

# TRENDS IN PATIENTS' SATISFACTION WITH FAMILY PRACTICE IN SLOVENIA

## TRENDI V ZADOVOLJSTVU BOLNIKOV Z ZDRAVNIKOM DRUŽINSKE MEDICINE V SLOVENIJI

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### Abstract

**Objective:** To compare patient's views on family practice in Slovenia in 1998 and 2004.

**Methods:** The EUROPEP instrument, consisting of 23 questions was used in both cross-sectional surveys. The first study was performed in 1998 including a sample of 36 family practices and 2160 patients. The second study was conducted in 2004 on a sample of 31 practices and 930 patients.

**Results:** The response rates were 83,8% and 99,6%. Overall, patients' satisfaction has increased from 86,6 to 87,7 points on a 100-point scale ( $p = 0,034$ ). Improvement is seen in all but four items. Making it easy to tell about their problems was evaluated with same mean score. Involving patients in decisions about their medical care and being able to speak to general practitioner on the telephone were evaluated lower, but non-significant. The only item that shows statistically significant decrease in the mean scores is getting through to the practice on the phone. By far the lowest satisfaction was reported with waiting in the waiting room in both surveys. The highest scores got in both surveys the confidentiality of medical records, and listening capacity of family doctors.

**Conclusion:** The results of our study provide a clear insight in the trends of satisfaction of family practice visitors in Slovenia. These trends are positive but the results also identified possible areas for quality improvement, such as in the telephone accessibility, management of waiting time in the waiting room and doctor-patient communication skills

**Key words:** family medicine, patient satisfaction, quality of care, Slovenia

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### Izvleček

**Namen:** Primerjava ravni zadovoljstva bolnikov z zdravniki družinske medicine v Sloveniji v letih 1998 in 2004.

**Metode:** V dveh presečnih raziskavah je bil uporabljen EUROPEP vprašalnik s 23 vprašanji. V prvo raziskavo, izvedeno leta 1998, je bilo vključenih 36 ambulant družinske medicine iz različnih zdravstvenih ustanov in 2160 bolnikov. Druga raziskava, ki je potekala leta 2004, pa je v vzorec zajela 31 ambulant družinske medicine in 930 bolnikov.

**Rezultati:** Na vprašalnike je odgovorilo 83,8 % bolnikov iz prve in 99,6 % iz druge raziskave. Povprečna skupna ocena zadovoljstva bolnikov se je dvignila s 86,6 na 87,7 točk na lestvici s 100 točkami ( $p = 0,034$ ). Izboljšanje je opazno pri vseh, razen pri štirih vprašanjih. Vprašanje: »Ali vam je zdravnik pomagal, da ste mu povedali o svojih težavah?« je dobilo enako dobro oceno. Vključevanje bolnika v odločanje o zdravljenju in možnost telefonskega pogovora z zdravnikom sta bili ocenjeni slabše, a statistično neznčilno. Možnost dobiti telefonsko zvezo z ambulanto je bilo edino vprašanje s statistično značilno slabšo oceno. V obeh raziskavah je najnižjo oceno dobilo čakanje v čakalnici. Najbolj so bolniki cenili zaupnost ravnanja s podatki in zdravnikovo pripravljenost, da jih posluša.

**Zaključek:** Rezultati naše raziskave jasno kažejo na pozitivne trende zadovoljstva z zdravniki družinske medicine

*pri obiskovalcih ambulant družinske medicine. Izsledki obeh študij pa so pokazali tudi na možna področja za izboljševanje kakovosti: izboljšanje telefonske dostopnosti ambulante, zmanjšanje čakanja v čakalnici in večji poudarek veščinam sporazumevanja.*

**Ključne besede:** družinska medicina, zadovoljstvo bolnika, Slovenija

## 1 Introduction

Family medicine is a key discipline of primary care and there are growing trends to address quality issues in it (1, 2). As improving the sensitivity of primary health care to patient's preferences is an important challenge in health care today, the role of patient in assessing quality of care has further evolved (3). Patients can offer valuable contributions to assessment of communication skills of the doctor and important views on the organisational aspects of care (4-7). Patients' compliance and satisfaction with care are positively influenced by effective communication (8). On the other hand, good management of primary health care is considered as a prerequisite for patients to receive the clinical care they need (9, 10).

In the last decade, a validated instrument for measuring patient satisfaction was developed and used in many European countries, including Slovenia (11). In our country, disparities in patient satisfaction in ethnic minorities were found (12), but the results of the national study on patient satisfaction showed overall high patient satisfaction, which could be compared to other European countries (5, 6).

Slovenia has a population of two million people and joined the EU in May 2004. It has transformed its health care system from the state run to a decentralised model in the last decade (13). The country had reformed its health care system adopting the following features of primary health care: family physicians keep patients lists, they have gate-keeping role and they are paid by mixed capitation – fee for service scheme. Due to EU regulations and recommendations vocational training in family medicine became mandatory in 2000. Under the umbrella of EU recommendations several initiatives are currently being undertaken to strengthen health promotion and prevention activities within primary health care. As a result a new national preventive program for adults that is directed mainly to cardiovascular prevention was introduced in 2001. We have been also witnessing a rapid academic growth of family medicine in the country and there is general

belief that the quality of the health service provision is high (14). Despite many new challenges family medicine regained its importance in that period.

On the other hand, the number of consultations per working day and the number of referrals is increasing, leading to shortening of the consultation time (15). The physicians are overwhelmed also by increasing bureaucracy and are more and more dissatisfied with the amount of time they can spend with patients (16). In some parts of Slovenia there is a shortage of the doctors and those have to see even more patients per working day and fill in more forms to maintain their incomes and satisfy health policy makers, who demand high availability of the services for the citizens. There is a growing belief that these changes have also affected patient satisfaction, regardless active efforts of the profession to improve quality of GP's work.

Patients' evaluation of the family practice in our country was shown to be relatively high in the 1998 survey (17). We were thus interested to get insight if changes in last years have affected patients' views on care received in general practice. The aim of our study was therefore to compare practice attendees' views on family practice in 1998 and 2004 studies in Slovenia and to identify aspects for health care improvement. However, until now, there were no studies done that would evaluate trends in patient satisfaction with family practice in Slovenia.

## 2 Methods

### 2.1 Design and research population

We made a comparison of two cross-sectional studies on the two samples of Slovene family practices attendees using the questionnaire for measuring patient satisfaction. The first study was undertaken as a part of EUROPEP (the European Task Force on Patients' Evaluation of General Practice) research and the second study as a part of EPA (European Practice Assessment) project. In both studies practice visitors

were asked to evaluate family practice care, taking into account at least 12 months of their experiences with the practice under the study. The adult patients aged 18 or more without reading problems, able to understand the national language were approached and informed about the purpose, anonymity and possibility to refuse the participation in the studies. Patients' characteristics, like age, gender, number of contacts and history of chronic disease are presented in Table 1.

stratified sample of urban and rural practices, single-handed, dual and group practices. After the visit, 930 self-administrated questionnaires were handed out by the family physicians or by the practice nurse. The questionnaires were distributed to 930 consecutive patients visiting family physicians from a convenience sample of 31 Slovenian family practices after a chosen starting day. Patients filled in the questionnaires in the waiting room and left them in the special box at the entrance.

Table 1. *Characteristics of responders in 1998 and 2004 studies.*  
Tabela 1. *Značilnosti sodelujočih v raziskavah v 1998 in 2004.*

	1998 (n = 1809)	2004 (n = 926)
Gender:		
male	36%	44,7%
female	64%	55,3%
Age groups:		
≤ 40 years	27,8%	39,5%
41 – 65 years	51,6%	50,3%
>65 years	20,6%	10,2%
Age average	50,9	45,8
No. of contacts with GP over the last 12 months	6,7	6,1
History of chronic disease	49,2%	46,3%

The first study was performed in spring 1998 on a stratified sample of Slovene family practices. We used the common EUROPEP study protocol: 60 consecutive patients of 36 family practitioners in different practices in the country (18). The self-administered questionnaires were handed out by the doctors to 2160 consecutive patients after a visit to a family physician after a chosen starting day. A convenience sample of 36 family practices was selected according to the size of the population as urban or rural and according to the type of practice as group or single-handed. Patients in this study were asked to fill in the questionnaire at home and post it back in a prepaid and addressed envelope to the research institute. After 14 days they received a reminder.

In the second study that was conducted in spring 2004 we used the common EPA study protocol: convenience sample of at least 30 practices per country and at least 30 consecutive patients per practice (19). We made a

The study design in both investigations ensured participation of patients from public and private practices. The selection of practices and family physicians was made using national data on the location of practices, and the age and sex of the family physicians, so that physicians under both studies fairly good represent national situation. (20, 21)

The ethical approvals for both studies were obtained from National Ethical Committee of Slovenia.

## 2.2 Instrument

An internationally standardised and validated self-administrated instrument EUROPEP for patients' evaluations of family practice care was used in both surveys. The data set collected with questionnaire in both studies included patient demographic statistics, health characteristics, as well attitude and experiences with health care services. The instrument consists

of 23 questions and covers two dimensions of care: clinical behaviour (communication, technical aspects and information giving) and organisation of care. The development and validation process of the instrument are described in details elsewhere (4). Patients were asked to evaluate scale following items on a five point Likert scale related to their practice with the extremes labelled "poor" and "excellent". The validity of the instrument was assured through explicit translation procedures using three forward and two backward translations of the original English version of the instrument.

### 2.3 Analysis

Data were analysed using the Epi-info and SPSS (version 11) statistical package. We used a two-sample z-test in large samples to test the differences between the item means (22).

## 3 Results

The response rate in the first study was 83,8% and in the second 99,6%. The respondents in the 2004 sample were with the average age of 45,8 years (sd = 14,5 years) younger than in the 1998 sample with the average of 50,9 years (sd = 15,4 years,  $p < 0,001$ ) and there were more male patients in the 2004 sample (44,7% vs. 36%,  $p < 0,001$ ). The patients in the 2004 study had less contacts (6,1 vs. 6,7 contact) with the GPs ( $p = 0,02$ ) over the last 12 months and were less likely to have a history of chronic disease (46,3% vs. 49,2%,  $p = 0,01$ ). Age, gender, number of contacts and presence of chronic condition did not predict any difference in patient satisfaction rate in 1998 sample and predicted 6% of variation in patient satisfaction rate in 2004.

Mean patient satisfaction in 2004 sample with 87,7 (sd = 12,9; CI 86,6 – 88,7) was significantly higher ( $p = 0,034$ ) than in 1998 sample 86,6 points (sd = 12,6; CI 85,9 – 87,4).

The comparison of items' means of patients' satisfaction from both studies is shown in Table 2. There is a significant improvement in all but nine aspects. Making patients it easy to tell about their problems was evaluated with the same mean score. Slight improvement but not any statistical difference is seen in: interesting in patients' personal situation; helping to feel well so that they can perform normal daily activities; helping patients deal with emotional problems related to their health status; helping them understand the importance of following doctor's

advice; preparing patients for what to expect from specialist or hospital care. The only item that shows statistically significant decrease in the mean scores is getting through to the practice on the phone. Aspects where slight but non-significant decrease was found were: involving patients in decisions about their medical care and being able to speak to GP on the phone.

Waiting in the waiting room got lowest scores in both surveys. On the other hand the patients still valued most confidentiality of medical records, and listening capacity of doctors.

When comparing the scores, one can also see that the biggest gains in scores were recorded for: helpfulness of the staff (other than the general practitioner), getting an appointment to suit patient and waiting time in the waiting room.

## 4 Discussion

The study provides information on what patients expect and value in family medicine in Slovenia. The main strength of the study is that it is based on two large samples of practice attendees from family practices stratified to cover the country specifics and thus can be generalised to the whole population of family practice attendees. The study design from both studies ensured participation of the patients from different settings all over Slovenia, including: urban, rural practices, group and solo practices as well private and public practices. Use of the EUROPEP instrument, an internationally developed and validated instrument for patients' evaluations of family practice, in both studies, ensures accurate insight in the development of an important element of quality in family medicine in the country.

Several factors should be taken into account when considering the generalisability of our results. Firstly, since we compare results from cross-sectional studies our findings should be regarded with circumspection. Secondly, family practitioners participated voluntarily in both surveys and may thus have been more interested and motivated than family practitioners in general which may, in turn, have resulted in more positive evaluations. Thirdly, as the study samples of patients weren't been selected randomly were therefore potentially not representative. Next, the questionnaires in both studies were handed out by the doctor or practice nurse, which may have given the staff the possibility of excluding some patients (e.g. those with the most negative attitudes) from the

Table 2. Comparison of items' means of patients' satisfaction in 1998 and 2004.

Tabela 2. Primerjava srednjih ocen postavk v raziskavah o zadovoljstvu bolnikov, opravljenih v 1998 in 2004.

	Item mean 1998	SD	Item mean 2004	SD	z	p
1. Making you feel you had time during consultation?	4,43	0,70	4,49	0,670	2,18	0,03
2. Interest in your personal situation?	4,16	1,02	4,17	0,993	0,25	0,8
3. Making it easy for you to tell him or her about your problems?	4,35	0,85	4,35	0,849	0,00	1
4. Involving you in decisions about your medical care?	4,40	0,83	4,39	0,812	-0,30	0,7
5. Listening to you?	4,63	0,63	4,71	0,580	3,31	0,001
6. Keeping your records and data confidential?	4,74	0,52	4,81	0,454	3,63	0,001
7. Quick relief of your symptoms?	4,56	0,67	4,62	0,643	2,28	0,02
8. Helping to feel well so that you can perform normal daily activities?	4,54	0,67	4,56	0,656	0,75	0,4
9. Thoroughness?	4,48	0,73	4,57	0,668	3,23	0,001
10. Physical examination of you?	4,44	0,73	4,53	0,680	3,19	0,001
11. Offering you services for preventing diseases?	4,30	0,98	4,39	0,900	2,40	0,02
12. Explaining the purpose of tests and treatments?	4,43	0,76	4,53	0,734	3,33	0,001
13. Telling you what you wanted to know about your symptoms and/or illness?	4,52	0,72	4,58	0,644	2,21	0,03
14. Helping you deal with emotional problems related to your health status?	4,36	0,88	4,37	0,851	0,29	0,7
15. Helping you understand the importance of following his or her advice?	4,48	0,71	4,50	0,716	0,69	0,5
16. Knowing what s/he had done or told you during contacts?	4,43	0,75	4,50	0,732	2,35	0,02
17. Preparing you for what to expect from specialist or hospital care?	4,36	0,82	4,37	0,827	0,30	0,7
18. The helpfulness of the staff (other than the general practitioner)?	4,36	0,90	4,64	0,637	9,41	<0,001
19. Getting an appointment to suit you?	4,28	1,04	4,51	0,785	6,47	<0,001
20. Getting through to the practice on the phone?	4,61	0,73	4,48	0,798	-4,15	0,001
21. Being able to speak to the general practitioner on the telephone?	4,60	0,81	4,56	0,752	-1,28	0,2
22. Waiting time in the waiting room?	3,67	1,07	3,93	1,019	6,21	<0,001
23. Providing quick services for urgent health problems?	4,47	0,86	4,54	0,761	2,18	0,03

study and therefore presented a possible selection bias. One possible limitation of the study could be that patients were included when attending the surgery and frequent attendees (e.g. patients with chronic disease) were thus more likely to be included. This fact gave the possibility that opinion of patients who rarely visit these practices may be underrepresented. The same is true for patients who do not master the national language well.

We obtained a high response rate in both surveys, minimizing the risk of selection bias due to dropout. One can argue that the very high response rate (99,6%) in the second study can be related to a slightly different method in collecting questionnaires. In the EUROPEP study the answers were posted back to the research institute while in the 2004 study the filled-in questionnaires were put in the sealed box in the waiting room. But in this way we probably received the answers even from those who otherwise would not like to participate because of time constrains. Compared with 1998 results, we received more questionnaires from men, younger patients and those who had fewer contacts with their family doctor. Regarding the data from literature, all those groups of patients are usually less satisfied with health care (7, 23, 24). The 2004 results present higher overall satisfaction scores in spite there were younger practice visitors, more men and more those with fewer contacts in the sample. This important finding adds to the reliability of the study.

The study demonstrates that high rates of patient satisfaction in 1998 remained high also in 2004. There may be several explanations for these findings. The first may be that patient satisfaction in our country is a stable category, which is relatively immune to changes in the health policy. Professional organisations and the media have perceived restrictive policy changes from 1998 till 2004 as important, but they perhaps did not affect patient satisfaction, which may be more linked to a personal doctor-patient relationship. In the period we have examined, the role of a personal doctor was strengthened that worked towards improving patient satisfaction. The second explanation may be the improvements in the quality of family practice in the country during the process of accession to EU counteracted the negative effects of the health policy decisions on patient satisfaction.

Probably the most interesting points to examine are the areas where patients perceive the biggest improvements. They all relate to organisational aspects of care and probably reflect the growing importance of management of family practices that was considered important after the health care reform. Management

became a frequent topic in CME (continual medical education) meetings in recent years and an obligatory topic in the new vocational training for family physicians in the country (25). Nevertheless, patients still complain about the time spent waiting to see their doctor. Even we are witnessing lack of family doctors in almost all regions of the country and the average consultation time in doctor's office is among the lowest in Europe, doctors and practice managers should focus more on this field.

The second survey has shown a decrease in patient's satisfaction with telephone access to the practice and their doctor. Telephone appointments can reduce patient's office visits and they have become increasingly popular in recent time (26, 27). Obviously, the practices have not adequately adapted to this challenge. One of the excuses is that telephone consultations are not recognised as a part of the contract with the payer.

Among the highly rated items in both surveys were the confidentiality of medical records, and listening capacity of family doctors. Demands of the national insurance institutions to review patients records to remain in financial control, and the demands of different insurance companies to have access to patients' records are a great challenge to the confidentiality so highly prized by patients today. In spite of lack of time, family doctors appeared to be good listeners and focused on actual patient problems. The study also demonstrated that there is still space to improve doctor-patient communication. Probably even more efforts in postgraduate education and CME activities are needed in this area in the future years.

## 5 Conclusion

The relatively high scores, after administering the questionnaire on patients' satisfaction with family medicine to practice attendees, observed in 1998 study even slightly increased in 2004 study. So, we may expect that results of our study provide a clear insight in the trends of satisfaction of family practice visitors in Slovenia. These trends are positive but the results also identified possible areas for quality improvement, such as in the telephone accessibility, management of waiting time in the waiting room and doctor-patient communication skills.

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