STATE PRIMARY HEALTH CARE –

ADDRESSING

MEDICAL MANPOWER NEEDS

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Declaration of Originality

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I the undersigned hereby attest as to the originality of the work within this management report (dissertation) entitled 'State Primary Health Care - Addressing Medical Manpower Needs', which is being submitted in part-fulfilment of the Masters in Health Science (Health Services Management) at the Institute of Health Care, University of Malta.

MARIO R SAMMUT

Supervisor’s signature

Dr KENNETH GRECH
Acknowledgements and dedication

Acknowledgements:

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Dedications:

This project is dedicated to my family: my children Graziella (watching over us from Heaven), Chris and Emily; and my wife Carmen without whose patience and support my studies over the past two years would not have been possible.
Executive Summary

Reason for the research:

It has been suggested that the lack of general practitioners (GPs) working in government health centres in Malta is a result of poor job satisfaction. This situation impedes the Health Division's plans to strengthen primary health care. This project set out to investigate this hypothesis and recommend solutions.

Method:

A mixed methodology was used. The quantitative method measured GPs' job satisfaction using the Spector 'Job Satisfaction Survey'. The qualitative procedure involved analysis of replies to open questions put to GPs to express their feelings about the GP service, suggest reasons for shortages and propose solutions. The implementation of these solutions was then discussed during focus group and elite interviews.

Results:

Quantitative analysis: Seventy-one questionnaires out of 136 were returned, giving a response rate of 52%. Job dissatisfaction was confirmed among health-centre doctors during 1998-2003. Taking significance as p<0.05, univariate regression analysis revealed that doctors formerly working in health centres were significantly more dissatisfied (p=0.033) than present state GPs, and that working part-time is significantly more satisfying (p=0.007) than working full time. The categories of being male and of doing private practice were negatively related to satisfaction,
although such relationships only approached statistical significance (p=0.082 and p=0.076 respectively). Multiple regression analysis showed that the only category having a statistically significant relationship with total satisfaction was that of working part-time (p=0.039).

Qualitative analysis: A few respondents did share positive feelings about being a government GP. However, the great majority of GPs revealed overwhelmingly negative feelings, experiencing job dissatisfaction to stress and depression; feeling unappreciated, neglected and disrespected and also verbally and physically used, misused and abused. Doctors believed that the top three causes of the lack of government GPs were poor pay and ancillary benefits (cited 50 times), poor training prospects/career progression (38 times) and poor working conditions (33 citations).

Discussion:

Doctors have no doubt that job dissatisfaction is the sole cause of the shortage of state GPs. The following solutions for this shortage were discussed:

- Direct solutions: enhancement of working conditions through remuneration, non-monetary benefits and working environment; development of training in family medicine and of specialist status with career progression.

- Indirect solutions: introduction of continuity of information and care; implementation of better management, organisation of service delivery, curtailment of client abuse; optimisation of health-centre use and raising of GPs' status through educational campaigns.
Recommendations and conclusion:

Recommendations include:

- Improving and maintaining the supply of GPs: through appropriate remuneration, training in family medicine (undergraduate, vocational and continuing) with career progression to specialist posts.
- Reducing demand on GPs by job facilitation: through improving working arrangements and conditions (mainly by flexible working patterns, interdisciplinary teamwork and continuity of care through information technology); educational campaigns to combat client abuse and raise the profile of the state GP; better management.

Such human resource management policies (appropriate remuneration, professional development schemes and improved working arrangements and conditions) have the potential to enhance job satisfaction, reduce turnover and improve the care that state general practitioners provide to patients.

Key Words:

State primary health care; medical manpower; recruitment and retention; human resources management; job satisfaction; general practitioners.

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Contents

CONTENTS .................................................................................................................. 7

LIST OF FIGURES AND TABLES ............................................................................ 9

CHAPTER 1: INTRODUCTION ............................................................................... 11

1.1 BACKGROUND: REASON FOR SELECTING TOPIC, ITS IMPORTANCE AND SIGNIFICANCE .............................................................. 11

1.2 STATEMENT OF PROBLEM TO BE RESEARCHED ......................................................... 13

1.3 AIM, OBJECTIVES AND RESEARCH QUESTIONS .................................................. 13

1.3.1 Aim .................................................................................................................... 13

1.3.2 Objectives ......................................................................................................... 13

1.3.3 Research questions .......................................................................................... 14

1.4 BENEFIT TO ORGANISATION AND TO HEALTH SERVICES MANAGEMENT RESEARCH .............................................................................. 14

CHAPTER 2: LITERATURE REVIEW .................................................................. 16

2.1 JOB SATISFACTION AND MANAGEMENT .............................................................. 16

2.2 JOB SATISFACTION IN GENERAL PRACTICE ....................................................... 17

2.3 JOB SATISFACTION AND HUMAN RESOURCES MAINTENANCE ..................... 19

2.4 HUMAN RESOURCES MAINTENANCE IN THE STATE HEALTHCARE ENVIRONMENT ......................................................................................... 20

CHAPTER 3: METHODS ......................................................................................... 23

3.1 STUDY QUESTIONS .............................................................................................. 24

3.2 SELECTION OF PARTICIPANTS ............................................................................. 25

3.3 DATA COLLECTION AND ANALYSIS ................................................................. 26

3.4 ETHICAL CONSIDERATIONS ................................................................................. 27

3.5 LIMITATIONS OF STUDY ..................................................................................... 28

CHAPTER 4: RESULTS ............................................................................................. 30

4.1 QUANTITATIVE ANALYSIS ................................................................................... 30

4.1.1 Demographic and professional details ............................................................ 30

4.1.2 Analysis of total satisfaction mean scores ..................................................... 34

4.1.3 Analysis of facet mean scores ........................................................................ 38

4.2 QUALITATIVE ANALYSIS ..................................................................................... 42

4.2.1: How does / did it feel to be a doctor within the government GP service? 42

4.2.2: What are the causes of the shortage of GPs in state primary health care? 53

4.2.3: What solutions are needed to tackle this problem? ...................................... 56

4.2.4: Focus group and elite interviews .................................................................. 63

CHAPTER 5: DISCUSSION ......................................................................................... 79

5.1 JOB SATISFACTION AS A CONTRIBUTING FACTOR TO THE SHORTAGE OF STATE GENERAL PRACTITIONERS ................................................................. 79

5.2 WHAT OTHER CAUSES COULD BE CONTRIBUTING TO THE LACK OF DOCTORS IN THE GOVERNMENT GP SERVICE? ............................................................................ 83
5.3 Solutions addressing medical manpower needs in state primary health care

5.3.1 Direct Solutions to Medical Manpower Needs ............................................. 85
5.3.2 Indirect Solutions to Medical Manpower Needs ........................................... 94

CHAPTER 6: RECOMMENDATIONS ............................................................................ 100

6.1 Improving and maintaining the supply of GPs .................................................. 100
  6.1.1 Appropriate remuneration: ............................................................................. 100
  6.1.2 Training in family medicine and career progression to specialist posts ... 101
6.2 Reducing demand on GPs through job facilitation ........................................... 102
  6.2.1 Improving working arrangements and conditions ......................................... 102
  6.2.2 Educational campaign .................................................................................... 105
  6.2.3 Better management ....................................................................................... 106
6.3 Conclusion ........................................................................................................... 106

REFERENCES .......................................................................................................... 108

APPENDICES ............................................................................................................. 115

APPENDIX A: JOB SATISFACTION SURVEY ............................................................ 116
APPENDIX B: INSTRUCTIONS FOR SCORING THE JOB SATISFACTION SURVEY .... 118
APPENDIX C: SCORES IN JOB SATISFACTION SURVEY ........................................ 120
APPENDIX D: FORMAL APPROVAL FOR PROJECT .................................................. 122
APPENDIX E: COVERING LETTER ACCOMPANYING QUESTIONNAIRE ............... 123
List of figures and tables

Figures

Figure 1: Expectancy Model of Motivation with the Porter-Lawler Extension 20
Figure 2: Age distribution of respondents (by gender) 32
Figure 3: Distribution of respondents’ year of graduation 33
Figure 4: Distribution of years-spent by respondents in health centres (by gender) 33

Tables

Table 1: Demographic and professional details of questionnaire respondents 31
Table 2: Correlation of ‘hours worked’ between GPs presently in state primary care and those of them who participated in the survey 32
Table 3: Continuing education activities undertaken in health centres 34
Table 4: Mean scores for total satisfaction and their interpretation according to categories 36
Table 5: Results of regression analysis of those categories that were statistically significant (p-value <0.05) or nearly so 38
Table 6: Job Satisfaction Survey mean scores and interpretations (according to facet subscale and in total) for all doctors 40
Table 7: Job Satisfaction Survey mean scores and interpretations (according to facet subscale and in total) for doctors presently and formerly in health centres 41
Table 8: Job Satisfaction Survey mean scores and interpretations (according to facet subscale and in total) for full-time doctors, those working on reduced hours and those on part-time

Table 9: Feelings to be a doctor within the government GP service

Table 10: Causes of the lack of GPs in state primary health care (classified into themes)

Table 11: Proposed direct and indirect solutions for the lack of doctors in state primary health care

Table 12: Recommendations to improve satisfaction and medical manpower
Chapter 1: Introduction

1.1 Background: reason for selecting topic, its importance and significance

The Alma-Ata Declaration defines primary health care 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 through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the first level of contact of individuals, the family and 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. (Declaration of Alma-Ata, 1978).

The general practitioner (GP) or family doctor 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 (taken from the 1974 Leeuwenhorst definition, as cited by Olesen et al., 2000).

The backbone of local state primary care services is in fact the General Practitioner Service, which is available on a 24-hour basis in four of eight health centres in Malta, and during the day in the rest. A GP and nurse also attend local clinics (known as ‘bereg’ in Maltese) in some 40 localities that open for specific times on weekdays only (Dipartiment tal-Kura Primarja, 1997). As health-care providers in health centres are salaried civil servants, the state primary care service is offered free-of-charge at the point of use to all types of customers. In spite of this, it has been estimated that state primary care only services one-third of the population, with two-
thirds of primary health care being provided by private GPs (Azzopardi Muscat, 1999).

State primary care services are characterised by poor continuity of care and a weak doctor-patient relationship, due to non-registration of patients and incomplete record-keeping. Although there are adequate facilities (health centres, clinics and equipment), there is a lack of general practitioners working in the local government health centres, with the number of full-time doctors presently standing at approximately two-thirds of the recommended complement (Sammut, 2000b).

Sammut (2000b) has proposed that the unsatisfactory conditions of work coupled with a low income have resulted in an inadequate number of doctors having to see a disproportionately large amount of clients, often for minor ailments at all hours and on unwarranted house calls. This author goes on to suggest that this has resulted in the development of a 'laissez-faire' attitude among a few doctors. Others are making the decision to switch to private practice when their income from the latter reaches a sufficient level, with the shortage of doctors thus being exacerbated further.

Unfortunately, this dire situation goes against the plans of the Health Division for primary health care, which are to strengthen it through providing seamless public/private care, and thus avoid inappropriate, ineffective and inefficient use of costly secondary hospital care (Azzopardi Muscat, 1999).
1.2 Statement of problem to be researched

This management project intends to address the problem of an inadequate number of doctors within the government GP Service by investigating the hypothesis made by Sammut (2000b) that it is a result of poor job satisfaction, whilst allowing GPs to come up with other possible reasons and propose practicable solutions.

1.3 Aim, objectives and research questions

1.3.1 Aim

This management project intends to propose creative, innovative and practical recommendations to stem the drain of doctors from the government GP service (and attract new resources) by investigating job satisfaction of state GPs, whilst being open to the possibility of other causes of, and solutions to, this problem.

1.3.2 Objectives

It is intended that this report will enable the Health Division and Department of Primary Health Care to:

1. Objectively assess the job satisfaction of general practitioners in state primary health care;
2. Investigate the cause or causes of the lack of doctors in the government GP service;
3. Suggest creative and innovative solutions to the above problem;
4. Propose practical recommendations to implement effective human resource maintenance in state primary care, with specific regard to doctor retention and recruitment.

1.3.3 Research questions

- Is job satisfaction a contributing factor to the shortage of state general practitioners?
- What other causes, besides job dissatisfaction, could be contributing to the lack of doctors in the government GP service?
- What creative and innovative solutions are needed to address this problem and how can these solutions be implemented as practical recommendations to improve human resource maintenance in state primary health care?

1.4 Benefit to organisation and to health services management research

Although job satisfaction has been shown to have no effect on performance (Iaffaldano & Muchinsky, 1985, as cited in Hellriegel et al., 1995), job dissatisfaction has been associated with job turnover, not only among workers in general (Hellriegel et al., 1995) but also in general practitioners (Sibbald et al., 2003). This report therefore will:

- provide the organisation (the Department of Primary Health Care and the Health Division) with recommendations (utilising research methodologies and instruments) for human resource maintenance within the state primary care system; and
• break new ground in local health services management research by using a 'bottom-up' approach to assess primarily government GPs themselves (using both qualitative and quantitative methodologies) in order to manage this human resource problem, and not just consult policymakers and managers/administrators of state primary care through a 'top-down' process.
Chapter 2: Literature review

2.1 Job satisfaction and management

Job satisfaction has been defined as the general attitude towards a job (O’Reilly, 1991, as cited in Hellriegel et al., 1995) that “reflects the extent to which an individual is gratified by or fulfilled in his or her work” (Griffin, 1996). It is not a single concept, but is made up of a number of aspects, including pay, promotion, supervision, co-workers and the work itself (Hanisch, 1992, as cited in Hellriegel et al., 1995). Moreover, the job itself would provide different sources of satisfaction or dissatisfaction, including challenge, interest, physical demands and working conditions (Hellriegel et al., 1995).

Herzberg has gone as far as to develop the 'two-factor theory of motivation', which divides the above aspects of dis/satisfaction into two independent sets. Motivation factors related to work content (including achievement, recognition, responsibility, advancement/growth and the work itself) were found by Herzberg to influence satisfaction, while hygiene factors related to the work environment (comprising supervisors, working conditions, interpersonal relations, pay/security and administrative policies) were presumed to affect dissatisfaction. He thus postulated that, while the provision of hygiene factors would merely ensure the absence of dissatisfaction, motivation factors would then have to be experienced by workers for them to achieve a high level of satisfaction and motivation (Griffin, 1996).
"A happy worker is a good worker" is an old adage that is often quoted in relating job satisfaction and performance, but this has been disproved in a meta-analysis by Iaffaldano and Muchinsky (as cited in Hellriegel et al., 1995). However, job dissatisfaction has been linked to physical and mental health problems, high absenteeism and job turnover. Thus a high level of dissatisfaction is of importance to managers, as it would bring to their attention any problems that exist with the individual's work experience (Hellriegel et al., 1995).

2.2 Job satisfaction in general practice

Despite there being widespread satisfaction with clinical, psychosocial and managerial aspects of British general practice in 1988 (Branthwaite & Ross, 1988), a review of the literature also reveals job dissatisfaction, both among young GP registrars (Branthwaite & Ross, 1988; Chambers et al., 1996), and established GPs (Appleton et al., 1998; Lambert et al., 2002; Sutherland & Cooper, 1992). Women GPs were found to be more satisfied with their job than their male colleagues (Cooper et al., 1989; Sibbald et al., 2000 and 2003; Sutherland & Cooper, 1993). According to a 2001 survey of over 23,500 GPs by the General Practitioners Committee of the British Medical Association, "the level of disillusionment among GPs is so widespread that a quarter want to leave the profession and many more plan to retire sooner than they had anticipated", with over 90% feeling overworked and undervalued (Kmietowicz, 2001).

In the U.S., as much as one-third of family physicians were found to be dissatisfied with their professional lives (Skolnik et al., 1993), and reduced job satisfaction has
also been registered among young primary care residents (Randall et al., 1997). In the state of Massachusetts, a study by Murray et al. (2001) described primary care physician satisfaction as "extremely low". Moreover, national satisfaction levels have declined among primary care physicians between 1997 and 2001 (Landon et al., 2003). Work-place and work-related conditions are a major determinant of well-being in U.S. primary care physicians (Williams et al., 2002; Landon et al., 2003), of which those who were dissatisfied with their jobs were much more likely to report difficulties in caring for patients (DeVoe et al., 2002) and more than twice as likely to leave as satisfied doctors (Buchbinder et al., 2001).

Job dissatisfaction has also been found among general practitioners outside the UK and the USA. While in New Zealand dissatisfaction was discovered mostly among rural and solo practitioners (Dowell et al., 2000), 50% of GPs in Victoria, Australia were not satisfied with their work (McGlone & Chenoweth, 2001). General practitioners were the most dissatisfied among self-employed physicians in Slovenia (Svab et al., 2001), and dissatisfaction has been documented among primary care physicians in Israel (Kushnir et al., 2000) and in Saudi Arabia (Kalantan et al., 1999).

However, it must be pointed out that doctor discontent has been documented as a worldwide phenomenon also among medical practitioners in general. Factors associated with doctor dis/satisfaction include workload, pay, autonomy, support and incentives, together with different expectations of the job from society and the doctors themselves (Edwards et al., 2002; Landon et al., 2003; Murray et al., 2001; Smith, 2001).
2.3 Job satisfaction and human resources maintenance

Although a study by Grol et al. (1985) revealed that general practitioners’ dissatisfaction (frustration and lack of time) correlated with poor quality of care (a high prescription rate and poor communication), job satisfaction has been shown by meta-analysis to have no effect on performance (Iaflaldano & Muchinsky, 1985, as cited in Hellriegel et al., 1995). On the other hand, job satisfaction has been associated with job turnover and high absenteeism (Hellriegel et al., 1995).

In Malta it has been suggested that the lack of general practitioners working in the government health centres is a result of poor job satisfaction (Sammut, 2000b). Job satisfaction is an important determinant of physician retention and turnover (Lichenstein, 1998, as cited in Sibbald et al., 2000), and a national survey among GPs in England has found that the proportion intending to quit direct patient care within 5 years rose from 14% in 1998 to 22% in 2001, with a decrease in overall job satisfaction cited as the most important factor underlying this rise (Sibbald et al., 2003).

Satisfaction with the work environment is one of three factors (the others being ability and effort) which, according to the Expectancy Model of Motivation, together result in performance with various outcomes that are given different values of attractiveness (valences) by the individual (Griffin, 1996). Porter and Lawler (as cited in Griffin, 1996) proposed an extension to this model (see Figure 1), with the outcomes being classified as extrinsic (e.g. pay and promotions) or intrinsic (e.g. self-esteem and
accomplishment). They suggested that the individual is satisfied if he or she perceives that the rewards are equitable or fair in relation to the effort and performance.

Figure 1: Expectancy Model of Motivation with the Porter-Lawler Extension

Sibbald et al. (2003) recommend that, as job satisfaction is an important factor underlying GPs' intention to quit, attention should be given to this aspect of doctors' working lives to help increase the supply of general practitioners. Thus, the rationale behind this study was for participants to come up with practicable work environment factors and realistic intrinsic/extrinsic rewards, so that the manager could link these to the desired performance (according to the motivation model - above) and, if the system is equitable, be able to improve their satisfaction, and consequently their retention (together with the recruitment of new doctors).

2.4 Human resources maintenance in the state healthcare environment

According to Griffin (1996), recruitment and retention (which is known as 'human resources maintenance') within an organisation depends on three factors:

- compensation (financial remuneration: hourly wages, annual salaries and incentives);
• benefits (non-financial: leave, insurance, pension plan, and other service benefits such as tuition reimbursement, recreational opportunities and on-site childcare);
• career planning, to the benefit of both the individual and the organisation.

One factor not mentioned by Griffin, the working environment, has been tackled by the U.K. Department of Health. Although there are those who have argued in the past that the British National Health Service (NHS) was overstaffed and inefficient, in recent years the U.K. Department of Health identified understaffing as the main constraint facing the NHS and started to address the problem of recruitment and retention. A human resources performance framework was devised where the first objective is ‘Improving Working Lives’ (IWL) through making the NHS a service that is seen to be sensitive to people’s needs and a place where people want to work. In 1999 the IWL Standard was launched ‘to create a well managed flexible working environment that supports staff, promotes their welfare and development and provides a productive balance between work and life outside work’ (Department of Health, 1997; 2001; n.d.)

The implementation of this standard in the U.K. is also being applied to NHS doctors, including general practitioners, through making real and tangible improvements in their working lives. In fact a ‘Flexible Careers Scheme’ has been launched in this respect, with “practical examples of what can be achieved with a little imagination and a fresh approach” (Donaldson, 2001, as cited in Department of Health, 2001). These include flexibility in work, professional and personal support, new ways of
working with new support roles, and better working environments (Department of Health, 2001).

The aim of this management project was to go beyond just an assessment of the job satisfaction of general practitioners in government health centres. The ‘bottom-up’ strategy of the project was to serve as a catalyst in bringing doctors in state primary health care together to highlight causes of the sector’s medical manpower problems and share fresh and new ideas about how they work. The ultimate objective was for recommendations to be made for practical and significant improvements in morale, efficiency and complement of staff with a consequent betterment in the quality of service provided to users.
Chapter 3: Methods

A mixed methodology was used, involving a combination of quantitative and qualitative techniques.

The quantitative method entailed the measurement and analysis of general practitioners’ job satisfaction through a questionnaire, which also served to gather the participants’ demographic details.

The qualitative procedure involved a two-step process:

1. The analysis of the replies to a number of semi-structured questions included in the same questionnaire, where GPs were asked to describe their feelings as doctors with the GP service, and given the opportunity to suggest their own reasons for staff shortages and propose solutions;

2. An in-depth discussion of such solutions during a focus group and elite interviews to allow participants to come up with practical recommendations regarding implementation. Health centre GPs were invited to take part in a focus group of up to 12 doctors (Clifford, 1997), while key-persons in the field (policy-makers and managers / administrators) were approached to participate in elite interviews.

This methodological mix enabled the comparison or ‘triangulation’ of different kinds of data (quantitative and qualitative, with the latter comprising semi-structured questions, and focus group and elite interviews). Just as in navigation different bearings give the correct position of an object, triangulation improves research
validity through the collaboration of findings from the different methods used (Silverman, 1993).

3.1 Study Questions

Quantitative: For an assessment of doctors’ job satisfaction to be made, they were asked to complete the Job Satisfaction Survey (Spector, 2001) seen in Appendix A (Spector, 1994). This survey is a 36 item, nine-facet scale to assess employee attitudes about the job and aspects of the job. Each facet is assessed with four items, and a total score is computed from all items. A summated rating (Likert) scale format is used, with six choices per item ranging from "strongly disagree" to "strongly agree". The nine facets are Pay, Promotion, Supervision, Fringe Benefits, Contingent Rewards (performance based rewards), Operating Procedures (required rules and procedures), Co-workers, Nature of Work, and Communication.

The survey was originally developed for use in human service organisations, and has been used to assess over 4000 medical workers by 1999. Although the survey is copyrighted, the author allows its use free-of-charge for non-commercial educational or research purposes as long as results are shared with him in order to enable updating of the norms and bibliography.

Qualitative: In order to gather information that is descriptive, explanatory and interpretative, the following open-ended questions were put in the questionnaire to allow the GPs to present their own views:

- How does/did it feel to be a doctor within the government GP service?
• What are the causes of the shortage of GPs in state primary health care?
• What solutions are needed to tackle this problem?

The answers to the last question were then discussed in more depth and considered from a practical and procedural aspect by GPs during a focus group, and by policymakers and managers/administrators during elite interviews.

3.2 Selection of Participants

The study included all doctors (n=84), permanent and temporary, working as GPs in the Department of Primary Health Care in January 2003, together with those (n=52) who left primary health care during the previous 5 years (1998-2002). The focus group was formed of six general practitioners, all presently working in health centres, who accepted a written invitation to participate and were able to attend on the agreed date. Two GPs were from the northern health centres (Mosta, Rabat and B’kara), two from the central health centres (Floriana, Gzira and Qormi) and two from the southern health centres (Paola and Cospicua). Policy makers and managers/administrators from the Primary Health Care Department (the Director of Primary Health Care, the Manager of Nursing Services and the Coordinator of the Professional Development Unit), the Ministry of Health (the Information Management Officer) and the Foundation for Medical Services (the Manager Information Systems) kindly accepted an invitation to contribute their expertise by means of elite interviews. The latter two were approached because information management emerged as an important issue from the qualitative part of the questionnaire.
3.3 Data Collection and Analysis

Doctors were sent a copy of the questionnaire by mail, to be completed anonymously on an informed-approach basis, and then returned to the researcher by post in a pre-addressed and stamped envelope. A reminder was posted to participants after the set closing date.

Analysis of the Job Satisfaction Survey was performed using the ‘Instructions for Scoring the Job Satisfaction Survey’ (Spector, 1999) provided by the author and Microsoft Excel 2000 (see Appendices B and C). The statistical software programmes SPSS (version 11) and Intercooled Stata (version 7) were used for further analysis.

The analysis of the data collected from the semi-structured questions in the questionnaire was performed in two stages. First, all replies were input into a Microsoft Word 2000 document and key data were highlighted in the replies to enable cross analysis on a case-by-case basis - this is termed ‘data reduction’. In the second stage, called ‘data interpretation’, a model (e.g. a table or figure) was used to present in a lucid manner any differences and similarities within the clients’ recommendations, thus allowing any trends to be more easily identified and interpreted (Miles & Hubermans, 1994, as cited in Clifford, 1997).

Participants in the focus group were provided with a copy of the solutions proposed by the questionnaires to read prior to the meeting, and asked to participate in a SWOT analysis (strengths, weaknesses, opportunities and threats) of the proposals as regards
their implementation in practice. The proposals together with the results of the SWOT analysis were then passed on to participants in the elite interviews for their reactions. While the focus group and elite interviews were recorded on audiotape (with the participants’ permission), proceedings of the former were also written on flip charts during the meeting. Immediately after the group meeting and the interviews, the charts and tapes were transcribed onto Microsoft Word 2000 (being translated from Maltese to English where necessary), to facilitate their eventual incorporation into the discussion process of this project.

3.4 Ethical considerations

The Director General of Health on the 4th July 2002 signed a letter authorising the study to take place (Appendix D), in the absence of a Director of Primary Health Care at that time.

Participants were informed that they would be part of a research study that was intended to assist the Department in evaluating and improving conditions of work within the GP service in Malta. This would involve completion and return of the anonymous questionnaire, and participation in a focus group and elite interviews, with participation being entirely voluntary (see Appendix E for covering letter accompanying questionnaire).

The confidentiality of participants in the survey and focus group was ensured as only the researcher analysed the data, and no reports of this study will ever identify participants in any way. Participation or non-participation / refusal to answer
questions will have no effect on services that participants or any member of their families may receive from the Health Division and the Department of Primary Health Care, and they will receive no direct benefit as a result of participation. (Polit and Hungler, 1995)

3.5 Limitations of Study

The reactivity of participants may have been a limitation, in that the person filling the questionnaire would have wanted to give the researcher a reply to please the latter (the ‘halo effect’), not to mention the tendency to wish to leave a good impression. Moreover, as the researcher was an officer senior to the GPs, the latter may have found it difficult to discuss frankly some aspects of job satisfaction where they thought he might have been negatively involved. However, this effect was diluted during the focus group interview where participants found more courage to be honest in the presence of other colleagues.

A bias may also have been introduced from three aspects: that of non-response, recollection and interpretation. A non-response bias could have occurred through the self-limitation of doctors satisfied with the GP service who felt that they did not need to participate. This could have been tackled if a mini-sample of the non-respondents was taken and these were contacted directly to inquire as to the reason for their non-response. A recollection bias could also have been introduced if past health-centre GPs did not recollect the circumstances of their employment in the state GP service, especially if they had left the service quite some time ago. However, this bias was
limited, as former employees included in the survey were restricted to those who had left within the past five years.

An *interpretation bias* may have been introduced if the researcher had pre-conceived ideas of what the study should reveal, and allowed his interpretation to be affected by such ideas. As in this case the researcher forms part of the service, it was important that he did his utmost to retain such objectivity. Possible solutions here could have included the employment of a research assistant, or the commissioning of a second opinion, for the interpretation of the results. However, these were precluded by the fact that the study is a management report / dissertation in part-fulfilment for a university master's degree and, as such, the researcher must be solely responsible for the work presented. On the other hand, the researcher has already undertaken a previous research project evaluating a health service in which he was personally involved, and he was successful in not allowing the less-than-optimal results to affect the interpretation together with the subsequent conclusions and recommendations (Sannumut, 2001a).
Chapter 4: Results

4.1 Quantitative analysis

Seventy-one questionnaires were returned out of 136 that were mailed, giving an overall response rate of 52%. Of these, 53 were from the 84 GPs presently in primary health care (62% response) and 18 were from the 52 doctors that had left the government GP service over the past 5 years (35% response).

4.1.1 Demographic and professional details

The demographic and professional characteristics of the respondents are illustrated in Table 1.
Table 1: Demographic and professional details of questionnaire respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>Percent</th>
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<tbody>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Male</td>
<td>51</td>
<td>71.8</td>
</tr>
<tr>
<td>• Female</td>
<td>20</td>
<td>28.2</td>
</tr>
<tr>
<td><strong>Status:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Married</td>
<td>52</td>
<td>73.2</td>
</tr>
<tr>
<td>• Single</td>
<td>15</td>
<td>21.1</td>
</tr>
<tr>
<td>• Separated</td>
<td>4</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>When based in health centres:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Presently</td>
<td>53</td>
<td>74.6</td>
</tr>
<tr>
<td>• Formerly</td>
<td>18</td>
<td>25.4</td>
</tr>
<tr>
<td><strong>Hours of work in health centres:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full hours</td>
<td>55</td>
<td>77.5</td>
</tr>
<tr>
<td>• Reduced hours</td>
<td>7</td>
<td>9.9</td>
</tr>
<tr>
<td>• Part-time</td>
<td>9</td>
<td>12.7</td>
</tr>
<tr>
<td><strong>Private practice (after hours) while employed in</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>the Primary Care Department:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>43</td>
<td>60.6</td>
</tr>
<tr>
<td>• No</td>
<td>28</td>
<td>39.4</td>
</tr>
<tr>
<td><strong>Housework, caring for children / elderly while</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>employed in the Primary Care Department:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>39</td>
<td>54.9</td>
</tr>
<tr>
<td>• No</td>
<td>32</td>
<td>45.1</td>
</tr>
<tr>
<td><strong>Continuing education activities when in health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>centres:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>41</td>
<td>57.7</td>
</tr>
<tr>
<td>• No</td>
<td>30</td>
<td>42.3</td>
</tr>
</tbody>
</table>

The gender distribution of 71.8% males versus 28.2% females corresponds closely with the distribution in the target population of 75.7% males and 24.3% females (respectively 103 and 33 out of 136).

As information regarding hours worked by former state GPs was not available, the distribution of this characteristic was compared between GPs presently in state primary care and those of them who participated in the survey. Here the correlation was even closer, as shown in Table 2.
Table 2: Correlation of ‘hours worked’ between GPs presently in state primary care and those of them who participated in the survey

<table>
<thead>
<tr>
<th></th>
<th>GPs presently in state primary health care</th>
<th>Those of them participating in the survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Full hours</td>
<td>58</td>
<td>69.0</td>
</tr>
<tr>
<td>Reduced hours</td>
<td>12</td>
<td>14.3</td>
</tr>
<tr>
<td>Part-time</td>
<td>14</td>
<td>16.7</td>
</tr>
</tbody>
</table>

The distribution of the ages of respondents (by gender), their year of graduation and the length of time they have spent working in health centres (by gender) are shown in Figures 2, 3 and 4.

Figure 2: Age distribution of respondents (by gender)
Figure 3: Distribution of respondents’ year of graduation

![Figure 3](image)

- Std. Dev = $6.25$
- Mean = 1990.8
- N = 71.00

Figure 4: Distribution of years-spent by respondents in health centres (by gender)

![Figure 4](image)

Of the above three figures, Figure 2 showing the age distribution by gender is worthy of comment. Only 4 doctors (one of them female) from the 71 participants are aged
over 45 years, which could be interpreted as a sign that dissatisfaction may help GPs to decide to leave the service before reaching that age. Also, males outnumber females in all age-ranges except in the 35-39 year range, perhaps due to the return to work at that age of females (nine in number) with family commitments (8 out of 9, i.e. 89%) on part-time or reduced hours (7 from 9, or 78%).

Of the eighteen respondents who had left the health centres over the previous 5 years:

- nine (50.0%) are now private GPs, one of whom being also a housewife;
- seven (38.9%) are senior house officers, with one (5.6%) a principal medical officer;
- and one (5.6%) did not specify his/her present occupation.

The types of continuing education activities (both medical and non-medical) undertaken by respondents while working in health centres are shown in Table 3.

Table 3: Continuing education activities undertaken in health centres

<table>
<thead>
<tr>
<th>Medical</th>
<th>Number</th>
<th>Percent</th>
<th>Non-medical</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CME</td>
<td>18</td>
<td>25.4</td>
<td>Hobbies / interests</td>
<td>6</td>
<td>8.5</td>
</tr>
<tr>
<td>Masters</td>
<td>5</td>
<td>7.0</td>
<td>Diploma</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>MRCP</td>
<td>4</td>
<td>5.6</td>
<td>Masters</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Diploma</td>
<td>2</td>
<td>2.8</td>
<td>Unspecified</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>2</td>
<td>2.8</td>
<td>No reply</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>1</td>
<td>1.4</td>
<td>None</td>
<td>61</td>
<td>85.9</td>
</tr>
<tr>
<td>MRCGP</td>
<td>1</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRCS</td>
<td>1</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhD</td>
<td>1</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLAB</td>
<td>1</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reply</td>
<td>1</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>34</td>
<td>47.9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The 18 doctors (25.4%) who replied ‘CME’ did not elaborate further as to the type of continuing medical activities undertaken. Of note is the fact that nearly one half of respondents (34 out of 71, or 47.9%) declared that they did not participate in any form of CME at all.

4.1.2 Analysis of total satisfaction mean scores

Scores for total job satisfaction in the Job Satisfaction Survey are based on the sum of all 36 items in the questionnaire, and can range from 36 to 216. As each item is scored from 1 to 6, with high scores on the scale representing job satisfaction, the total score obtained may be interpreted as follows (P.E. Spector, personal communication, August 18, 2003):

<table>
<thead>
<tr>
<th>Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;36</td>
<td>Very dissatisfied</td>
</tr>
<tr>
<td>37-72</td>
<td>Moderately dissatisfied</td>
</tr>
<tr>
<td>73-108</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>109-144</td>
<td>Slightly satisfied</td>
</tr>
<tr>
<td>145-180</td>
<td>Moderately satisfied</td>
</tr>
<tr>
<td>181-216</td>
<td>Very satisfied</td>
</tr>
</tbody>
</table>

The scoring of the Job Satisfaction Survey revealed a total satisfaction mean score of 91 to the nearest digit, which confirmed slight job dissatisfaction among all doctors based in health centres over the past 5 years. The mean scores for total satisfaction and their interpretation according to different categories assessed are shown in Table 4.
Table 4: Mean scores for total satisfaction and their interpretation according to categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Male</td>
<td>91</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• Female</td>
<td>100</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td><strong>Status:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Married</td>
<td>94</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• Single</td>
<td>94</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• Separated</td>
<td>90</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td><strong>When based in health centres:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Presently</td>
<td>96</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• Formerly</td>
<td>85</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td><strong>Hours of work in health centres:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full hours</td>
<td>91</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• Reduced hours</td>
<td>96</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• Part-time</td>
<td>109</td>
<td>Slightly satisfied</td>
</tr>
<tr>
<td><strong>Private practice (after hours) while employed in the Primary Care Department:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>90</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• No</td>
<td>98</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td><strong>Housework, caring for children / elderly while employed in the Primary Care Department:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>95</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• No</td>
<td>92</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td><strong>Continuing education activities when in health centres:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>95</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>• No</td>
<td>91</td>
<td>Slightly dissatisfied</td>
</tr>
</tbody>
</table>

In fact, most category scores were in the nineties, with the lowest score of 85 seen in doctors formerly working in health centres (compared to 96 scored by present health-centre GPs), and the highest score of 109 denoting slight satisfaction observed in doctors working on a part-time basis (compared to 91 scored by full-timers and 96 scored by those working on reduced hours). Differences were also seen in the categories of gender and private practice. Females were more satisfied than males.
(scoring 100 and 91 respectively), and doctors with private practice were less satisfied than those not practising privately (with scores of 90 and 98 respectively).

In order to assess any statistical significance between the total satisfaction scores and the various categories, a statistical technique known as regression analysis (used to view the relationship between two or more numerical variables [Levine et al., 1999]) was applied to the results obtained in the Job Satisfaction Survey. Univariate regression analysis was used to look at the individual relationship between one category and the mean score, while multiple regression analysis was used to examine the relationship of each category with the mean score while compensating for all the other categories where association of significance (or approaching significance) was shown. Table 5 shows the results of regression analysis of those categories that were statistically significant (with significance taken as a p-value of less than 0.05) or nearly so.
Table 5: Results of regression analysis of those categories that were statistically significant (p-value <0.05) or nearly so

<table>
<thead>
<tr>
<th>Category</th>
<th>Univariate regression analysis</th>
<th>Multiple regression analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coefficient</td>
<td>Confidence interval 95%</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>8.56</td>
<td>-1.12, 18.24</td>
</tr>
<tr>
<td>In health centres:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presently</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Formerly</td>
<td>-10.80</td>
<td>-20.70, -0.90</td>
</tr>
<tr>
<td>Hours of work¹:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Reduced</td>
<td>5.69</td>
<td>-8.65, 20.02</td>
</tr>
<tr>
<td>Part-time</td>
<td>18.07</td>
<td>5.22, 30.91</td>
</tr>
<tr>
<td>Private practice²:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>8.04</td>
<td>-0.86, 16.94</td>
</tr>
</tbody>
</table>

¹ When in health centres;
² After hours, while employed in the Primary Care Department

The categories of:

- age,
- status (married, single or separated),
- year of graduation,
- years in health centres,
- housework, caring for children / elderly and
- continuing education activities

were shown by univariate regression analysis to have no significance at all in their relationship with the total satisfaction mean score, with significance taken as a p-value of less than 0.05.
Univariate regression analysis revealed that doctors formerly working in health centres were significantly more dissatisfied (p = 0.033) than GPs presently in health centres, and that working on a part-time basis is significantly more satisfying (p = 0.007) than working full time. Univariate analysis also showed that the categories of being male and of doing private practice were negatively related to satisfaction, although such relationships were only approaching statistical significance (p = 0.082 and p = 0.076 respectively).

However, after compensating for all the other categories where association of significance (or approaching significance) was shown, multiple regression analysis revealed that the only category with a statistically significant relationship with total satisfaction was that of working on a part-time basis (p = 0.039).

4.1.3 Analysis of facet mean scores

Scores for each of the nine facet subscales in the Job Satisfaction Survey (Pay, Promotion, Supervision, Fringe Benefits, Contingent Rewards, Operating Procedures, Co-workers, Nature of Work, and Communication) are based on 4 items each, and can range from 4 to 24. As each item is scored from 1 to 6, and high scores on the scale represent satisfaction, the facet score obtained may be interpreted as follows (P.E. Spector, personal communication, August 18, 2003):

<table>
<thead>
<tr>
<th>Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;4</td>
<td>Very dissatisfied</td>
</tr>
<tr>
<td>5-8</td>
<td>Moderately dissatisfied</td>
</tr>
<tr>
<td>9-12</td>
<td>Slightly dissatisfied</td>
</tr>
</tbody>
</table>
13-16 Slightly satisfied  
17-20 Moderately satisfied  
21-24 Very satisfied

When examining the mean scores for all doctors according to the nine facets (see Table 6), dissatisfaction was revealed in all subscales except for ‘supervision’ (of the doctors by superiors) which totalled 15, and relationship with ‘co-workers’ which scored 14, denoting slight satisfaction in both cases. Moderate dissatisfaction, the lowest level which was obtained, was shown with pay, promotion, fringe benefits and contingent rewards (with scores of 7 or 8), which are all aspects of remuneration.

Table 6: Job Satisfaction Survey mean scores and interpretations (according to facet subscale and in total) for all doctors

<table>
<thead>
<tr>
<th>Facet subscale</th>
<th>Mean score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>8</td>
<td>Moderately dissatisfied</td>
</tr>
<tr>
<td>Promotion</td>
<td>7</td>
<td>Moderately dissatisfied</td>
</tr>
<tr>
<td>Supervision</td>
<td>15</td>
<td>Slightly satisfied</td>
</tr>
<tr>
<td>Fringe Benefits</td>
<td>8</td>
<td>Moderately dissatisfied</td>
</tr>
<tr>
<td>Contingent rewards</td>
<td>7</td>
<td>Moderately dissatisfied</td>
</tr>
<tr>
<td>Operating conditions</td>
<td>10</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>Co-workers</td>
<td>14</td>
<td>Slightly satisfied</td>
</tr>
<tr>
<td>Nature of work</td>
<td>12</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td>Communication</td>
<td>10</td>
<td>Slightly dissatisfied</td>
</tr>
<tr>
<td><strong>Total satisfaction</strong></td>
<td><strong>91</strong></td>
<td><strong>Slightly dissatisfied</strong></td>
</tr>
</tbody>
</table>

1 Of the doctors by superiors

The two categories where statistical significance was shown in their relationship with total satisfaction (in Section 4.1.2) were then examined more closely according to facet subscale satisfaction.
When facet mean scores for *doctors presently and formerly in health centres* were calculated separately, the scores in seven out of nine subscales (excluding supervision and co-workers) were very similar and nearly all indicated dissatisfaction (Table 7), with the exception of ‘nature of work’ where present GPs were slightly satisfied with a score of 13 while former GPs were slightly dissatisfied with a score of 12. On the other hand, the scores for ‘supervision’ and ‘co-workers’ were quite dissimilar for the two categories. However, while scores for ‘supervision’ indicated satisfaction both for GPs presently in health centres (17) and those who had left over the past 5 years (13), scores for ‘co-workers’ revealed that present GPs were satisfied (16) while former GPs were dissatisfied (12).

Table 7: Job Satisfaction Survey mean scores and interpretations (according to facet subscale and in total) for doctors presently and formerly in health centres

<table>
<thead>
<tr>
<th>Facet subscale</th>
<th>Doctors presently in health centres</th>
<th>Doctors formerly in health centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>8 - Moderately dissatisfied</td>
<td>7 - Moderately dissatisfied</td>
</tr>
<tr>
<td>Promotion</td>
<td>6 - Moderately dissatisfied</td>
<td>7 - Moderately dissatisfied</td>
</tr>
<tr>
<td>Supervision</td>
<td>17 - Moderately satisfied</td>
<td>13 - Slightly satisfied</td>
</tr>
<tr>
<td>Fringe Benefits</td>
<td>8 - Moderately dissatisfied</td>
<td>8 - Moderately dissatisfied</td>
</tr>
<tr>
<td>Contingent rewards</td>
<td>7 - Moderately dissatisfied</td>
<td>7 - Moderately dissatisfied</td>
</tr>
<tr>
<td>Operating conditions</td>
<td>10 - Slightly dissatisfied</td>
<td>10 - Slightly dissatisfied</td>
</tr>
<tr>
<td>Co-workers</td>
<td>16 - Slightly satisfied</td>
<td>12 - Slightly dissatisfied</td>
</tr>
<tr>
<td>Nature of work</td>
<td>13 - Slightly satisfied</td>
<td>12 - Slightly dissatisfied</td>
</tr>
<tr>
<td>Communication</td>
<td>10 - Slightly dissatisfied</td>
<td>9 - Slightly dissatisfied</td>
</tr>
<tr>
<td><strong>Total satisfaction</strong></td>
<td>96 - Slightly dissatisfied</td>
<td>85 - Slightly dissatisfied</td>
</tr>
</tbody>
</table>

1 Of the doctors by superiors

When facet mean scores were then calculated for *full-time doctors, those working on reduced hours and those on part-time*, all three sub-categories were found to be satisfied with ‘supervision’ and ‘co-workers’ (Table 8). Doctors on reduced hours and on part-time were slightly satisfied with ‘nature of work’ (scoring 14), with which
full-time doctors were slightly dissatisfied with a score of 12. Although still dissatisfied with contingent rewards, part-time doctors averaged a higher score in this subscale (10) than full-timers (7) and doctors on reduced hours (5). In the remaining facet subscales, the scores for all three sub-categories were very similar.

Table 8: Job Satisfaction Survey mean scores and interpretations (according to facet subscale and in total) for full-time doctors, those working on reduced hours and those on part-time

<table>
<thead>
<tr>
<th>Facet subscale</th>
<th>Full-time doctors</th>
<th>Doctors on reduced hours</th>
<th>Part-time doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>7 - Mod. dissatisfied</td>
<td>8 - Mod. dissatisfied</td>
<td>8 - Mod. dissatisfied</td>
</tr>
<tr>
<td>Promotion</td>
<td>6 - Mod. dissatisfied</td>
<td>6 - Mod. dissatisfied</td>
<td>9 - Sl. dissatisfied</td>
</tr>
<tr>
<td>Supervision¹</td>
<td>16 - Sl. satisfied</td>
<td>19 - Mod. satisfied</td>
<td>18 - Mod. satisfied</td>
</tr>
<tr>
<td>Fringe Benefits</td>
<td>8 - Mod. dissatisfied</td>
<td>8 - Mod. dissatisfied</td>
<td>9 - Sl. dissatisfied</td>
</tr>
<tr>
<td>Contingent rewards</td>
<td>7 - Mod. dissatisfied</td>
<td>5 - Mod. dissatisfied</td>
<td>10 - Sl. dissatisfied</td>
</tr>
<tr>
<td>Operating conditions</td>
<td>10 - Sl. dissatisfied</td>
<td>9 - Sl. dissatisfied</td>
<td>10 - Sl. dissatisfied</td>
</tr>
<tr>
<td>Co-workers</td>
<td>15 - Sl. satisfied</td>
<td>17 - Mod. satisfied</td>
<td>17 - Mod. satisfied</td>
</tr>
<tr>
<td>Nature of work</td>
<td>12 - Sl. dissatisfied</td>
<td>14 - Sl. satisfied</td>
<td>14 - Sl. satisfied</td>
</tr>
<tr>
<td>Communication</td>
<td>10 - Sl. dissatisfied</td>
<td>11 - Sl. dissatisfied</td>
<td>12 - Sl. dissatisfied</td>
</tr>
<tr>
<td>Total satisfaction</td>
<td>91 - Sl. dissatisfied</td>
<td>96 - Sl. dissatisfied</td>
<td>109 - Sl. satisfied</td>
</tr>
</tbody>
</table>

¹ Of the doctors by superiors.
4.2 Qualitative analysis

4.2.1: How does / did it feel to be a doctor within the government GP service?

The various replies to the above question were classified into the themes shown in Table 9.

Table 9: Feelings to be a doctor within the government GP service

<table>
<thead>
<tr>
<th>A. Positive feelings</th>
<th>B. Negative feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A positive experience</td>
<td>1. From job dissatisfaction to stress &amp; depression, due to:</td>
</tr>
<tr>
<td>• Job satisfaction</td>
<td>(a) The nature of the work</td>
</tr>
<tr>
<td>• Job security</td>
<td>(b) The conditions of work</td>
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<td>• The nature of the work</td>
<td>(c) The set-up of the system</td>
</tr>
<tr>
<td>• Patient gratitude</td>
<td>2. Unappreciated, neglected and disrespected in the perceptions of others</td>
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<tr>
<td>• Pride</td>
<td>3. Used, misused, abused by others, both verbally and physically</td>
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<td></td>
<td>4. Poor service to client</td>
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</tbody>
</table>

A. Positive feelings

The intrinsic value of working in state general practice was highlighted by a male graduate of 1999 who is presently working as a hospital SHO. He affirmed that:

Being a doctor in the government GP service was for me a good experience. I appreciated the necessities the community had for good quality GP service. I learned from my work the need for appropriate care of both acute and chronic cases in health centres.

Being on the ‘frontline’ of general practice, the GP’s important role in health promotion and preventive medicine was also appreciated, as was the opportunity of helping people who are genuinely in need and could not afford to pay for it.

Twelve doctors (17% of all respondents) were of the opinion that being a GP with the government service did provide job satisfaction. A male doctor (graduated 1986),
who is now a private GP and admitted to “loving GP work”, pointed out the advantages of working with good support services in the state GP service (i.e. nurses, radiology and investigations). The fact that one participates in teamwork alongside other doctors, nurses, etc. was mentioned as making the experience more valid and enjoyable. Some degree of job satisfaction was also noted from continuity of care, especially when always working at the same health centre. Satisfaction was expressed in treating the patient and getting feedback about his or her progress, even on rare occasions from certain consultants at hospital.

The feeling of having job security as a health centre GP was shared by one respondent. The time-limitation (i.e. arriving and leaving at fixed times irrespective of workload) was regarded as a bonus, as was the facility of working flexible hours as a part-timer in accommodating one’s role as a parent. In fact the availability of parental leave, reduced and part-time hours within the government GP service was seen as a positive benefit, especially by female doctors in helping them to safeguard their profession.

Compared with working in a government hospital, the nature of the work was judged by a couple of doctors as better and not tiring at all. Moreover, it was felt that there is less stress at the work place in state health centres than in the hospital setting e.g. at the Casualty Department. The work was judged interesting because of the semi-emergency cases one gets to deal with. A male full-time health-centre GP who graduated in 1981 declared that “acute trauma management in the health centre I feel
is the best part of my job. I feel I treat cases of trauma fast, efficiently, correctly, with a minimum of fuss and see some gratitude from the patient here”.

**Patient gratitude** and appreciation for attention, treatment and services provided was experienced by five state GPs.

More than 50% of the patients which I see in the GP clinic show their appreciation and gratitude before they leave the GP room by asking who I am or whether I serve privately. They also wait to be seen by me next time round: then I know I am doing a good job. (Female health-centre GP on reduced-hours, graduated 1991)

To conclude this short account of positive experiences of state primary health care, another female health-centre GP working on reduced hours (graduated in 1990) declared that:

I feel as **proud** working in this section of healthcare as any other department and even in the private sector. I do not feel inferior. I even feel I am in a better position to provide care to the patient without biases arising from who can pay and who cannot pay.

**B. Negative feelings**

**1. From job dissatisfaction to stress and depression**

Twenty-eight doctors (39% of respondents) specifically declared a range of negative feelings about their work, ranging from job dissatisfaction (9 GPs), through feeling overworked (5 doctors), frustrated (9 GPs), and demotivated / demoralised / deluded (5 doctors), to stress and depression (5 GPs). Five respondents expressed feelings in more than one category.
In general terms, the GPs regarded their job as routine and at times boring, ranging from mundane to downright depressing. Frustration was expressed with knowing what should be done but being unable to do it, and at not reaching one’s full potential. Due to excessive bureaucracy, one sometimes regards oneself as a clerk; as graphically put by a male part-time health-centre GP who graduated in 1988, “it is the “supermarket” experience. People come, get served (demand to be) and vanish. We always have to deliver – always plus “the customer is always right”.

Respondents’ views as to the causes of their dissatisfaction may be classified under the following three headings:

(a) **The nature of the work:** this was described as repetitive and in most cases boring (with the occasional interesting case) because of the following:

- The heavy load of clerical paperwork (filling in prescriptions, certificates, referrals and investigations for patients), which was criticised as senseless and a waste of time by 14 GPs, one in five of respondents.
- Patients’ too-frequent attendance for trivial reasons, such as routine measurement of blood pressure.

Through the help of other employees and/or computerisation, it was felt that such time could be used more constructively, allowing one to practise his/her job as a medical doctor better.
(b) The conditions of work: just over one-third of respondents (24 doctors) felt unhappy with various aspects of conditions of work in the health centres. The main ones included:

- The inadequate remuneration and lack of other benefits (such as little prospects of promotion / continuing education and training, and the lack of rewards for a job well done) cited by 19 GPs;
- The lack of staff coupled with a huge workload (mentioned by 7 doctors), resulting in one doing one’s job less well than desirable due to lack of time for each patient, leading to a lower quality of care;
- Long, irregular and tiring hours due to the complicated ‘split shift system’;
- High occupational risks (e.g. of contracting diseases from patients, of driving at night, of dealing with criminals and psychiatric cases) coupled with the absence of medico-legal insurance;
- Poor or lack of equipment (medical and non-medical) and an inadequate working environment (both clinics and rest rooms).

As well described by a male part-time health-centre GP (graduated 1989), “I feel like the civil servant who is expected to do an infinite amount of work, at a low wage, but with very high responsibility”.

(c) The set-up of the system: working in the disorganised environment provided by the primary health care system was said to be a poor source of satisfaction by 13 GPs, due to the following reasons:

- Seven of these emphasised the poor continuity of care due to the dismissive set up (shifting responsibility to hospital doctors), the lack of communication with
hospitals and with private GPs, and minimal record keeping. This resulted in doctors being unable to treat and follow patients properly, and consequently wasting resources e.g. thorough duplication of investigations or performing unwarranted house calls.

- The situation is compounded by the lack of a patient-appointment system, with any number of people being able to attend at any given time, causing a lot of chaos and stress due to excessive queuing times.
- The system provides no incentives (positive or negative) for GPs to exert their gate-keeping role through following provided guidelines.
- GPs also lamented the apparent absence of long-term plans for the primary care system, and their lack of participation in any policies or decisions, which served to make the future of the government GP service unclear to them.

A male full-time health-centre GP (graduated 1984) in fact highlighted doctors’ frustration with their “work in a poorly structured service which gives no professional satisfaction, no “doctor-patient” relationship and (the) practising of defensive medicine”.

2. Unappreciated, neglected and disrespected

Variations of the above feelings were expressed by 29 doctors (41% of respondents to the questionnaire). Of these, fifteen GPs felt unappreciated, not praised or taken for granted; nine felt neglected, badly treated or not backed/heeded/supported/trusted; and another nine mentioned feelings of disrespect and degradation. Four respondents expressed feelings in more than one category.
A male hospital SHO (graduated 1997) described his experience of working in the government GP service as "it felt like being a denigrated, second-class medical professional", and went on to comment that "in the UK, the GP is the fulcrum of the NHS. In Malta he is merely a lame duck, a disrespected professional who is underpaid and is looked down by fellow colleagues and the administration". This was echoed by a female part-time health-centre GP (graduated 1997) who remarked: "instinctively, my first reply would be 'a second-rate doctor' ... not because I think I am less capable than other doctors, but because I feel that this is the way the general public, and 'hospital' doctors, often conceive us!"

Such perceptions were felt as originating from different sources, including patients and the general public, the administrative system, and even fellow colleagues.

(a) Seventeen respondents felt that patients and the general public were not being appreciative of GPs' heavy workload in health centres and not respectful of their professional role, regarding them as little more than civil appendages or simply as second class doctors who are not good enough for the private sector.

(b) The administrative system too was regarded by fifteen GPs as never duly appreciating, respecting or recognising doctors. Superiors seem to be uncaring towards doctors' needs, indifferent to their opinion during decision taking, and also show a lack of trust by requesting court-attendance certificates and verification of sick leave. Five doctors specifically criticised the lack of support (vis-à-vis unjustified
patient complaints) provided to doctors by the department when assuming that the client is always right.

(c) Problems with fellow colleagues were reported by nine doctors; these included selfishness, side kicking and making obstacles. There were complaints about the elitist attitude of hospital doctors towards state GPs, infighting and distrust between health centre doctors, and disharmony between the latter and the senior medical officer. Nursing staff were criticised for their lack of support despite being more plentiful than doctors, while backing staff such as health assistants were said to be generally uncooperative and unhelpful.

3. Used, misused, abused

Although at first sight the feelings of ‘use, misuse and abuse’ might be said to be similar to those of ‘lack of appreciation, neglect and disrespect’, in actual fact they have different meanings. While feeling unappreciated, neglected and disrespected refers to the perceptions or attitudes of others towards doctors, the words use, misuse and abuse were expressed in cases where there was actual verbal abuse from others towards doctors or else tangible physical misuse of their services.

Over 30% of respondents (22 doctors) specifically said that they felt used, misused or abused, with the following graphic descriptions being provided by three of them:

- “The best way I can describe what I feel to be a doctor within the government GP service is “a paid slave” (male, full-time health-centre GP, graduated 1985).
• "Like a puppet with everyone trying to pull your strings in opposite directions. Pathetic and frustrating!" (male, full-time health-centre GP, graduated 1987).

• "Like a “bicca ta’ l-art” (floor cloth)! Used and abused by the “patients” and unfortunately also by “colleagues” (male, private GP, graduated 1995).

As mentioned by the latter, doctors felt that such abuse was originating from multiple sources, namely patients and the general public, the administrative system and even from colleagues.

(a) Abuse by patients and the public was described by fourteen doctors, and included:

• Abuse of the doctor’s time, through attendance for trivial and silly complaints, sometimes out of normal hours, and through requests for unwarranted home visits.

• Verbal abuse of the doctor as a person, including the use of obscenities (both face to face and over the phone), which tended to lead to a ‘defensive’ attitude by doctors with all clients, to the ultimate detriment of true GP work.

• Abuse of the system since it comes without a (direct) price and lacks a framework for rules and procedures to follow in seeing to clients’ requests.

(b) The administrative system was mentioned as a source of abuse by eight respondents to the questionnaire, with half of them feeling as if they were being used “biex isoddu it-toqob”, i.e. to compensate for the shortcomings of the primary health care system in general. Doctors cited different causes for such shortcomings and abuse, namely:
• The primitiveness of the organisation, with its lack of structure and guidelines. It was felt that this called for a reshuffling of the system, to enable patients to have same-doctor follow-up, an appointment system to reduce abuse, and more advanced time-saving technology;

• The lack of involvement of GPs in decision making regarding running of the clinic, with conditions being imposed instead;

• The inaction of the authorities towards improving the situation.

(c) Abuse by fellow colleagues was revealed by no less than eight different respondents, and included:

• Some senior GPs (who knew the way the system worked) abusing the service to do their private practice, at the expense of more junior doctors;

• Other doctors earmarking the cushy jobs because of their seniority;

• Abuse of sick leave, which one doctor lamented as originating always from the same doctors.

4. Poor service to client

Just five doctors acknowledged that the service’s poor reputation of a low-quality customer service could partly be due to the staff, perhaps due to laziness and lack of courtesy or effort. A female full-time health-centre GP (graduated 1988) admitted that “government GPs have the reputation of civil servants, and in some cases justify so, i.e. lazy, scroungers, living off peoples’ backs”. A male private GP (graduated 1995) went further by stating that “the bad services provided by other doctors
reflected in a general hostile attitude from patients. When I tried to give a good service, I was criticised by my colleagues".
4.2.2: What are the causes of the shortage of GPs in state primary health care?

The replies to the above question were classified into different themes, with such themes and the relevant number of citations shown in Table 10:

Table 10: Causes of the lack of GPs in state primary health care (classified into themes):

<table>
<thead>
<tr>
<th>Themes</th>
<th>Times cited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor pay and ancillary benefits/incentives/reimbursement in comparison to responsibility of job, long hours and quantity of patients</td>
<td>50</td>
</tr>
<tr>
<td>Poor training prospects (no postgraduate or vocational training/recruitment scheme, no CME) and poor career progression / no prospect for advancement, promotion or specialisation / lack of incentive or motivation to use full potential or initiative and thrive as a GP</td>
<td>38</td>
</tr>
<tr>
<td>Poor working conditions / poor recreation &amp; rest facilities / lack of personal safety (e.g. risk of infection, going out on home-visits at night or to dangerous sites) / difficulty in taking vacation leave / use of own equipment (due to lack) &amp; car / disorganised environment / no appointment system / no computer support / unhelpful support staff</td>
<td>33</td>
</tr>
<tr>
<td>Poor administration / management (e.g. bureaucratic, inefficient, no accountability or audits, little feedback, dismissal of older part-timers) and poor doctor-administrator relationship (lack of support/backing/trust, no consultation/communication/agreement)</td>
<td>26</td>
</tr>
<tr>
<td>Poor continuity of care (no registration, poor record-keeping, no doctor-patient relationship, poor communication between doctors and between health centres and hospital)</td>
<td>23</td>
</tr>
<tr>
<td>Abuse by patients (“free for all” use of services), doctors (uncooperative/malingering/sick-leave), and administration</td>
<td>19</td>
</tr>
<tr>
<td>Little appreciation of doctors’ work and rights by government, superiors, public and patients themselves, with no reward for doing one’s job well</td>
<td>18</td>
</tr>
<tr>
<td>No respect with antagonism from patients / authorities</td>
<td>17</td>
</tr>
<tr>
<td>Poor job satisfaction</td>
<td>16</td>
</tr>
<tr>
<td>Inflexible roster with erratic and awkward split-shift times</td>
<td>15</td>
</tr>
<tr>
<td>Nature of work repetitive, boring, unsatisfying, basic, monotonous and not challenging (too much paperwork, dumping grounds for social and police cases, defensive medicine, inefficient work practices)</td>
<td>14</td>
</tr>
<tr>
<td>Poor perception/reputation/status of GPs (2nd class doctors, failed specialists) and GP service (dumping ground) – may be self-induced – with young doctors opting not to consider general practice</td>
<td>11</td>
</tr>
<tr>
<td>Overworked and stressed (covering up for shortage of staff, abuse by doctors &amp; patients)</td>
<td>11</td>
</tr>
</tbody>
</table>
Absolute lack of planning and resources by successive governments
with poorly structured service, resulting in disastrous health care provided
in primary level - Political interference in GP system - GPs feel that the
government does not truly want to improve the polyclinic services - The
future of the government GP service is unclear

| Absolute lack of planning and resources by successive governments | 11 |
| Poor job description / lack of definition of services/protocols | 5 |
| Lack of autonomy in decision-making with feelings of ‘restriction’ and loss of freedom when compared to private GP set-up | 5 |
| Conflict between private and public sector: gradual increase in one’s private practice / other source income, with health centre used as a stepping-stone | 4 |

It is evident from the above list that practically all the reasons given were of an internal nature, i.e. originated from within state primary health care. Only the last item in the list (conflict between private and public sector) can be considered as external, as it involved the doctor’s time gradually being taken over by a growing private practice. Two other causes (poor training prospects and poor career progression), while strictly speaking are internal causes, may be considered also as external factors as they could push a doctor to seek such goals elsewhere (external to state primary health care).

One difference of note between doctors presently and previously employed in state primary health care is that 33% (6 from 18) of former health-centre GPs (compared to 4 out of 53 or 8% of present health-centre GPs) cited abuse through malingering by fellow colleagues as a reason for doctors leaving the government GP service. In fact, this collaborates the finding in Section 4.1.3 where analysis of facet mean scores showed that, while doctors presently in health centres were satisfied with ‘coworkers’, those who had left health centres over the past 5 years showed dissatisfaction under this facet.
Also, 3 doctors each from previous and present health centre doctors (giving percentages of 17% and 7% respectively) mentioned antagonism and abuse by supervisory administrators as a cause of lack of state GPs, which correlates with their respective dissatisfaction and satisfaction with ‘supervision’ shown by the Job Satisfaction Survey.
4.2.3: What solutions are needed to tackle this problem?

The solutions proposed by questionnaire respondents to question 3 (above) have been classified under the themes shown in Table 11.

Table 11: Proposed direct and indirect solutions for the lack of doctors in state primary health care

<table>
<thead>
<tr>
<th>A. Direct Solutions</th>
<th>B. Indirect solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enhance working conditions: remuneration, other benefits and working environment</td>
<td>1. Introduce continuity of information and care</td>
</tr>
<tr>
<td>2. Develop undergraduate, vocational and continuing training in family medicine,</td>
<td>2. Implement better management, organise service delivery, curtail client abuse</td>
</tr>
<tr>
<td>with the introduction of specialist status and career progression</td>
<td>3. An educational campaign to optimise use of health centres by clients and to raise the status of the state GP among the general public</td>
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</tbody>
</table>

A. Direct Solutions

1. Enhance working conditions: remuneration, other benefits and working environment

Improvements in working conditions were proposed to ensure that doctors would be more committed and motivated and give their job in the state sector priority over their private practice. Such conditions would include better remuneration (cited by 49 out of 71 doctors, i.e. 69%), other benefits (29 citations or 41%) and a suitable working environment (suggested by 22 or 31% of respondents).

It was recommended that a fair salary scale be established for GPs, which befits the importance of their work in an area of need (as is primary health care) and reflects the much higher responsibility of a medical doctor’s work (relative to other healthcare
staff). At the same time, the salary should be in some way related to an individual’s performance and work-conduct, enhanced by certain allowances.

Doctors working in health centres should also enjoy additional emphasis on non-monetary benefits, such as professional indemnity / insurance cover. Other benefits that would be appreciated include increased autonomy for the medical practitioner and greater flexibility regarding working hours.

GPs’ working environment should also be given due attention. While ancillary staff should be competent and friendly, nurses and paramedical staff need to work hand in hand with doctors. Moreover, if nurses were to accept increased responsibility for certain procedures (e.g. routine blood pressure measurement), and refer to the GP only for advice as necessary, there could be scope for increasing (and making more interesting) the role of GPs through their providing some special services themselves (e.g. Well Baby and Gynaecology Clinics) and even performing minor surgery.

Certain health centres need to be refurbished and better equipped, with modern GP-consulting rooms and adequate equipment, together with comfortable waiting areas and staff quarters. Effective security cover also is recommended to ensure GPs’ protection at work from deliberate or accidental injury.
2. Develop undergraduate, vocational and continuing training in family medicine, with the introduction of specialist status and career progression

The above proposals were made by 24 (or 34%) of the questionnaire respondents. Training in family medicine needs to be developed at all levels. Better undergraduate exposure to general practice in medical school was recommended, followed by vocational training in family medicine and formal recognition of qualifications.

There should also be opportunities for continuing medical training and postgraduate courses – provided, approved and fully sponsored by the Primary Health Care Department – that could include experience abroad. More specifically, a need was identified for regular refresher courses / in-course retraining in areas related to acute medicine and various specialities.

As befits the specialist status family medicine enjoys in Europe, GPs who undergo specialisation in family medicine should be recognised as specialist GPs in their own right. Vocational and continuing training in family medicine would need to be complemented by the introduction of career progression in a clinical stream, with the creation of the posts of ‘General Practitioner’, ‘GP Registrar’ and ‘Consultant GP’.

Thus, if general practice is treated as a specialty in itself and career progression is introduced, the recruitment of new doctors may be enhanced through the vision of primary health care as an opportunity for specialisation.
B. Indirect Solutions

1. Introduce continuity of information and care

From replies to the questionnaire (45 citations from 71 respondents, i.e. 63%), it emerged that an important factor that would lead to improved job satisfaction for doctors is continuity of care. This would streamline doctors’ duties, with GPs having more time to devote to more important matters - their clients’ problems - and a consequent improvement in the quality of care provided to patients.

A basic prerequisite needed for the improvement in the continuity and level of care is the provision of continuity of information. This may be achieved through the following:

- Patient registration, with so many persons allocated to each GP practice;
- An appointment-based system, with exceptions for emergency cases;
- Better coordination with other clinics/hospitals;
- A good medical records system, with efficient record entering and retrieval, which probably would only be feasible through the use of information technology.

Such introduction of comprehensive computerisation would also facilitate:

- The elimination of excess paperwork and frequent repetition of work;
- A complete overhaul of the prescriptions system, with all repeat prescriptions being handled by other qualified staff (e.g. nurses) and the doctor just verifying and signing them;
- The setting-up of ‘on-line’ regularly-updated guidelines on a variety of procedures, and a system of protocols to facilitate patient management;
- The performance of research and regular audits to measure, improve and sustain the quality of care;
- The avoidance of any medico-legal problems through keeping accurate records.

2. **Implement better management, organise service delivery, curtail client abuse**

Better management, organisation of service delivery and curtailment of abuse were suggested as indirect solutions by 33 (46%), 24 (34%) and 17 (24%) of doctors respectively.

**Better management:**

A team spirit among GPs needs to be infused by setting up lines of communication between people in top management, middle management and the GPs themselves through regular discussions. Such meetings would minimise red tape and facilitate participation in decision and policy making by doctors, with each health centre ideally having a management committee to enable more consultation with colleagues on any problems or work-related changes before decisions are taken.

The policing role of the senior medical officers over fellow-doctors should be given secondary importance. Instead, support and appreciation of GPs’ work can be shown through such initiatives and incentives as merit awards, educational programmes, promotion and adequate remuneration according to good performance (such as the quality of work provided and the amount of time spent at the clinic). This should not
only result in an increase in the motivation of all GPs, but also a consequent improvement in the quality of service provided.

Organise service delivery:
Management also needs to consider certain organisational changes in service delivery that indirectly would improve job satisfaction among GPs, such as:

- Reassessment of the effectiveness of district clinics, which have been described as ‘useless’ and a drain on already limited manpower, and which also serve to perpetuate the mentality of ‘shopping-list’ prescriptions for free medicines;
- Good computer networking system, to facilitate the provision of care provided by medical officers through electronic patient records;
- Better utilisation of resources (human, physical and financial).

Curtailing abuse:
Doctors are unhappy with abuse of the system, both by staff and by the public. While abuses and blatant skiving by doctors needs to be cut down through the introduction of accountability and the even distribution of work, abuse by clients is considered to be a bigger problem.

The curtailment of client abuse may be tackled as follows:

- Primarily through a more serious approach in educating people to use health centres sensibly and to eliminate verbal abuse on doctors and other staff members.
- An appointment system could be implemented from 8 a.m. to 8 p.m., limited to patients within the catchment area.
• Continuity of information through a good patient record system (preferably computerised) would cut down on abuse by patients.

• Cost sharing (e.g. a minimal charge to patients for use of the GP service).

3. Educational campaign to optimise use of health centres by clients and to raise the status of the state GP among the general public

Twenty-three doctors (32%) proposed an educational campaign for clients and the general public as another indirect solution for doctor dissatisfaction in state primary health care.

Clear educational campaigns are needed to achieve better patient understanding regarding optimal access of services available at health centres and the proper use of the GP service system. Information could also be provided to private general practitioners regarding services available in health centres.

Moreover, a better image of state GPs should be promoted also among the general public (using media tools such as television and newspapers if necessary). Such a sustained media campaign could highlight the important role of the GP as the first port of call for advice on family health. Also, a website (in Maltese and English) could be developed to promote family health for patients, e.g. regarding specific common diseases and their control, such as hypertension and the role of blood pressure monitoring.
4.2.4: Focus group and elite interviews

The above solutions, proposed by doctors to tackle the shortage of GPs in state primary health care, were then presented for discussion to the focus group of GPs and to the elite interviewees. Their recommendations regarding implementation of these solutions will be considered next.

4.2.4.1 The enhancement of working conditions through better remuneration, other benefits and working environment

(a) Remuneration.

Both the local focus group of six health-centre GPs and the Director of Primary Health Care (in his elite interview) agreed that remuneration is an obvious issue, but that as long as one talks in terms of salary scales within the Maltese civil service this is a waste of time. The Director went on to declare that the salaried GP system is inappropriate for a civilised country in this day and age, and that the only form of adequate remuneration was outside the civil service through contractual packages (renewable if set targets are reached). He however warned of certain drawbacks that would need to be tackled, such as employees' present attitude of 'jobs-for-life' and the provision of adequate funding. The focus group emphasised that vocal expression of these ideas were needed to get the message through to politicians (who were perceived to care more about private GPs than public sector GPs) and put pressure on them to overcome civil service red tape and shift some money from secondary care into primary care.
(b) Non-monetary benefits.

The local GPs' focus group agreed on the need for professional indemnity insurance cover. The Director of Primary Health Care revealed that there is a move for such cover by the Medical Association of Malta. However this would imply a change in political mentality by Cabinet if doctors remain part of the civil service, as government services have no insurance cover at present. Moreover the commitment of funds for such cover would be quite difficult to obtain due to the financial constraints facing the country.

The focus group of GPs envisaged increased autonomy as an opportunity for self-empowerment for doctors, which could be enhanced through regular meetings where problems might be shared, situations reviewed, and audit facilitated. On the other hand, the Director of Primary Health Care stated that health centres doctors already have the autonomy to take patient-related decisions, and that he will back definitely any GP's decision with a patient. However he did emphasise that the doctor has to speak to every patient, even the ones that drop by during emergency hours.

The GPs' focus group believed that greater flexibility of working hours would be possible in the local state primary care system, as long as individual requirements were complementary. Although roster flexibility would be difficult to implement organisationally with a large body of people, this would be facilitated if managed at a local level with the help of an appointment system for patients.
(c) Working environment.

During the focus group interview, GPs agreed that interdisciplinary teamwork with other healthcare professionals would lead to working in a relaxed rather than in a harassed or hostile environment. Focusing on the nursing profession, although there are nurses who are very helpful, there are others who may not be used to cooperating with doctors, in spite of the doctors' impression that ample nursing staff was available in health centres for such collaboration. The group in fact suggested that, while the nurses' union needed to be involved to forestall any resistance, the nursing administration at the Primary Health Care Department should be involved to improve nursing cooperation, starting with a survey to assess what nurses are doing so that they could be better distributed according to need. The focus group also proposed that nurses be given ownership to manage certain clinics, e.g. a Hypertension Clinic (run jointly by a nurse and doctor, like the Diabetes Clinic) which would give appointments to people for BP checks and repeat prescriptions.

The Manager of Nursing Services and the Coordinator of the Professional Development Unit within the Primary Health Care Department support the concept of interdisciplinary teamwork with the patient at the centre, where healthcare professionals work in harmony to provide their individual aspects of care. Rather than being there to 'help' doctors, nurses have their own philosophy, responsibility and accountability in patient care, many times looking after an aspect of care which the doctor has no idea how to tackle. Any resistance from nurses may be averted if they are prepared for the idea and are provided with the necessary preparation and a plan. Regarding the availability of nurses, one first must assess the needs of the
community for nursing functions and services, following which human resource requirements can be planned accordingly.

The nursing profession on the continent and in America has evolved extensively through its involvement in special clinics and this would be a very positive step for local nurses. Some nurses with certain academic qualifications are ready to participate, but a great emphasis must be put on preparation, training, recognition and accreditation. Moreover nurses in specialised areas need a defined role description (with accountability and monitoring), together with remuneration appropriate to the responsibilities assigned (such as training other nurses in the speciality to provide continuity).

Besides such ‘specialist nurses’, there can be various categories of nurses in the community:

• the ‘practice nurse’ who works hand-in-hand with a GP in his/her care of patients (a far cry from the health centre nurse today);

• the ‘treatment room nurse’ who handles emergency care, tissue viability/wound dressings, and needs training and guidelines in such areas;

• the ‘family health nurse’, who after a post-qualification diploma course, is assigned to look after the health of a group of families in the community, handling minor complaints and referring any problem to the doctor as necessary;

• the ‘nurse practitioner’ who is a higher-flown Masters-level nurse and could take over part of the medical load and issue minor prescriptions (which would however entail changes in legal provisions).
The Manager of Nursing Services and the Coordinator of the Professional Development Unit agreed that all these different categories of nurses would enable better utilisation of the doctor, both in the health centres and in the local clinics. An initial step towards interdisciplinary teamwork was taken in 2002, when, during a meeting with representatives of the University and the Health Division, the Manager of Nursing Services and the Coordinator of the Professional Development Unit of the Department of Primary Health Care proposed that a course of studies for the Family Health Nurse be introduced at the Institute of Health Care (Borg, 2003).

The Director of Primary Health Care was in favour of the creation of nurse practitioners, and believed that there should be many special clinics run solely by such nurse practitioners with prescribing rights, and referrals on as required. In fact, this is already the case at the National Immunisation Service, which is run by a nurse manager who has nurse practitioners running their own clinics and prescribing vaccines with no involvement of doctors at all. Thus nurses are ready (from an attitudinal point of view) to take on the role of nurse practitioner. However, legal issues would need to be tackled before nurses are allowed such prescribing rights, and doctors have to be prepared to accept the enhanced role of nurse practitioners if they want them to develop and take over some of their load.

The focus group also highlighted weaknesses in ancillary staffing, specifically the lack of clerical support and the inadequate numbers of security guards, whose competence varied greatly. Provision of enough security guards was recommended,
together with training them in how to deal with people. The Manager Nursing Services was of the opinion that the present use of nursing aides and health assistants as receptionists was a waste of resources, and revealed that a job description has been prepared for ‘reception desk staff’, which includes certain competencies such as communication skills and computer literacy.

Regarding refurbishment of health centres, the Director of Primary Health Care explained that is an ongoing project and, if the government puts its mind to it, can be done properly as evidenced by the high quality of facilities at Cospicua Health Centre. However, health centres can only be tackled one by one, due to the limited financial backing afforded to the primary health care sector in comparison to the hospital sector.

4.2.4.2 The development of undergraduate, vocational and continuing training in family medicine, with the introduction of specialist status and career progression

(a) Training in family medicine.

The focus group of GPs commented that local training in family medicine today may be considered a strength as it starts at the undergraduate level in medical school; this should then be built up to counter the idea that GPs become so by default. Thus there should be specific vocational training in family medicine, plans for which (together with the setting-up of the University Department of Family Medicine in 2001) were triggered by Malta’s application for EU membership. However a doubt was
expressed that doctors might not apply for vocational training knowing that they would end up in health centres with their present unfavourable conditions.

While agreeing that in-service training too is a strength, the GPs' group noted that past requests for in-service speciality attachments were turned down by the administration and that present CME initiatives are different in different health centres. The problem of doctors not being spared to attend in-service training due to their limited number within health centres could be overcome if CME courses were held after hours and compensated by time-in-lieu. CME initiatives in primary health care could be opened to all GPs, including those working privately, and this was seen as an opportunity to bring state and private GPs closer together.

The Director of Primary Health Care noted that, when the new Health Care Professions Act comes into force, specialist training and accreditation will have to be autonomous and provided by the professions themselves. He was of the opinion that the government cannot (and should not) organise training, with its role being just that of support through study leave, premises, etc. (within the available budget). On the other hand, in order to generate the team approach, the department is planning to organise a conference on an annual basis for all professions in primary health care.

(b) Specialist status and career progression.

The GPs in the focus group envisaged career progression to specialist grades as a natural progression for training in family medicine at undergraduate and postgraduate levels. They also agreed that this might enhance the recruitment of new doctors
through inspiring a vision of primary health care as an opportunity for specialisation. However, doubts were expressed regarding the threats of resistance from present state GPs who do not want to improve themselves, and also from private GPs who couldn’t be bothered or who could be fearful of the advance of state GPs.

The Director of Primary Health Care reiterated that it is the profession which should self-regulate and lead itself towards family medicine as a specialty: the government should not be at all involved, except by providing support. The provision of career posts and progression has already been accepted within the present structure. In a contractual service, one imagines that this would be specialist led, with the specialist given a contract, for which the trainee only qualifies on becoming a specialist, and if posts are available.

4.2.4.3 The introduction of continuity of information and care

(a) Continuity of care.

According to the GPs interviewed in the local focus group, essential components within a system providing continuity of information and care were proper medical record keeping (with data on computers in GP rooms protected by password), and an appointment system that would ensure registration with a particular health centre (and decrease health-centre shopping). Although such a system would be time-consuming in the beginning (until one gets used to it) and implies the need for training and technical back-up, advantages would include the printing of prescriptions for long periods (e.g. for 6 months), the avoidance of needless repetition of tests, the
facilitation of follow-up of hospital referrals, with long-term benefits to the quality of care provided. Threats to implementation which were mentioned included dependence on ancillary support from technical staff, pressure from patients due to lack of education, lack of support by administration and powers that be, negative pressure by the private sector (who may perceive the subsequent improved service as a threat), and, last but not least, the lack of funds.

While everyone agrees with continuity of medical information, and in private practice most GPs do it, the Director of Primary Health Care was of the opinion that the only reason for its poor state in health centres was a directive by the Medical Association of Malta not to fill in records because of the lack of doctors. If not for this, the department would be insisting on medical records and would be doing spot-checks and validity controls. The appointment system as a means of organising the service has support, not only in a proposed reform but also at top level, and thus may be introduced. The Director also revealed that a working party on prescriptions has almost finalised its work on a system of computerised repeat prescriptions that has wide support and should be introduced.

(b) Comprehensive computerisation.

The focus group argued that, while the introduction of comprehensive computerisation of medical records, appointments and registration would be hard-going in the beginning as it could slow doctors down, in the long run it would result in a better quality of care as doctors would have more time to see less patients. While present government initiatives in information technology were seen as an opportunity,
perceived threats included lack of money (all going to the new hospital), logistical problems, the shortage of manpower, and the lack of departmental determination and of political good will.

During elite interviews, the Information Management Officer (IMO) of the Ministry of Health and the Manager of Information Systems (MIS) at the Foundation of Medical Services revealed that the 1992 information systems strategic plan for the Ministry of Health is to be superseded by the new IT-systems strategy being developed for (and funded by) the Mater Dei Hospital project. This would be more sophisticated and offer seamlessly integrated services to all the public healthcare system, to which the health centres are already networked. Rather than the electronic patient record, an electronic health record is intended with an open-standard means of communication. Through some form of token, the patient would be able to authorise any GP to see and update his/her public health records as long as the doctor has the right means of communication. One incentive to the development of the system is the use of the European electronic health insurance card, which is planned to facilitate reimbursement of health services to EU citizens throughout the union, and, moreover, provide basic medical information. EU membership might also prove an opportunity through the availability of funds, experience, and consultancies.

The IMO and the MIS envisaged certain obstacles which needed to be overcome in implementation, including:

- the limited budget for investment in, and running costs of, IT in public healthcare;
- money getting even scarcer as a result of greater demand and throughput;
• the patient accepting the doctor’s use of the computer during the consultation;
• some resistance from the medical profession regarding the use of IT services;
• people stating they will only participate in IT if they derive a direct benefit;
• the need of training for users of the system, and of necessary technical support.

However the IMO and the MIS were confident that obstacles would be offset by a number of advantages, which include:

• tagging certain sensitive information with audit trails, to assure the individual that the data is being used for his/her benefit;
• people being allowed access to certain levels of their own information;
• the patient’s medical history being online for doctors in various sectors;
• doctors will appreciate the availability of user-friendly information and services;
• on-line IT facilities will improve the quality of service provided.

The Director of Primary Health Care, while appreciating that electronic health records in the long-term save space (replacing paper-based records) and time (in audits), queried if the doctor is ready and has enough time to type in medical records. He also asked how the interest of the GPs could be maintained and their input standardised. With the government being extremely committed to computerising the whole system, the Director felt that the problem was more for management to see how the system is going to work at grass root level. While warning that such a system is not top priority, he assured that it would definitely form part of an autonomous state primary care structure.
4.2.4.4 The implementation of better management, organisation of service delivery, and curtailment of client abuse

(a) Better management

The GPs' focus group agreed that regular meetings should be held between management and doctors to provide continual liaison and tackle problems as they arise. Goodwill and team spirit are needed from both sides, including that of doctors who need to participate by doing their duties properly and avoid just looking after themselves. To avoid people becoming disillusioned with lack of change, regular meetings would serve to monitor progress by following up proposals and seeing that they are implemented. A committee formed of management and elected representatives from GPs could coordinate remuneration according to performance, and control malingering and abuse by doctors.

The Director of Primary Health Care expressed his disappointment with the comment on "the policing role of senior medical officers", which showed a lack of sensitivity towards the administration. There are doctors who break the rules, and as a result someone has to act as a policeman. Administrative rules are there to be kept - if people do not follow them, especially during times when there is a lot of stress on the system, there is much less output from the few people available.

The Director of Primary Care went on to reveal his plans to make the senior medical officer (SMO) more autonomous, although this is difficult in the present structure. The SMO should be seen as the 'director' of a region of three health centres, with
regular meetings of a ‘management board’ formed of representatives of the various disciplines in the centres. However, for this to work, each region of health centres has to be autonomous through having its own budget, assuming the present health centres system remains. Although these plans do not have a lot of support, the Director expressed his determination to push them through, as this system would be able to control better any ‘health-centre shopping’ by clients, and provide flexibility in the day-to-day distribution of staff between the health centres within one region.

(b) Organisation of service delivery

Besides reducing the load on the health centres, the GPs in the focus group agreed that the bereg have a number of other strengths, namely through providing easy accessibility for old people confined to their villages, an element of continuity as clinics are performed usually by the same one or two doctors, together with some patient empowerment by the use of patient-held blood pressure records. If the threats of lack of money and bureaucratic resistance to change were overcome, and the poor facilities in some of the clinics were upgraded (with computers linked to the public healthcare IT system), proper GP work could then be done at the bereg, and even appointments given. A number of further suggestions were made, including an audit so that the opening times of certain clinics are adjusted according to use, and an overhaul of the prescriptions system (perhaps to involve community pharmacy dispensing).

The Director of Primary Health Care recalled that the bereg are a legacy from the time when there was the ‘poor people’s doctor’ and have only survived because of political
pressure. As the ideal GP service should be locally run and based, the local council is the best structure to support such a service, either by incorporating the village clinic through providing rooms, or by directly offering the service of prescriptions and delivery of medicines for old people (which does not necessarily need to be done through a clinic). While the bereg cannot be as efficient as a health centre, they cannot be considered as ‘useless’ but can have a separate role, which however needs to be more efficient.

(c) Curtailment of abuse.

The focus group of local health-centre GPs agreed that an educational campaign, an appointment system, a good patient record system and cost sharing could help to tackle client abuse. However, they also doubted if cost sharing, despite the opportunity of using clients’ money-mindedness, would have political backing due to the failure of the 50-cent prescription scheme a few years ago.

While agreeing that education is always good and a small minority of people do listen, the Director of Primary Health Care did not think this would have any effect in reducing abuse of services. A better way to tackle the problem would be by organising and curtailing services through an appointment system and limited opening times (both of which should be in the next reform package). The Director doubted whether a patient record system would affect abuse, and was more in favour of clearly defining services to the individual by registration to a group practice. Thus the GP and the patient would be jointly responsible for the provision of care as needed rather than services as demanded. This doctor-patient partnership in care would entail an
informal ‘contract’ agreed between both sides and developed through a sound doctor-patient relationship.

4.2.4.5 An educational campaign to optimise the use of health centres by clients and to raise the status of the state GP among the general public

An educational campaign for clients and the general public was deemed an important and urgent issue by the focus group meeting of GPs. Starting from the young in schools, use of different forms of media could be made, with GPs offering themselves to counter incomplete or misleading messages on the media and to raise the profile of the health centre doctor. One doubt expressed was if such campaign would have any effect where most needed, i.e. on the poorly educated, while another was trying to get busy GPs to participate.

The GPs’ group recommended that a committee could be formed to draw up a series of talks to reduce unnecessary attendance and ensure optimal use of health centres. Another proposal was for the selection and issue of evidence-based guidelines on management of common problems (e.g. hypertension) for doctors, patients and the public. Such guidelines must not be rigid, as they may need to change from time to time, and must leave some discretion to the doctor (to avoid losing patients’ trust through changing advice e.g. as to frequency of blood pressure checks). The Manager of Nursing Services and the Coordinator of the Professional Development Unit emphasised that a prior needs assessment would serve in the preparation of educational campaigns according to the people’s needs.
On the other hand, the Director of Primary Health Care believed that the image of the GP (state or private) is up to the GPs and their College to alter, and no one can do it for them. More than just a media initiative, GPs need to develop a ‘hearts-and-minds’ programme, continuously showing GPs working with patients, participating in teamwork, and contributing to other professional associations’ conference. “GPs, like most doctors, are conservative and expect people to come to them. That has to change – if you want to win people you have to go to them”, he concluded.
Chapter 5: Discussion

5.1 Job satisfaction as a contributing factor to the shortage of state general practitioners

The total mean score of 91 obtained in the Job Satisfaction Survey confirms that general practitioners in government health centres are dissatisfied with their job. Looking at the scores according to categories, the lowest score of 85 was found among doctors formerly working in health centres (compared to 96 scored by present health-centre GPs). This difference was found to be statistically significant (p = 0.033) using univariate regression analysis, with significance taken as a p-value of less than 0.05. While not excluding the existence of other reasons, this collaborates the hypothesis by Sammut (2000b) that job satisfaction is a contributing factor to the lack of medical manpower in state primary health care.

When comparing facet mean scores for doctors presently and formerly in health centres, while scores in most subscales were very similar, this was not the case for 'supervision' and 'co-workers'. Present GPs were more satisfied with supervision (scoring 17) than former GPs (who scored 13). This could be due to a gradual change from the department's past strict disciplinarian methods to a more conciliatory approach taken today.

Former GPs were dissatisfied with their co-workers (scoring just 12), while present GPs’ score of 16 indicated their satisfaction in this facet. The reason for former GPs’ dissatisfaction here may have been their 'abuse' by more senior colleagues through
their earmarking of cushy jobs, and doing their private practice at the expense of junior doctors. On the other hand, remaining GPs may have resisted and overcome such abuse, perhaps with the backing of their supervisors.

Differences in job satisfaction scores were also seen in the categories of gender and private practice. Females were less dissatisfied than males, scoring 100 in the survey compared to 91 for the latter, which difference approached statistical significance ($p = 0.082$). This finding concurs with British studies where women GPs were found to be more satisfied with their job than their male colleagues (Cooper et al., 1989; Sutherland & Cooper, 1993; Sibbald et al., 2000 & 2003). A reason for the local gender difference in dis/satisfaction could be that, as most of female respondents are married (65%) and have housework and relatives to care for (80%), they are appreciative of the opportunity provided by state primary health care to continue to practise their profession despite their family commitments.

Doctors doing private practice over and above their duties in health centres were more dissatisfied than those not practising privately (scoring 90 and 98 respectively in the survey), which difference too approached statistical significance ($p = 0.076$). This corresponds to anecdotal reports (which, however, did not emerge from this study) that local health centre GPs would rather not devote their free time to performing private practice, but are constrained in doing so by their inadequate financial remuneration. This is reflected in a survey of government-employed doctors with private practice in Bangladesh, where commitment to government services was found
to be greater among doctors in primary health care who reported that they would give up private practice if paid a higher salary (Gruen et al., 2002).

The category that showed the strongest statistically significant relationship with total satisfaction was that of working on a part-time basis compared to working full-time. In fact the former scored 109 (the highest score of the survey and the only total mean score indicating some satisfaction) while the latter only scored 91. This was the only category where both univariate and multiple regression analyses give significant p values (of 0.007 and 0.039 respectively). Part-time working has been shown in a sample of British GPs to be associated with generally higher levels of job satisfaction than is full-time working (Kirwan & Armstrong, 1995, as cited in Sibbald et al., 2000).

Reasons why local part-timers were satisfied could include:

- their choice of which hours to work (according to the doctor’s availability, as long as the times fall within normal working hours);
- their working short periods lasting only a few hours (longer reported working hours have been associated with lower levels of satisfaction [Sibbald et al., 2003]);
- their selection of what health centre to work in (while other doctors are regularly asked to replace sick colleagues in other centres);
- their higher hourly rate of pay (compared to GPs employed on a permanent basis);
- their facility to simply not turn up for work when unable to (without having to ask for official vacation leave or take sick-leave); and last but not least
• their opportunity to find an optimal and satisfying balance between the exercise of
their profession and the management of their family commitments (67% of part-
timers performed housework and cared for children and/or elderly relatives).

Moreover, looking at the subscale scores according to the different facets of
satisfaction, doctors on part-time were slightly satisfied with ‘nature of work’ (scoring
14), with which full-time doctors were dissatisfied with a score of 12. This could be
due to the fact that part-timers look at the nature of their work in a more favourable
light than full-timers, being more grateful for the opportunity to work as GPs than
full-timers who have no other choice. Although still dissatisfied with contingent or
performance-based rewards, part-time doctors averaged a higher score in this subscale
(10) than full-timers (7). This could be due to the need for part-timers to apply for a
renewal of contract on a six-monthly basis, which may be regarded by them
(consciously or unconsciously) as a performance-based arrangement. The above
would put forward the possibility of full-time doctors working on a flexitime
arrangement to mirror part-timers’ conditions of work, which have been shown to
provide some job satisfaction.
5.2 *What other causes could be contributing to the lack of doctors in the government GP service?*

Respondents to the first open question in the questionnaire did share a few positive feelings about being a doctor within the government GP service (a positive experience, providing job satisfaction and security, with the work being of interest and not tiring, and experiencing patient gratitude and pride). However, the great majority of GPs revealed overwhelmingly negative feelings, experiencing job dissatisfaction, stress and depression (due to the nature and conditions of work and the set-up of the system), feeling unappreciated, neglected, disrespected (in the perception of others) and used, misused, abused (by others, both verbally and physically) and, last but not least, admitting to the provision of a poor service to the client.

In reply to the second open question “What are the causes of the shortage of GPs in state primary health care?”, most of the replies given in Table 1 (Section 4.2.2) could be related to the different facets of job dis/satisfaction in Spector’s Job Satisfaction Survey (1999) as follows:

- **Pay**: poor pay;
- **Promotion**: poor training prospects; poor career progression;
- **Supervision**: poor administration / management;
- **Fringe benefits**: poor ancillary benefits; poor working conditions;
- **Contingent (performance based) rewards**: little appreciation (with no reward for doing one’s job well);
- **Operating procedures (required rules and procedures)**: inflexible roster;
- **Co-workers**: abuse; little appreciation;
Nature of work: poor job satisfaction; nature of work repetitive; overworked and stressed;

Communication: poor continuity of care.

The other reasons of:

- abuse by clients, and of
- little appreciation, no respect and poor perception/reputation/status of GPs from patients and the public,

do not fit neatly into one of Spector’s nine facets of satisfaction (Spector, 1999). However, they all may be classified under one of the motivation factors – recognition (or the lack of it, in this case) – found by Herzberg to influence satisfaction (Griffin, 1996). A sample of GP registrars from southwest England viewed patient demands and expectations as a negative aspect of general practice, and admitted feeling that there was a lack of respect for general practitioners (Roswell et al., 1995). The opinion of British GPs that the public is more demanding and less respectful of medical professionals (Calnan & Williams, 1995, as cited in: Sibbald et al., 2000) was supported by Sibbald et al. (2000) who showed rising GP dissatisfaction with lack of recognition for good work.

It is evident from their answers to questions one and two in the questionnaire that doctors have no doubt that job dissatisfaction is the sole cause of the shortage of GPs in state primary health care, although this does not exclude the existence of other factors.
5.3 Solutions addressing medical manpower needs in state primary health care

5.3.1 Direct Solutions to Medical Manpower Needs

5.3.1.1 The enhancement of working conditions through better remuneration, other benefits and working environment

(a) Remuneration.

Poor pay and ancillary benefits was considered by GPs as the most important cause of state GP shortages, in fact being the reason cited most times by respondents to the questionnaire (50 citations from 71 doctors, i.e. 70%). This weakness was reflected by the low scores for pay, fringe benefits and contingent rewards (8, 8 and 7 respectively) in the Job Satisfaction Survey, all of which indicated moderate dissatisfaction. For suitable remuneration to be utilised as a strength by being related to doctors' responsibility, performance and work-conduct, serious consideration must be given to overcoming the threat imposed by the constrictions of government salary scales through the employment of doctors on a contract basis outside the civil service. Remuneration by contract could also act as an opportunity to facilitate flexible working arrangements (an important factor in part-time GPs' satisfaction) and allow certain allowances to be introduced. On the other hand, as GPs are already dissatisfied with the nature of their work (scoring just 12 in the relevant facet subscale of the Job Satisfaction Survey), one must guard against the threat of introduction of further administrative work that would curtail the time doctors devote to seeing their patients, with a consequent adverse effect on job satisfaction.
An increased level of remuneration was given importance by recently appointed GPs in south-east England and thus recommended by Gosden et al. (2000) for inclusion in potential policy interventions to recruit GPs. In fact British GPs voted in June 2003 to accept by four to one a new contract that will see a rise of 26% in their annual income over the next three years (from an average of £65,000 to £82,000) tied to a new quality and outcomes framework. With a survey by the British Medical Association revealing that 3.4% of GP posts in England have been vacant for 3 months or more (representing a shortage of 970 GPs), negotiators hope that this new deal will lift morale in general practice and drive up recruitment. The new contract will in future allow GPs to control their workload better and trade leisure for income or vice versa. (Lewis & Gillam, 2002; Kmietowicz, 2003; Mayor, 2003).

However, while low pay may be a significant source of job dissatisfaction, high pay has a limited ability to offset dissatisfaction with other aspects of work (Sibbald et al., 2000). The majority of GPs in Britain are ‘independent contractors’ who agree to supply general medical services to the National Health Service under an agreed national contract with remuneration based mainly on capitation supplemented by allowances, fee-for-service and target payments. However, since 1998, GPs could be employed also on a salaried basis to provide ‘personal medical services’ (PMS), and Williams et al. (2001) have found that salaried contracts offer positive incentives to recruitment in terms of reduced hours of work and freedom from administrative responsibility (which standard GP contracts entail). Handysides (1994b) has emphasised that the contract status should not involve tipping the balance of GP work from clinical autonomy to excessive bureaucracy.
(b) Non-monetary benefits.

Employment of state GPs on a contract basis would also be an opportunity for the introduction of other non-monetary benefits highlighted by GPs in the questionnaires as being important to combat factors threatening job satisfaction. These include professional indemnity insurance cover (which suggestion has been triggered by the slow but sure rise of local court cases that has raised fears among doctors of being sued for professional misconduct), increased autonomy for state GPs (to take decisions free from perceived intrusions by the department and politicians), and flexibility in working arrangements (to allow doctors to more easily balance work commitments with their family life and other personal pursuits). Of course, success in introducing such benefits would depend on consultation, open communication and the involvement of all those concerned.

GPs' proposal for professional indemnity insurance cover was collaborated by the view of 99% of a sample of GP registrars in southwest England that general practitioners increasingly fear litigation (Roswell et al., 1995). Research also suggests that, for medical professionals, clinical autonomy is an important determinant of job satisfaction (Lichenstein, 1998, as cited in Sibbald et al., 2000), and the low level of job satisfaction in general practice is, to a degree, a reflection of the beliefs held by GPs that their professional autonomy in controlling their work is low (McGlone & Chenoweth, 2001).
The benefits of improved recruitment through salaried contracts need to be enhanced by the addition of professional development schemes and flexible working arrangements (Williams et al., 2001). The adoption of flexibility in working arrangements and the establishment of an appointment system should help to balance the workload (Kalantan et al., 1999). Doctors’ desires for less-than-full-time work need to be fulfilled through a greater variety of contractual arrangements for more flexible patterns of working in general practice (Evans et al., 2002), which in turn would allow more GPs to continue their careers (Baker et al., 1995). By breaking down existing conventions of how, and between what hours, a job should be done, it also becomes more feasible to deliver care in patterns that extend access for users (Department of Health, 1997).

(c) Working environment.

Poor working conditions were cited by 46% of doctors (33 out of 71 who replied to the questionnaires) as an important weakness in state primary health care, resulting in a lack of GPs. On the other hand, an opportunity was revealed by the Job Satisfaction Survey where ‘co-workers’ was one of just two facets where slight satisfaction was registered among participating doctors. When facet mean scores for doctors presently and formerly in health centres were calculated separately, scores for ‘co-workers’ revealed that present GPs were satisfied while former GPs were dissatisfied.

In fact, respondents to the questionnaires proposed that ancillary staff should provide more competent help, while doctors and other healthcare professionals need to work
together in an interdisciplinary manner. Besides improving GPs’ satisfaction with their work, sharing of patient care through interdisciplinary teamwork would also act as a strength by providing GPs with more time to develop the doctor-patient relationship and improve and extend their care of clients through the provision of special services. GPs’ satisfaction would be enhanced also if they were provided with a pleasant working environment through the necessary refurbishment of certain health centre premises, the poor state of which was considered as another weakness of state primary care.

Doctors from three continents agree that teamwork is a positive aspect of primary health care activities and should be encouraged and promoted, as it has the potential to prevent job turnover (Gosden et al., 2000; Kalantan et al., 1999; Williams et al., 2000). In 1997, Mathie recommended major changes in the skill-mix of primary health care teams so that appropriately trained nurses could undertake many of the tasks now managed by GPs. Nurses’ roles could include working on healthy behaviour change, providing self-management support through training patients to manage chronic conditions themselves, and checking reminder systems to make sure that patients receive the chronic and preventive services they need (Bodenheimer, 2003).

Finally it must be noted that GPs’ recommendation on the refurbishment and upgrading of certain health centres had already been made by the Auditor General (2001) in a report entitled ‘Performance Audit. Primary Health Care – The General Practitioners’ Function within Health Centres’. 
5.3.1.2 The development of undergraduate, vocational and continuing training in family medicine, with the introduction of specialist status and career progression

Fifty-four per cent (38 out of 71) of doctors completing the questionnaire listed poor training prospects and poor career progression as a weakness and a main cause of the shortage of GPs in state primary health care. This was collaborated by the fact that nearly one-half of respondents (34 out of 71, or 48%) declared that they did not participate in any form of continuing medical education (CME), the lack of which may be considered as a threat to job satisfaction. Moreover, 'promotion' was one of the two facets in the Job Satisfaction Survey that scored the lowest mean score of 7, indicating moderate dissatisfaction with its absence.

Among the solutions proposed by GPs was the development of training in family medicine for medical students (a present strength) and newly qualified doctors (a future opportunity), together with other opportunities for CME and post-graduate courses. These would help to raise the practice of family medicine to specialist status as is the case in the rest of Europe, and facilitate the introduction of career progression for family doctors. Thus while students and new doctors would be attracted to specialise in family medicine, already practising GPs might be tempted by a registrar or consultant post to stay in state primary health care instead of turning to more lucrative private practice.
(a) Training in family medicine.

Medical students and graduates in the UK agree that proper holistic training in family medicine could attract doctors to work in primary health care (Evans et al., 2002; Henderson et al., 2002). In 1995, McBride & Metcalfe commented that undergraduate education had become increasingly disease-centred rather than patient-centred, with ‘good medicine’ being regarded and lauded as the clever diagnoses of rare conditions and their sophisticated treatment. As a result, the newly qualified practitioner did not appreciate the real value in general practice of using clinical skills to exclude such illnesses, together with the intimacy, trust, informality and continuity shared with patients. Final-year students at two London medical schools have suggested that a more balanced, community-based undergraduate curriculum is needed to enhance positive general practice role models (Henderson et al., 2002). Greater exposure to general practice not only promotes it as a positive career choice but also kindles enthusiasm and helps the medical student in making an informed career decision (Evans et al., 2002).

UK graduates praised GP-based postgraduate training for its good formal teaching that met educational needs (in comparison to hospital-based training which was seen as of poor quality, irrelevant and run as if it were of secondary importance to service commitments). Thus measures should be taken to ensure relevance of hospital attachments to general practice (Evans et al., 2002). There are plans for vocational training in Malta to be GP-run (by a co-ordinator and a number of trainers) and GP-based (with the GP-trainers overseeing the trainees during the first two-year hospital attachment, before their final year in family practice) (Sammut, 2000a & 2001b).
The construction of vocational training must be flexible to meet individual training needs (Evans et al., 2002): rather than 'teachers', trainers should be 'mentors' who facilitate general practitioners' awareness for self-motivated study (Handysides, 1994a). Last but not least, there needs to be assessment of the need for re-entry courses to general practice for doctors on a career break who wish to return to medical work (Baker et al., 1995; Young & Leese, 1999).

Although this was not found to be the case in Malta, participation in CME activities abroad has been associated positively with job satisfaction among family physicians (Kushnir et al., 2000). Moreover, professional development schemes enhance the benefits of improved recruitment through salaried contracts and flexible working arrangements (Williams et al., 2001). Courses of higher training in general practice (e.g. Masters degree) need to be made available to train and qualify people for career mobility, e.g. as a trainer, course organiser, or lecturer (Handysides, 1994a; McBride & Metcalfe, 1995). The extension of one's professional skills and knowledge would need to be facilitated through the provision of protected study time, prolonged study leave and sabbaticals (Handysides, 1994a). Branthwaite & Ross (1988) have suggested that CME could also attenuate continuing problems affecting young GPs (uncertainty and insecurity about work, isolation, poor relationships with other doctors, disillusion with the GP's role, and an awareness of changing demands). They further argued that, besides teaching knowledge and skills, the emphasis of CME should be also on developing support, confidence and better contacts between GPs. This could be developed through peer groups (which, besides offering CME and social meetings for doctors and their spouses, would also provide a forum for
discussing personal and practice problems) (Handysides, 1994a), and through training in social and managerial skills (including time management, people management, and work organisational skill management) which would help overcome job stressors and increase job satisfaction (Cooper et al., 1989).

(b) Specialist status and career progression.

GP registrars and principals in the U.K. have been concerned with the lack of career structure and trajectories in general practice (McBride & Metcalfe, 1995; Roswell et al., 1995), together with its portrayal, by some hospital-based teachers, as a second-class career compared to hospital medicine (Evans et al., 2002). Lipman (2000) explains that, while academic schemes designed for GPs have been well received, there are few career posts in academic general practice, leaving general practice academically disadvantaged compared with hospital medicine. As career opportunities appear to be of high importance for job satisfaction (Gruen et al., 2002), this situation is leading to falling recruitment of junior doctors and registrars into general practice (Lipman, 2000). "Once a principal, there is nothing else to aim for. With no target, there is no motivation to learn, to grow or to change" (McBride & Metcalfe, 1995). Career paths thus need to be varied through alternative activities to bring progression in general practice closer to the goal-oriented career available in hospital medicine (Handysides, 1994a; Young & Leese, 1999), with skilled mentors / career counsellors available to provide personal and career guidance and support at every stage of doctors' careers (Mathie, 1997; McBride & Metcalfe, 1995; Department of Health, 2001).
5.3.2 Indirect Solutions to Medical Manpower Needs

5.3.2.1 The introduction of continuity of information and care

One factor identified in the questionnaires as a weakness in state primary care and a cause of the shortage of GPs was the poor continuity of care (cited by 23 out of the 71 doctors, i.e. 32%). Another related weakness that emerged from the Job Satisfaction Survey was the facet of 'communication', which scored only 10, indicating slight dissatisfaction. A system with good communication and continuity enjoys such strengths as patient registration, the keeping of proper medical records, and an appointment system, all facilitated through information technology (IT). If initial threats to the introduction of IT (due to difficulties in implementation and lack of funding) are overcome, continuity of information would streamline GPs' duties through curtailing repeat prescriptions and eliminating excess paperwork. This would in turn provide GPs with the opportunity to enhance continuity of care by developing the doctor-patient relationship, improving cooperation with colleagues in primary and secondary care, following guidelines and protocols, and performing research and audit.

(a) Continuity of care.

Continuity of care for patients using a holistic approach is an important determinant of physician satisfaction in general practice (Blankfield et al., 1990; Randall et al., 1997; Roswell et al., 1995), and it has been suggested that interventions based on this characteristic may increase doctor satisfaction and lead to more success in recruitment.
(Randall et al., 1997). In his 2001 report on the general practitioners’ function within health centres, the Auditor General found that, although users seem satisfied with the service, its effectiveness is diminished as the service is not considered a personalised one. In many instances, medical records are either not updated, more than one personal file may exist for the same user, or a file may be non-existent. As such, the system would benefit from the use of information technology (Auditor General, 2001).

One effective and efficient appointment system is that of ‘advanced access’ or ‘same day scheduling’, where the doctor starts work in the morning with a number of appointment slots open, and patients who call in are offered an appointment the same day. While a balance would need to be found between slots available for immediate access and long waiting lists, advantages would include improved access, decreased patient frustration, freeing of nurses free to do other tasks, and less interruptions for the doctor (Bodenheimer, 2003). Such a system could also facilitate continuity through the implementation of a ‘collaborative model of care’, where the doctor and the patient first define what the problem is and then agree on a realistic action plan (Bodenheimer, 2003).

(b) Comprehensive computerisation.

International literature has shown that good quality electronic medical records can enhance patient registration and appointment systems and repeat prescribing, improve co-ordination of care between primary and secondary care, can be of value in monitoring the health of populations, and are used for primary care based research.
Moreover, previous concerns regarding the reliability of hardware and the confidentiality and legality of the electronic patient records have been resolved. In a study of British general practices, paperless electronic records were found to compare favourably with records using paper-based systems as they contain significantly more words and abbreviations, are more legible and easier to understand, and contain more diagnoses and details of referral and of medication. On the other hand, use of electronic records does not affect the doctor’s recall of patients or their consultations. (Hippisley-Cox et al., 2003).

5.3.2.2 The implementation of better management, organisation of service delivery, and curtailment of client abuse

(a) Better management

From replies to the second open question in the questionnaire, poor administration / management was cited by 37% of doctors (26 out of 71) as a cause of the shortage of state GPs. However, an opportunity to convert this weakness into a strength was revealed by the score of 15 (indicating slight satisfaction) for ‘supervision’ of doctors by their superiors in the Job Satisfaction Survey. In fact, GPs recommended improved communication between doctors and management through regular meetings at health centre and departmental levels. Such meetings would provide opportunities for facilitation of decisions through consultation and provision of support and appreciation, with a consequent improvement in job satisfaction.
(b) Organisation of service delivery

'Operating conditions' was another weakness with which GPs were slightly dissatisfied, scoring just 10 in the Job Satisfaction Survey. GPs felt that poor service delivery was especially present in the village clinics or 'bereg', where the so-called 'wasting' of a doctor to issue repeat prescriptions for chronic conditions was a definite weakness. On the other hand, the fact that the bereg do handle such prescriptions could be considered as a strength for health centres because less people need to go there for prescriptions. However, if the opportunity is taken for such repeat prescriptions to be streamlined (e.g. by being issued by computer and for longer periods), doctors both at the health centres and the village clinics would benefit from more time to devote to patient care.

In the Auditor General's report on the GP service, it appeared that these village clinics are taking the load off health centres but doing so inefficiently, with the cost per visit averaging Lm1.43. The service provided in these bereg is mostly limited to the renewal of prescriptions, besides which 27% of users calling at the health centres do so for renewal of prescriptions. Thus the department has to decide whether it is more economical to direct all patients requiring prescription renewals to local bereg or to health centres, or else retain the status quo (Auditor General, 2001).

(c) Curtailment of abuse.

Abuse of doctors and their services in the health centres was ranked as the sixth most important cause of job dissatisfaction and lack of medical manpower, being cited by 27% (19 out of 71) GPs. If cost-sharing is excluded due to its lack of success in
controlling prescriptions in the past, other opportune measures to tackle this weakness could include client education in the proper use of services, together with the curtailment of the availability of the latter through continuity of care, appointment systems and limited opening times.

The Auditor General's report confirmed that there are instances of misuse and abuse by the public of health centre services, which not only expend resources but also may impinge on the quality of services provided. As such, although the public does not actually pay for the service, it was recommended that its members should be made aware that the service is not gratuitous (Auditor General, 2001). In the UK too, general practitioners have complained of overwork and late calls (with a third of consultations being trivial, inappropriate or unnecessary), resulting in a lack of leisure and feeling tied down (Cartwright & Anderson, 1981, as cited in Handysides, 1994c).

5.3.2.3 An educational campaign to optimise the use of health centres by clients and to raise the status of the state GP among the general public

Among replies to the second open question in the questionnaire, besides abuse of doctors and their services in the health centres (mentioned by 27% of GPs), another cause for the lack of state GPs was the poor perception/reputation/status of GPs and the GP services (cited by 15% or 11 from 71 respondents). To combat these weaknesses of state primary care, doctors proposed that an educational campaign for the general public would provide them with the opportunity to learn use health centres
properly and also to appreciate the strengths of state GPs and the services they provide.

GP registrars in southwest England have perceived of lack of respect for general practitioners, and viewed patient demands and expectations as a negative aspect of general practice (Roswell et al., 1995). Calnan & Williams (as cited in Sibbald et al., 2000) too have found that, in the opinion of British GPs, the public is more demanding and less respectful of medical professionals. This view was supported by Sibbald et al. (2000), who moreover showed rising GP dissatisfaction with lack of recognition for good work. Recognition is one of the motivation factors found by Herzberg to influence satisfaction (Griffin, 1996) and, as such, an educational campaign with this aim could allow GPs to experience such satisfaction.

The GPs’ proposal for an information campaign had already been made by the Auditor General in 2001 in order to promote awareness relating to the proper use of health centre services. Such an initiative would not only enhance customer care and address issues of quality of service, but would also increase health centre effectiveness (Auditor General, 2001).
Chapter 6: Recommendations

The following recommendations are being made to ameliorate the job satisfaction of general practitioners in state primary health care and address the sector’s medical manpower needs. They have been divided into measures to improve and maintain the supply of GPs and others that reduce the demands made upon them through job facilitation (see Table 12).

<table>
<thead>
<tr>
<th>1. Improving and maintaining the supply of GPs</th>
<th>2. Reducing demand on GPs through job facilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Appropriate remuneration</td>
<td>2.1 Improving working arrangements and conditions through:</td>
</tr>
<tr>
<td>1.2 Training in family medicine:</td>
<td>• flexible working patterns;</td>
</tr>
<tr>
<td>• undergraduate,</td>
<td>• interdisciplinary teamwork;</td>
</tr>
<tr>
<td>• vocational and</td>
<td>• continuity of care through information technology;</td>
</tr>
<tr>
<td>• continuing,</td>
<td>• reassessment of role of village clinics;</td>
</tr>
<tr>
<td>with career progression to specialist posts</td>
<td>• development of ancillary staffing;</td>
</tr>
<tr>
<td></td>
<td>• refurbishment of premises.</td>
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<tr>
<td>2.2 Educational campaigns to:</td>
<td>2.3 Better management</td>
</tr>
<tr>
<td>• combat client abuse;</td>
<td></td>
</tr>
<tr>
<td>• raise the profile of the state GP.</td>
<td></td>
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</tbody>
</table>

6.1 Improving and maintaining the supply of GPs

6.1.1 Appropriate remuneration:

The salary of a health-centre general practitioner needs to be of a level appropriate to the type of work performed and responsibility carried. Given present circumstances, this would only be possible outside the civil service salary scales. Employment should be on a renewable contract basis, related to the individual’s performance and
work-conduct and tied to quality and outcomes, and be complemented with further appropriate allowances and professional indemnity insurance cover. Due to the financial constraints facing the country at present, any success in introducing such benefits would depend on consultation, communication and the involvement of all those concerned to persuade the government that investment in primary care would result in long-term savings in the cost of the country’s health system.

6.1.2 Training in family medicine and career progression to specialist posts

Positive role models in general practice need to be enhanced among medical students through an undergraduate curriculum that is community-based. In fact the recently set-up University Department of Family Medicine (of which the author is a member), gives great importance to community attachments in its curriculum for senior medical students, which will also help to promote family medicine as a career among them.

Although due for introduction by 2004 (the date of Malta’s accession to the European Union), full details of the format of a specific vocational training scheme in family medicine remain unavailable. This should be run by GP trainers with a view to preparing trainees for their role in family practice by mentoring self-motivated study according to individual needs. Moreover, special ‘re-entry’ training attachments should be considered for former GPs who wish to return to work.

Initiatives for continuing medical education in primary health care need to be GP-run, with support provided by the Department of Primary Health Care through
protected study time, prolonged study leave and sabbicals. A Masters Degree in Family Medicine planned by the University Department of Family Medicine would provide career mobility and satisfaction for graduates. Job satisfaction could also be improved by training in social and managerial skills and the formation of support groups with peers.

Last, but not least, training in general practice must be accompanied by the availability of career progression to specialist posts in clinical and academic general practice. Job satisfaction could also be enhanced by personal and career guidance and support provided by mentors and/or counsellors towards an alternative career activity (such as research, part-time university teaching post, post-graduate trainer, course organiser, self-training in management skills, medical commitment outside general practice – e.g. occupational health, sports health).

6.2 Reducing demand on GPs through job facilitation

6.2.1 Improving working arrangements and conditions

(a) Flexible working patterns provided by a sensitive and caring health service could accommodate different aspirations of a work/life balance, and GPs would be better able to control their workload and trade leisure for income or vice versa. Flexibility makes general practice more attractive not only in recruitment but also in retention, enabling the employment of those with increasing family responsibilities or a yearn for a concurrent activity (e.g. research), and allowing retiring doctors to phase their retirement through part-time working. Besides the present facilities in state primary
health care for casual work, parental leave and working part-time or on reduced hours, other arrangements could include flexi-time, job-sharing and career breaks. As a result, sufficient numbers of qualified, well-motivated staff with a richer blend of skills and experience would be available to look after patients and deliver effective healthcare.

(b) Interdisciplinary teamwork. While ensuring the state general practitioners’ clinical and professional autonomy, the introduction of interdisciplinary teamwork would enable better utilisation of the doctor in state primary health care. After suitable preparation and appropriate arrangements, nurses could be increasingly involved in running special clinics. In addition to services that are already run solely by nurses (Immunisation Service and Glaucoma Clinic), the nursing role could be strengthened in other health centre services (Treatment Room, Diabetes, Well-Baby, Gynae and Obstetrics). Moreover, new services run by specialist nurses could also be introduced, such as a Health Information and Guidance Clinic, Child Health Clinic, Youth Health Clinic, Well-Woman Clinic, Well-Man Clinic, Family Matters/Planning Clinic, Wound Management Clinic, Asthma Clinic, Lipid & Blood Pressure Lowering Clinic, Continence Clinic, Sexual Health Clinic, Mental and Physical Disability Support, Counselling & Mental Health Clinic (Borg, 2003).

Besides specialist nurses, other categories of community nurses could be developed, including practice nurses, treatment room nurses, family health nurses, and nurse practitioners. Routine acute problems could be handled by nurse practitioners while specialist nurses see planned follow-ups of chronic cases. As a result, the physician
would see fewer patients per day, having more time to focus on those with complex problems. However, for teamwork to be successful, members need to meet regularly and each member must understand his or her own role and responsibilities and also the roles of others, with all members treating each other with mutual respect. Core-groups made up of representatives from the different professions should be set up within the Health Division to develop, prepare and adopt interdisciplinary teamwork through a common vision and strategy.

(c) **Continuity of care through the use of information technology.** In order to improve continuity of care (both within the primary care sector and between the primary and secondary care sectors), the implementation of patient registration and a proper electronic health record are recommended through the use of information technology (IT). IT would also facilitate the issue of repeat prescriptions and appropriate appointments, which allow doctors more time to collaborate with patients in their care. Of course, such systems would need the support of training and technical back up, and the involvement of all concerned from the start, not only to avoid any resistance, but also to make them feel part of the process and work towards making the system ‘their own’.

(d) **Reassessment of role of village clinics.** A committee needs to be formed, with representatives of all those involved, to reassess the role of the village clinics (bereg) through an audit of reasons for use and of opening times, with the aim of increased local council involvement. Local clinics could be upgraded (with computers linked to the public healthcare IT system), then enabling appointments to be given, health
records accessed, computerised prescriptions issued and proper GP work done. Alternatively the local councils could directly offer the service of prescriptions and delivery of medicines for old people.

(e & f) Amongst other working conditions that need to be seen to, importance should be given to the development of ancillary staffing (proper reception desk staff and adequate numbers of trained security guards) and the refurbishment and upgrading of premises.

6.2.2 Educational campaign

Educational campaigns could be carried out on two fronts, primarily to improve client use of the health centres and also to raise the image of state GPs.

Besides controlling client abuse through an appointment system and limited opening times, the Primary Health Care Department could set up a Public Awareness Committee to first undertake a relevant needs assessment, which would serve in the preparation of educational campaigns according to the needs of the service and its users. The committee could then coordinate a campaign for optimal use of health centres and cut down client abuse. Moreover, evidence-based guidelines on management of common problems could be compiled and issued to primary healthcare professionals to ensure the provision of evidence-based care.

On the other hand, as state GPs are responsible for own image with hospital doctors and the public, their image needs to be tackled by the general practitioners
themselves, perhaps through their representative organisation, viz. the Malta College of Family Doctors. A ‘hearts-and-minds’ programme needs to be developed, showing GPs working with patients, participating in teamwork, and actively contributing to research and conferences.

6.2.3 Better management

For all the above recommendations to be implemented, a proper management system needs to be in place. Successful management entails not just having the responsibility for running a service, but also the authority to make the changes deemed necessary to improve such service. The responsibility for running health centres should be transferred to local management boards formed of representatives of the various disciplines, which would meet regularly to consider proposals, and have the authority to take decisions and monitor progress in implementation. A committee formed of management and elected representatives from GPs could coordinate remuneration according to performance, and control malingering and abuse by doctors.

6.3 Conclusion

Unless the government can be persuaded to invest money in primary health care and contract out the provision of an alternative system that is autonomous from the civil service, the present health centre system needs to undergo changes in order to ameliorate GPs’ job satisfaction and improve recruitment and retention. If primary care policy-makers and managers fail to recognise the value that doctors attach to
certain characteristics of their jobs, they will continue to experience difficulties in efficiently managing their most important human resources. More sophisticated human resource management policies are needed to promote professional integration and closer doctor-patient relationships, and to help clinicians to better juggle their hectic lives. Such policies should include appropriate remuneration accompanied by professional development schemes and improved working arrangements and conditions, and have the potential to enhance job satisfaction, reduce turnover and improve the care that state general practitioners provide to their patients.
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Appendices

A. Job Satisfaction Survey
B. Instructions for Scoring the Job Satisfaction Survey
C. Scores in Job Satisfaction Survey
D. Formal approval for project
E. Covering letter accompanying questionnaire
**Appendix A: Job Satisfaction Survey**

**JOB SATISFACTION SURVEY**  
Paul E. Spector  
Department of Psychology  
University of South Florida  
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<table>
<thead>
<tr>
<th>Question</th>
<th>Disagree very much</th>
<th>Disagree moderately</th>
<th>Disagree slightly</th>
<th>Agree slightly</th>
<th>Agree moderately</th>
<th>Agree very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I feel I am being paid a fair amount for the work I do.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 There is really too little chance for promotion on my job.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3 My supervisor is quite competent in doing his/her job.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 I am not satisfied with the benefits I receive.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 When I do a good job, I receive the recognition for it that I should receive.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Many of our rules and procedures make doing a good job difficult.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 I like the people I work with.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 I sometimes feel my job is meaningless.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Communications seem good within this organization.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Raises are too few and far between.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Those who do well on the job stand a fair chance of being promoted.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 My supervisor is unfair to me.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 The benefits we receive are as good as most other organizations offer.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>14 I do not feel that the work I do is appreciated.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 My efforts to do a good job are seldom blocked by red tape.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 I find I have to work harder at my job because of the incompetence of people I work with.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 I like doing the things I do at work.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 The goals of this organization are not clear to me.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT.</td>
<td></td>
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<td>Copyright Paul E. Spector 1994, All rights reserved.</td>
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<tr>
<td></td>
<td></td>
<td>Disagree very much</td>
<td>Disagree moderately</td>
<td>Disagree slightly</td>
<td>Agree slightly</td>
<td>Agree moderately</td>
</tr>
<tr>
<td>19</td>
<td>I feel unappreciated by the organization when I think about what they pay me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20</td>
<td>People get ahead as fast here as they do in other places.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21</td>
<td>My supervisor shows too little interest in the feelings of subordinates.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22</td>
<td>The benefit package we have is equitable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23</td>
<td>There are few rewards for those who work here.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24</td>
<td>I have too much to do at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25</td>
<td>I enjoy my co-workers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26</td>
<td>I often feel that I do not know what is going on with the organization.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27</td>
<td>I feel a sense of pride in doing my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28</td>
<td>I feel satisfied with my chances for salary increases.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29</td>
<td>There are benefits we do not have which we should have.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30</td>
<td>I like my supervisor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31</td>
<td>I have too much paperwork.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32</td>
<td>I don't feel my efforts are rewarded the way they should be.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>33</td>
<td>I am satisfied with my chances for promotion.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>34</td>
<td>There is too much bickering and fighting at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>35</td>
<td>My job is enjoyable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>36</td>
<td>Work assignments are not fully explained.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix B: Instructions for Scoring the Job Satisfaction Survey

Instructions for Scoring the Job Satisfaction Survey, JSS

Paul E. Spector
Department of Psychology
University of South Florida

The Job Satisfaction Survey or JSS, has some of its items written in each direction—positive and negative. Scores on each of nine facet subscales, based on 4 items each, can range from 4 to 24; while scores for total job satisfaction, based on the sum of all 36 items, can range from 36 to 216. Each item is scored from 1 to 6 if the original response choices are used. High scores on the scale represent job satisfaction, so the scores on the negatively worded items must be reversed before summing with the positively worded into facet or total scores. A score of 6 representing strongest agreement with a negatively worded item is considered equivalent to a score of 1 representing strongest disagreement on a positively worded item, allowing them to be combined meaningfully. Below is the step-by-step procedure for scoring.

1. Responses to the items should be numbered from 1 representing strongest disagreement to 6 representing strongest agreement with each. This assumes that the scale has not been modified and the original agree-disagree response choices are used.

2. The negatively worded items should be reverse scored. Below are the reversals for the original item score in the left column and reversed item score in the right. The rightmost values should be substituted for the leftmost. This can also be accomplished by subtracting the original values for the internal items from 7.

\[
\begin{array}{c|c}
1 & 6 \\
2 & 5 \\
3 & 4 \\
4 & 3 \\
5 & 2 \\
6 & 1 \\
\end{array}
\]

3. Negatively worded items are 2, 4, 6, 8, 10, 12, 14, 16, 18, 19, 21, 23, 24, 26, 29, 31, 32, 34, 36. Note the reversals are NOT every other one.

4. Sum responses to 4 items for each facet score and all items for total score after the reversals from step 2. Items go into the subscales as shown in the table.
5. If some items are missing you must make an adjustment otherwise the score will be too low. The best procedure is to compute the mean score per item for the individual, and substitute that mean for missing items. For example, if a person does not make a response to 1 item, take the total from step 4, divide by the number answered or 3 for a facet or 35 for total, and substitute this number for the missing item by adding it to the total from step 4. An easier but less accurate procedure is to substitute a middle response for each of the missing items. Since the center of the scale is between 3 and 4, either number could be used. One should alternate the two numbers as missing items occur.

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## Appendix C: Scores in Job Satisfaction Survey

| Dr. No | Presently or Formerly in Health Centres | Age | Gender | Status | Year of Graduation | Years in Health Centres | Hours of Work | Private Practice | Housework, etc. | Continuing Education (CE) | Pay | Promotion | Supervision | Fringe Benefits | Contingent Rewards | Operating Conditions | Co-workers | Nature of Work | Communication | TOTAL |
|--------|----------------------------------------|-----|--------|--------|--------------------|-------------------------|------------------------|-----------------|------------------|------------------|-------------------------|-----|-----------|-------------|----------------|----------------|-------------------|------------|--------------|---------------|-------|
| 1      | 0 35 1 0 1991 6.00 1 1 0 0 | 11 | 23 | 6 | 4 | 7 | 16 | 9 | 10 | 92 |
| 2      | 0 37 1 0 1990 10.00 1 0 0 0 | 1 | 4 | 22 | 9 | 4 | 8 | 15 | 21 | 9 | 105 |
| 3      | 0 36 1 0 1991 8.00 1 1 0 1 | 1 | 8 | 22 | 11 | 6 | 7 | 19 | 16 | 19 | 119 |
| 4      | 0 41 0 0 1985 15.00 0 0 0 0 | 1 | 9 | 23 | 10 | 10 | 11 | 16 | 12 | 10 | 111 |
| 5      | 0 44 0 1 1981 20.00 0 0 0 0 | 7 | 20 | 11 | 10 | 7 | 17 | 12 | 9 | 100 |
| 6      | 0 30 0 0 1995 6.00 1 0 0 1 | 5 | 18 | 6 | 5 | 10 | 14 | 19 | 19 | 14 | 84 |
| 7      | 0 27 0 1 1999 1.00 0 1 1 1 | 1 | 8 | 11 | 8 | 7 | 10 | 11 | 16 | 7 | 90 |
| 8      | 0 40 1 0 1986 14.00 0 1 0 0 | 1 | 8 | 11 | 8 | 7 | 10 | 11 | 16 | 7 | 90 |
| 9      | 0 29 1 0 1997 3.00 1 0 0 0 | 4 | 19 | 8 | 5 | 11 | 17 | 8 | 4 | 83 |
| 10     | 0 40 0 0 1985 16.00 0 0 1 1 | 4 | 17 | 8 | 9 | 17 | 15 | 16 | 100 |
| 11     | 0 40 0 0 1987 6.00 0 0 1 0 | 4 | 20 | 5 | 6 | 10 | 16 | 5 | 12 | 84 |
| 12     | 0 33 0 0 1993 8.00 2 0 0 0 | 6 | 14 | 9 | 7 | 12 | 19 | 16 | 7 | 95 |
| 13     | 0 43 0 1 1985 15.00 0 1 0 0 | 4 | 24 | 6 | 7 | 13 | 20 | 16 | 19 | 115 |
| 14     | 0 42 0 0 1985 16.00 0 1 0 0 | 1 | 4 | 22 | 13 | 9 | 7 | 17 | 13 | 11 | 107 |
| 15     | 0 35 1 0 1992 3.00 1 1 0 0 | 6 | 23 | 8 | 9 | 11 | 22 | 20 | 21 | 128 |
| 16     | 0 34 0 0 1992 7.00 0 0 0 0 | 4 | 14 | 4 | 9 | 6 | 15 | 11 | 6 | 73 |
| 17     | 0 42 0 0 1984 16.00 0 0 1 1 | 4 | 23 | 10 | 7 | 16 | 17 | 10 | 15 | 107 |
| 18     | 0 43 0 2 1985 16.00 0 0 0 0 | 4 | 23 | 8 | 12 | 9 | 23 | 20 | 17 | 124 |
| 19     | 0 40 0 0 1988 13.00 0 0 1 0 | 1 | 4 | 10 | 8 | 9 | 7 | 13 | 6 | 10 | 78 |
| 20     | 0 28 0 0 1997 3.50 0 0 0 0 | 5 | 23 | 5 | 5 | 5 | 17 | 7 | 8 | 70 |
| 21     | 0 36 1 0 1990 10.00 2 1 0 0 | 8 | 20 | 8 | 14 | 12 | 20 | 18 | 15 | 122 |
| 22     | 0 28 1 0 1997 3.00 2 1 0 0 | 1 | 9 | 21 | 11 | 14 | 10 | 15 | 17 | 7 | 114 |
| 23     | 0 40 1 2 1986 11.00 0 1 0 0 | 4 | 20 | 4 | 5 | 4 | 16 | 14 | 5 | 76 |
| 24     | 0 39 1 0 1988 6.00 2 1 0 0 | 1 | 7 | 22 | 11 | 10 | 11 | 15 | 13 | 118 |
| 25     | 0 43 0 0 1984 16.00 0 0 0 0 | 5 | 13 | 13 | 7 | 11 | 13 | 13 | 12 | 95 |
| 26     | 0 42 0 1 1984 16.00 1 1 0 1 | 4 | 4 | 9 | 4 | 7 | 15 | 5 | 8 | 63 |
| 27     | 0 37 0 0 1989 10.00 2 0 1 0 | 4 | 20 | 4 | 6 | 13 | 21 | 13 | 13 | 98 |
| 28     | 0 42 0 2 1985 14.00 0 0 0 0 | 10 | 18 | 8 | 8 | 8 | 14 | 9 | 7 | 86 |
| 29     | 0 36 0 0 1993 5.00 0 1 0 0 | 1 | 10 | 7 | 11 | 11 | 9 | 10 | 9 | 7 | 84 |
| 30     | 0 42 0 0 1986 10.00 0 0 0 0 | 1 | 4 | 16 | 7 | 8 | 13 | 16 | 13 | 7 | 89 |
| 31     | 0 28 0 0 1997 3.50 0 0 0 0 | 4 | 11 | 8 | 6 | 7 | 13 | 5 | 4 | 64 |
| 32     | 0 41 0 0 1988 2.00 0 0 0 0 | 9 | 11 | 9 | 4 | 14 | 16 | 5 | 4 | 76 |
| 33     | 0 39 0 0 1989 13.00 0 0 1 1 | 4 | 6 | 11 | 9 | 11 | 21 | 20 | 17 | 110 |
| 34     | 0 42 0 0 1988 5.00 2 1 0 0 | 9 | 10 | 12 | 7 | 4 | 15 | 10 | 11 | 86 |
| 35     | 0 30 0 0 1997 3.00 0 0 0 0 | 9 | 12 | 5 | 4 | 9 | 12 | 5 | 4 | 64 |
| 36     | 0 62 0 0 1963 1.00 2 0 1 1 | 1 | 13 | 15 | 7 | 10 | 6 | 17 | 9 | 10 | 99 |
| 37     | 0 27 0 1 1999 1.50 0 0 0 0 | 5 | 19 | 5 | 4 | 13 | 18 | 13 | 10 | 96 |
| 38     | 0 34 0 0 1992 8.00 0 1 0 0 | 4 | 20 | 5 | 5 | 10 | 18 | 17 | 11 | 95 |
| 39     | 0 45 0 0 1982 18.00 0 0 1 0 | 4 | 9 | 4 | 4 | 6 | 15 | 5 | 10 | 62 |
| 40     | 0 30 0 1 1995 5.50 0 0 1 0 | 1 | 8 | 22 | 13 | 11 | 10 | 19 | 22 | 14 | 130 |
| 41     | 0 28 0 1 1997 3.50 0 0 1 1 | 6 | 9 | 5 | 4 | 11 | 14 | 4 | 15 | 70 |
| Dr No | Presently or Formerly in Health Centres | Age | Gender | Status | Year of Graduation | Years in Health Centres | Hours of Work | Private Practice | Housework, etc. | Continuing Education (CE) | Pay | Promotion | Supervision | Fringe Benefits | Contingent Rewards | Operating Conditions | Co-workers | Nature of Work | Communication | TOTAL |
|-------|----------------------------------------|-----|--------|--------|--------------------|-------------------------|------------------------|-----------------|-----------------|-----------------|------------------------|-----|-----------|------------|----------------|-----------------|-----------------------|-----------|--------------|-------------|------|
| 42    | 0 45 1 1 1988 3.00 0 0 1 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 97 |
| 43    | 0 31 1 1 1993 8.00 0 1 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 110 |
| 44    | 0 42 0 0 1985 16.00 0 0 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 101 |
| 45    | 0 35 1 1 1993 3.00 0 1 0 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 72 |
| 46    | 0 30 1 1 1995 5.50 0 1 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 72 |
| 47    | 0 35 0 0 1995 7.00 0 0 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 60 |
| 48    | 0 42 0 0 1986 14.00 0 0 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 101 |
| 49    | 0 34 0 0 1992 8.00 0 0 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 700 |
| 50    | 0 34 1 0 1993 7.50 0 1 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 31 |
| 51    | 0 50 0 0 1977 1.00 2 0 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 52    | 0 30 0 0 1995 5.00 2 1 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 53    | 1 32 0 0 1995 1.17 0 0 1 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 700 |
| 54    | 1 31 0 0 1995 0.75 0 0 1 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 55    | 1 30 0 0 1995 1.67 0 1 1 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 700 |
| 56    | 1 33 0 0 1993 5.25 0 0 1 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 57    | 1 41 0 0 1985 0.00 0 0 1 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 58    | 1 30 0 0 1995 0.50 0 0 1 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 700 |
| 59    | 1 29 1 1 1997 0.25 0 1 1 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 60    | 1 29 0 1 1997 0.50 0 1 1 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 61    | 1 30 0 0 1995 1.00 0 0 1 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 62    | 1 29 1 0 1997 0.50 0 1 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 63    | 1 40 0 0 1986 11.00 0 0 1 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 64    | 1 25 0 0 1999 0.25 0 1 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 65    | 1 29 1 2 1997 0.25 0 1 0 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 66    | 1 29 0 0 1997 0.75 0 1 1 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 67    | 1 28 0 1 1999 1.00 0 0 1 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 68    | 1 38 1 0 1988 10.00 0 0 1 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 69    | 1 26 0 0 1999 0.17 0 1 1 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 70    | 1 30 0 1 1997 1.00 0 0 1 0 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |
| 71    | 0 38 1 0 1989 12.00 0 1 0 1 | 1 | 4 | 13 | 9 | 11 | 12 | 16 | 12 | 9 | 136 |

Codes:
Presently or Formerly in Health Centres: Present-0; Former-1
Gender: Male-0; Female-1
Status: Married-0; Single-1; Separated-2
Years in Health Centres: No reply-0
Hours of Work: Full-0; Reduced-1; Part-time-2
Private Practice: Yes-0; No-1
Housework, etc.: Yes-0; No-1
Continuing Education: Yes-0; No-1
Appendix D: Formal approval for project

Health Division
15 Merchants Street
Valletta CMR 01
Malta

4 July 2002

To whom it may concern

This is to confirm that, as Director General (Health), I have given my consent to Dr Mario R Sammut to undertake a study of job satisfaction of general practitioners employed by the Department of Primary Health Care, in fulfilment of a research project required as part of his studies for a Masters in Health Science (Health Services Management) 2001-3 at the Institute of Health Care of the University of Malta.

Dr RAY BUSUTTIL
Director General (Health)
Appendix E: Covering letter accompanying questionnaire

Name
Address
Telephone number
E-mail address

10th January 2003

Dear Colleague,

As part of my studies for a Masters in Health Science at the University of Malta, I am undertaking a management project entitled ‘State primary health care – addressing medical manpower needs’. The project will address the shortage of GPs working in government health centres. With your help, I hope to come up with creative but practical recommendations in human resource maintenance to tackle this problem of doctor retention and recruitment.

As such, I would be very grateful if you would find the time to complete this questionnaire and return it in the enclosed stamped addressed envelope by Monday 27th January 2003. The confidentiality of your participation will be ensured as the questionnaire is anonymous.

After the replies are analysed, I intend to set up a number of focus groups to try and concretise your suggestions into practical solutions. If you would be interested in participating, please let me know by phone or e-mail (separately from this questionnaire to preserve its anonymity).

Thank you for your interest and cooperation.

Yours sincerely,

Mario R Sammut