Richard Grol and Michel Wensing

PATIENTS EVALUATE GENERAL/FAMILY PRACTICE

The EUROPEP instrument

THE TASK FORCE ON PATIENT EVALUATIONS OF GENERAL PRACTICE CARE

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Foreword

Medicine is concerned with medical care for individual patients in the context of their social functioning. General practice in particular has developed the skills and methodology of a professional orientation on the patients' perspective, because, in the words of James McCormack, "knowing the patient who has the illness is as important as knowing the disease the patient has". There is more and more evidence that this is not just the decoration on the wall, but indeed the very core of high quality medical care. Quality of care in fact forms a summary of the prevailing medico-professional standards and patients' values, each in their own right and context. To paraphrase James McCormack's aphorism, "knowing the values of of the patient who has the illness is as important as knowing the standards of the disease the patient has, in establishing the quality of care".

It is important to appreciate the importance of patients' values towards good medical care, but that might still elude the possibility of including this in the framework and indicators to monitor the quality of care. Methodology has to be developed to explore patients' views in a systematic way. The EUROPEP instrument opens the possibility to do this for the general practice setting on a European level, and it heralds an exciting new chapter in quality assurance.

EUROPEP is the brain-child of EQUIP, the quality of care network of WONCA-Europe, and it is with great pride that I recommand this new milestone. It heralds the network's seminal work to develop ever better methods to further improve primary care for patients throughout Europe. I am sure it will find its way around.

Professor Chris van Weel
President WONCA-Europe/ESGP-FM

1. Involving patients in improving quality

Introduction

In improving the quality of health care the ultimate criterion is the extent to which health care succeeds in meeting the (subjective and objective) needs of patients well. At the end of the day it is the patient who determines whether care provided helped to improve their health status or quality of life. Not only the outcomes of care in terms of health gains or needs met are important in this respect, but also the ways in which care is provided: the accessibility of care, the organisation of services, the attitude of care providers, and their education of and communication with the patient. There is an increasing awareness among policy makers and clinical practitioners that patients can and must play a more central role in defining what optimal care is and in improving the quality of health care. Involving patients in (improving) health care is not only desirable, according to WHO, but also a social, economic and technical necessity (Guadagnoli 1998). New concepts as patient centred care, patient empowerment, patients as partners and shared decision-making express this emancipation of the patient. Involving patients is not only important from an ethical perspective (Grol 2000). Patients are much better informed than before and can often be a real partner in debates about the optimal management of their condition. In many chronic conditions patients know, much better than clinicians, the desired outcomes of care. Patients have important experiences with care provision, unknown to care providers; expressing these experiences can be very valuable and educational for care providers. Patients also often have other expectations, wishes and priorities than care providers and it is – for effective care - crucial to know them. They are easily misinterpreted as was found in different studies. Finally, patients are usually the co-producers of the outcomes of care. Whether (evidence based) care provision will lead to optimal and expected outcomes depends to a large extent on patients factors, patient behaviour and compliance.

The *question* is, however, how to involve patients effectively in (improving) care and how to strengthen their role. What methods and models are effective and feasible?

Methods and models for involving patients in improving general practice care

Different methods are now used to involve patients in quality improvement, such as patient laws and policies, complaint procedures, legal pursuits, satisfaction surveys, or training of practitioners to improve their communication with patients. Recently new methods have been introduced, for instance patient panels, interactive education on video or CD-Rom, information sites on Internet, consultations through e-mail, and decision-aids for treatment or screening decisions. The value of all these methods is not yet clear, since research in this field is in its infancy.

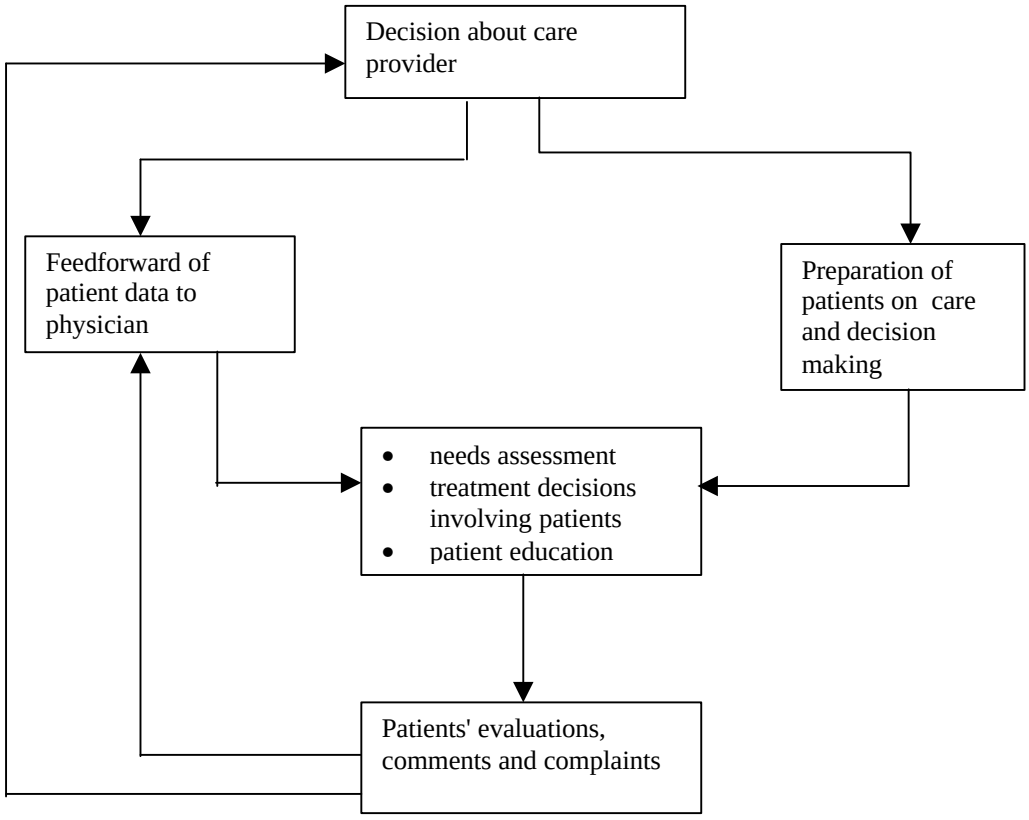
The different models and methods to involve patients in improvement of care can be ordered in different categories (Wensing 1998) (figure 1):

- Methods to influence the decision to seek and use health care or not and to use a specific health care provider (hospital, primary care provider): for instance, report cards or physician profiles are used in some countries to inform the public about the quality of care provided by a hospital or practice, compared to other hospitals or practices. This may help the patients to make decisions about the selection of a care provider. In order to influence the decision to use health care or not patient education on appropriate utilisation of care through mass media can be undertaken.
- Methods to prepare patients and care providers on actual care provision: patients planning to visit a care provider can be prepared on the decisions to be made in the contact by means of educational materials, by interactive video's or computer programmes or by short interviews with trained staff. Another method is that patients complete a questionnaire on potential problems that should be addressed, while the results are fed forward to the care provider who can use these in contact with the patient. For instance, in an experiment with asthma and COPD patients, completing a very short questionnaire on problems in their quality of life and handing this over to the GP at the beginning of the consultation, performance of GPs proved to be influenced by signals of a bad quality of life (non-published report, Jacobs 1999). At an aggregated level information on priorities or expectations of populations of patients in a practice or a region can be used by a practice to plan improvement in care provision.
- Methods to support active involvement of the patient in the diagnostic process and in treatment decisions: during the contact with a patient a GP can use shared-decision

making principles, such as portrayal of options and alternatives and asking explicit involvement of the patient in choosing from the alternatives (Elwyn 1999).

- Methods to use data on care provision in improvement of care on a next occasion: data from individual patients and groups of patients on their health status, quality of life, satisfaction or generated costs can be collected and fed back to care providers to be used in plans and focused actions aimed at improving patient care.

Figure 1: Involving patients in improving care



As was said, the evidence for the effectiveness of the different approaches and strategies is still limited and anecdotical, but experiences with various methods are positive and promising. We will not discuss them all here, but focus in this book *on patient evaluations on family practice care*, as collected with an internationally validated instrument EUROPEP. Before introducing this instrument, the results of preparatory work in the EUROPEP project

on priorities of patients in general practice care are discussed. Evaluations of care by patients can only be valued when there is an understanding of their expectations and opinions on good care.

2. Priorities of patients on general/family practice care

Literature reviews

Improving the sensitiveness of family practice to the needs and expectations of patients is an important challenge in health care today. Therefore patients expectations are increasingly explored by means of interviews, focus groups and surveys. This is a good step, since priorities in health care are still usually determined by professionals and health authorities. However, insight into patients' views on good general practice are still limited (Baker 1995).

So, a systematic literature analysis on patients' opinions and priorities with respect to primary care was undertaken (Wensing 1998). A systematic search, using electronic and manual searches, was performed resulting in 57 studies that met the inclusion criteria. Analysis of these studies was done by two researchers, using a taxonomy of aspects of care based on a qualitative pilot study. It showed that these 57 different studies focused on largely different aspects of care many addressing only one or two aspects (for instance competence or humaneness). Based on a detailed analysis of 19 studies that were able to rank different aspects of care the following aspects were seen by patients as most important in at least 50% of the studies: humaneness, competency/accuracy, patient involvement in decisions, time for care provision, availability/accessibility, informativeness, exploring patients' needs, and availability of special services. It was also concluded that a good survey study, addressing a wide variety of all the aspects of general practice care, was actually lacking.

In depth analysis of the relationship between specific characteristics of patients and their priorities with respect to general practice care was next performed (Jung, unpublished report 1999). This showed 33 studies with 687 relations between a particular patient feature (e.g. age, sex, health status, economic status) on the one hand and a patient priority on the other. For more than 200 relations a difference was found between groups of patients with different characteristics. Particularly younger patients showed to have other priorities than older patients – for instance, with respect to being involved in decisions or to provision of medical care - and patients with a poorer health status proved to have other priorities than patients with a better health status, for instance with respect to preventive services and involvement in decisions. Significant differences were also found for economic status and level of education. Awareness of such differences in different populations in the practice is quite crucial for family doctors and staff to meet patients' expectations well. It can facilitate more effective

communication to know such differences and include them in responding to patients' health problems.

A survey in 8 countries

A survey study was next set up in 8 European countries (Norway, Sweden, Denmark, U.K. Netherlands, Germany, Portugal and Israel) (Grol 1999). A questionnaire was developed including a structured list of 38 relevant aspects of family practice care delivery, divided into five sections: medical-technical care, doctor-patient relationship, information and support, availability and accessibility and organisation of services. All of the 38 aspects were seen as important in the context of general practice care. But patients could rate their opinion on the (relative) importance as well as rank them according to importance. The survey was conducted in a consecutive sample of 60 patients visiting their GP from at least 12 practices per country. In total 3540 patients responded (response rate of 55%). Aspects of general practice care most (highly) valued in all countries were (table 1):

- Getting enough time during consultations
- Quick service in case of emergencies
- Confidentiality of information on patients
- Telling patients all they want to know about their illness
- Making patients feel free to talk about their problems
- Appointment at short notice
- GPs attending courses regularly
- Offering preventive services

A relatively low ranking was giving to aspects such as waiting time before the consultation, GPs helping patients to deal with emotional problems related to their health problems, convenient facilities in the practice, concern about costs of medical treatment and written information on surgery hours and phonenumbers of the practice. Nevertheless some interesting differences between countries could be identified. Generally, patients in different countries had many opinions on optimal care in common.

Table 1: Description of patients' priorities percentages 'very/most important' and rank numbers (N=3540)

Mean rank	What would make for a good general practitioner	Denmark	Germany	Israel	The Netherlands	Norway	Portugal	UK	Sweden
1	During the consultation a GP should have enough time to listen, talk and explain to me.	91 *1*	88 *2*	85 *5*	91 *2*	93 *1*	89 *1*	90 *2*	89 *1*
2	A GP should be able to provide quick service in case of emergencies	88 *2*	89 *1*	89 *1*	94 *1*	88 *4*	87 *2*	91 *1*	80 *6*
3	A GP should guarantee the confidentiality of information about all his patients.	84 *5*	82 *5*	88 3	85 *3*	91 *2*	77 *8*	88 *3*	85 *3*
4	A GP should tell me all I want to know about my illness.	85 *4*	84 *3*	89 *2*	82 *5*	76 *9*	69 *14*	84 *5*	85 *4*
5	A GP should make me feel free to tell him or her my problems.	87 *3*	82 *4*	68 *16*	75 *9*	89 *3*	82 *6*	86 *4*	81 *5*
6	It should be possible to make an appointment with a GP at short notice	74 *11*	74 9	69 *14*	84 *4*	86 *5*	77 *10*	81 *6*	86 *2*
7	A GP should go to courses regularly to learn about recent medical developments.	80 *7*	77 ***7***	80 *6*	79 *7*	80 *8*	84 *4*	77 *9*	70 *19*
8	A GP should not only cure diseases, but also offer services in order to *prevent* diseases.	73 *12*	76 8	79 *8*	64 *15*	82 *7*	86 3	79 *8*	79 *8*
9	A GP should critically evaluate the usefulness of medicines and advice.	79 *9*	79 *6*	74 *10*	79 *8*	74 *11*	75 *12*	66 *13*	74 *14*
10	A GP should explain the purpose of tests and treatment in detail.	72 *14*	73 *10*	79 *7*	61 *18*	68 *17*	65 *17*	79 *7*	79 *7*
11	A GP should work according to accepted knowledge about good general practice care.	84 *6*	65 *15*	74 *11*	72 *10*	75 *10*	69 *15*	59 *19*	73 *15*
12	A GP should guide me in taking my medicines correctly.	75 *10*	64 *17*	85 *4*	46 *26*	68 *18*	83 *5*	74 *11*	72 *18*

Mean rank	What would make for a good general practitioner	Denmark	Germany	Israel	The Netherlands	Norway	Portugal	UK	Sweden
13	It should be possible to see the same GP at each visit.	73 *13*	69 *12*	63 *18*	64 *17*	84 *6*	75 *11*	47 *28*	79 *9*
14	A GP and other care providers (e.g. the specialist) should not give contradictory information to me.	71 *15*	65 *16*	55 *22*	81 *6*	68 *15*	59 *23*	76 *10*	72 *16*
15	A GP should understand what I want from him or her.	68 *16*	67 *13*	71 *12*	67 *13*	61 *21*	54 *27*	61 *17*	76 *12*
16	A GP should only refer me to a specialist if there are serious reasons for it.	64 *19*	54 *26*	68 *15*	68 *12*	70 *13*	59 *24*	63 *15*	68 *21*
17	A GP should critically evaluate the usefulness of medical investigations.	68 *17*	60 *20*	70 *13*	68 *11*	66 *19*	64 *19*	57 *20*	67 *22*
18	A GP should be ready to discuss the tests, treatment or referral that I want.	63 *21*	62 *18*	61 *20*	65 *14*	68 *16*	46 *29*	60 *18*	77 *11*
19	There should be good cooperation between GP and his or her staff.	50 *27*	59 *21*	77 *9*	54 *20*	51 *27*	64 *18*	66 *12*	65 *26*
20	A GP should guide me in my relationship with specialist care.	57 *24*	67 *13*	39 *34*	46 *24*	70 *14*	56 *26*	55 *22*	78 *10*
21	A GP should be willing to make home visits.	63 *20*	69 *11*	50 *27*	64 *16*	58 *24*	57 *25*	62 *16*	58 *29*
22	A GP should be willing to check my health regularly.	50 28	55 *25*	57 *21*	49 *22*	61 *22*	77 9	53 *24*	63 *27*
23	It should be easy to speak to a GP by telephone.	62 *22*	52 *29*	50 *24*	51 *21*	70 *12*	35 *32*	41 *31*	74 *13*
24	A GP should take a personal interest in me as a person and in my life-situation.	53 *26*	58 *23*	37 *35*	41 *29*	52 *26*	80 *7*	48 *26*	71 *17*
25	A GP should often visit me when I am seriously ill.	79 *8*	49 *30*	47 *30*	43 *27*	42 *29*	61 *22*	65 *14*	55 *32*
26	A GP should co-ordinate the different types of care I get.	53 *25*	56 *24*	50 *26*	41 *30*	63 *20*	64 *20*	48 *27*	66 *24*

Mean rank	What would make for a good general practitioner	Denmark	Germany	Israel	The Netherlands	Norway	Portugal	UK	Sweden
27	A GP should help me to deal with emotional problems related to my health problems.	67 *18*	53 *28*	44 *31*	48 *23*	56 *25*	67 *16*	50 *25*	59 *28*
28	A GP should acknowledge that the patient has the final choice regarding tests and treatments.	60 *23*	58 *22*	42 *32*	55 *19*	59 *23*	32 *33*	57 *21*	66 *25*
29	The treatment of a GP should help me to perform my normal daily activities.	42 *31*	54 *27*	64 *17*	46 *25*	40 *31*	30 *34*	46 30	68 *20*
30	A GP should be able to relieve my symptoms quickly.	30 *34*	62 *19*	49 *28*	40 *31*	36 *33*	40 *31*	54 *23*	67 *23*
31	It should be possible to have the same GP for the entire family.	49 *29*	36 *34*	48 *29*	35 *33*	45 *28*	63 *21*	39 *33*	57 *31*
32	The facilities in a general practice should be convenient.	24 *36*	33 *36*	62 *19*	29 *34*	38 *32*	71 *13*	39 *32*	37 *37*
33	A GP should allow a second opinion of a different doctor.	22 *37*	39 *33*	52 *23*	42 *28*	34 *34*	46 *28*	47 *29*	53 *33*
34	When I have an appointment with a GP, I should not have to wait long in the waiting room.	40 *32*	44 *31*	50 *25*	27 *36*	42 *30*	29 *35*	35 *34*	58 *30*
35	A GP should help my relatives to support me.	43 *30*	33 *35*	39 *33*	19 *37*	30 *35*	42 *30*	22 *37*	45 *35*
36	A GP should accept when I seek 'alternative treatment'.	34 *33*	40 *32*	32 *36*	36 *32*	27 *36*	24 *37*	29 *35*	47 *34*
37	A GP should be concerned about the cost of medical treatment.	25 *35*	22 *37*	27 *37*	28 *35*	24 *37*	26 *36*	21 *38*	43 *36*
38	A GP should give me written information about surgery hours, telephone number of the practice, etc.	10 *38*	16 *38*	21 *38*	15 *38*	9 *38*	14 *38*	26 *36*	29 *38*

Different priorities in different health care systems

The organisation of primary care varies across different countries, for instance with respect to the gatekeeper role of the family physician to secondary care. Differences in priorities on general practice care may be related to such characteristics of the health care systems. Systems in the 8 countries were therefore categorized on the following features: involvement in out-of-hours service, provision of routine screening, care for a defined population, formal gatekeeper role to secondary care and home visit routines. Differences in opinion on the importance of various aspects of general practice care between patients from countries with different systems were studied (Wensing 1998). The results did not offer a clear picture, but some potential problems in the quality of care were identified, e.g. the lack of a defined patient population in Germany; the lack of a formal gatekeeper role in Germany and Sweden; the low number of home visits in Sweden; and the low provision of routine prevention and screening in Sweden, Norway and the Netherlands.

Different views of patients and doctors on good general practice care

Family doctors are expected to be responsive to patients' expectations and needs. However, doctors and patients may have different views on what constitutes good practice. It is important to be aware of areas of controversy as well as areas of mutual agreement between GPs and patients. Therefore a study was conducted in the Netherlands (Jung 1999) to explore which aspects of general practice care are prioritised differently by GPs and patients. The study included three different, independent samples: 455 patients completed the questionnaire with the list of 38 relevant aspects of family practice care and rated the importance of each of the aspects; 263 GPs completed the same questionnaire and gave their personal opinions on the importance of the 38 aspects and 237 GPs completed the questionnaire, but estimated how important each aspect would be for patients.

This study showed that there is a high correlation between the priorities of patients and doctors and doctors were also able to estimate the priorities of patients reasonably well. However, some interesting differences were found as well. Patients gave, for instance, a higher importance rating than GPs to:

- provision of information on illness
- appointment within short time
- same GP at each visit

- GPs who are willing to check general health regularly
- easy to speak to GP on the phone

GPs on the other hand, gave a higher priority than patients to:

- written information on practice organisation
- good cooperation between GP and staff
- making visits to seriously ill patients
- GP co-ordinating different types of care

GPs proved to underestimate the value that patients attach to critically discussing the need for and usefulness of investigations, referrals and medications and to GPs going to courses regularly. On the other hand they overestimated the priority given by patients to showing a personal interest in the patients life and to making home visits when patients are seriously ill.

A good exploration and understanding of the patients' expectations and priorities with respect to family practice care seems to be crucial for an optimal communication with patients.

3. Patients' evaluations of general/family practice care

Introduction

It is not only important to explore expectations, needs and priorities of patients related to general practice care, but also to gather information on the experiences of patients with actual care provision. Most patients are very able to provide opinions and evaluations of the care and treatment received by the doctor and the staff. This information can be very educational. It can help the practice to select aspects of care that are really in need of improvement (Baker 1996). On the other hand, patient satisfaction and patients' evaluations of care can be seen as one of the important outcomes of care delivery, since it expresses the extent to which subjective and objective needs of patients have been met and satisfied. It cannot be seen as the only relevant outcome and sometimes patients may have unrealistic demands, but most of the time patient satisfaction can be regarded as a valuable addition to other types of outcome measures (health status, quality of life or costs) to evaluate the quality of general practice care. The question is how to gather information on this variable?

Measuring patient satisfaction and evaluations of care

Information on patients' evaluations of care are usually gathered by (written) questionnaires which are completed by patients who come to the practice or receive the questionnaire by mail. On the whole, using surveys among patients is one of the most popular methods of quality assurance in health care, although widespread use in primary care has yet to start.

Measuring patient satisfaction or evaluations of care is not without problems. We will describe a few here:

- First of all, there is a theoretical debate about the concepts of satisfaction and evaluation of care: what do these concepts include (affective or cognitive aspects), how are they related to needs and expectations, and what does a positive or negative evaluation of general practice care actually mean? There is an extensive theoretical literature on these concepts as well as different definitions. We will use the concept of 'patient evaluations' here, referring to 'subjective assessments of different aspects of care provision in positive and negative terms' (Wensing 1997, Jung 1999). It is assumed to be a cognitive reaction, in contrast to satisfaction, which is assumed to be a (general) emotional reaction to a specific situation.

- Many of the instruments used now to measure satisfaction or evaluations of care are 'home made' and hardly validated by good scientific research.
- Such instruments are usually developed by professionals (researchers or clinicians); the voice of the patients (their priorities, needs) are often not included in the developmental process.
- An instrument developed within one group of patients (one cultural group, a region, a country) is not necessarily suitable for use in another group of patients. Nevertheless instruments are uncritically transferred from one setting to another without knowing whether the answers of patients have the same meaning.
- It is yet unclear whether patients can give a good evaluation of care provision in general practice. It is assumed that they are able to give a good judgement of different aspects of care, but in reality they probably lack the understanding of some decisions or basic processes in general practice to provide a good assessment. Therefore, it is unclear what a positive or negative evaluation of some of the aspects of care means.

  For example:

  To explore in more detail what the evaluations of patients of general practice actually mean, 30 patients completed a questionnaire (14 aspects of general practice care) after a consultation with their GP and were next interviewed by telephone. They were asked which specific behaviour of the GP has led to giving a positive or negative evaluation of a certain aspect of care. This showed that patients were very able to link some specific evaluations to concrete behaviour, while they had more problems with other evaluations. Evaluations of aspects such as 'GP understands what I want', 'Having faith in the GP', or 'Being involved in decisions' were based on a variety of physicians' behaviours, which were partly not related directly to the aspect of care involved (Jung 1998).

- Patient questionnaires consume time of doctors, staff and patients. Hearnshaw (1996) calculated that the total costs for using a patient survey in the U.K. ranged from 0 to 2200 pounds per practice. Home made questionnaires proved to be more expensive than standardised questionnaires developed by external institutes. The question is whether the costs are justified giving the profits for a practice and patients of performing such a survey. Research on the effects of performing patients evaluations of care are yet scarce.

Available experiences suggest that such evaluations should be integrated within a more comprehensive plan or system for assuring and improving care (see example).

An example:

A sample of 60 GPs was recruited for a study on the effectiveness of providing feedback on patient evaluations on family practice care. In each practice 100 patients on average (response 67 %) completed a validated questionnaire (Wensing 1997) with 53 questions on different aspects of care delivery. The GPs were next randomly allocated to an intervention and control group. The GPs in the intervention group received a well designed feedback report with the evaluations of their patients compared to the results of all practices as well as advice on how to use the results in improving practice. The control group did not receive the feedback. After one year a sample of patients completed the questionnaire again. Compared to the baseline results no change at all was seen in the evaluations of patients, both in the intervention and the control group. The conclusion was that feedback on patients' evaluations alone is not enough to induce change; a more comprehensive approach to improving care will be needed. (Vingerhoets 2000, unpublished report).

- It is unclear what the best method is to organise a survey: handing out a questionnaire to patients visiting the practice or sending it to a random sample of patients related to the practice. A study by Wensing (1996) showed that the response was higher in the hand-distributed survey (72% versus 63%), but the two methods provided similar results as far as the assessments concerned. An additional question is related to sending reminders or not. A study in the Netherlands showed that sending reminders by mail omitted in 86% response versus 55% in the group without reminders, but this effect was not found in a similar study in Denmark (Wensing 1999).
- A further question is what the best way or method is to give feedback on the survey results to doctors and staff. Which type of feedback is most informative and educational and will stimulate a critical reflection on current routines?
- Finally, many GPs still have a sceptical attitude towards asking patients about their experiences or judgements. Some lack a real interest, others fear criticism from their patients. In depth interviews with Dutch GPs in the middle of the nineties showed that

only 24% saw patient surveys as useful and only 1% had experience with them (Grol 1995). We may, however, expect that this situation is quickly changing in many countries.

Conclusion of this overview of potential problems in using patients' surveys for gathering evaluations on care delivery in general practice may be that this field is still under development and that valid, reliable, feasible and acceptable instruments are required to tackle some of the problems. Particularly, instruments that are validated in and can be used in different countries and cultural settings are needed. This motivated us to develop an internationally validated and standardised instrument for patients' evaluations on general/family practice care. The development of this instrument is described in the next chapter.

4. EUROPEP: an internationally standardised instrument to evaluate general/family practice

Introduction

The EUROPEP instrument has been developed to enable international comparison of (outcomes of) general practice care in Europe. Such comparisons between countries with different health care systems can help policy makers to improve primary care systems in Europe. The EUROPEP instrument has also been designed to provide educational feedback to general practitioners/family physicians, general practices and patient/consumer organisations. Such a feedback can stimulate practitioners to improve specific aspects of their professional performance and organisation of care. While several validated instruments were available at the start of the EUROPEP study in 1995, an internationally validated standardised instrument for measuring patients' evaluations of general practice care was lacking. The EUROPEP project aimed at providing such an instrument and using it to compare patients' evaluations of care across different European countries.

A working group with representatives from eight countries performed a number of studies and activities during the years 1995-1999 in order to develop and test the EUROPEP instrument. In the final phase (1998-1999), seven more countries joined the project. This chapter summarizes the development, the pilotstudies performed and the validation and psychometric testing of the EUROPEP instrument. Many international questionnaires have been developed in one specific country and were next translated into other languages, which may induce cultural and linguistic problems. The unique feature of the EUROPEP instrument is that it has been developed in an international group from the very beginning.

This chapter starts with a description of the assumptions underlying the EUROPEP instrument. This will be followed by a description of different studies and activities, organised in chronological order (box 1).

Box 1: Chronological overview of studies and activities

	Content
1995	**Development**
1	Studies of patient priorities and instrument development
1996	**Pilottesting**
2	Qualitative pilotstudy (UK, 47 item instrument, n=30 patients)
3	Quantitative pilotstudy (5 countries, 47 item instrument, n=239 patients)
1997	**Validation**
4	Formal translation procedure
5	Validation study (8 countries, 44 item instrument, n=1008 patients)
1998	**Psychometrics**
6	Final selection of items
7	Final validation: Psychometrics study (16 countries, 23 item instrument, n=23,892 patients)

Assumptions on validity and reliability

The EUROPEP instrument is based on some specific assumptions, which will be described in this paragraph. These assumptions have guided the different studies in the EUROPEP project.

- ***Concept***: The instrument focuses on patients' evaluations of specific aspects of general practice care. So the focus was neither on affective/emotional responses (patient satisfaction) nor on actual experiences with general practice care (patient reports), although we realized that the distinction between the different concepts is sometimes unclear. We did not assume that a simple rational decision making model would be valid, such as: 'evaluation = expectation minus experience'. Therefore we asked for patients' evaluations straightforwardly rather than for their expectations, experiences or other factors to combine these using one or the other formula.
- ***Patient population***: We focused on patients who have had recent experience with general practice care, because those patients are best able to provide evaluations based on actual experiences rather than general attitudes or feelings. Therefore the EUROPEP instrument has been designed for patients who are recruited among people consulting their general practitioner.
- ***Aspects of care (content validity)***: The aspects of general practice care covered by the instrument should reflect patients' priorities regarding the main areas of general practice care. The aspects of care should be relevant to patients in the sense that a considerable

proportion of patients actually have had experiences regarding that particular aspect. Particularly important was of course the relevance of aspects in countries with different cultures, languages and health care organisations. We used these assumptions to develop explicit criteria for the selection of questions in the questionnaire in order to garantuee good content validity.

- ***Reliability***: Each question in the EUROPEP instrument has its own specific content, so it is not just an indicator for an underlying dimension of general practice care. However, questions in the EUROPEP instrument are preferably consistent with other questions that are indicators for the same dimension. The dimensions should be empirically confirmed. These assumptions led to assessment of the psychometric characteristics of the EUROPEP instrument. The instrument should actually also have good test-retest reliability, but this has not yet been checked.
- ***Sensitiveness***: The EUROPEP instrument should be able to identify relevant variation in patients' evaluations of general practice care across different countries. Ideally it should also be able to identify variation across different general practitioners and practices, but we realized that this is difficult to combine with the first criterium (which requires consistency within the countries). An analysis of the variation has been performed to study these issues. The EUROPEP instrument should be responsive to changes over time as well, but this has not yet been checked.
- ***Criterion validity***: A gold standard for patient satisfaction with care is not available, but the instrument should yield data on evaluations of specific aspects of care in the various countries which are positively related to patients' overall attitudes to care provided by the general practitioner.
- ***Construct validity***: While there is obviously no golden standard to validate the EUROPEP instrument, the measurements should relate to other measurements in a way that could be predicted beforehand. For instance, it should, in line with most studies, show that older people have more positive evaluations than younger people. Therefore we assessed such relationships in different studies of the EUROPEP project.

Studies on validity and reliability of EUROPEP

1. Studies of patient priorities and instrument development

The aspects of general practice/family practice included in the EUROPEP instrument should first of all reflect patients' priorities on the quality of care. Therefore we performed a survey study in 8 countries to identify patient priorities as well as a systematic review of the literature in this area. These studies have been reported in chapter 2 of this book. A structured procedure was used to make a preliminary selection of items that reflect patient priorities and cover the main dimensions of general practice care, using the surveys on patient priorities. This procedure was repeated later to make the final selection of items, which will be described below.

Next, specific items were formulated by the core group of co-ordinating researchers and send for comments to members of the EUROPEP working group (March 1996). A list of items from about 50 published patient satisfaction questionnaires was used to support this process. A core group revised the items on the basis of the comments and developed a draft-questionnaire which was tested in a small qualitative study.

2. Qualitative pilotstudy

Objectives

This study aimed to construct an English source questionnaire that is clear, understandable for patients and that uses appropriate English.

Methods

Subjects: Patients were recruited from a group practice in inner city Leicester, United Kingdom. Patients were approached by the researcher (Hilary Hearnshaw) in the waiting room and asked if they would take home the questionnaire, fill it in and send it back in the reply paid envelope. Those who agreed were asked to help in further developing the questionnaire through a telephone interview. After 20 patients who agreed to be interviewed no further requests were made.

Measures: The first version of the EUROPEP instrument, comprising 48 questions, used a five point answering scale ranging from 'strongly agree' to 'strongly disagree'. Telephone interviews were conducted by two researchers over the two days following recruitment. A recording form was used in the interviews

Analysis: A straighforward summarizing description of patients' answers was made.

Results

Of the 20 patients who agreed to be interviewed 14 were actually interviewed; the remaining individuals could not be reached by telephone despite repeated attempts. Table 1 summarizes the answers on the general questions. A number of problems were raised with respect to specific questions in the questionnaire, which were used to improve these questions.

Table 2: Some results of the qualitative pilotstudy in UK

General questions	Summary of answers
1. What is your overall impression of the questionnaire?	Mixed: OK, quite good, enjoyed doing it, pretty straightforward; vague in places, not easy, repeated questions, did not concern me.
2. Concerning the instruction remarks: are they understandable?	No problems, but a few patients would have prefered more instructions.
3. How long did it take to fill in the questionnaire?	A range of 5-30 minutes.
4. Is the length of the questionnaire acceptable?	Some people felt it was OK, others felt it was too long.
5. Is the order of the questionnaire logical?	Most felt it was OK.
6. Would you consider any sections confusing or difficult to respond at?	A specific section was difficult for some patients. Some words and questions were a bit difficult.
7. Do you lack certain topics?	A few suggestions were made for additional questions.
8. Should any items and/or aspects not have been asked?	One person felt that a specific section was too political (organisation of care).
9. On the whole, is the questionnaire easy to understand? Uncomplicated?	No problems. One person answered: "the easiest questionnaire I've ever done".
10. Concerning the scale: Is it problematic to place oneself/the answer in a category? Do you have suggestions for improvement of the scale?	Most understood the scale, but a few persons expressed problems.
11. Do you have any other comments to the questionnaire?	It should be shortened, was mentioned by some people. Someone would like to make personal comments at the end of the questionnaire.
12. Did you receive any assistance from others in filling in the questionnaire? From whom?	Most people completed the questionnaire themselves.

3. Quantitative pilotstudy

Objectives

This study was performed to assess the variation of scores across patients, to determine the item response and to test the feasibility of procedures for recruiting patients in the different countries.

Methods

Subjects: In each of five countries about 50 patients from 2-4 practices were recruited. Patients were handed out a questionnaire consecutively when visiting the practice and asked to complete it and send it to the university or research institute.

Measures: The English source version of the questionnaire derived from the qualitative study in the UK was forward translated into different national languages. The 47 item EUROPEP instrument used questions that had a 5 point likert answering scale, ranging from 'strongly agree' to 'strongly disagree'. Questions used a 'The general practioner should have' format, like in the following example: "The general practitioner should have prescribed less medication". Ten more items were formulated that used a 'I would have liked' format, for instance: "I would have liked it if the general practitioner made me feel not so rushed during consultations." Finally, four questions on overall attitudes were formulated. All additional questions used the same 5 point likert answering scale.

Analysis: A straightforward counting of frequencies was made per country to determine the variation in scores across patients as well as the percentages of patients who responded the different types of questions.

Results

In sum 239 patients from 5 countries responded (53 from Denmark, 38 from Germany, 51 from the Netherlands, 44 from Norway and 53 from the UK). The percentage of patients who agreed or strongly agreed with the statements varied between the countries and between the questions. For instance, only 8% of the respondents in Germany and the Netherlands felt that the general practitioner should have taken more time to listen, talk and explain things to. This was 23% in Denmark and 34% in Norway. The questions that used the format 'I would have like' showed somewhat lower percentages 'agree/strongly agree' (suggesting criticism) than the questions that used the format 'The general practitioner should have '. A detailed overview of all figures is not given here. However, this study raised some fundamental questions that were discussed by the

EUROPEP group in June 1996 (box 2). On the basis of the discussions, a new version of the questionnaire was made comprising 44 items.

Box 2: Overview of problems concerning the draft-version of the EUROPEP questionnaire

(Coimbra, June 1996)

1. The size of the questionnaire? How many questions are acceptable?
2. Which answering scale? An adjective 5 point likert scale (agree/disagree) is proposed. Do we need a different scale? What would be the wording of the middle category?
3. Do we aim to a balance between positive and negative items?
4. What should be the wording of the items: "Should have been more", "would have liked", "should have been better"?
5. The instrument should focus on a specific general practitioner and general practice? What should the wording be "the" or "my" general practitioner?
6. What should be the time window: "6 months" or "one year"?
7. How should the quality of the practice in general be evaluated? Which specific questions should be asked regarding the staff?
8. What should be the number and type of open-ended questions?
9. Are internationally standardised questions regarding education, employment and diseases available? How can they be included in the questionnaire? Which question regarding socio-demographic data should be included?
10. Should questions regarding quality of life and/or health status measurement be included in the instrument? Which questions?

4. Formal translation procedure

In each of the participating countries a systematic procedure was followed to translate the new English source version of the 44-item questionnaire into the different languages:

- The English source version of the questionnaire was forward translated to the national language by three independently working individuals, including researchers in general practice and a professional translator. This allowed for the detection of error and divergent interpretation of ambiguous items.
- At a consensus meeting of these individuals the forward translations were compared and one forward translation version was derived. Each of the items was discussed seperately and all translation problems were recorded.
- The forward translation version was next backward translated to English by two other individuals, both professional translaters. Backward translation has shown to help improve the quality of the questionnaire. Unlike some of the first translators, back translators were preferably not aware of the interest and concepts underlying the study.

- At a consensus meeting of the back-translators and the EUROPEP researchers discrepancies were discussed and a final version of the national questionnaire was derived. Again each of the items was discussed separately and all translation problems were recorded.

5. Validation study

Objectives

This study was aimed at assessing the relevance of the questions to individual patients as well as their sensitiveness to variation across patients.

Methods

Subjects: Surveys among patients were performed in 8 countries to evaluate this version of the 44 item draft instrument. Adult patients (>18 years) consecutively visiting the general practice were given a written questionnaire. They filled in the questionnaire at home and sent it anonymously in a prepaid envelope to the research institute. In each country 200 patients from 4 or 5 practices were approached (250 patients in Norway). In nine countries a small number of patients (10-25 per country) were interviewed by telephone after they had returned the questionnaire in order to determine whether questions and instructions were adequately understood.

Measures: A list of 44 indicators for the quality of general practice care was developed in a series of studies. The resulting list of 44 indicators were used to formulate questions for patients, using the phrase: "What is your opinion of the general practitioner and/or general practice over the last 12 months with respect to ...". A five-point answering scale from 'poor' to 'good' was used without labels for the middle categories to avoid translation problems. Patients' responses to the questionnaire were recorded on a separate form (similar to that in phase 2).

Analysis: For each indicator we determined for each country the percentage of patients who gave a valid answer (=item-response) and the percentage of patients who used the most positive answering category ('good'). Results from the telephone interviews were summarized in structured forms per country.

Table 3: Description of patient sample (n=1008)

Sex	
female	67.6%
male	32.4%
Age (mean)	51.0 years (median: 51)
<40 years	31.2%
40-64 years	41.2%
>65 years	27.6%
Times seen GP in the last 12 months (mean)	6.15 times (median: 4)
Perceived health status	
very good/excellent	27.4%
good	36.3%
fair/poor	36.3%

Results

In sum 1008 patients from 8 countries responded (168 from Denmark, 104 from Finland, 125 from Germany, 142 from the Netherlands, 157 from Norway, 35 from Portugal, 117 from United Kingdom and 160 from Sweden). Table 3 describes the patient sample. Table 4 reports which items were not selected for the EUROPEP instrument and the variation of scores and item response on these items. The table shows that a few items had poor item response, and that most of these items showed little variation across scores. The structured item selection procedure will be described below (6).

The qualitative analysis gave a wide range of diverging comments and suggestions, which however did not identify needs for major changes in the questions. Table 5 reports, as an example, the results from telephone interviews with the Swedish patients. Most of these patients did not report difficulties with respect to the questionnaire, but they had some specific comments on parts of the questionnaire.

Table 4: Items <u>not</u> selected for the EUROPEP instrument

	Percentage of patients who used the most positive answering category='good' (lowest-highest per country between brackets)	**Item-response** (lowest-highest per country between brackets)
• explaining things to you	68.7 *(62-91)*	97 *(96-99)*
• the respect shown to you as a person	76.7 *(64-88)*	98 *(96-100)*
• help with your health problems	67.9 *(60-79)*	95 *(91-98)*
• ordering tests (e.g. blood test, X-ray etc.)	75.1 *(62-85)*	88 *(75-97)*
• deciding about your medication	69.9 *(61-79)*	89 *(74-97)*
• referring you (to a specialist or hospital)	74.5 *(68-81)*	77 *(58-86)*
• opportunities to ask questions about your problems	67.1 *(61-75)*	95 *(93-98)*
• explaining results of test (eg blood test, X-ray)	65.2 *(57-75)*	85 *(73-94)*
• discussion with you on how your symptoms affect your daily life	53.7 *(49-64)*	*78* (72-83)
• discussion with you on whether to refer you (to a specialist or hospital)	66.0 *(46-76)*	69 *(50-80)*
• willingness to make home visits	65.0 *(35-74)*	42 *(16-61)*
• instructing you in how to take your medicines correctly	71.2 *(64-79)*	80 *(68-89)*
• explaining what to do if you did not get better	54.1 *(39-73)*	67 *(37-84)*
• co-operation with other staff (not doctors) at the practice	68.7 *(55-81)*	75 *(58-89)*
• knowing what another general practitioner in the same practice had done or told you	49.2 *(40-65)*	46 (31-61)
• knowing what other care providers (eg doctors, physiotherapists, nurses, etc) outside the practice did or told you	49.3 *(33-65)*	48 *(41-57)*
• co-ordination of different types of care you received outside the practice	55.3 *(29-68)*	42 *(26-52)*
• the facilities at the practice	55.3 *(29-68)*	94 *(89-98)*
• seeing the same general practitioner at each visit	74.8 *(48-88)*	94 *(82-99)*
• travelling to the practice	71.8 *(53-84)*	88 *(80-98)*
• access to the building	75.0 *(67-87)*	92 *(80-98)*

Table 5: Some results from the telephone interviews: Sweden (example)

General questions	Summary of answers
1. What is your overall impression of the questionnaire?	Good, easy to understand, logical order.
2. Concerning the instruction remarks: are they understandable?	Two patients reported some problems, the rest said there were no problems. One person suggested larger fonts in the headings, one said that the introduction text was unneccesary long.
3. How long did it take to fill in the questionnaire?	Range 10-60 minutes.
4. Is the length of the questionnaire acceptable?	All said yes.
5. Is the order of the questionnaire logical?	All said yes.
6. Would you consider any sections confusing or difficult to respond at?	One person: some parts, not able to specify. The others said: no confusing parts.
7. Do you lack certain topics?	About hospitals. More focus on emergency situations. More about availability. More about waiting times. About privacy of information on patients. More focus on mental health problems.
8. Should any items and/or aspects not have been asked?	No, not at all.
9. On the whole, is the questionnaire easy to understand? Uncomplicated?	All except one answered yes. One said that it could be difficult to couple head-text of the section and the text in each question, had to read several times to understand the question properly.
10. Concerning the scale: Is it problematic to place oneself/the answer in a category? Do you have suggestions for improvement of the scale?	Not difficult for most. Three said: fewer alternatives, suggest three options.
11. Do you have any other comments to the questionnaire?	One patient suggested to ask for the name of the doctor. Two suggested more open questions. Three persons would have liked space for comments on each question. One patient commented: "feels like talking behind the back of my doctor". One person said that the personal questions should be asked first. Two patients said: "some questions are repeated, it's confusing."
12. Did you receive any assistance from others in filling in the questionnaire? from whom?	None did.

6. Final selection of items

Objectives

The aim of this activity was to make the final selection of items that would be included in the EUROPEP instrument in a way that was systematic and repeatable.

Methods

A systematic procedure was used to select questions from the list of 44 items for the final EUROPEP instrument. First, a number of criteria were formulated. Some criteria were *absolute*, which implied that the scores on these criteria had direct consequences for the inclusion or exclusion of questions (regardless of scores on other criteria). Other criteria were *relative*, which means that questions received scores and that the selection was based on the total score reached. It was not possible to indicate what total score was needed, but a restriction was that a maximum of 25 items should be used in the final questionnaire. The following criteria for selecting questions were formulated:

Criteria at the level of aspects of care

1. Coverage

At least 2 items were included for each of the following dimensions (absolute criterium): relation and communication; medical care; information and support; continuity and cooperation; facilities, availability and accessibility. The final number of questions per dimension did not need to be equal.

2. Importance

a. All aspects of care that were ranked in the top-10 of patients' priorities in at least 4 out of the 8 countries (data from EUROPEP priorities study) were included in the questionnaire (absolute criterium).

b. All spects of care that that were ranked in the top-10 of patients' priorities in at least one country in the priorities study got a positive score for importance (relative criterium).

Criteria at the level of individual questions

3. Item-response

a. Questions were excluded if the item-response was lower than 30% in more than one country (data from study 5) (absolute criterium).

b. Questions that had an item-response higher than 80% in at least 4 out of 7 countries (data from study 5) got a positive score for item-response (relative criterium).

4. Language

Items were excluded if a serious ambiguity or translation problem was found in at least two countries (data from study 5) (absolute criterium).

5. Discrimination

Items where less than 65% used the highest answering category (5: 'good') in at least 4 countries (data from study 5) got a positive score for discrimination (relative criterium).

Results

This procedure selected 23 items, which were included in the final EUROPEP instrument (table 6, next paragraph).

7. Final validation: Psychometrics study

Objectives

This study aimed to assess the psychometric characteristics of the final 23-item EUROPEP instrument with respect to content validity (item response) and reliability (internal consistency).

Methods

Subjects: A sample of 16 European countries was included in the study, reflecting a variety of primary health care systems. The sample of practices was stratified according to practice size and urbanization in each country to reflect the national situation as closely as possible. The patient population comprised individuals who had recently visited the general practitioner. We aimed at 1080 patients per country. The number of patients approached varied between 45 and 80 per practice, depending on the expected response rate. Patients were included if they were 18 years or older and able to understand the national language.

The GP handed out a written questionnaire to all eligible patients consecutively visiting their practice after a chosen starting point. The patient was asked to complete the questionnaire at home and send it in a prepaid envelope to the research unit (except in Israel, where questionnaires were collected in the practice). In 12 of the countries reminders were mailed to non-responders at three weeks after handing out the questionnaire. In the remaining countries no reminders were used because this was not feasible.

Measures: The final EUROPEP instrument is a multidimensional instrument comprising 23 questions on evaluations by patients of specific aspects of general practice care, using a five point answering scale with (only) the extremes labelled as 'poor'and 'excellent'.

Analysis: For each question the item-response was calculated: the percentage of responders out of the total number of responders who used one of the five answering categories. We considered an item-response of 90-100% good, 80-90% acceptable and less than 80% problematic. We calculated conventional Cronbach's alpha's (at the level of patients), both on the aggregated dataset and within each of the countries. More extensive psychometric analyses will be reported elsewhere.

Results

The actual number of practices recruited in each country varied between 28 and 48 (except for Finland, where it was 14). The number of general practitioners varied widely due to international variation in the number of practitioners per practice. The patient sample sizes per country were equal to or well above the required number of 1080, except for Wallonnia (990), France (473), Portugal (450) and Spain (316). The average response rate in the 12 countries which used reminders was 78.9%.

About two thirds of the sample were women (64.9%) and the mean age was 51 years. Respondents from Denmark were relatively young (mean age of 46 years), while they were relatively old in Sweden (57 years). The number of visits to the GP in the last 12 months varied from 3.7 in Sweden to 12.3 in Germany (overall mean was 7.8 visits). Overall about one third of the patients reported their health status to be poor or fair. This figure varied from 7% in Austria to 62% in Portugal. About 40% reported having a chronic disease, with a range from 19% in Iceland to 74% in Portugal.

The item-response rates in the total sample of responders varied between 73% and 98% per question (table 6).

Table 6: Item response for each of the items (n=23892)

	percentage item-response: overall mean
1. making you feel you had time during consultations	98.5
2. interest in your personal situation	96.3
3. making it easy for you to tell him or her about your problems	96.4
4. involving you in decisions about your medical care	93.7
5. listening to you	98.3
6. keeping your records and data confidential	87.9
7. quick relief of your symptoms	93.4
8. helping you to feel well so that you can perform your normal daily activities	89.4
9. thoroughness	96.0
10. physical examination of you	94.1
11. offering you services for preventing diseases	84.4
12. explaining the purpose of tests and treatments	93.6
13. telling you what you wanted to know about your symptoms and/or illness	95.5
14. help in dealing with emotional problems related to your health status	79.3
15. helping you understand the importance of following his or her advice	89.2
16. knowing what s/he had done or told you during previous contacts	89.0
17. preparing you for what to expect from specialist or hospital care	71.5
18. the helpfulness of staff (other than the doctor)	87.1
19. getting an appointment to suit you	94.9
20. getting through to the practice on the phone	94.1
21. being able to speak to the general practitioner on the telephone	82.5
22. waiting time in the waiting room	95.3
23. providing quick services for urgent health problems	81.7

This total item-response was good for 13 items, acceptable for 8 items, and low for 2 items (14 and 17), which referred to help in dealing with emotional problems and contact with

hospital or specialist care. A low response rate was found in two or more countries with respect to items 11, 14, 17, 18, 21 and 23.

The internal consistency of the aggregated scores on two dimensions was good: the reliability coeffiencients were 0.96 for 'clinical behaviour' (item 1-16) and 0.87 for 'organisation of care' (item 17-23), with little variation across the countries. The reliability of the 'organisation of care' dimension was slightly lower in Austria, Germany and Spain (range 0.82-0.84) and moderate in Slovenia and Switzerland (0.76 and 0.73, respectively).

Conclusion

The EUROPEP instrument has been developed in a series of studies, including qualitative research and small scale quantitative surveys in all participating countries. At several points in time questions have been changed or dropped, depending on the results of the studies and discussions in the EUROPEP group. Structured procedures have been used for the final selection of items, for the formal translation into different national languages and for the assessment of the study on psychometric characteristics of the instrument. So the EUROPEP instrument is indeed a standardised validated instrument for patients' evaluations of general practice care in Europe.

5. Patients in Europe evaluate general/family practice: results of a survey

Introduction

The internationally validated instrument was handed out and completed by a large number of patients in the following countries: Austria, Belgium (separate questionnaires in the Dutch speaking area – Flanders - and the French speaking area – Wallonia), Denmark, Finland, France, Germany, Iceland, Israel, Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, U.K. In each country a stratified sample of practices was recruited, using practice size (one GP versus more than one GP) and degree of urbanisation (villages with less than 15,000 inhabitants versus towns and cities with more than 15,000 inhabitants) as stratification variables in order to reflect the national situation as good as possible. We aimed for at least 36 practices and 1080 patients per country, but this proved to be not possible in all the participating countries. The patients studied comprised patients with recent experience with general practice care: participation was asked after a visit to the practice. Patients were included if they were 18 years or older and able to understand the national language (used in the questionnaire).

Procedures and analysis

The GP handed out the EUROPEP-questionnaire to all eligible patients consecutively visiting the practice after a chosen starting point. The patient was asked to complete the instrument at home and send it in a prepaid envelope to the research unit. Reminders were mailed to non-responders at three weeks after handing out the questionnaires. Patient addresses were documented and numbered identically to numbers in the questionnaire for this purpose. Reminders were send from the practice or the research unit, depending on the feasibility or the privacy regulations in a specific country.

Data-entry was co-ordinated by the research units in the different countries; further analysis conducted in the co-ordinating centre in Nijmegen. For describing frequency distributions we used the percentages of patients who used the scores 1, 2, 3, 4, 5, on a 5-point scale, running from poor to excellent.

Results

The sample of patients included 23,892 patients in 16 countries. The actual number of practices recruited varied between 28 and 48 per country (except for Finland, where it was

14). The patient sample sizes per country were equal to or well above the required number of 1080, except for Wallonia (900), France (473), Portugal (450) and Spain (316). The average response rate in the countries that used reminders was 78,9%.
About two thirds of the samples were women (64,9%) and the mean age was 51 year. Respondents from Denmark were relatively young (mean age of 46 years), while they were relatively old in Sweden (57 years). The number of visits to the GP in the last 12 months varied from 3.7 in Sweden to 12.3 in Germany (overall mean 7.8 visits). Overall about one third of the patients reported their health status to be fair or poor, but this figure varied from 7% in Austria to 62% in Portugal. About 40% reported having a chronic disease, with a range from 19% in Iceland to 74% in Portugal.

The frequencies of answers to the different items of the EUROPEP-questionnaire in the participating countries can be found on the next pages (table 7-23).

Patients in all countries proved to be very positive about their family doctor and their general practice. For most of the selected aspects of general practice care more than 80% of the patients viewed care provision as good or excellent. Particularly, keeping records confidential, GPs listening to patients, time during consultations and quick services in case of urgent problems were evaluated positively in most countries. Patients in some countries were relatively negative about organisational aspects of care, such as getting through to the practice and the GP on the telephone or waiting times. There were some interesting differences in evaluations by patients between the different countries, for instance, service and organisational aspects were evaluated more positively in fee-for-service health systems (Grol 2000).

Conclusions

A valid and easy to use instrument to gather information on the patients' experiences with and evaluations of general practice care has been developed by an international group of researchers for general practice/family medicine. This instrument can now be widely used. Reference data for 16 countries are provided on the next pages. Translations of the instruments of 15 languages can be found in the Appendix of this book.

Table 7: Patients from Austria evaluating general/family practice (N=1569, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	6	31	28	34
2.	Interest in your personal situation?	0	1	7	30	62
3.	Making it easy for you to tell him or her about your problem?	0	2	7	31	60
4.	Involving you in decisions about your medical care?	0	2	8	36	54
5.	Listening to you?	1	2	5	27	65
6.	Keeping your records and data confidential?	0	1	3	19	77
7.	Quick relief of your symptoms?	0	1	8	39	52
8.	Helping you to feel well so that you can perform your normal daily activities?	0	1	6	38	55
9.	Thoroughness?	0	2	7	26	65
10.	Physical examination of you?	1	2	6	31	60
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	3	3	9	31	54
12.	Explaining the purpose of tests and treatments?	0	2	8	28	62
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	2	8	32	57
14.	Helping you deal with emotional problems related to your health status?	1	1	7	33	58
15.	Helping you deal with emotional problems related to your health status?	1	3	8	33	55
16.	Knowing what s/he had done or told you during contacts?	1	2	7	33	57
17.	Preparing you for what to expect from specialist or hospital care?	1	2	7	32	58
18.	The helpfulness of the staff (other than the doctor)?	1	3	10	38	48
19.	Getting an appointment to suit you?	1	1	6	28	64
20.	Getting through to the practice on telephone?	0	2	4	27	67
21.	Being able to speak to the general practitioner on the telephone?	2	4	10	33	51
22.	Waiting time in the waiting room?	5	7	24	41	23
23.	Providing quick services for urgent health problems?	0	1	5	31	63

Table 8: Patients from Belgium (Wallonia) evaluating general/family practice (N=990, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	0	1	9	25	65
2.	Interest in your personal situation?	0	2	8	30	60
3.	Making it easy for you to tell him or her about your problem?	0	1	7	23	69
4.	Involving you in decisions about your medical care?	1	1	10	30	58
5.	Listening to you?	0	1	6	23	70
6.	Keeping your records and data confidential?	0	1	2	14	83
7.	Quick relief of your symptoms?	1	2	13	41	43
8.	Helping you to feel well so that you can perform your normal daily activities?	1	2	9	34	54
9.	Thoroughness?	0	1	10	32	57
10.	Physical examination of you?	1	2	8	30	59
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	2	4	12	23	59
12.	Explaining the purpose of tests and treatments?	0	2	8	28	62
13.	Telling you what you wanted to know about your symptoms and/or illness?	0	2	7	30	61
14.	Helping you deal with emotional problems related to your health status?	1	3	9	33	54
15.	Helping you deal with emotional problems related to your health status?	1	2	7	31	59
16.	Knowing what s/he had done or told you during contacts?	1	2	10	30	57
17.	Preparing you for what to expect from specialist or hospital care?	2	3	12	32	51
18.	The helpfulness of the staff (other than the doctor)?	1	5	15	28	51
19.	Getting an appointment to suit you?	2	3	11	27	57
20.	Getting through to the practice on telephone?	1	3	9	28	59
21.	Being able to speak to the general practitioner on the telephone?	2	3	9	24	62
22.	Waiting time in the waiting room?	9	9	28	32	22
23.	Providing quick services for urgent health problems?	2	3	8	22	65

Table 9: Patients from Belgium (Flanders) evaluating general/family practice (N=2530, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	0	1	7	28	64
2.	Interest in your personal situation?	0	2	8	30	60
3.	Making it easy for you to tell him or her about your problem?	1	2	9	30	58
4.	Involving you in decisions about your medical care?	1	2	10	30	57
5.	Listening to you?	0	1	6	27	66
6.	Keeping your records and data confidential?	0	1	3	17	79
7.	Quick relief of your symptoms?	0	2	13	40	45
8.	Helping you to feel well so that you can perform your normal daily activities?	0	1	9	40	50
9.	Thoroughness?	0	1	10	32	57
10.	Physical examination of you?	1	2	9	31	57
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	2	5	16	27	50
12.	Explaining the purpose of tests and treatments?	1	1	9	27	62
13.	Telling you what you wanted to know about your symptoms and/or illness?	0	2	8	29	61
14.	Helping you deal with emotional problems related to your health status?	1	3	11	30	55
15.	Helping you deal with emotional problems related to your health status?	1	2	12	31	54
16.	Knowing what s/he had done or told you during contacts?	1	3	12	34	50
17.	Preparing you for what to expect from specialist or hospital care?	1	3	11	33	52
18.	The helpfulness of the staff (other than the doctor)?	1	2	14	32	51
19.	Getting an appointment to suit you?	1	2	8	27	62
20.	Getting through to the practice on telephone?	1	1	5	23	70
21.	Being able to speak to the general practitioner on the telephone?	1	2	7	27	63
22.	Waiting time in the waiting room?	4	8	22	37	29
23.	Providing quick services for urgent health problems?	0	1	6	27	66

Table 10: Patients from Denmark evaluating general/family practice (N=1307, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	2	5	18	40	35
2.	Interest in your personal situation?	1	4	16	40	39
3.	Making it easy for you to tell him or her about your problem?	1	5	19	39	36
4.	Involving you in decisions about your medical care?	1	5	21	39	34
5.	Listening to you?	2	4	15	39	40
6.	Keeping your records and data confidential?	0	0	3	21	76
7.	Quick relief of your symptoms?	2	6	18	41	33
8.	Helping you to feel well so that you can perform your normal daily activities?	2	5	19	42	32
9.	Thoroughness?	1	5	15	37	42
10.	Physical examination of you?	2	4	15	37	42
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	6	9	17	31	37
12.	Explaining the purpose of tests and treatments?	1	4	17	40	38
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	5	19	41	34
14.	Helping you deal with emotional problems related to your health status?	3	7	23	34	33
15.	Helping you deal with emotional problems related to your health status?	1	3	17	46	33
16.	Knowing what s/he had done or told you during contacts?	2	7	18	44	29
17.	Preparing you for what to expect from specialist or hospital care?	3	8	21	38	30
18.	The helpfulness of the staff (other than the doctor)?	1	4	16	39	40
19.	Getting an appointment to suit you?	5	8	16	34	37
20.	Getting through to the practice on telephone?	9	13	25	28	25
21.	Being able to speak to the general practitioner on the telephone?	7	13	21	32	27
22.	Waiting time in the waiting room?	5	10	26	37	22
23.	Providing quick services for urgent health problems?	2	6	11	31	50

Table 11: Patients from Finland evaluating general /family practice (N=1073 , percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	3	23	52	21
2.	Interest in your personal situation?	1	7	32	43	17
3.	Making it easy for you to tell him or her about your problem?	2	6	30	46	16
4.	Involving you in decisions about your medical care?	2	6	24	50	18
5.	Listening to you?	1	2	16	50	31
6.	Keeping your records and data confidential?	0	1	6	48	45
7.	Quick relief of your symptoms?	1	4	23	50	22
8.	Helping you to feel well so that you can perform your normal daily activities?	1	5	27	49	18
9.	Thoroughness?	1	5	25	45	24
10.	Physical examination of you?	1	3	19	51	26
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	4	13	27	38	18
12.	Explaining the purpose of tests and treatments?	1	6	20	49	24
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	4	20	48	27
14.	Helping you deal with emotional problems related to your health status?	2	8	30	44	16
15.	Helping you deal with emotional problems related to your health status?	1	4	26	52	17
16.	Knowing what s/he had done or told you during contacts?	2	8	24	46	20
17.	Preparing you for what to expect from specialist or hospital care?	3	9	25	45	18
18.	The helpfulness of the staff (other than the doctor)?	0	1	11	58	30
19.	Getting an appointment to suit you?	1	4	17	52	26
20.	Getting through to the practice on telephone?	4	9	28	43	16
21.	Being able to speak to the general practitioner on the telephone?	3	12	26	45	14
22.	Waiting time in the waiting room?	2	6	42	41	9
23.	Providing quick services for urgent health problems?	2	5	19	50	24

Table 12: Patients from France evaluating general/family practice (N=473, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	6	31	28	34
2.	Interest in your personal situation?	2	4	27	35	32
3.	Making it easy for you to tell him or her about your problem?	1	6	22	34	37
4.	Involving you in decisions about your medical care?	1	4	33	36	26
5.	Listening to you?	0	4	22	37	37
6.	Keeping your records and data confidential?	1	1	17	33	48
7.	Quick relief of your symptoms?	0	8	35	38	19
8.	Helping you to feel well so that you can perform your normal daily activities?	1	4	35	36	24
9.	Thoroughness?	2	7	31	35	25
10.	Physical examination of you?	2	6	26	39	27
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	4	9	26	30	31
12.	Explaining the purpose of tests and treatments?	2	7	22	38	31
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	5	25	35	34
14.	Helping you deal with emotional problems related to your health status?	3	9	28	32	28
15.	Helping you deal with emotional problems related to your health status?	0	5	31	37	27
16.	Knowing what s/he had done or told you during contacts?	2	12	22	36	28
17.	Preparing you for what to expect from specialist or hospital care?	3	8	32	33	24
18.	The helpfulness of the staff (other than the doctor)?	1	6	28	33	32
19.	Getting an appointment to suit you?	2	5	26	36	31
20.	Getting through to the practice on telephone?	0	5	21	36	38
21.	Being able to speak to the general practitioner on the telephone?	2	6	25	35	32
22.	Waiting time in the waiting room?	8	24	32	22	14
23.	Providing quick services for urgent health problems?	3	8	20	32	37

Table 13: Patients from Germany evaluating general/family practice (N=2224, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	0	2	7	30	61
2.	Interest in your personal situation?	0	2	7	30	61
3.	Making it easy for you to tell him or her about your problem?	0	2	9	30	59
4.	Involving you in decisions about your medical care?	0	2	11	30	57
5.	Listening to you?	0	1	7	27	65
6.	Keeping your records and data confidential?	0	1	5	21	73
7.	Quick relief of your symptoms?	1	2	14	38	45
8.	Helping you to feel well so that you can perform your normal daily activities?	0	2	10	35	53
9.	Thoroughness?	0	2	7	27	64
10.	Physical examination of you?	1	2	6	30	61
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	4	13	27	38	18
12.	Explaining the purpose of tests and treatments?	0	2	9	31	58
13.	Telling you what you wanted to know about your symptoms and/or illness?	0	2	8	30	60
14.	Helping you deal with emotional problems related to your health status?	1	3	12	30	54
15.	Helping you deal with emotional problems related to your health status?	1	3	10	31	55
16.	Knowing what s/he had done or told you during contacts?	1	3	11	31	54
17.	Preparing you for what to expect from specialist or hospital care?	1	3	11	32	53
18.	The helpfulness of the staff (other than the doctor)?	1	1	7	27	64
19.	Getting an appointment to suit you?	0	1	5	27	67
20.	Getting through to the practice on telephone?	0	1	4	21	74
21.	Being able to speak to the general practitioner on the telephone?	1	3	9	30	57
22.	Waiting time in the waiting room?	3	5	22	39	31
23.	Providing quick services for urgent health problems?	0	1	4	25	70

Table 14: Patients from Iceland evaluating general/family practice (N=1058, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	1	5	17	76
2.	Interest in your personal situation?	2	4	16	25	53
3.	Making it easy for you to tell him or her about your problem?	1	2	9	20	68
4.	Involving you in decisions about your medical care?	2	4	11	23	60
5.	Listening to you?	1	1	5	14	79
6.	Keeping your records and data confidential?	1	0	2	6	91
7.	Quick relief of your symptoms?	1	3	8	20	68
8.	Helping you to feel well so that you can perform your normal daily activities?	1	2	7	18	72
9.	Thoroughness?	1	3	11	24	61
10.	Physical examination of you?	1	2	10	22	65
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	5	7	14	18	56
12.	Explaining the purpose of tests and treatments?	2	4	9	18	67
13.	Telling you what you wanted to know about your symptoms and/or illness?	2	3	6	18	71
14.	Helping you deal with emotional problems related to your health status?	5	5	14	22	54
15.	Helping you deal with emotional problems related to your health status?	2	4	11	21	62
16.	Knowing what s/he had done or told you during contacts?	2	3	14	22	59
17.	Preparing you for what to expect from specialist or hospital care?	3	5	10	19	63
18.	The helpfulness of the staff (other than the doctor)?	4	4	11	16	65
19.	Getting an appointment to suit you?	6	7	9	14	64
20.	Getting through to the practice on telephone?	7	7	11	16	59
21.	Being able to speak to the general practitioner on the telephone?	8	8	12	15	57
22.	Waiting time in the waiting room?	6	8	16	25	45
23.	Providing quick services for urgent health problems?	3	3	8	15	71

Table 15: Patients from Israel evaluating general/family practice (N=1603, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	3	3	10	34	50
2.	Interest in your personal situation?	4	6	9	24	57
3.	Making it easy for you to tell him or her about your problem?	2	4	10	24	60
4.	Involving you in decisions about your medical care?	5	6	8	26	55
5.	Listening to you?	3	5	9	24	59
6.	Keeping your records and data confidential?	2	2	3	18	75
7.	Quick relief of your symptoms?	3	3	10	34	50
8.	Helping you to feel well so that you can perform your normal daily activities?	1	4	8	28	59
9.	Thoroughness?	3	5	13	27	52
10.	Physical examination of you?	3	4	12	27	54
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	7	8	14	22	49
12.	Explaining the purpose of tests and treatments?	3	5	11	36	45
13.	Telling you what you wanted to know about your symptoms and/or illness?	2	4	9	28	57
14.	Helping you deal with emotional problems related to your health status?	7	7	11	28	47
15.	Helping you deal with emotional problems related to your health status?	2	5	9	25	59
16.	Knowing what s/he had done or told you during contacts?	2	3	12	37	46
17.	Preparing you for what to expect from specialist or hospital care?	4	4	13	26	53
18.	The helpfulness of the staff (other than the doctor)?	2	4	11	32	51
19.	Getting an appointment to suit you?	7	8	14	27	44
20.	Getting through to the practice on telephone?	4	5	10	30	51
21.	Being able to speak to the general practitioner on the telephone?	4	4	9	25	58
22.	Waiting time in the waiting room?	14	16	23	23	24
23.	Providing quick services for urgent health problems?	5	7	13	27	48

Table 16: Patients from the Netherlands evaluating general/family practice N=1772, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	2	10	33	54
2.	Interest in your personal situation?	1	4	13	32	50
3.	Making it easy for you to tell him or her about your problem?	1	4	13	33	49
4.	Involving you in decisions about your medical care?	1	3	15	33	48
5.	Listening to you?	1	2	8	33	56
6.	Keeping your records and data confidential?	0	1	4	26	69
7.	Quick relief of your symptoms?	1	5	19	40	35
8.	Helping you to feel well so that you can perform your normal daily activities?	1	4	16	41	38
9.	Thoroughness?	1	3	14	38	44
10.	Physical examination of you?	2	3	13	39	44
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	3	6	15	27	49
12.	Explaining the purpose of tests and treatments?	1	3	12	36	48
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	3	13	35	48
14.	Helping you deal with emotional problems related to your health status?	3	6	16	29	46
15.	Helping you deal with emotional problems related to your health status?	1	4	15	37	43
16.	Knowing what s/he had done or told you during contacts?	1	4	18	37	40
17.	Preparing you for what to expect from specialist or hospital care?	3	6	16	34	41
18.	The helpfulness of the staff (other than the doctor)?	1	3	12	34	50
19.	Getting an appointment to suit you?	3	5	14	29	49
20.	Getting through to the practice on telephone?4	4	7	17	32	40
21.	Being able to speak to the general practitioner on the telephone?	3	7	18	35	37
22.	Waiting time in the waiting room?	4	9	26	36	25
23.	Providing quick services for urgent health problems?	1	3	11	33	52

Table 17: Patients from Norway evaluating general/family practice (N=1609, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	2	4	16	33	45
2.	Interest in your personal situation?	1	3	12	34	50
3.	Making it easy for you to tell him or her about your problem?	1	5	14	32	48
4.	Involving you in decisions about your medical care?	2	4	15	33	46
5.	Listening to you?	1	3	11	29	56
6.	Keeping your records and data confidential?	1	2	6	23	68
7.	Quick relief of your symptoms?	2	3	14	37	44
8.	Helping you to feel well so that you can perform your normal daily activities?	1	2	14	37	46
9.	Thoroughness?	1	3	14	32	50
10.	Physical examination of you?	1	5	14	36	44
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	6	8	19	28	39
12.	Explaining the purpose of tests and treatments?	2	4	15	31	48
13.	Telling you what you wanted to know about your symptoms and/or illness?	2	5	15	33	45
14.	Helping you deal with emotional problems related to your health status?	4	7	20	30	39
15.	Helping you deal with emotional problems related to your health status?	1	4	17	36	42
16.	Knowing what s/he had done or told you during contacts?	2	6	18	36	38
17.	Preparing you for what to expect from specialist or hospital care?	4	7	18	33	38
18.	The helpfulness of the staff (other than the doctor)?	2	3	12	28	55
19.	Getting an appointment to suit you?	4	6	13	25	52
20.	Getting through to the practice on telephone?	11	12	21	25	31
21.	Being able to speak to the general practitioner on the telephone?	13	13	20	28	26
22.	Waiting time in the waiting room?	6	11	25	33	25
23.	Providing quick services for urgent health problems?	3	3	11	26	57

Table 18: Patients from Portugal evaluating general/family practice (N=450, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	2	10	47	40
2.	Interest in your personal situation?	0	2	7	37	54
3.	Making it easy for you to tell him or her about your problem?	1	1	4	35	59
4.	Involving you in decisions about your medical care?	1	5	18	32	44
5.	Listening to you?	1	0	5	32	62
6.	Keeping your records and data confidential?	0	1	4	31	64
7.	Quick relief of your symptoms?	1	3	22	46	28
8.	Helping you to feel well so that you can perform your normal daily activities?	2	1	17	44	36
9.	Thoroughness?	1	1	6	35	57
10.	Physical examination of you?	1	1	11	36	51
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	2	4	13	32	49
12.	Explaining the purpose of tests and treatments?	1	2	11	38	48
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	2	12	38	47
14.	Helping you deal with emotional problems related to your health status?	1	3	10	40	46
15.	Helping you deal with emotional problems related to your health status?	1	2	12	38	47
16.	Knowing what s/he had done or told you during contacts?	1	1	13	46	39
17.	Preparing you for what to expect from specialist or hospital care?	3	6	21	38	32
18.	The helpfulness of the staff (other than the doctor)?	6	10	32	32	20
19.	Getting an appointment to suit you?	11	15	18	34	22
20.	Getting through to the practice on telephone?	8	9	24	29	30
21.	Being able to speak to the general practitioner on the telephone?	5	7	21	34	33
22.	Waiting time in the waiting room?	15	17	28	29	11
23.	Providing quick services for urgent health problems?	5	10	19	38	28

Table 19: Patients from Slovenia evaluating general/family practice (N=1808, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	0	1	7	41	51
2.	Interest in your personal situation?	3	5	12	34	46
3.	Making it easy for you to tell him or her about your problem?	1	3	9	35	52
4.	Involving you in decisions about your medical care?	1	2	8	34	55
5.	Listening to you?	0	1	4	26	69
6.	Keeping your records and data confidential?	0	0	2	21	77
7.	Quick relief of your symptoms?	0	1	5	30	64
8.	Helping you to feel well so that you can perform your normal daily activities?	0	1	5	33	61
9.	Thoroughness?	1	1	6	32	60
10.	Physical examination of you?	0	1	8	34	57
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	3	3	10	26	58
12.	Explaining the purpose of tests and treatments?	1	2	8	32	57
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	1	6	30	62
14.	Helping you deal with emotional problems related to your health status?	2	3	8	33	54
15.	Helping you deal with emotional problems related to your health status?	1	1	7	33	58
16.	Knowing what s/he had done or told you during contacts?	1	1	8	33	57
17.	Preparing you for what to expect from specialist or hospital care?	1	2	8	35	54
18.	The helpfulness of the staff (other than the doctor)?	1	3	7	31	58
19.	Getting an appointment to suit you?	2	5	8	25	60
20.	Getting through to the practice on telephone?	1	1	6	21	71
21.	Being able to speak to the general practitioner on the telephone?	2	1	4	21	72
22.	Waiting time in the waiting room?	4	9	27	34	26
23.	Providing quick services for urgent health problems?	2	2	7	27	62

Table 20: Patients from Spain evaluating general/family practice (N=316, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	2	10	47	40
2.	Interest in your personal situation?	0	2	7	37	54
3.	Making it easy for you to tell him or her about your problem?	1	1	4	35	59
4.	Involving you in decisions about your medical care?	0	1	10	43	46
5.	Listening to you?	3	1	5	10	81
6.	Keeping your records and data confidential?	1	0	4	8	87
7.	Quick relief of your symptoms?	2	4	15	27	52
8.	Helping you to feel well so that you can perform your normal daily activities?	5	2	8	15	70
9.	Thoroughness?3	2	3	6	9	80
10.	Physical examination of you?	4	2	5	13	76
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	3	3	7	10	77
12.	Explaining the purpose of tests and treatments?	2	3	6	13	76
13.	Telling you what you wanted to know about your symptoms and/or illness?	4	3	5	13	75
14.	Helping you deal with emotional problems related to your health status?	6	2	6	19	67
15.	Helping you deal with emotional problems related to your health status?	2	4	3	14	77
16.	Knowing what s/he had done or told you during contacts?	2	3	5	15	75
17.	Preparing you for what to expect from specialist or hospital care?	3	3	6	13	75
18.	The helpfulness of the staff (other than the doctor)?	2	4	11	16	67
19.	Getting an appointment to suit you?	6	3	10	14	67
20.	Getting through to the practice on telephone?	7	7	11	6	69
21.	Being able to speak to the general practitioner on the telephone?	15	6	8	7	64
22.	Waiting time in the waiting room?	10	8	19	19	44
23.	Providing quick services for urgent health problems?	4	4	5	13	74

Table 21: Patients from Sweden evaluating general/family practice (N=1652, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	2	12	33	52
2.	Interest in your personal situation?	1	5	17	29	48
3.	Making it easy for you to tell him or her about your problem?	1	5	19	31	44
4.	Involving you in decisions about your medical care?	1	5	15	34	45
5.	Listening to you?	1	3	11	29	56
6.	Keeping your records and data confidential?	1	1	9	28	61
7.	Quick relief of your symptoms?	2	4	15	33	46
8.	Helping you to feel well so that you can perform your normal daily activities?	1	5	17	35	42
9.	Thoroughness?	1	3	13	32	51
10.	Physical examination of you?	1	4	15	31	49
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	3	7	15	24	51
12.	Explaining the purpose of tests and treatments?	1	4	15	32	48
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	4	14	30	51
14.	Helping you deal with emotional problems related to your health status?	3	7	20	27	43
15.	Helping you deal with emotional problems related to your health status?	1	3	16	32	48
16.	Knowing what s/he had done or told you during contacts?	2	4	16	30	48
17.	Preparing you for what to expect from specialist or hospital care?	2	7	18	31	42
18.	The helpfulness of the staff (other than the doctor)?	0	2	11	29	58
19.	Getting an appointment to suit you?	2	4	11	28	55
20.	Getting through to the practice on telephone?	6	9	18	28	39
21.	Being able to speak to the general practitioner on the telephone?	7	11	17	25	40
22.	Waiting time in the waiting room?	4	7	24	32	33
23.	Providing quick services for urgent health problems?	2	2	12	31	53

Table 22: Patients from Switzerland evaluating general/family practice (N=1497, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	0	1	3	28	68
2.	Interest in your personal situation?	0	1	4	31	64
3.	Making it easy for you to tell him or her about your problem?	0	1	5	32	62
4.	Involving you in decisions about your medical care?	0	1	8	33	58
5.	Listening to you?	0	0	3	25	72
6.	Keeping your records and data confidential?	0	1	3	21	75
7.	Quick relief of your symptoms?	0	2	12	42	44
8.	Helping you to feel well so that you can perform your normal daily activities?	0	1	8	37	54
9.	Thoroughness?	0	1	9	30	60
10.	Physical examination of you?	0	1	6	34	59
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	1	4	11	35	49
12.	Explaining the purpose of tests and treatments?	0	2	6	29	63
13.	Telling you what you wanted to know about your symptoms and/or illness?	1	1	5	29	64
14.	Helping you deal with emotional problems related to your health status?	0	2	8	34	56
15.	Helping you deal with emotional problems related to your health status?	0	2	9	36	53
16.	Knowing what s/he had done or told you during contacts?	0	2	9	34	55
17.	Preparing you for what to expect from specialist or hospital care?	0	2	9	32	57
18.	The helpfulness of the staff (other than the doctor)?	0	2	6	24	68
19.	Getting an appointment to suit you?	0	1	2	20	77
20.	Getting through to the practice on telephone?	0	1	3	21	75
21.	Being able to speak to the general practitioner on the telephone?	1	2	6	28	63
22.	Waiting time in the waiting room?	3	4	14	33	46
23.	Providing quick services for urgent health problems?	0	1	3	19	77

Table 23: Patients from the United Kingdom evaluating general/family practice (N=1934, percentages)

		Poor				Excellent
		1	**2**	**3**	**4**	**5**
1.	Making you feel you had time during consultation?	1	3	16	33	47
2.	Interest in your personal situation?	2	5	16	31	46
3.	Making it easy for you to tell him or her about your problem?	1	4	14	29	52
4.	Involving you in decisions about your medical care?	2	5	18	31	44
5.	Listening to you?	1	3	13	29	55
6.	Keeping your records and data confidential?	1	1	8	24	67
7.	Quick relief of your symptoms?	2	6	25	36	31
8.	Helping you to feel well so that you can perform your normal daily activities?	2	5	24	36	33
9.	Thoroughness?	2	5	15	32	46
10.	Physical examination of you?	3	5	17	32	43
11.	Offering you services for preventing diseases (eg screening, health checks, immunisations)	3	7	16	25	49
12.	Explaining the purpose of tests and treatments?	1	4	16	33	46
13.	Telling you what you wanted to know about your symptoms and/or illness?	2	4	15	33	46
14.	Helping you deal with emotional problems related to your health status?	3	7	19	27	44
15.	Helping you deal with emotional problems related to your health status?	1	4	19	32	44
16.	Knowing what s/he had done or told you during contacts?	2	5	21	33	39
17.	Preparing you for what to expect from specialist or hospital care?	2	6	20	32	40
18.	The helpfulness of the staff (other than the doctor)?	3	6	22	32	37
19.	Getting an appointment to suit you?	7	10	21	29	33
20.	Getting through to the practice on telephone?	6	9	18	28	39
21.	Being able to speak to the general practitioner on the telephone?	10	15	24	27	24
22.	Waiting time in the waiting room?	8	13	29	33	17
23.	Providing quick services for urgent health problems?	4	7	18	29	42

6. How to use EUROPEP in evaluating care?

Introduction

The EUROPEP instrument has been designed to assess the quality of general practice/family medicine and to provide relevant feedback to general practitioners, patients and health care policy makers at different levels. While the emphasis in the EUROPEP project has so far been on the development and validation of the instrument, most participants in the project also have developed feedback reports for general practitioners on their patients' evaluations of care. Such reports comprise feedback on the care provided, reflecting patients' perspective on the quality of care. This type of feedback complements assessment of professional performance from a professional and management perspective.

Feedback on patients' evaluations raises a number of questions. What is the validity and reliability of the instrument used? Is adjustment for case-mix needed? Which aspects of general practice/family medicine are related to patient satisfaction? What type of feedback is most helpful? This chapter briefly discusses these questions and it provides some specific examples of feedback reports.

Interpretation of patients' evaluations of care

1. *What is the validity and reliability of the instrument used?*

The EUROPEP instrument has been developed and validated in a series of studies, which focused on the selection of important aspects of care to be included in the questionnaire and on a good and understandable phrasing of the questions (see chapter 4). It is important that a systematic selection of questions is made, based on explicit assumptions. A gold standard or strong criterion variable for patient satisfaction is not yet available, however. Reliability can be assessed at the level of the individual patients' judgements or different levels of aggregated judgements (per GP, general practice, region, or country). It is important to note that for conclusions about GPs, practices or regions the reliability is adequate at that specific level (see box).

Box 3: Reliability of patients' evaluations of care

A study was performed to estimate the number of questions and patients needed for achieving reliable measurements of patients' judgements of general practice care. A sensitivity study was done, using generalizibility theory, to assess the reliability of scores, using data from 23 GPs and 739 patients. For most dimensions the reliability per patient was 0.80 or higher if three questions were used. The reliability of scores per GPs is however determined by both the number of questions and the number of patients. This study led to the practical advise to use for this purpose at least three questions and 90 patients, or five questions and 60 patients for each of the dimensions of general practice care included in a questionnaire (Wensing 1997).

2. ***Is adjustment for patient case-mix needed?***

It has been shown that patient characteristics such as age and health status influence their evaluations of care to some extent. A general practice with many young patients with poor health status should expect less positive evaluations than a general practice with many old patients with good health status. It can therefore be considered to correct statistically for the composition of the patient population, particularly if the figures are used for accountability rather than improvement. The magnitude of the effect of patient characteristics on evaluations of care is, however, small. Corrected figures may guide quality improvement activities in the wrong direction. The general practitioner or policy maker has to deal with the evaluations and complaints of a specific patient population, not with those of a hypothetical standardised patient population.

Box 4: Effect of interactions between patient characteristics and patients' opinions of general practice care

The literature shows that patients' positive opinions on general practice care are associated with being older, of low educational level, high social status and being married, but there is no association with the sex of the patient. The health related characteristics of patients, such as self-reported health status, chronic condition and utilization of care, also predict judgements of the quality of some aspects of general practice care. A study was performed to identify relationships between patient characteristics and patients' opinions of general practice care, using a preliminary version of the EUROPEP instrument. The questionnaire was distributed in eight European countries among patients consecutively visiting general practices: 1008 questionnaires (63%) were returned. The patient chararacteristics which influenced patients' evaluations of care were age, level of education, length of relationship with the practice, and whether they had a chronic condition. There were also differences between countries. No interaction effects between the patient characteristics were found. Patients' opinions were not influenced by sex, levels of utilization of care and self-reported health status.

Source: Hearnshaw H, Wensing M, Mainz J, Grol R, Ferreira P, Hjortdahl P, Mäkelä M, Olesen F, Ribacke M, Szescenyi J. The effect of interactions between patient characteristics on patients' opinions of general practice care in eight European countries. Unpublished report, Warwick 2000.

3. ***Which aspects of general practice/family medicine are related to patient satisfaction?***

It is important to know which aspects of care are related to patient satisfaction, as quality improvement should focus on those aspects. The research literature suggests that specific aspects of the doctor-patient communication, such as needs assessment and provision of information, are related to patient satisfaction with care. Some aspects of the organisation of care, for instance those related to continuity of care, may also be related to patients' evaluations of care. The magnitude of these relationships is small, however, and the literature probably suffers from publication bias (significant relationships are more often reported than non-significant relationships). It seems obvious that specific aspects of care are related to patient satisfaction care, but which ones exactly has yet to be identified.

4. ***What type of feedback is most helpful?***

We do not yet know the answer to this question, but we have several experiences with providing feedback to general practitioners and practices. Different types of feedback reports have been developed by EUROPEP participants and a few examples are given below. All feedback reports include a comparison between patients of a specific general practitioner or practice and the total sample of patients from all (other) doctors. Either the average figures or

the best ratings were provided as reference numbers. The effect of feedback on the behaviour of health providers is mixed; additional activities may be needed to be effective.

Example: QUALI DOC PRAXISEVALUATION, Switzerland (Künzi, 2000)

QualiDoc is the Swiss version of the EUROPEP instrument and feedback report. The report reports, among others, in 10 pages on the following aspects:

- for each question the percentage of patients who answered 'excellent', both for patients of the specific general practitioner and for patients from 36 randomly chosen Swiss general practitioners (reference group)

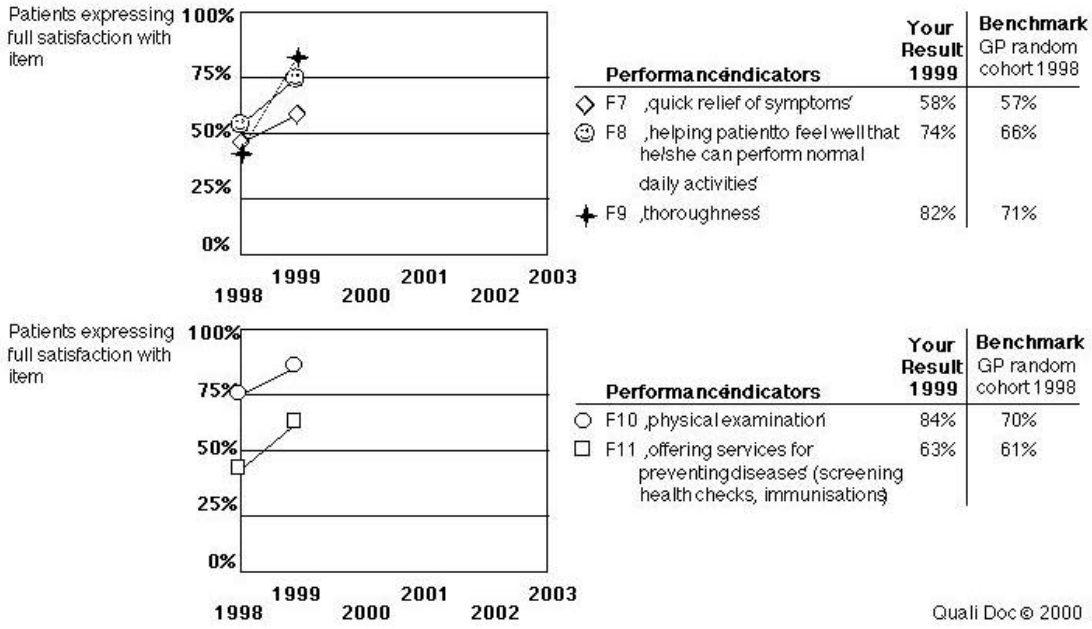


Figure 1 .Example of an individual GP'sfeedback report showing the results ofa follow-up assessment after a multidimensional intervention. Items used for evaluating medical-technical performance from patients'experience improved consistently

- for each question graphs that show the change of patients' evaluations over time
- for each chapter in the questionnaire an assessment based on a comparison with the 10% highest scores in the sample of patients from other doctors (benchmarking); the chapters are relation and communciation, medical care, information and advice, co-ordination and continuity, and organisation and availability
- a graph which summarizes the results of all chapters
- an overview of the composition of the patient sample in terms of age, sex, diseases, etc

- patients' answers to open questions, including an overview of negative and positive comments according to 8 major dimensions of care
- measured and perceived workload including Maslach burnout index (MBI) of participant in comparison with reference group

SOURCE: 'QUALIDOC', PRAXIS EVALUATIONS-PROGRAMM, SWISSPEP BERN (WWW.SWISSPEP.CH)

Example: DER PRAXISSPIEGEL/DER NETZSPIEGEL–Germany
(Klingenberg, Szecsenyi)

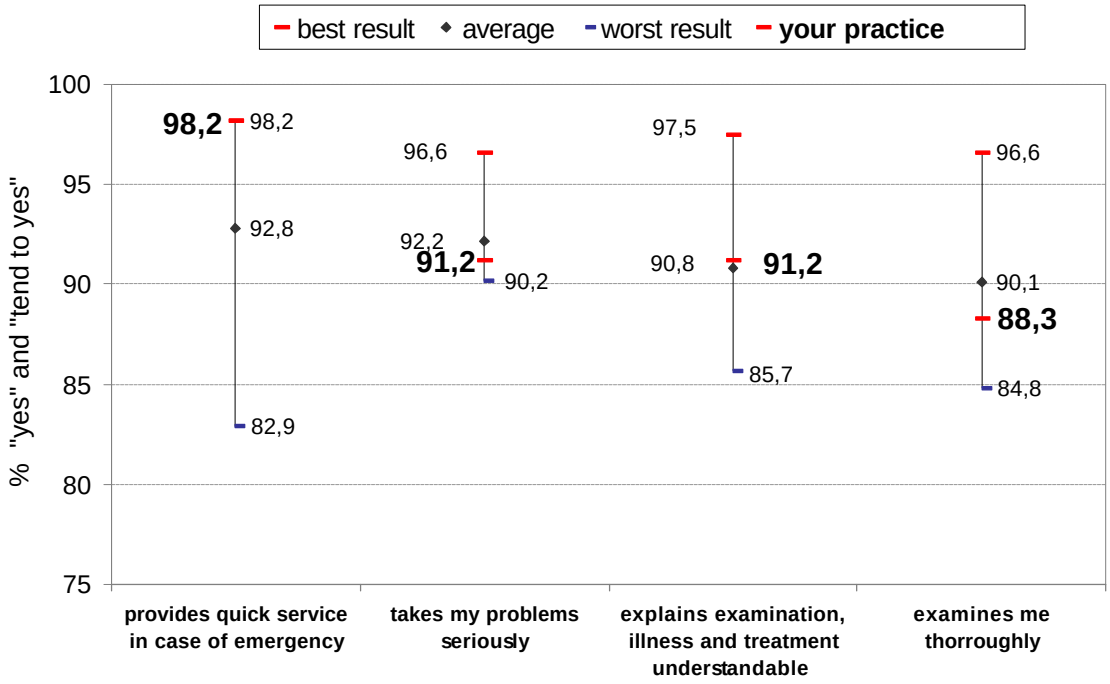
DER PRAXISSPIEGEL is an instrument which was developed on the background of EUROPEP; it was adapted especially to the situation in Germany. It comprises the questionnaire, the organisation of the study and the individual feedback report. DER NETZSPIEGEL is a more comprehensive instrument developed for practice networks (individual practice associations). It focuses also on the interface to specialist and hospital care as well as on general aspects of health care delivery in a certain region.

In the individual feedback report the following aspects are presented on 30 pages:

- Introduction: some general remarks on patient satisfaction
- A table, showing the most important expectations of patients respecting general practice care in Germany (Results of the “Priorities Study” of EUROPEP)
- Explanation on how to interpret the results of the survey
- Figures, showing a comparison of the results of the own practice compared to the average results from all practices, including following data: best result – worst result – average result – result of own practice, (see below).
- Answers of patients to the open questions
- Summary of the results
- References
- Questionnaire

Figure 2: Example from a feedback report of DER PRAXISSPIEGEL

My general practitioner ...



SOURCE: DER PRAXISSPIEGEL AND DER NETZSPIEGEL ARE SERVICE PRODUCTS OF THE INSTITUTE ON APPLIED QUALITY IMPROVEMENT AND RESEARCH IN HEALTH CARE (AQUA), HOSPITALSTRAßE 27, D-37037 GÖTTINGEN.

Example: Feedback Report for Portugal (Ferreira, 2000)

A sample of 4000 patients (40.5% of response rate) was obtained from a survey performed in major urban and rural area. Several feedback reports were built based on four levels of disaggregation: a condensed feedback report for the whole area corresponding to the Regional Health Authority of Lisbon; a report for each of the three sub regions of Lisbon, Santarém and Setúbal; a report for each of the 86 health centres participating in the study; a report, only when specifically asked for, for each of the GPs involved.

The content on each report is the following:

- Descriptive statistics (frequency table and corresponding chart) for each sociodemographic variable;
- A distribution frequency table (with percents) for each of the main 23+2 questions of the EUROPEP questionnaire;
- An aggregated chart with the average values for each of the 23 satisfaction questions;

- An aggregated chart with the average values for each of the five dimensions (relationship & communication, medical care, information & support, continuity & cooperation, and service organisation);
- A distribution frequency chart for each of the five dimensions
- A list of all actual comments that patients gave regarding this level of disaggregation.

SOURCE: PEDRO LOPES FERREIRA, CENTRE FOR HEALTH STUDIES AND RESEARCH, UNIVERSITY OF COIMBRA, PORTUGAL.

Conclusions

Feedback on patients' evaluations of general practice/family practice care to practitioners and managers could be an effective method for quality improvement. The feedback can help to identify opportunities for improvement and it can induce change in general practitioners, as they are probably sensitive to patients' views on the health care provided. A number of issues related to interpretation and use of patients' evaluations of care have been addressed in this chapter. There are so far very few well designed studies which evaluate the actual effects of feedback on patients' views, but such studies are urgently needed.

Box 5: Randomized trial on educational feedback by patients

A randomized trial was performed to assess the effects of written feedback on patients' evaluations of care. In sum 55 general practitioners in the Netherlands participated in this study. GPs in the intervention group obtained a personal, structured feedback report concerning patient satisfaction of their own patients. Reference figures were added together with suggestions for interpretation of this feedback as well as an evidence based overview of factors determining patient satisfaction. Before and after this intervention surveys were done among 100 patients per GP, resulting in samples of 3691 patients before the intervention and 3595 patients after the intervention. Patients' evaluations of nine dimensions of general practice care were measured with the CEP, a previously validated instrument. Multilevel regression analysis showed that, after correction for baseline scores, post intervention satisfaction with most aspects of care did not differ between the groups. The exception was evaluations of continuity of care, which were less positive in the intervention group. The conclusion was that educational feedback by patients as a single strategy may not be powerful enough to induce change.

Source: Vingerhoets E, Wensing M, Grol R. Patients' influence on doctors: a randomized trial on educational feedback by patients. WOK: unpublished report, 2000.

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Appendix

The instruments: translation of EUROPEP in 15 languages

- French
- Danish
- Dutch
- English
- Finnish
- German
- Icelandic
- Israeli
- Norwegian
- Portuguese
- Slovenian
- Spanish
- Swedish
- Swiss: French version
  German version