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HOW DO PATIENTS EVALUATE THE NEW HEALTH CARE SYSTEM IN GENERAL PRACTICE? RESULTS FROM THE EUROPEAN PROJECT ON PATIENT EVALUATION OF GENERAL PRACTICE CARE (EUROPEP) IN ADANA, TURKEY

Ersin Akpinar[1] † --- Fatih Mutlupoyraz[2] --- Esra Saatci[3] --- Nafiz Bozdemir[4]
[1,3,4]Prof. Dr., Cukurova University Faculty of Medicine, Department of Family Medicine, Adana, Turkey
[2]Specialist, Cukurova University Faculty of Medicine, Department of Family Medicine, Adana, Turkey

ABSTRACT

Aim: Evaluation of patient satisfaction is accepted as a valuable addition to other types of outcome measures (such as health status, quality of life or costs) in measuring the quality of general practice care. The aim of this study is to assess the patient satisfaction for primary care before and after the transition of health care system in Turkey. Methods: The study included a sample of 588 patients from three public family health centers (FHCs) in Adana. The study was conducted between March and April 2008 and May and June 2009. The patients were asked to assess their family physician based on their contact experience before and after the health care system transition in Turkey. Results: Overall satisfaction was %74.6 before and %93.5 after the transition (p=0.0001). The "Organization of care" was evaluated as the most improving dimension. However, the "Medical care" change was the worst rated. "Providing quick services for emergency health problems", "Knowing what s/he had done or told you during contacts" "Preparing you for what to expect from specialist or hospital care", "Being able to speak to the general practitioner on the telephone", "Getting through to the practice on telephone" and "Helping you deal with emotional problems related with your health status" were evaluated as improving items (p=0.0001). Conclusion: Patient evaluation of care can contribute to make practices and their teams more responsive to patient's needs.

Keywords: Patient satisfaction, Family medicine, EUROPEP, Health system transition, Turkey.

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Contribution/ Originality

This study is one of very few studies which have investigated the patient satisfaction for primary care before and after the transition of health care system in Turkey.

† Corresponding author

1. INTRODUCTION

Patient-centredness has been one the cornerstones of general practice since the early years of the profession [1]. The patient-centred clinical method implies that a physician should 'understand the meaning of illness for the patient as well as interpret it in terms of the medical frame of reference' [2]. Assessing the quality of care is now increasingly tending to integrate measurements of patient perception [3-6]. Evaluation of patient satisfaction is accepted as a valuable addition to other types of outcome measures (such as health status, quality of life or costs) in measuring the quality of general practice care [7, 8]. Patient satisfaction is a multidimensional concept, based on a relationship between experiences and expectations. The term patient satisfaction as used herein means the positive emotional reaction to the consultation and the positive experience of the treatment in its various aspects. Good communication [9] comprehensive assessment of patients' needs and provision of information [7] shared decision-making [10] supportive and well understanding physician-patient relationship, the physician's personal qualities [11] or simply positive treatment results for the patient have all been shown to improve patient satisfaction.

1.1. Health Care System in Turkey

The Turkish Health Socialization Law (1961) emphasized social justice as the primary aim of the health care services [12]. The 1982 Turkish Constitution states that everyone has the right to live in a healthy and balanced environment [12]. The *National Health Policy* document of the Ministry of Health in 1993 stated that the ultimate objective of the health care system is to create a healthy community made up of healthy members [13]. The document emphasized that this aim cannot be reached by health care services alone and stressed the need for intersectoral action.

Turkey's health care system has a highly complex structure that is at once centralized and fragmented. The current system is the result of historical developments rather than a rational planning process. Consequently, decision-making and implementation bodies vary in form, structure, objectives and achievements. United Nations Development Programme (UNDP) provides support to the Turkish Ministry of Health in order to facilitate the implementation of the Health Transition Project (HTP), which aims to enhance the quality of human life in Turkey, by improving health status indicators and reducing disparities among different regions and socio-economic groups [14]. After the full implementation of the current reform package, quality will be an important dimension within a competitive health services environment.

The HTP in Turkey added effectiveness (setting primary objectives such as increasing the health status of the population) and efficiency (using resources in the best possible manner and at low cost) as goals. These latter goals indicate an underlying concern with equity.

Patients' participation in health care policies and decisions is quite limited in Turkey. However, proposed reform measures are being considered that would improve the situation. As part of the health technology assessment (HTA), the Ministry of Health has emphasized patient

satisfaction in all recent policy documents, and it has already incorporated satisfaction levels of patients and their relatives as an input in determining institutional performance [13].

The aim of this study is to assess the patient satisfaction for primary care before and after the transition of health care system in Turkey.

2. PATIENTS AND METHODS

2.1. Sampling and Study Design

The study included a sample of 588 patients from three public family health centers (FHCs) in Adana, a province in the southern Mediterranean of Turkey. The selection of FHCs was based on the socioeconomic status (low, moderate or high) of the population served. The inclusion criteria for the patients were: ≥18 years old (in case of pediatric patients the questionnaire was completed by the accompanying parent), understanding of the Turkish language and no mental retardation, psychosis or demans. The study was conducted between March and April 2008 and May and June 2009.

2.2. Procedure

The first step was to contact the practice, to explain the aim and procedure and to send a standardized introductory letter. Afterwards, one of the investigators (FM) called the family physician to set a date for the practice visit. He was trained about the instrument and received a visitor manual with written instructions. Then, a standardized confirmation letter was sent and the practice was visited. The duration of the visit was 5–6 hours on one day. Patients were interviewed by the investigator before and after the consultation with their family physician at the FHC. They were asked to complete the sociodemographic questionnaire before the consultation with the family physician in the waiting room and they were asked to complete the European Task Force on Patient Evaluations of General Practice (EUROPEP) questionnaire after the consultation with the family physician again in the waiting room. Patient satisfaction was assessed twice; first, before the initiation of the national health care system transition and second, one year after the transition. The participants of the first assessment were not necessarily the ones of the second assessment. However, there was no significant difference between these two groups.

2.3. Instrument

The European Task Force on Patient Evaluations of General Practice (EUROPEP) is a 23-item validated and internationally standardized instrument to evaluate general practice care from the perspective of patients [7, 15, 16]. An international consortium of researchers and general practitioners, linked to EQuiP, developed the instrument in the years 1995 - 1998. The instrument has been used in about 20 countries and is available in Dutch, Danish, English, French, German, Hebrew, Italian, Norwegian, Portugese, Swedish, Slovenish, and Turkish. The reliability and validity analysis of Turkish version was published [17, 18]. EUROPEP

instrument covered aspects of general practice with the following five dimensions: doctor–patient relationship, medical care, information and support, organization of care and accessibility to healthcare system. An additional sixth dimension contained two questions on general satisfaction. Answers were marked on a five-point Likert scale (1=poor, 5=excellent). Alternatively, the patients could choose the category 'not able to answer/not relevant'. Finally, there were questions about the patient's gender, age, educational status, and frequency of attendance to the general practice, duration of the consultation and/or procedure, self-rated health, and the chronic conditions.

2.4. Statistical Analysis

Data were installed and analyzed using the Statistical Package for Social Sciences software, version 15.0 (SPSS Inc., Chicago, IL, USA). Summary statistics were generated for baseline characteristics and clinical evaluations. The EUROPEP questionnaire was evaluated based on the mean values for each separate question from each group. Data derived from the EUROPEP questionnaire were also reduced to a two-level scale with the most favorable answer category coded as one and all other non-missing categories as zero. Data was analyzed using hierarchical multivariate procedures for each individual question. T-Test and chi-square tests were used to assess descriptive findings compared to baseline characteristics. The level of significance was set as $p \leq 0.05$ for all variables.

3. RESULTS

The distribution of the respondents according to the FHCs is presented in Table 1 and the sociodemographic details are presented in Table 2.

There was no significant difference in terms of number of patients between the FHCs before and after the transition (p=0,897). There was no significant difference in terms of age, gender, educational or marital status of the respondents before and after the transition (p=0,139, p=0,055, p=0,493, and p=0,693, respectively).

Overall satisfaction was %74.6 before and %93.5 after the transition (p=0.0001) (Table 3).

The "*Organization of care*" was evaluated as the most improving dimension (+1,17 increase). However, the *"Medical care"* change was the worst rated (+0,75). *"Providing quick services for emergency health problems", "Knowing what s/he had done or told you during contacts" "Preparing you for what to expect from specialist or hospital care", "Being able to speak to the general practitioner on the telephone", "Getting through to the practice on telephone" and "Helping you deal with emotional problems related with your health status"* were evaluated as the best improved items (+1.3, +1.18, +1.17, +1.01, +0.99, and +0.99, respectively) (p=0.0001). Other items with lower ratings of change were: "*Making it easy for you tell him/her about your problem*", "*Keeping your records and data confidential*" and "*Offering you services for preventing diseases (eg screening, immunizations)"* (+0.57, +0.57, and +0.63, respectively) (p=0.0001).

4. DISCUSSION

Patient evaluations have become an integral part of the quality assessment of health care. By basing the methods for patient evaluations on studies of patients' priorities regarding the quality and by singling out aspects of care that are particularly important from their perspective, patients become a crucial source of information in quality improvement efforts [19, 20]. Improvement of general practice care based on such assessment requires that the family physicians is motivated for change and is sensitive to patients' opinions. The evaluation process therefore should not raise barriers for using the results, and the feedback should be immediately interpretable by the evaluated family physicians [21-23].

Recent studies have been performed for both inpatient and outpatient satisfaction in Turkey [17, 18, 24-26]. In 2005, the overall level of satisfaction with health care services was found to be 55.2%, compared with 39.5% in 2003 while the latest figure for 2010 was 73.04% [24, 25]. To our knowledge, our study is the first to investigate patient satisfaction for primary care providers before and after the health care transition in Turkey. In a study of patients' evaluations of European general practice in eight European countries: Austria, Belgium, United Kingdom, France, Germany, The Netherlands, Slovenia and Switzerland in 2009 patient satisfaction was compared with that of 1998 Of respondents, 80% rated the general practice care as 4 or 5 on the 5-point Likert scale. However, 72.1% rated their satisfaction with the waiting time in the waiting room as 4 or 5 on the 5-point Likert scale. Overall, somewhat less positive evaluations were found for telephone accessibility of the general practitioner (82.7%), for dealing with emotional problems (83.2%), and for the preparation for visits of medical specialists (83.4%). Less positive evaluations for specific items were found in specific countries, such as dealing with emotional problems, the preparation for specialist care and telephone accessibility of the practice in the Netherlands and the United Kingdom; interest in their personal situation in Slovenia; quick relief of symptoms and knowledge about previous contacts in Germany; getting a suitable appointment in the United Kingdom. However, more positive evaluations were found for having enough time for the doctor–patient consultation and enough interest in the patient's personal situation in Switzerland and Belgium; listening to the patients in Switzerland, keeping records confidential in Belgium, France, Slovenia, Switzerland and the United Kingdom, informing about symptoms in Switzerland and providing quick service if necessary in Belgium and Switzerland [26].

One possible conclusion from the EUROPEP results would be that family physicians should give more advice on prevention of disease and should have longer and perhaps more comprehensive consultations with their patients. Also advisable would be an improved working relationship between family physicians in which the strengths with interdisciplinary case studies, consultations, liaison projects, or formation of practices or hospitals. This could increase patient satisfaction and thereby improve overall patient care. Viewed from the patients' perspective, those aspects of care least positively evaluated are potential candidates for improvement, as all aspects of care included in the EUROPEP questionnaire reflect patients' priorities. The aspects "waiting time in waiting room" and "Offering you services for preventing diseases (eg screening,

immunizations)" were rated poorly by patients and may therefore be good topics for quality improvement. Family physicians should therefore be prepared to focus on these aspects of care as indicators of potential opportunities for improvement.

Additional research is needed to further clarify patients' evaluations of care in general or in specific aspects, in order to answer the key question: what is the meaning of generally good patients' assessments, and how, if ever, do they reflect optimal care and outcomes? Positive practice and family physician evaluations are important outcomes of care but they have to find their place among other outcomes.

The "*Providing quick services for urgent health problems*" item was rated as the highest score. However, although there was a difference between the perception of family physicians and of patients in terms of "urgent", it seems that family physician's perceptions of their patients' perceptions showed and improvement after the transition.

4.1. Limitations

The extent to which out results can be generalized is limited by the presumed higher motivation of family physicians that may have positively influenced patient satisfaction. Alternatively, it may be that our results are skewed from patients previously having had good experience with their physicians. The inhomogeneity and the wide range of patient expectations and the different types of practices with different objectives, makes it complicated and difficult to assess and compare the two groups.

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Table-1. Socioeconomic characteristics of the patients before and one year after the health care system transition

		Patients				Total		P†
		Before the health care system transition		After the health care system transition				
		n	%*	n	%*	n	%*	
Practice setting location's socioeconomic status	High	98	33.2	100	34.1	198	33.7	0.897
	Moderate	96	32.5	98	33.4	194	33.0	
	Low	101	34.2	95	32.4	196	33.3	
Gender	Male	100	33.9	78	26.6	178	30.3	0.055
	Female	195	66.1	215	73.4	410	69.7	
Age (years)	18-24	28	9.5	42	14.3	70	11.9	0.139
	25-34	70	23.7	71	24.2	141	24.0	
	35-44	74	25.1	57	19.5	131	22.3	
	45-54	50	16.9	63	21.5	113	19.2	
	55-64	46	15.6	34	11.6	80	13.6	
	≥ 65	27	9.2	26	8.9	53	9.0	
Marital status	Married	231	78.3	238	81.2	469	79.8	0.693
	Single	35	11.9	31	10.6	66	11.2	
	Divorced	9	3.1	10	3.4	19	3.2	
	Widowed	20	6.8	14	4.8	34	5.8	
Education	Illiterate	46	15.6	41	14.0	87	14.8	0.493
	Reading-writing skills	9	3.1	18	6.1	27	4.6	
	Primary school graduate	83	28.1	73	24.9	156	26.5	
	Secondary school graduate	23	7.8	23	7.8	46	7.8	
	High school graduate	80	27.1	77	26.3	157	26.7	
	University	54	18.3	61	20.8	115	19.6	

*: percentage of column, †:Chi-square test

Table-2. Overall patient satisfaction

		Patients		P†
		Before the health care system transition	After the health care system transition	
		n (%)*	n (%)*	
Patient Satisfaction	Satisfied	220 (74.6)	274 (93.5)	0.0001
	Uncertain	0 (0)	1(0.3)	0.0001
	Not satisfied	75(25.4)	18 (6.1)	0.0001
Total		295(100.0)	293(100.0)	

*: percentage of column, †:Chi-square test

Table-3. Mean scores of the EUROPEP questionnaire before and after the transition (n=588)

	Scores (mean±SD)		
	Before the health care system transition	**One year after the health care system transition**	**Change***
Questions What is your opinion of the GP and/or general practice over the last 12 months with respect to:			
Doctor–patient relationship	3.83±1.15	4.59±0.75	+0.76
1 Making you feel you had time during consultation	3.65±1.25	4.55±0.77	+0.9
2 Interest in your personal situation	3.52±1.17	4.45±0.86	+0.93
3 Making it easy for you tell him or her about your problem	4.00±1.06	4.57±0.83	+0.57
4 Involving you in decisions about your medical care	3.45±1.29	4.42±0.91	+0.97
5 Listening to you	4.09±1.05	4.76±0.60	+0.67
6 Keeping your records and data confidential	4.24±1.08	4.81±0.55	+0.57
Medical care	3.74±1.19	4.49±0.86	+0.75
7 Quick relief of your symptoms	3.91±1.06	4.60±0.71	+0.69
8 Helping you to feel well so that you can perform your normal daily activities	3.81±1.00	4.59±0.70	+0.78
9 Thoroughness	3.97±1.01	4.73±0.65	+0.76
10 Physical examination of you	3.70±1.38	4.56±0.91	+0.86
11 Offering you services for preventing diseases (eg screening, immunizations)	3.33±1.49	3.96±1.35	+0.63
Information and support	3.63±1.27	4.45±0.67	+0.82
12 Explaining the purpose of tests and treatments	3.63±1.32	4.37±1.03	+0.74
13 Telling you what you wanted to know about your symptoms and/or illness	3.82±1.24	4.62±0.80	+0.8
14 Helping you deal with emotional problems related with your health status	3.44±1.29	4.43±0.85	+0.99
15 Helping you understand the importance of following his or her advice	3.63±1.23	4.36±1.01	+0.73
Organisation of care	3.03±1.34	4.2±1.14	+1.17
16 Knowing what s/he had done or told you during contacts	3.02±1.38	4.20±1.18	+1.18
17 Preparing you for what to expect from specialist or hospital care	3.04±1.30	4.21±1.10	+1.17
Accessibility	3.28±1.17	4.25±1.03	+0.97
18 The helpfulness of the staff (other than the doctor)	3.85±1.28	4.65±0.81	+0.8
19 Getting an appointment to suit you	3.58±1.27	4.45±0.86	+0.87
20 Getting through to the practice on telephone	3.40±1.47	4.39±0.99	+0.99
21 Being able to speak to the general practitioner on the telephone	2.98±1.61	3.99±1.31	+1.01
22 Waiting time in the waiting room	2.66±1.35	3.51±1.26	+0.85
23 Providing quick services for urgent health problems	3.19±1.33	4.49±0.94	+1.3

*Independent Samples Test, p<0.001 for