually work and have more commitments than lesser educated people. They are likely to have less time to spend in the waiting room and become easily impatient when they have to wait. In such cases it is understandable that they would wish for improvements in accessibility.

It follows that an important feedback of this result should be a recommendation to general practitioners to seek to provide flexible consultation hours that would facilitate accessibility for patients who work late hours or have commitments after usual working hours. In addition, although educational attainment does not seem to have much influence on patients' appreciation of general practice care, the author of this study believes that general practitioners should be prepared to adapt their approach to patients according to their educational attainment. The better educated patients usually seek to be well informed on the nature of their ailment and the treatment that is needed. They usually expect their general practitioner to provide an adequate explanation of the medical problem and the cure prescribed.

The study worked out the distribution of respondents according to perceived health status (Figure 3). Once more there is a strong correlation between the results obtained by this study and those obtained by the HIS 2008 survey. In this study 52% of respondents reported normal health status (HIS 2008 survey 53.0%), 1% reported very poor health status (also 1% in the HIS 2008 survey), and 9% reported excellent health status (here the comparison with the HIS survey cannot be done because the survey uses the “very good” classification. This classification scored 26.0%)

The study examined the relation between perceived health status of respondent
to their evaluation of general practice care (Table 4). The dimensions of doctor–patient relationship, and of information and support are the two dimensions shown to have been varied according to the perceived health status of respondents. A possible explanation is that respondents with poor health status are bound to visit their general practitioner more often and need much information and support from their general practitioner to deal with their illness. Respondent with a self-perceived good health status may not even bother to visit a general practitioner and feel that they do not need information and support. They will therefore show less appreciation for these two dimensions. This is in line with results of the use of EUROPEP in other European countries, where older and more vulnerable respondent were found to be more positive in their evaluation of general practice care. (Grol R., Wensing M., et al 2000)

It is to be expected that patients with a perceived good health status would visit their general practitioner less often and express less need of general practice care. However, the author of this study believes that this perception should be corrected and that efforts should be made by the Health authorities and the medical profession to persuade that section of the population with a perceived good health status of the very important need of preventive care and regular monitoring of their health. People in good health need to visit their general practitioner as much as those with health problems. Regular check ups and advice on lifestyle and preventive medicine are not only advisable but essential to the maintenance of good health.

The study explored the distribution of respondents who reported one or more chronic conditions (Figure 4). It found that 39% of respondents reported that they do have one or more chronic conditions. The remaining 61% reported no such conditions.
This result is entirely consistent with the finding of the this same study on perceived health status, where 52% reported having normal health status, 37% having good health status and 9% excellent health status. An analysis of the findings of the HIS 2008 survey on morbidity in the Maltese Islands also compares well with the findings of this study regarding chronic conditions.

The study examined the relation between chronic conditions and patient's evaluation of primary health care (Table 6). This table represents equality of means according to reported presence of chronic disease for the five dimensions of the EUROPEP instrument. In none of the five dimensions was there any significant statistical difference. This means that the presence of chronic disease did not have any impact on patients' evaluation of their general practice care. One possible explanation is that chronic disease is not being adequately addressed by general practitioners and as a consequence chronically ill patients are indifferent to the performance of their general practitioner and to the care they receive. If this explanation is correct the situation calls for improvement since it is the general practitioner who carries the responsibility to treat chronically ill patients on a day-to-day basis.

A possible tool to bring about the required improvement in the treatment of chronically ill patients could certainly be the introduction of registration. In the current primary health care system in Malta patients visiting Health Centres are not registered with a particular general practitioner and are seen by the doctor who happens to be on duty. Lack of registration is not conducive to adequate continuity of care, which is crucial to the treatment of chronic conditions.
The study also examined the distribution of the primary health care provision in the Maltese Islands. 59% of respondents reported that they resort to the private primary health service, 13% that they use the public primary health care service, and 28% that they visit both (Figure 5) This result is once more consistent with the findings of the HIS 2008 survey, which concludes that the ratio of private to public GP visits is roughly 3 : 1. Figure 6 gives the percentages for doctor utilisation by respondent during the last four months. Once again the frequency of visits to private general practitioners far outnumbers that to public general practitioners, again be a ratio of 3 : 1. It is also relevant to note the relatively low percentage, less than 20%, of respondents who had never contacted a general practitioner over the last four months. This may reflect the growing awareness among the Maltese population of the need for a regular monitoring of one's health.

The obvious recommendation that follows from this result of the EUROPEP application as well as of the findings of the Health Interview Survey is that the public primary health care service needs to be improved in order to provide the same level of satisfaction among patients as the private primary health service. This objective should be at the basis of any reform of the health sector that is envisaged.

This discussion of the results has gone to some length in comparing the findings of this study with regard to distribution of respondents by gender, education, perceived health status, chronic conditions and private to public sector ratio to those in the HIS 2008 survey. This has been necessary in order to highlight the consistency of the Maltese EUROPEP instrument. The high correlation on these variables between the results of the application of EUROPEP in Malta and those of the HIS 2008 survey
strongly point to the validity and reliability of the Maltese version of EUROPEP.

The EUROPEP questionnaire covers five dimensions of care: relation and communication (doctor – patient relationship) (questions 1 - 6); medical care (questions 7 - 11); information and support (questions 12 - 15); continuity and cooperation (organisation of care) (questions 16 – 17); and facilities availability and accessibility (questions 18 - 23). Figure 7 gives the average scores for each of these dimensions. One should note the overall positive evaluation of Maltese patients for the general practice care they receive, especially with regard to doctor – patient relationship. These average scores indicate, however, that some problems with accessibility may exist, since this dimension gets the lowest score.

It is clear that the issue of accessibility needs to be holistically addressed. Accessibility involves a number of ways through which a patient may seek to get in touch with his general practitioner. Aspects of accessibility include trying to get an appointment with the general practitioner by phoning his clinic, speaking to the general practitioner himself on the phone, time scale for an appointment, waiting time in the clinic, duration of the consultation, and the attitude of the general practitioner during consultation – whether he/she is in a rush or whether he/she gives the impression that he/she has plenty of time at his/her disposal and is prepared to listen. Problems with accessibility usually result from a combination of most of these aspects. They all seem to be related to the time constraints on the general practitioner. In Malta most general practitioners run a solo practice, without secretarial or nursing staff support. Home visits are frequent, resulting in time wastage on driving to reach the patient's residence. Many of the younger general practitioners try to run a private practice in addition to their work
in the public general practice in order to improve their income. All these circumstances impose severe time limitations on general practitioners who on many occasions find it difficult to cope with their private or public practice, or a combination of both. In the author's view problems of accessibility can only be solved within the framework of a reform of the primary health sector, which will lead to a lighter workload and appropriate remuneration for general practitioners. This will allow general practitioners to manage their practice better, which will obviously ease problems of accessibility. Group practice, which is only just beginning in Malta, may also lead to the development of practices that are better organised and within which the general practitioner is supported by secretarial and nursing staff.

Figure 8 represents the mean dimension scores and gender differences. These scores are highly significant and quite specific to Malta. A study by Campell, Ramsey and Green in the UK (reviewed earlier in this thesis) found that differences between men and women in GPAQ scale scores were generally small, and attained statistical significance for none of the 13 aspects of general practice care examined. The authors themselves found this rather surprising since women on the whole have more frequent consultations.

The difference between genders in patient evaluation of general practice care in Malta is highest for the first dimension, doctor - patient relationship, followed by the organisation of care, accessibility, and medical care. Evaluation by sexes for information and support is nearly at the same level. One clear explanation for this difference in score according to gender is that women visit their general practitioner much more often than man. This is particularly relevant for Malta where the care of young children is still very
much the responsibility of the mother. This explanation is supported by the fact that the dimensions where women’s evaluation of general care is significantly more positive than that of men are those of doctor-patient relationship, organisation of care and accessibility. These are dimensions particularly relevant for frequent users of primary health care.

The study examined the scores for each of the five dimensions, distinguishing between the providers of care (Figure 9). First of all it is to be noted that respondents in general have a very high appreciation of the primary health care they receive. The highest score was 4.50 out of a possible 5.00 (private sector on doctor-patient relationship) and the lowest was 3.30 out of a possible 5.00 (public sector on accessibility). This high evaluation of general practice care among Maltese respondents corresponds to the result obtained by the HIS 2008 survey which found that 96% of those interviewed were satisfied with their private GP, and 78.3% were satisfied with the public GP. The dissatisfaction rate was only 0.3% with private GP and 5.2% with public GP. The high score in patient evaluation resulting from the application of the Maltese EUROPEP, also tallies with the findings of the application of EUROPEP in other European countries. The application of EUROPEP in ten European countries as reported by Grol R. Wensing M et al. found that over 80% of respondents expressed the opinion that the general practice care they receive was good or excellent.

The second important observation is that for all dimensions the private sector is perceived as providing a better service. This indicates that in the Maltese Islands, in general patients report that private general practice care is better than that provided by the public sector. The HIS 2008 survey confirms this result where it compares the
satisfaction rates for private and public practice across the whole health sector. It reports that 96% of patients are satisfied with the private GP, while only 78.3% express satisfaction with their public GP. This trend is confirmed by results on specialist care and on hospital care. In both instances the satisfaction rates are higher for private specialists and for private hospitals. The above mentioned report by Grol., Wensing et al on the EUROPEP application in ten European countries supports the trend that patients' evaluation of general practice care is more positive in countries with a fee-paying system, like Switzerland. Germany and Belgium, than in centralised national health systems, as in the UK and the Slovenia.

Grol and Wensing explain this tendency by means of the hypothesis that in the private sector system there is a more competitive environment which makes doctors "compete" for clients. This accounts for the higher flexibility, the better organisation and the quicker service of the private sector, which patients obviously prefer. However, the hypothesis of Grol and Wensing does not in my opinion account fully for the Maltese scenario. In the first place, in the Maltese primary health care system there is a flexible interchange between the private and the public sector which is well accepted by the population. According to one result of this study discussed earlier, 29% of respondents said that they visit both a private and a public GP. (Table 5) This flexible interchange and interaction between private and public general practice is extremely high considering that in many cases the general practitioners employed in the public sector also have their own private practice. Therefore, when respondents gave lower scores to the public sector, they were probably pointing their fingers to the physical environment, such as the reception area, to longer queues, to lack of continuity since when they visit the health centre they are not necessarily seen by the same doctor, to a
longer waiting time, and perhaps to a more hasty approach by the general practitioner resulting from the large work load of public general practitioners. This can explain the lower evaluation scores for the public general practice in all the dimensions covered by the EUROPEP questionnaire.

This explanation is further supported by surveys that have been reviewed earlier in this study which indicate that where patients are unable to judge the level of the technical care they receive, they give their judgment on the basis of aspects where they perceive themselves to be competent, like the physical environment and the affective behaviour of their general practitioner. (Jung H.P., Van Horne F. et al 1998)

One needs to look closer at the finding, both of the EUROPEP application and of the Health Interview Survey, that patients in general express a higher appreciation of the private general practice. As indicated earlier this does not necessarily point to a lesser competence or a lesser attention to patients on the part of general practitioners operating in the public sector. In many cases it is the same doctor who sees patients in the morning at a health centre or public hospital and in the evening goes on his rounds or holds consultations at his private clinic. A detailed analysis of the results of the EUROPEP application clearly indicates that the lack of satisfaction with the public general practice refers to the organisational aspects of care, such as long queues in public clinics, lack of continuity of care, lack of welcoming facilities, the state of the building, lack of comfort in the waiting rooms, etc. This situation can only be adequately addressed within the context of an overall reform of the public primary health sector, which would include, among other measures, a system of patient registration, better remuneration and working conditions to attract a sufficient number of general practitioners to the public sector, and
an upgrading of the physical environment of public health centres and clinics.

The results of the study show that the highest satisfaction scores were obtained for the dimension of doctor – patient relationship. This is an encouraging result since the cornerstone of general practice care is a formal yet personal and sustained relationship between the GP and his/her patient. This result is also consistent with the findings from the application of EUROPEP in other European countries. Grol and Wensing in the above mentioned report state that the most positive patients’ judgments were for keeping records confidential, for listening to patients and for time during consultation. All these aspects relate to the dimension of doctor – patient relationship.

The results also show that the dimension of accessibility scored lowest on the patient satisfaction scale. Once more this result from the application of EUROPEP in Malta correlates well with results on accessibility obtained from the EUROPEP application in other European countries. Grol and Wensing in their survey on ten European countries (Grol R., Wensing ., et al 2000) report that relatively negative judgments were for the evaluation of waiting times in the waiting room, speaking to the GP on the telephone, and getting through to the practice on the telephone. All these are aspects related to accessibility.

The scores obtained for the dimensions of medical care and information and support are all close to the scores obtained in other European countries where the EUROPEP questionnaire has been used.

The mean scores of patient evaluation of general practice care for ten European
countries as reported by Grol, Wensing et al. are reproduced in table form earlier in this thesis under section 4. The high correlation between these results and those obtained by the use of the EUROPEP instrument in Malta has been highlighted throughout this discussion of results. Two conclusions follow from this: first that the level of satisfaction of patients with their general practice care in Malta is similar to that expressed by patients in most other European countries; the second is that the validation of the Maltese version of EUROPEP instrument for patient evaluation of general practice care has been confirmed.

Limitations of this study

The major limitations of this study are similar to those inherent in any research on patient evaluation of primary health care. The team of researchers who developed the EUROPEP instrument were well aware of these limitations and did their best to overcome them. Similarly, the author of this thesis recognised that his research had to deal with a number of limitations, and did every effort to eliminate or reduce as much as possible their impact on the results. Nonetheless, some assumptions had to be made.

The most significant limitation of this and similar studies concerns the subjective nature of evaluation. The variables that can influence a patient's evaluation of the primary care he receives are limitless. They may range from a news item that the patient may have heard just before he replied to the questionnaire to a recent accident or illness. This thesis tried to keep a clear distinction between the cognitive and the affective aspects of the evaluation of primary health care. The research did everything possible to ensure that the Maltese text of the EUROPEP questionnaire would, like the
original version, be as clear and unambiguous as possible, and that emotive wording, or wording that could elicit an affective response, would be left out or neutralised. Furthermore, every effort was made to conduct the interviews in an atmosphere as neutral and emotion free as possible. The interviewers were carefully selected from among profession telephone interviewers, and were especially trained and briefed for this task. In addition total anonymity was maintained throughout the interviews. Notwithstanding these efforts one can never exclude an emotive component affecting the objectivity of the replies given.

Another significant limitation of this research, which again is common to all similar work on patient evaluation of primary health care, results from the technical complexity of today's primary health care. The literature review given in Section 3 refers to a number of surveys that suggest that patients are not entirely competent to grasp the technical nature of the medical treatment they receive, and when they are unable to understand what their doctor is doing, they tend to evaluate the care they receive on the basis of unrelated factors, such as the physical surroundings or the welcoming smile of the receptionist. The EUROPEP questionnaire tries to deal with this problem by formulating the questions dealing with medical care (questions 7 – 11) in such a way that the patient is encouraged to respond on the basis of the effects on his health of the treatment received rather than on the technical aspects of the treatment itself. In this thesis every effort was made to ensure that the Maltese version of the EUROPEP instrument would be as near to the original text as possible. Nonetheless, one cannot exclude the possibility that when patients gave their evaluation of the medical care they received they did not have their views muddled by a lack of understanding of the technical nature of the treatment.
These considerations on the limitations of this work and of similar ones lead to the crucial question on the reliability of patient evaluation of primary health care. In the literature review given in Section 3, the thesis refers to a number of studies which question the reliability of patients' evaluation of primary health care. Patients' evaluation of care can certainly provide useful information with regard to the predictors of good quality care; however, on its own it cannot be regarded as providing a definite judgement on the quality of care.

This issue of reliability is directly related to that of feedback. One is bound to question the extent to which patient's evaluation of primary health care can provide clear indications on how the primary health care system or a particular practice can be improved. Once again, it would be prudent to conclude that, while the results of patients' evaluation of primary health care do provide useful indicators for improvements in the quality of care, they cannot be taken to provide a definite guide for deciding which improvements are necessary and how they can be best implemented.

Indeed another limitation of this study, which is also shared by other similar studies, is that it does not provide a clear methodology on how the results are to be transformed into feedback for the improvement of the quality of care. The formulation of such a methodology was outside the scope of this thesis, though it attempted to submit a number of recommendations based on the results obtained. Indeed the author sincerely hopes that the results obtained from this study would raise awareness of certain problems that exist in general practice care in Malta, and that the suggestions that are put forward would make a useful contribution to the current debate on a reform
of the primary health care system.
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Appendices

The EUROPEP-questionnaire:

What is your opinion of the general practitioner and/or general practice over the last 12 months with respect to...

1. Making you feel you had time during consultations?
2. Interest in your personal situation?
3. Making it easy for you to tell him or her about your problems?
4. Involving you in decisions about your medical care?
5. Listening to you?
6. Keeping your records and data confidential?
7. Quick relief of your symptoms?
8. Helping you to feel well so that you can perform your normal daily activities?
9. Thoroughness?
10. Physical examination of you?
11. Offering you services for preventing diseases?
12. Explaining the purpose of tests and treatments (eg. screening, health checks, and immunisations)?
13. Telling you what you wanted to know about your symptoms and/or illness?
14. Helping you deal with emotional problems related to your health status?
15. Helping you understand the importance of following his or her advice?
16. Knowing what he or she had done or told you during contacts?
17. Preparing you for what to expect from specialist or hospital care?

18. The helpfulness of the staff (other than doctor)?

19. Getting an appointment to suit you?

20. Getting through to the practice on the phone?

21. Being able to speak to the general practitioner on the telephone?

22. Waiting time in the waiting room?

23. Providing quick services for urgent health problems?
Din il-fraż ghandek tirrepetiha qabel kull mistoqsija - X'taħseb dwar il-tabib tal-familja u/jew is-servizz li tak tul l-ahħar tnaħ-il xahar dwar... (1 - dghajjej 5 - edċellenti)

1  Komm kellek hin bżejjed waqt il-vista?
2  Komm ha/det interess fis-sitwazzjoni personali tieghek?
3  Komm kellek ċans biex tkellmu/imha dwar il-problemi tieghek?
4  Komm involviek/lek fid-deċiżjoni dwar il-kura medika tieghek?
5  Komm semghek/tek b'attenzjoni?
6  Il-kunfidenzjalità tar-rekords u l-informazzjoni tieghek?
7  Komm irkuprajt malajr fejn dan kien possibbli?
8  L-ghajnuna li tak biex thossok tifah tkompli bi-aktivitajiet normali ta' kujum?
9  Servizz shih, metikoluż u komplut?
10 Ezami fiżiku fuq persuntek?
11 Servizzi ta' prevenzjoni minnn xi kundizzjoni?
12 Spjegazzjoni ta' l-iskop tat-testlijiet u l-kura li ordnalek?
13 Komm qallek/lek dak li ridt tkun taf dwar is-sintomi u/jew mard tieghek?
14 Ghajnuna biex tkampa ma' problemi emozzjonali relatati mal-istik tal-sahhtek?
15 Komm qhinek/qhinitek tifhem l-imptanza li ssegwi il-parir tieghu/ha?
16 Komm fhint dak li qallek/lek u ghamel/let kull meta tkellimtu?
17 Komm ippreparak/tek dwar x'ghandek tistenna minn kura ta' speċjalista jew kura fi sptar?
18 L-ghajnuna li hadt minn staff iexor barra t-tabib?
19 Komm kellek appuntament jew tak hin li kien konvenjenti għalik?
20 Komm kien fa'di taqbad miegħu/ha bit-telefon?
21 kemm hassejtek komdu/a li stajt ttilklem mat-tabib/a bit-telefon?
22 Komm domt tistenna qabel dhalt għand il-tabib/a?
23 Servizz malajr fil-każ ta' problemi medici serji?
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Insellimlek.

Jien jisimni ____________________________.

Qeghdin naghmlu stharrig f’Malta u Ghwadex sabiex insiru nafu x’inhi l-opinjoni tieghek dwar il-kura tas-sahha primarja li tirčievi minghand it-tobba tal-familja sew privati kif ukoll dawk tač-čentri tas-sahha bl-għan li dan is-servizz intejbuh.

Nixtieqk tghinna nfasslu sistema ahjar għalik u għal qrabatek.

Dan huwa hin konvenjenti għalik biex titkellem mieghi?
1. □ Iva (mur fuq kunsens).
2. □ Le (Staqsi l-mistoqsija t’hawn taḥt).
Fi x’hin ikun l-ahjar għalik sabiex incempillek lura?
Irregistra t-twegiba __________________ u għid:
Nirringrazzjak tal-hin tieghek; incempillek lura f’dak il-hin sabiex inkun nista’ nkellmek.

1. Kunsens

Ħalli nghidlek ftit aktar dwar l-istharriġ. L-iskop ta’ dan l-istharriġ hu sabiex niktelmu direttament man-nies dwar x’jahbsu fuq it-tabib u s-servizz tas-sahha primarja. L-intervisti se jghinuna nagħrfu liema servizzi ghandhom bżonn jiġu mtejba.

Inti se tigi intervistat minni li ġejt imharreġ sabiex nagħmel l-intervisti fuq it-telefon. L-intervista tiehu total ta’ ghaxar minuti.

M’hemmx vantagżi diretti għalik jekk tagħżel li tirrispondi l-mistoqsijiet, iżda r-rizultati ta’ dan l-istudju huma importanti hafna sabiex jghinuna ntejbu l-kura tas-sahha.


L-informazzjoni miġbura minn dan l-istdju se tintuża biss bhala parti minn studju dwar il-kura tas-sahha. Ismek u l-indirizz tieghek m’humiex parti mill-informazzjoni miġbura waqt l-intervista, u għalhekk it-tweġibiet tieghek ma jistghux ikunu identifikati. Minhabba li t-tweġibiet moghtija huma privati u ta’ natura kunfidenzjali, it-tim li qiegħed iwettaq dan l-istudju biss se jara dan l-istharriġ.

Il-partecipazzjoni tieghek f’dan l-istharriġ hi kompletament volontarja. Inti għandek id-dritt li ma tweġibx għal xi mistoqsijiet jew li twaqqaf l-intervista fi kwalunkwe hin. Tkun xi tkun id-deċiżjoni tieghek, din mhix se tbiddel il-kura tas-sahha li soltu inti tirċievi jew l-impjieg tieghek.

Inti lest/a li tiegżeb mistoqsijiet waqt stharrig dwar il-kura tas-sahha?

1. □ Iva (Mur fuq il-kwestjonarju tal-EUROPEP).