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FAMILY PRACTICE IN LITHUANIA DURING TEN YEARS OF PRIMARY HEALTH CARE REFORM: TASK PROFILES, JOB SATISFACTION AND PATIENTS’ ATTITUDES

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## CONTENTS

**ABBREVIATIONS**........................................................................................................... 5

**INTRODUCTION**......................................................................................................... 6

1. **AIM AND OBJECTIVES OF THE STUDY** ........................................... 8
   1.1. Aim of the study.................................................................................. 8
   1.2. Objectives of the study................................................................. 8
   1.3. The novelty of the study............................................................... 8
   1.4. Personal contribution to the survey........................................ 9

2. **LITERATURE REVIEW**.............................................................................. 10
   2.1. Primary health care policy and its conception ..................... 10
   2.2. The implementation of primary health care in Lithuania........ 14
      2.2.1. Preconditions to PHC development................................ 14
      2.2.2. Conceptual primary health care reform.......................... 15
      2.2.3. Financial primary health care reform.............................. 16
      2.2.4. Structural primary health care reform............................. 16
   2.3. The importance of the research in primary health care............ 18
   2.4. Evaluations of patients’ attitudes............................................... 19
      2.4.1. Characteristics influencing patients’ satisfaction.......... 21
      2.4.2. Patients’ attitude to different health care aspects.......... 22
      2.4.3. Results of patients’ attitudes surveys in Lithuania.......... 23
   2.5. Family physicians’ surveys regarding their task profiles, job
       satisfaction.......................................................................................... 26
   2.6. Data regarding family physicians’ surveys in Lithuania......... 28

3. **STUDY DESIGN AND METHODS**......................................................... 33
   3.1. District and family physicians’ surveys........................................ 33
   3.2. The patients’ attitudes surveys.................................................... 36
   3.3. Statistical analysis.......................................................................... 39
4. RESULTS ........................................................................................................... 43

4.1. Physicians’ workload and task profiles ......................................................... 43
   4.1.1. Changes in physicians’ workload .............................................................. 43
   4.1.2. The use of equipment ............................................................................. 49
   4.1.3. Involvement in the medical procedures ................................................. 54
   4.1.5. Preventive care ...................................................................................... 61
   4.1.6. Involvement in particular services .......................................................... 66

4.2. Family physicians job satisfaction and their attitudes towards health care in Lithuania .......................................................... 68
   4.2.1. Family physicians’ satisfaction with their job ............................................. 68
   4.2.2. Family physicians’ attitudes regarding health care in Lithuania .................. 73

4.3. Patients’ attitudes ......................................................................................... 84
   4.3.1. Patients attitudes about the different health care aspects in general ................ 84
   4.3.2. Patients attitudes according their different characteristics .............................. 90

5. DISCUSSION ..................................................................................................... 109

5.1. Physicians’ workload and tasks ................................................................. 109
5.2. Family physicians job satisfaction ............................................................... 114
5.3. Patients’ attitudes towards PHC ................................................................. 116

CONCLUSIONS ........................................................................................................ 125

RECOMMENDATIONS ......................................................................................... 127

For PHC policy makers and authorities ............................................................... 127
For future researchers......................................................................................... 128

LIST OF PUBLICATIONS .................................................................................. 129

REFERENCES ..................................................................................................... 131

SUPPLEMENTS .................................................................................................. 146
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMTI</td>
<td>Institute for Biomedical Research of Kaunas University of Medicine (LT)</td>
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<tr>
<td>CME</td>
<td>Continues Medical Education</td>
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<tr>
<td>FM</td>
<td>Family medicine</td>
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<td>GPAS</td>
<td>General Practice Assessment Survey</td>
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<tr>
<td>KMU</td>
<td>Kaunas University of Medicine (LT)</td>
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<tr>
<td>Min</td>
<td>Minimum</td>
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<td>Max</td>
<td>Maximum</td>
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<tr>
<td>NIVEL</td>
<td>Netherlands Institute for Health Services Research, Utrecht (NL)</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>TSF</td>
<td>Territorial Sick Funds</td>
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<td>QUOTE</td>
<td>Quality Of care Through the patients' Eyes</td>
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<td>WHO</td>
<td>World Health Organization</td>
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INTRODUCTION

The primary health care (PHC) institution has a core value in comprehensive health care systems. PHC have been presented as an effective resolution in improving health care since Alma-Ata conference in 1978 [122]. The importance of PHC has been continued by “Health for all in the twenty-first century” policy, based on the integrated family and community oriented PHC, supported by a flexible and responsive hospital system [59]. The importance of PHC was highlighted “more then ever” in World Health Organization (WHO) Health report (2008), because the globalization is putting the social cohesion of many countries under stress, and health systems as well, people are increasingly inpatient with the inability of health services, in addition health care systems should correspond to their needs and expectations [176]. Why PHC is so important? Firstly, it is associated with the better health outcomes. It was proved that primary care system and practice characteristics such as geographic regulation, longitudinally, coordination, and community orientation are improving population health [100]. In addition having more specialists, or higher specialist to population ratios, reflects no advantages in meeting population health needs [142]. Secondly, PHC lower health costs: patients who are visiting the same family physician had a lower total cost for medical care [101]. Thirdly, PHC is related to a greater equity in health [143].

Problems regarding the increasing aging, multimorbidity [155], prevalence of the risk factors may be solved by professionals who have holistic approach, skills in cooperation and communication, are able to guarantee continuity [50]. Regarding the mentioned above, PHC system is very important for the future of our society.

PHC institution was newly presented in Lithuania since the beginning of health care reform. There were introduced conceptual, structural and financial changes in the PHC level [48]. The most similar family physicians functions were provided by contemporary district physicians (i.e. pediatricians and internists). Consequently there were decided to qualify family physicians: some of them were retrained from district physicians and others graduated family medicine residency.

There is no doubt that recent years have been challenging for Lithuanian family medicine institution and family physicians. There were delegated new functions to family physicians: they supposed to provide a wide range of services: children, antenatal, adolescent care; be involved in the treatment of acute and chronic diseases and palliative care. Family physicians were also obligated in provision of preventive services and in patients’ education.
as well. Summarizing family physician was presented as the central figure in the reformed health care system. It was a great challenge for family physicians to cooperate with other medical professionals (medical specialist, social workers, and public health institutions), ensure a gate keeping function and provide patient centered care. Have the mentioned challenges been achieved? Do retrained district physicians and newly developed physicians after family medicine residency provide similar PHC services, what are the workload and organizational aspects of family physicians performance? Doesn’t family physician feel exhausted? On the other hand it was also valuable; to find out the attitudes of the PHC users: are they satisfied with the PHC? These questions need to be answered by researchers, because: (1) the evidence based information provides basis for continues monitoring of ongoing health reform and it is essential for further analytical work; (2) the identification of possible problems are available of which policy-makers need to be aware and require more in-depth analysis; (3) helps to exchange of experiences of reform strategies between policy-makers and analysts in different countries [30, 38].

There were few researchers in Lithuania assessing the ongoing PHC reform [66, 124, and 117]. Therefore there is no data available regarding the changes from the very begging of PHC reform, there is lack of information about the provision of services according family physicians background (retrained form district physicians and physicians after family medicine residency), thier workload and task profiles. In addition, health care quality surveys needs versatile view: the attitudes of users and providers are preferable [179]. Aiming to achieve the missing information has been presented our investigation.
1. Aim and Objectives of the Study

1.1. Aim of the study

To evaluate changes in family physicians’ task profiles and job satisfaction, and to assess patients’ attitudes towards PHC during ten years of PHC reform in Lithuania.

1.2. Objectives of the study

1. To evaluate and compare changes in the workload and task profiles between district and family physicians.
2. To compare family physicians’ job satisfaction and attitudes towards health care and to assess factors influencing their attitudes.
3. To analyze patients’ attitudes towards the performance of PHC settings and their cooperation with the medical staff.

1.3. The novelty of the study

This is the first national study, which evaluates changes in the task profiles of family physicians ten years after the beginning of PHC reform in Lithuania. It provides new information about the differences and similarities in the services of retrained district physicians and physicians after family medicine (FM) residency and assesses the family physicians’ workload as well as physicians’ involvement in various tasks such as treatment of diseases, preventive care, use of medical equipment and provision of medical procedures.

The thesis is the first to evaluate family physicians’ satisfaction at National level: are they happy with new role? It also analyzes possible factors influencing family physicians’ (dis)satisfaction.

The study gives insight into the attitudes of PHC services users, an important indicator of the quality of health care [174]. This survey at national level is exceptional because it combines data from patients and their family physicians. The patient’s attitude survey was a unique survey: the instrument was based on two valid and reliable questionnaires, used widely in number of countries: Quality Of care through the patients’ Eyes (QUOTE) and General Practice Assessment Survey (GPAS) [136]. The patients’ survey instrument was designed in accordance with the latest recommendations: the different health care aspects (performance, family physician, community nurse and health care in general) were measured using rating
Therefore the impact of different characteristics towards patients’ attitudes was assessed – and this adds to the novelty of our survey.

The study results may be helpful for the policy makers, stakeholders and researchers as well. The continuity and follow up of changes at PHC level, revealed important aspects of the positive and negative sides of the PHC reform and may be the basis for the future policy. According to the study findings some practical recommendations may be presented, e.g. how to increase family physicians’ work satisfaction. It is the hope that the methodology, study design and instruments of the survey may be useful for future of PHC research.

1.4. Personal contribution to the survey

The main idea, study instruments and methodology of the survey were presented by prof. I. Misevičienė, prof. W.G.W. Boerma, prof. L. Valius, doc. Ž. Milašauskienė. Personal contribution to the survey was presented since 2004 in family physician and patients’ surveys. The family physicians survey in 2004 was organized in Kaunas University of Medicine (KMU), family medicine department with the help of prof. L. Valius. I was responsible for the preparation of the questionnaires, survey coordination. I also participated in patients’ survey, which was provided by Institute for Biomedical Research of Kaunas University of Medicine (BMTI); in some of the PHC centers I was interviewing the patients.

The study in both of the surveys was provided in collaboration with Netherlands Institute for Health Services Research, Utrecht (NL) (NIVEL).
2. LITERATURE REVIEW

2.1. Primary health care policy and its conception

Governments are searching for ways to: (1) improve health status of the population and the equity of health status distribution across the population; (2) ensure fairness in the financing of health care, with expenditure reflecting patients’ ability to pay rather than their risk of illness; (3) guarantee the responsiveness of health care systems (respect for dignity, confidentiality, autonomy of the patients) [186]. According to that, PHC have been presented as an effective resolution in improving health care. PHC in Alma-Ata conference (1978) was defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” [122]. All the governments were called at this conference to develop and implement PHC throughout the world and particularly in developing countries, to formulate national policies, strategies and plans of action to launch and sustain PHC as part of a comprehensive national health system and in coordination with other sectors [175].

It was also admitted that PHC and health promotion are strikingly similar in their conception and evolution; originally conceived as global strategies to reduce inequities in health between and within nations and emphasizing intersectional and community action, both have tended to be reduced to a more limited and technical approach to selected diseases within nations [10]. That PHC was always alongside the health promotion and this was proved by Ottawa Charter (1986) and Ljubljana Charter (1996), Bangkok Charter (2005). In Ottawa Charter (1986) was revealed the exceptional importance of PHC in building healthy public policy and creating supportive environment [184]. The Charter positioned health not as an end in itself but as a “resource for living” and primary care should be positioned as part of an overall strategy for health promotion, disease prevention and population health [36]. In Ljubljana Charter on Reforming Health Care (1996) was sta-
ted that health systems needs to be oriented towards PHC: “reforms, with PHC as a philosophy, should ensure that health services at all levels protect and promote health, improve the quality of life, prevent and treat diseases, rehabilitate patients and care for the suffering and terminally ill; they should reinforce joint decision-making by the patient and care provider and promote the comprehensiveness and continuity of care within their specific cultural environments” [99].

As a consequence of the changes in the global context for health promotion since the development of the Ottawa Charter, the Bangkok Charter has been presented in 2005. Some critical factors are highlighted: increasing inequalities within and between countries; new patterns of consumption and communication; commercialization; global environmental change, and urbanization [147]. The required actions were to: “advocate for health based on human rights and solidarity; invest in sustainable policies, actions and infrastructure to address the determinants of health; build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy; regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people; partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions” [147].

In the Health for all in the 21st century framework (1998) was stated: “by the year 2010, people in the region should have much better access to family and community oriented PHC, supported by a flexible and responsive hospital system”, in particular: “ (1) at least 90% of countries should have comprehensive PHC services, ensuring continuity of care through efficient and cost-effective system of referral to, and feedback from, secondary and tertiary services; (2) at least 90% of countries should have family physicians and nurses working at the core of this integrated PHC service, using multiprofessional teams from the health, social and other sectors and involving local communities; (3) at least 90% of countries should have health services that ensure individuals’ participation and recognizes and supports people as producers of health care” [127]. In 2005 Health for all policy framework for the WHO European Region was updated; it reviewed and reaffirmed the previous update made in 1998 and is known as Health21, and incorporated the knowledge and experiences that have been accumulated since then. “The 2005 update upholds and reinforces the values, basic principles, coverage and vision of Health21. Specifically, it reiterates the following key principles underpinning the framework: (1) the ultimate goal of health policy is to achieve the full health potential of everyone, (2) closing the health gap between and within countries (i.e.
solidarity) is essential for public health in the Region, (3) people’s participation is crucial for health development, (4) health development can be achieved only through multisectoral strategies and intersectional investments that address health determinants, (5) every sector of society is accountable for the health impact of its own activities. In particular, the update addresses Health21’s call to “provide up-to-date evidence-based tools that countries can use to turn policies based THE HEALTH FOR ALL POLICY FRAMEWORK FOR THE WHO EUROPEAN REGION on health for all into action” [150].

Another important event for PHC policy was the international Conference, which was dedicated to the 30th anniversary of the Alma-Ata on Primary Health Care in 2008. Some conclusions and recommendations are summarized as follows [176]:

- too few countries have fully adopted PHC, countries should take action to strengthen their health systems based on the values and principles of PHC;
- countries should ensure strong community (society, community leaders, in particular young people) involvement in PHC;
- integrated models of PHC which include preventive, promotive and primary care are the best models to deliver holistic and people-centered services and should be adapted to the specific needs and resources of individual countries;
- human resources development is a key challenge in ensuring the delivery of quality services at all levels: strong emphasis on people-centered approaches and capacity to work with other sectors;
- PHC is essential to achieve the Millennium Development Goals [156];
- direct payment for services remains a major obstacle to achieving universal access, countries should commit to developing health financing methods that ensure universal health protection and avoid direct payment at point of access to services;
- Ministries of Health have critical leadership roles in directing and overseeing the changes necessary to establish and sustain PHC-based health systems, this includes continuous dialogue with the health workforce and engaging with other sectors, including local government, in defining their roles in intersectional action for health;
- countries should develop information systems that can monitor and measure the development and impact of health systems based on PHC; also they should make increase investment in health systems research.
In 2008 WHO Health report the PHC importance was highlighted “more than ever”, because: (1) globalization is putting the social cohesion of many countries under stress, and health systems; (2) people are increasingly inpatient with the inability of health services to deliver levels of national coverage that meet stated demands and changing needs, and with their failure to provide services in ways that correspond to their expectations; (3) health systems need to respond better and faster [176].

Summarizing the previously mentioned statements we should agree with the importance of PHC. Furthermore in countries in transition PHC can be viewed as “a strategy to integrate all aspects of health services” [165]. The available evidence demonstrates some advantages for health systems that rely relatively more on PHC and general practice in comparison with systems more based on specialist care in terms of better population health outcomes, improved equity, access and continuity and lower costs [6].

According to the discussion above, there is no doubt about the need of PHC. Though the following attributes of PHC should be mentioned [185, 181]:

- general: the unselected health care problems are managed regardless certain categories of the population: gender, age, social class, ethnicity, religion; it must be easily accessible;
- continues: the health care is patient-centered, based on relationship between the patient and the doctor, covering individuals’ health care longitudinally;
- comprehensive (integrated): provision of health promotion, disease prevention, curative care, rehabilitation, physical and psychological and social support to individuals;
- coordinated: family physician should ensure appropriate and timely referral of the patient to specialist services, the family physician should inform about possible HC services and be able to coordinate it; family physician as a gatekeeper;
- collaborative: family physicians should be able to work with other medical, health and social care providers, delegating to them the care of their patients; they should contribute to and participate in multidisciplinary care team and must be prepared to exercise leadership of the team; family physician ability working in team;
- family oriented: family practice addresses the health problems of individuals in the context of their family circumstances, their social and cultural networks;
- community oriented: the patient’s problems should be seen in the context of his/her life in the local community; the family doctor
should be aware of health needs of the population living in this community;

- personal: PHC should be primarily person-centered, rather than disease-centered; it is based on the personal relationship between the patient and the doctor;
- holistic: health problems of individuals, families and the community should be considered from the physical, psychological and social perspectives;
- accessible: easy access to PHC services with a minimum delay; this access should be ensured as well on geographical and cultural terms and not be affected by financial factors.

The mentioned attributes of PHC and its central figure – family physician have been also presented in Lithuania health policy.

2.2. The implementation of primary health care in Lithuania

2.2.1. Preconditions to PHC development

In 1990 Lithuania declared the independence from USSR. Since then, enormous changes have been started in Lithuanian policy. The need of health care reform was obvious, because Soviet health care system was:

- disease centered and hospital – based [66];
- unequal: contemporary studies demonstrated unequal health status in different urbanization areas and socio-economic groups [97]. Other important issue was unequal access of the health care: hospitals and ambulatory centers have been located in large cities or towns, not in the rural areas: the accessibility differed according urbanization area;
- inefficient and monopolistic financing system: it was based on Semashko model, all the expenses were covered from the central budged [24,95];
- duplicated medical services: there were no separation of the primary, secondary and tertiary health care levels and there were no gatekeeping function [154];
- lack of continuity and holistic approach: family medicine institution didn’t exist. The health care for the children was provided by pediatricians and internal medicine care doctors took care with the adults [37];
- health system was separated: there were no intersectional action to achieve better outcomes for population [46];
• private medicine didn’t exist: there was no competition between health care providers [154].

As the result of all the mentioned problems above, the old Soviet health policy came on a deadlock condition: it led to high mortality and morbidity of Lithuanian population [97]. Massive changes had to be started in National level with the purpose to achieve better health outcomes in Lithuanian society. It was obvious that new health programs had to be orientated towards disease prevention instead of concentrating on disease treatment. Generalizing PHC reform process it is useful to divide it into three categories: conceptual, financial and structural reforms [48].

2.2.2. Conceptual primary health care reform

Contemporary collaboration of medical professionals with WHO even under Soviet regime were considered very important in the origin of new health policy ideology which was based on „health for all“ conception [48]. The Lithuanian health care reform picked up the steam with the adoption of National health system conception in 1991. Several important goals should be mentioned:
• to recognize family medicine institution;
• to restructure and decentralize health care sector;
• to achieve intersectional collaboration;
• to inform and involve entire society in decision making;
• to concentrate on health promotion and disease prevention;
• to ensure the qualitative and accessible health services;
• to present private practice.

The mentioned goals were also reflected in National health program, which legislative basis obtained just in 1998 [96]. The exceptional importance to the implementation of health reform had “Bureau of health care reform”, “Council of National health” and international cooperation. Unfortunately there were many factors; those obstructed the process of health reform [47]:
• traditions from previous health care model, inflexibility and resistance of the medical profession;
• the alternation in Government, delayed legislation of health care conception;
• the absence of chronology;
• lack of intersectional coordination and cooperation;
• poor economical status.
In 1991–1992 departments of Family Medicine were established and family medicine residency program was created in two Lithuanian universities (dept. of Family Medicine of Kaunas University of Medicine and Training Center of General Practitioners of Vilnius University): family physicians had to take district internists’ and pediatricians’ place. In 1996 the Lithuanian College of General Practitioners was established, which in 1999 became a full member of World Organization of Family doctors. In 1997 a scientific journal for general practitioners was first published. PHC development strategy has been mapped out for 1996–2005. In 1996–1997, the general practitioner’s role, including gate – keeping function and operational service standards were set for general practitioners, and the functions of general nurses were defined.

2.2.3. Financial primary health care reform

The reform was impossible without changes in financing system. The new concepts of payment systems were based on German and Great Britain models [26]. The payment system is based on social insurance; it is centralized and depends on government indicated fees. Law on Social insurance was approved in 1991, starting nationwide development of statutory social insurance. The social insurance was administrated by National Social Insurance Agency, which budget was separated from the central one. The next step was the recognition of the obligatory insurance: Health Insurance Law approved in 1996: all the Lithuanian residents had to be insured. The State and Territorial Sickness Funds (TSF) have been established. In 1997 majority of by- laws related to Health Insurance Law approved, more then 50% of residents became registered with PHC institutions. The payment system was elaborated during the health care reform [89]:

- from 1997 the payment system was based on capitation fee;
- from 1998 additional payment according the patients’ age groups and from 1999 additional payment for the residents in rural areas;
- from 2000 the mix payment system was presented: capitation fee, additional fee for stimulant services (ex.: preventive services) and beneficent healthcare outcomes (timely diagnostic of cancer).

2.2.4. Structural primary health care reform

All forms of decentralization have been carried out in the health system reform process in Lithuania. Small PHC settings in different urbanization levels had to take place instead of huge ambulatory centers and guarantee equal access to the PHC. There were inadequate numbers of PHC centers in
the beginning of the reform. The private system existence was very poor. The reform policy was to increase the activity of private sector in Lithuania. The biggest support for implementing private practice was received from “PHARE” program, financial support of the World Bank in 2000. Total number of PHC centers there were 160 in 1998 (public – 152, private – 8), respectively there were 322 PHC centers in year 2003 (public – 198, private – 124). The amount of PHC settings increased 2.4 times during 10 years of the health system reform, therefore private sector increased in 34 times [89].

The private PHC settings are independent contractors with TSF: patients don’t have to pay for the defined PHC services, the expenses are covered by social insurance. According National Health program family physicians until 2005 had to take place instead of district physicians in PHC level. After ten years of HC reform family physicians covered 66 percent of the population [89].

The changes in PHC structural reform in 2002–2006 and some prediction for 2008 was confirmed by Plieskis et al., using data from the compulsory health insurance system. The following results were presented: “share of private PHC institutions, the persons enrolled with them, and visits in such institutions from all PHC institutions during the study period have significantly statistically increased (average annual changes were 6.9%, 22.2%, and 27.2%, respectively) for 2002–2006 period. In 2008, this part would make up 61.0%, 30.6%, and 27.2%, respectively. The proportion of persons registered with family physicians and the number of visits to family physicians were significantly increasing (average annual changes were 22.5% and 27.2%, respectively). It is predicted that this part would make up 27.8% and 35.2% in 2008. More detailed analysis has shown that relatively more young and working-age persons (aged 18–44 years) were enrolled in private PHC institutions. It is in particular evident in Vilnius and Kaunas where the choice of such institutions is high. The number of persons registered with family doctors was increasing in both private and public institutions (average annual changes were 22.5% and 8.3%, respectively; p ≤ 0.05). In private institutions, the proportion of persons registered with local district pediatricians was also significantly increasing. The study results have shown significant differences in the developments of primary health care in 2002–2006 by various indicators. The objective defined in the strategy of restructuring will be achieved in 2008 only in respect of the number of institutions. Assessing by the aspect of services, the results achieved will be approximately two times lower. The practice of the institution of the family doctor is becoming more intensive in both private and public institutions [117].
In conclusion, the system of family medicine in Lithuania nowadays is based on the following basic elements: segment of health care system, providers (family physicians, community nurses), family medicine as academic and clinical discipline, and research in PHC that is only making first steps. Though there are a lot of problems in the system:

1. Lack of family physicians: not all of physicians after family medicine residency graduates are practicing family medicine (almost 30% of them after graduating of retraining returns to district doctor practice) [159].
2. Family medicine is not based on a team work: lack of general practice nurses, social workers, psychologists [159].
3. Family medicine is not oriented to community: free choice of family physician disrupted communities especially in the cities [159].
4. Family physicians do not operate in full professional competence range [124].
5. Family physicians are not fully invested into preventive programs and health promotion in the community [157].
6. There is no enough stimulation to perform quality and/or comprehensive services by family physicians (as appropriate fee for service) [158].
7. Family physicians and other PHC service providers are overloaded by paper work – to 60% of daily working time physicians spend on paper works [158].
8. The problems of financing: unequal financing for different PHC sectors (public and private), inappropriate financing for services (the same service is valued differently according the health care level) [191].
9. The incomplete separation of primary and secondary levels [159].
10. The stagnant contemplation of society: lack of involvement in self health care [116].

2.3. The importance of the research in primary health care

PHC research as a part of the health system, presents a wide range of topics: epidemiology of common PHC problems; effectiveness of diagnoses and treatment; methods to improve the process of PHC (including team development; integration of community), the relevance of evidence based medicine and treatment guidelines for PHC patients with multiple problems; determinants of patient and physician satisfaction in PHC and etc. [168].
The research related to PHC quality assurance have an exceptional importance in countries in transition (Lithuania as well). Family medicine after disintegration of Soviet Union was presented as newly institution in such countries. It is valuable to compare the main changes in PHC sector during HC reforms and to assess the performance of PHC [180]. It is impossible to transfer and adopt a certain Western example of PHC system in countries in transition, because: (1) every country is specific with its own social standards; (2) there is a gap in PHC systems between the Western and European countries [12]. According to the mentioned above, the policy makers and stakeholders should find their own consensus how to improve PHC quality. And the quality of care improvement starts from underlying health care evaluation. Patients, family physicians, community nurses, stakeholders, policy makers may consider different PHC dimensions: equity (services are provided to all who require them); accessibility (ready access to services is ensured); acceptability (care meets the expectations of those who use the services); appropriateness (required care is provided, unnecessary of harmful care is avoided); comprehensiveness (care provision covers all aspects of diseases management from prevention to rehabilitation, psychosocial aspects of care are considered); effectiveness (care produces positive change in the health status or quality of life of the patient); efficiency (high quality care is provided at the lowest possible cost) [183, 181].

The PHC as a research object in Lithuania was presented during the first years of health care reform and became more popular in the recent years. There were (and still are) different target groups for investigation in PHC: patients, providers and others (research based on statistical data and etc.). Most of the research was related to evaluation of PHC quality.

2.4. Evaluations of patients’ attitudes

Looking back twenty years ago from Donabedian health care quality assessment and following with WHO recommendations in nowadays the importance of patients’ views surveys (including patient satisfaction surveys) are indisputable [174]. Firstly, patient satisfaction is a paramount importance with respect to quality assurance [28, 136 and 137]. Secondly, patients’ attitudes are very important in decision making. Studies show, that patients, professionals and authorities may have completely different notions of good quality care [41]. Smith and Armstrong carried out the study with the aim to see whether patients' criteria of good health care in general practice were different from those of the government and doctors: the
criteria originated by patients (“having a doctor who listens”, “having a doctor who sorts out problems”, “usually seeing the same doctor”) scored significantly more highly than those originated by government (such as “health education”, “being able to change doctor easily”, “well decorated and convenient premises”) [139]. Other researchers also proved that patients’ attitudes may differ from the health care services providers opinion [179] and in some cases patients family attitude may be very important and it also need to be measured [107]. Jung et al. revealed that patients put more emphasis then family physicians on the availability and accessibility of general practice care (“same physician each visit”, “easy to speak to physician by phone”, “appointment within a short time”), on specific services (“health checks available”, “accept alternative treatment”) and on communication (“tell all about illness”, “explain in detail”, “enough time to listen and explain”); whereas family physicians have their own interests with respect to workload, time and practice management [73]. Thirdly, patient satisfaction is regarded as an outcome of care in itself and is one of the major contributors towards better patient compliance leading to better clinical outcomes [145]. Other researchers also proved that patients’ trust in their physician correlates to adherence of physician's advice and improved health status [13, 132]. In observational cohort study by Stewart et al. was reflected that positive patients’ perceptions were associated with better recovery from their discomfort and concern, better emotional health two months later, and fewer diagnostic tests and referrals [145].

Some authors in comprehensive literature review identified three purposes for patient satisfaction measures: (1) to describe healthcare services from patient perspective; (2) to identify problem areas in healthcare organizations; (3) to evaluate healthcare and generate ideas for solution [135].

Therefore there are some common problems evaluating patients’ attitudes in research. A lot of surveys have been provided assessing health care quality from the patient perspectives. Rivkin and Bush reveals some reasons, why patients satisfaction is so problematic: (a) satisfaction is very individual and subjective; (b) patients’ personal evaluation and expectations makes a huge influence on satisfaction with the health care services (e.g. the health care quality may be evaluated incorrectly in a positive way, if patients’ have low needs); (c) depends on the outcome of health care services; (d) personal health care might be evaluated differently for the general health care [128]. The mentioned above is a great challenge to the researchers with the respect to find most sensitive technique and trial method with the purpose to achieve most reliable and valid data [53, 110]. Some metaanalyses confirmed the vulnerably side of the patient satisfaction
surveys: usually they didn’t meet standards of conceptual or methodological rigor and were not designed to facilitate quality improvement efforts; the surveys results were difficult to interpret or were subjective [20, 130].

2.4.1. Characteristics influencing patients’ satisfaction

The review of the literature showed that some patient characteristics have significant associations with the preferences for PHC [74.]. Age and economic status also education, health status, family situation, gender and utilization of HC significantly related to patients preferences. Lower educated, older, poorer health status reflects to most positive satisfaction [131]. Patients with poorer health status, disabled, those who have psychological tension effects negatively heir satisfaction with the HC services [22, 49, 61, 113, 169].

Age is also important to the patients’ evaluations. Older patients tend to evaluate HC more positive [25]. Some authors relate this to the lower expectations of older patients [2].

Income status and gender in relation with satisfaction is ambiguous [25]. The impact of social participation, trust and miniaturization of community on patient satisfaction with PHC was assessed in National survey in Sweden. Low levels of trust and miniaturization of community may enhance non – specific patient dissatisfaction, such as experience of lack of openness by the patient.

There were some relations with patients’ evaluations and family physicians’ age and gender. Some interesting findings were in Fang et al. survey: female physicians are more likely then male in PHC, because they were more active in preventive services [32]. The lower level of satisfaction was related with increasing age of family physicians’ [9].

Patients’ attitudes differ according their education: lower educated prefer continuity of care, to solve personal problems, give greater prefer to home visits in the case of serious illness and drug prescription, have paternalistic view. Higher educated placed a greater emphasis on self referral to specialist, desired more active participation in the treatment, show higher information seeking, they prefer prevention services as well [74].

Patients preferences according their economical status: higher economical status give greater preference to self referral, want more consultation by phone, for annual preventive services as well/ lower economic status give greater preference to prescription of drugs, prefer continuity of care [74].

Utilization of health care services: patients lower utilization of health care, have a greater preference for self referral, for drug prescription, involvement in decisions; patients with higher utility of services have a higher
preference for help and advice with regard to smoking cessation, to have a same physician for every visit, prefer the doctor who make home visiting and is able to consult on phone [74].

PHC setting characteristics were also important for patients’ evaluations. Private PHC was assessed more positively than public ones in Poland [90]. Patients favor small practices and full-time family physicians in western EU countries. Patients more positive evaluations were associated with fewer family physicians in the practice, except for quick services [173]. The patients prefer smaller practices, non-training practices and practices that had personal list system was proved in the survey of Baker: larger services, which provide a wider range of services don’t lead to a decline in patient satisfaction [8]. If more patients were booked in the appointment system per hour, satisfaction with the perceived length of consultations fell [9].

Practices with a higher numbers of care providers received less positive patient evaluations. Other practice characteristics were not related with patients’ evaluations. Only a small proportion of the total variation in patient evaluations of accessibility and co-ordination (1.8%) was explained by characteristics of the general practice organizations. General practices have become larger in most developed countries in recent years, but patients seemed to prefer general practice organizations with fewer health professionals [171].

2.4.2. Patients’ attitude to different health care aspects

Some surveys revealed that assessments of health care should be very careful if it is based on older patients’ view, because it was proved that older patients in primary care didn’t distinguish between technical quality of care and other quality related aspects [126].

Patients in different countries with different health care systems may have common view. It was proved in EUROPEP survey. Aspects that got a highest ranking in all the countries were related to doctor-patient communication and accessibility of the services. Aspects that were preferred most were: getting enough time during consultation, quick services in emergencies, confidentiality of information, telling patients all they want to know about their illness, making patients feel free to talk about problems, family doctors attending courses regularly and offering preventive services [54].

Values concerning respectfulness are seen as more important than service aspects such as waiting time was also proved in another international survey using QUOTE questionnaire [52]. Patient satisfaction is associated with the continuity, especially for high clinic users [108]. Which aspects of care have
been used in foreign studies on patients’ priorities with regard to PHC? The most often included aspects were: uninformativeness, humanness, and competency/accuracy. The most important aspects in different of the studies were: humanness, competency/accuracy, patients’ involvement in decisions, time for care, other aspects of availability and accessibility, informativeness, exploring patients’ needs [172].

It is important to measure some aspects in an appropriate time. The results of the study provide evidence that care coordination is more closely related to global ratings of primary care over several visits than are qualities of care experienced at a current visit, where communication is the most salient predictor. This finding suggests that ratings of health care quality for a specific visit are distinct from ratings of care over the past year, and that both types of ratings may be needed to adequately assess the range of core topics relevant to patient satisfaction [3].

2.4.3. Results of patients’ attitudes surveys in Lithuania

The patients (or citizens) attitude surveys started to be carried out in Lithuania in very beginning of health care reform. According to systematic literature analyses were selected 19 reviews [94]. “The amount of the surveys increased during health care reform. Most of the studies – cross sectional, common samples were: random, random – systematic and stratified samples (strata according patients age, gender, urbanization, PHC settings’ type: private or public). The mean sample size of national surveys were 1800 (SD ± 1685), with the response rate 65.6% (SD ± 7). Comparing the analogical data in foreign literature analyses, the median of the sample size in Lithuania is 1002, in foreign surveys – 260 and response rate in Lithuania 66.6% (varied from 56.4% to 74.4%), in foreign literature -76% (varied from 20% to100%) [74]. Most of the study instruments were designed by surveys’ researchers, just in a few studies the questionnaires were adopted from the foreign countries (Williams questionnaire) or it was a part of international projects (EUROPEP, WHO, FINBALT). The questionnaires usually were handed out in PHC settings (39%), also the citizens have been questioned at home (28%), less popular were mailed (22%) and other surveys (11%, e.g. in labor exchange office). In foreign surveys as in our country, the most frequent survey method was the hand out of a written questionnaire (39%). The mail surveys are more popular in Lithuania (10% in foreign countries), though the interviews by phone are more popular in foreign countries (16%) (were no such surveys in our country) [74]. Most frequent answers to the questions were categorical; few surveys used Likert scale and ranking technique. The open ended questions were used less
frequent. The statistical analyses were based on descriptive statistic, student t test, chi square, correlation, logistic regression, factor analyses. The data usually was analyzed considering these sociodemographic characteristics: gender, age, education and employment status; though income, family and health status were less popular.

The targets of the studies may be grouped into five common PHC quality dimensions: accessibility, doctor-patient communication, primary health care performance, provision of information, organizational peculiarities. After careful analyses of all the 19 reviews, it is possible to conclude that the most frequently analyzed dimensions were: accessibility, doctor-patient communication and evaluation of PHC.

Assessing the accessibility, the patients were often asked to evaluate waiting times, financial access, the distance, opportunity to have a consultation by phone. The respondents with poor health status, older age, lower educational and those who use public PHC services and live in the cities and towns indicated long waiting time to see their family physician. Telephone consultations were rare. The patients from big cities, private PHC centers and with higher education evaluated the distance of PHC centers positively. Financial access most favorable assessed of the patients with a higher education and good health. The patients were dissatisfied with long waiting times to see their family physician (above 20 min.).

Patient – physician communication was assessed as patients' possibility to participate in health care process, attention and appropriate time provided by physician, humanity of health care personal and respect of privacy. Most of the patients were satisfied with the attention and information provided by family physicians. Additionally, patients would like to discuss their personal problems and they need more information on side effects of the medications. The most acceptable model to cooperate with the health care providers was based on partnership.

The satisfaction with the PHC is increasing during health care reform. Most favorable are services provided in private PHC settings. More critical in this respect are younger and higher educated patients.

The organizational aspects of PHC services were rarely evaluated. Most of the respondents have been questioned about the premises, medical equipment.

The type of PHC centre (private, public), urbanization level (city, town and rural area), patients’ education, age, frequency of utility of health care services determined patients’ evaluations. The similar tendencies are seen in foreign surveys. Patients with higher education, better income, good health and younger age opinion usually contradict to the opposite groups of the patients (e.g. older, lower educated and etc.) [74]. Despite the mentioned above, it is obvious there is a lack of reliable information about the perfor-
mance of PHC services and health care providers. There are a lot of aspects, which requires attention of the researchers. Assessing accessibility, there is a lack of information about home visits (frequency, reasons), the accessibility of services in acute cases. There is a gap about the services provided by the community nurses. Additionally would be interesting to study patients’ evaluations on health care services such as: prevention, medical procedures and disease treatment. Assessing Lithuanian surveys regarding patients evaluations on PHC, it is possible to conclude that most of them are based on patients reports rather ratings; and on patients satisfaction rather their expectations or preferences. Also there is a lack of information about the studies’ validity and reliability properties.

After ten years of health care reform in Lithuania, the evaluation of PHC have a new tendency – some researches started to investigate an attitude of specific patients’ groups such as adolescents, unemployed. The survey assessing adolescent satisfaction with the PHC revealed the correlation between lower satisfaction and bigger patients’ flow; higher satisfaction was related to better cooperation with family physician, ensured confidentiality [69]. The interesting finding was presented assessing the quality of unemployed people: just one forth of them visit their family physician if they have some health problems and more then half of them take care about themselves, two thirds evaluated positively their health care [141].

More attention of researchers was related to patient’s rights and their information. The survey of pregnant women views on their rights to the health information revealed that pregnant women are better informed if their health care were provided by family physician rather by midwife and obstetrician, though quarter of them were not informed about the natural feeding, baby care, family planning [81].

Summarizing, we may conclude the exceptional importance of patients’ attitudes surveys. Lots of such surveys have been carried out using different techniques and methods aiming to reveal patients attitudes regarding PHC in international level and Lithuania as well. There is no doubt that patient views help to assess the quality of the services. Therefore patients’ attitudes surveys reflect the needs and preferences of the patients according their different characteristics.

Our patients’ attitude survey in 2004 is based on the mentioned principles and this is why it has an exceptional importance.
2.5. Family physicians’ surveys regarding their task profiles, job satisfaction

The main role of PHC is attributed to family physician. Wonca summarized general practitioners/family physicians’ definition as follows: “(1) primarily responsible for providing comprehensive HC to every individual seeking medical care, and arranging for other health personnel to provide services if necessary; (2) cares for the individual in the context of the family, and the family in the context of community, irrespective of race, culture or social class; (3) is clinically competent to provide the greater part of care, taking into account the cultural, socioeconomic and psychosocial background, in addition takes personal responsibility for providing comprehensive and continuing care; (4) exercises his/her professional role by providing care either directly to patients or through the services of others according to the health needs and recourses available within the community he/she serves” [182].

The previously stated definition of family physician obligates the scientists to evaluate family physicians from very different points of view. There are very interesting and important surveys held in international levels. The exceptional importance regarding the mentioned topics has an international study of variation in the tasks of general practitioners presented by Boerma WGW [12]. The survey gives an opportunity to compare PHC systems and the services provided by family physicians in Western (the PHC was experienced for many years) and Eastern (the PHC was newly presented) Europe. Assessing family physicians in Western Europe, they reported significantly greater involvement as doctors of first contact, in the application of medical techniques, in screening for blood cholesterol and in pediatric prevention. The weakest activities in task profiles were found among doctors in the former Soviet Union [12].

Primary care in healthcare systems is an important factor for the development and implementation of new approaches to manage and coordinate chronic conditions. Øvretveit et al. analysis supports the notion that countries with a strong primary care system tend to develop more comprehensive models to manage and coordinate chronic conditions [109].

The family physician is responsible for the performance of preventive services. The surveys revealed that delivery of preventive health services is lacking [104]. Yarnall et al. explain it with limited time of physicians: physicians spent over half their time taking histories and only 20% on health education; further, they spent almost no time addressing nutrition (2.7% of total time), exercise (2.0% of time), or smoking (1.3% of time) [65]. The services physicians address can be affected by patient factors (e.g., patient
motivation, health literacy), physician factors (e.g., knowledge of guidelines, outcome expectations that addressing behavior will improve patient health), and systems factors (e.g., reimbursement, time) [16, 166]. Pollak et al. in their survey reflected that preventive visits were longer than chronic care visits. Older and new patients required more time from physicians. Services on which physicians spent relatively more time were prostate specific antigen, cholesterol, Papanicolaou (Pap) smear, mammography, exercise counseling, and blood pressure. Physicians spent less time on tobacco cessation and Pap smear (in preventive visits), and nutrition counseling. The authors agreed that future research is needed to understand how physicians decide how to allocate their time to address preventive health.

Another important group of surveys were related to family physicians’ job satisfaction. The “job satisfaction” concept covers the individual attitudes, emotional stress and burnout, job motivation, healthy work environment, abilities for changes in organizational level and etc. Unfortunately, it has been increasingly recognized that family physicians are suffering from occupational stress [120]. The term burnout has come to mean emotional exhaustion, depersonalization, and a perceived lack of personal accomplishment. These findings encouraged the researches to find the reasons for occupational stress work dissatisfaction as well. Family physicians stressors by Lee et al. were grouped to several levels: personal (personality traits and the need to balance family and career), occupational, challenging patients, high workload, time limitations, competency issues, challenges of documentation and practice management, and changing roles within the workplace and health care system levels (limited resources, imposed rules and regulations, lack of support from specialists, feeling undervalued, and financial concerns) [91].

Another group of surveys were directed toward family physicians work improvement, e.g. some researchers suggested to improve patients visit efficiency using patient flow analyses and they proved that is an effective technique to identify inefficiencies in the patient visit and efficiently collect patient flow data [121].

Regarding our survey topic, the most important are the findings regarding evaluation of family physicians in Lithuania. These surveys should be described more in detail.
2.6. Data regarding family physicians’ surveys in Lithuania

The changes in the role of family physician during the reform were assessed by Jankauskienè (since 1999-2006) and Raila (since 1999–2001). Jankauskienè performed a comparative analysis of health policy and results of 2 sociological investigations by surveying family physicians in randomly selected Lithuanian public and private PHC institutions in 1999 and in 2006. The following conclusions were presented: “…legal basis for family doctor’s institution has been provided. The restructuring of health care institutions has been started by giving the priority to the institution of family doctor, which fulfills more functions and have the greatest number of patients (69% of population in 2006). The reasons hindering private practice have changed: in 1999 these reasons were characterized as uncertain future of the specialty, unfavorable financing, insufficient information on general practice. In 2006, the main reasons were described as insufficient financing and self-confidence. Both family doctors in public and private institutions have negative opinion in assessing health care reform, while they are satisfied with their professional practice. The mentioned above indicate that corrections in reform management are needed.” [68]. Raila analyzed family physicians activity and factors influencing it, compared physicians work according their background in urban and rural areas, public and private PHC centers. The results revealed that physicians during health reform are better provided with medical equipment, their clinical activity and scope of services became wider. Family physicians working in rural areas send fewer patients to consult to specialists, were more willing to use their equipment, and provided a wider range of clinical activity in ophthalmology, surgery, gynecology, neurology vs. urban family physicians. Family physicians in private PHC centers provide wider scope of services. The family physicians after FM were more involved in treatment of neurological diseases and gynecology, while those who were retrained from internists or pediatricians were more involved in surgery. The study results detected, that the cooperation with gynecologists, surgeons and other secondary levels specialists had an adverse effect on the extent of family physicians clinical activity. The availability of consultants is linked with the scope of clinical activity of family physicians – the longer the patient has to wait for a specialist – the wider is the scope of activity of a family physicians. A wider range of clinical activity is covered by those family physicians, who often participate in scientific conferences. Family physicians salary is directly related to the scope of their clinical activity – those receiving a higher salary – provide a wider scope of services [124].

There were a lot of other different surveys assessing family physicians during PHC reform. The recent studies should be more discussed. The
survey carried out in Klaipeda PHC centers investigated whether there were differences in referrals rates from different Lithuanian PHC models (rural state-owned family medicine practices, urban privately owned family medicine practices, state-owned polyclinics and privately owned polyclinics). The authors concluded that family medicine practices located in rural, but not in urban areas had significantly lower referral rates to specialized health care; gate keeping had an effect on the referral pattern with respect to co-morbidity level, so that those with a physician referral were more likely to have had higher co-morbidity [190].

The abilities to diagnose and treat mental disorders by family physicians were evaluated by Milašauskienė. It has been established that primary care centre is the place, where most mentally distresses people seek help, the treatment and follow up of these patients are problematic due to high workloads, lack of time to communicate with the patients, insufficient skills and knowledge in recognizing and treating mental illness; the ways to improve community mental health it is necessary to improve the socioeconomic situation, develop intersectional collaboration, promote mental illness prevention program [106].

According to the description of the family physicians’ professional norm, they should provide pregnant woman’s health care. Vanagienė et al. compared the quality of healthcare services provided by family physicians and by the obstetrician of pregnant women. The findings showed statistical significant differences, that pregnant women there were better informed and happier with the services provided by obstetrician rather by family physicians [161]. Though the authors (despite the mentioned findings) concluded that improving the weak sides of the services, family physicians are able to provide healthcare for pregnant women.

There were few surveys regarding the preventive services in PHC. Vaisvalavičius et al. assessed the control of overweight patients in PHC [157, 85]. There were assessed the level of giving advice on diet and physical activity by health care specialist, the possibilities of weight control in PHC applying the minimal intervention. Family physicians were not very active in advising overweight persons to change dietary habits and to increase physical activity: only every fourth obese man and every third obese women were advised to decrease body weight by a doctor, physicians more frequently advises those who assessed their health as poor. The authors concluded that minimal interventions helps to reduce body weight as well as other risk factors of chronic disease therefore it is beneficial to control of obesity in the community. There is an obvious need to enhance the role of family physicians in obesity control by developing their promotion skills and increasing motivation for preventive activities [157].
Armonaitė concluded in her thesis, that family physicians together with community nurses may reduce the risk factors of non-communicable diseases, by informing and teaching their patients about healthier lifestyle and providing their regular services (monitoring blood pressure, cholesterol level) [5]. Similar findings were of Andrijauskas, who evaluated the impact of PHC team activities in prevention and healthy nutrition of population in rural area. The main findings confirmed that PHC team is able to improve patients’ attitude towards their healthier lifestyle, to correct some risk factors of non-communicable diseases [4]. The benefit of prevention services in PHC was also proved by the survey carried out by Aukštakalniienė; the information provided by family physician about blood pressure and physical activity make an impact on the blood pressure management [7]. Gečaitė and Starkuvienė questioned the patients about the use of prevention services in PHC settings: most of the patients agreed that prevention related to non-communicable diseases is useful for them and family physicians provide this type of services [40]. Some surveys results regarding preventive services in PHC may be controversial. There were questioned the parents of the schoolchildren’ in Alytus schools, and the results showed that parents’ lack of prevention and health promotion of their children, they prefer health care services of their children at schools [146].

One of the most important factors in family physician and community nurse work – to provide information to the patients and to teach them health lifestyle and living. Buinovskienė et al. evaluated the knowledge of family physicians’ and community nurses’ about the breastfeeding; unfortunately just about half of them knew that breastfeeding till the 6 months old children is sufficient. Other knowledge related to breastfeeding was also unsatisfactory [15].

The confidentiality of sexual and reproductive health care of adolescent in PHC was assessed by Jaruševičienė et al. The study revealed the organizational problems (absence of private gynecological assessment for adolescents, lack of confidentiality during the consultation and patient’s documents safety) which negatively influence on the sexual and reproductive health care of adolescent [69].

Stress of family physicians and community nurses at work was assessed by Kalibatas et al. revealed that emotional distress is more common between the family physicians who are dissatisfied with their job and those who have inefficient payment [44]. The psychosomatic and emotional symptoms were noticed significantly higher between community nurses’ rather family physicians. The most negative factors to family physicians emotional status were additional working hours and inefficient payment for community nurses [79].
The analyses of factors influencing the motivation and quality of work of family physicians showed: that doctors who had longer duration of practice more frequently answered that such factors like satisfaction by job, good relation with patients, possibility to improve qualification, financial guarantees for the future, good conditions of work had much bigger influence for their job motivation as compare with doctors’ group who had less duration in practice; most of family physicians thought that the main reason decreasing the quality of work is related with overload in paperwork [43]. The motivation of family physicians was also assessed in Vladičkienė thesis. Almost two thirds of family physicians had motivation to their work: and with the increasing age job motivation statistically significantly was decreasing; there were statistically significant associations among level of work motivation and some professional and socioeconomic factors (future guarantee, interesting work, additional payment). Just half of the respondents were satisfied with their profession, and more then two thirds were dissatisfied with inefficient payment and overload in paperwork [164]. Vanagas and Bihari-Axelsson affirm that Lithuanians family physicians have high patients load and are at risk of stress, they have high job demands and low decision latitude. Older family physicians perceive less strain, lower job demands and higher decision latitude in case of low patient load, though the younger pones decision latitude has week associations to patient load. Regarding to the changes in patient load younger family physicians perceive it more sensitively as changes in job demands [160].

Darulis et al. assessed the usage of computer in family physicians’ practice. Half of the respondents used a computer; the most frequent users were middle aged family physicians of (statistically significant finding), most of the family physicians’ indicated the need of computer use in their practice; the most limits for computer use were explained as insufficient computer literacy, lack of motivation and time [27].

Pečiūra et al. analyzed the spatial accessibility of PHC services. The survey was exceptional with newly presented methodology: the methods of the study were geometrical modeling and applied graphics used for the quantitative determination of the ratios between the total zone area of the accessible PHC institutions and the area of the respective municipal territory. The proposed technique of the evaluation of the spatial accessibility of PHC services may be valuable in solving the problems of the development of PHC institutions primarily in the rural regions of Lithuania. The quantitative expression of the evaluation could be used in decision-making related to investments into the development of the PHC institution network in different administrational units of the country [114].
Summarizing the paragraph we have data about the provision of PHC services by family physicians, some factors influencing their job satisfaction. Unfortunately, there is lack of the data about family physicians’ attitude regarding the ongoing health care, we miss evidence about the other possible factors influencing physicians’ attitude (regarding physicians’ activity in different services, their working environment and etc.). We must admit that most of the surveys regarding family physicians provision of health care were instantaneous and we miss evidence about the changes in PHC during health care reform. Regarding the mentioned above our family physician survey in 2004 is able to answer to the mentioned questions.
3. STUDY DESIGN AND METHODS

Physicians’ survey was provided twice: in 1994 it was carried out with NIVEL and BMTI and in year 2004 with NIVEL and Family medicine department of KMU. Patients’ attitudes survey was carried out with NIVEL and BMTI in 2004. The study may be divided into three cross-sectional surveys and all of them have been implemented in a national level:

- district physicians’ survey in 1994;
- family physicians’ survey in 2004;
- patients’ survey in 2004.

3.1. District and family physicians’ surveys

**Study design.** The district physicians’ questionnaire survey was done in 1994. The district physicians were: internists (physicians who took care with the adults) and pediatricians (physicians who took care with the children till 18 years old). Contemporary district physicians’ were most related to PHC physicians’ role. The district physicians usually were the first contact physicians, followed up with the chronic diseases, provided home visits, took care with the patients on their list and etc. As the result of the PHC reform, it was decided to retrain district physicians’ into family physicians. Additionally family physicians were educated in Kaunas and Vilnius medical universities in FM residency since the beginning of PHC reform. There were three types of family physicians according their background in 2004: former internists, former pediatricians (i.e.: retrained district physicians), and physicians who graduated FM residency. Obviously, it was interesting to compare the changes in the task profiles between district physicians’ (1994) and former district physicians (2004), as well with the family physicians in 2004 according their background (former internists, former pediatricians and physicians after FM residency).

According to the mentioned above, another questionnaire survey was repeated in national level in 2004. Family physicians have been questioned using the same questionnaire as in 1994. The questionnaires in both of the studies were sent by mail. In 2004 survey the family physicians have been questioned by phone prior the mailing of the letter. They were informed about the aim of the study and were invited to participate in the survey. If the physician agreed to participate, the questionnaire had been sent to him. Additionally we were asking about the possibility to question their patients listed on his/her list.
Sampling procedure of district physicians’ survey in 1994. The sampling procedure was based on random sample in pre-selected regions according to the urbanization area: cities (Vilnius, Kaunas, Klaipėda, Panevėžys, Šiauliai) and particular districts (Varėna, Utena, Trakai, Alytus, Kaišadoriai, Kretinga, Prienai, Šilalė, Telšiai, Anykščiai, Kupiškis, Pasvalys, Akmenė, Joniškis, Mažeikiai). The district physicians were sampled in selected regions from the list of medical staff of polyclinics or health centers. In total 595 district physicians (pediatricians 232 and internists - 363) took part in the survey with the response rate – 87%.

Sampling procedure of family physicians’ survey in 2004. A computerized stratified random sampling was draw using the list of the Territorial Sick Funds (TSF) in 2004. Unfortunately, there were no available data on the distribution of family physician according their employment in private or public PHC centers. So family physicians were selected according their distribution in different Lithuanian regions (Table 3.1.1). The selected family physicians have almost the same proportion in percentages comparing to the data of TSF. In 2004 sample size was calculated using EpiInfo 2000 Statcalc software which argued the sample size of 328 family physicians with the 95% confidence level. Total number of respondents were 316 with response rate – 96.3%, due to intensive follow up (before the survey every practitioner was asked to participate in the study by phone).

Table 3.1.1. The distribution of family physicians according their gender in the different regions of Lithuania

<table>
<thead>
<tr>
<th>Region</th>
<th>Data from TSF (man/woman)</th>
<th>Data from TSF</th>
<th>Survey sample (man/woman)</th>
<th>Survey sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Vilnius</td>
<td>458 (57/401)</td>
<td>23.5 (12.5/87.5)</td>
<td>72 (11/61)</td>
<td>22.8 (15.3/84.7)</td>
</tr>
<tr>
<td>Kaunas</td>
<td>575 (72/503)</td>
<td>29.5 (12.5/87.5)</td>
<td>78 (9/69)</td>
<td>24.7 (11.5/88.5)</td>
</tr>
<tr>
<td>Klaipėda</td>
<td>217 (27/190)</td>
<td>11.1 (12.5/87.5)</td>
<td>49 (11/38)</td>
<td>15.5 (22.5/77.5)</td>
</tr>
<tr>
<td>Marijampolė</td>
<td>84 (12/72)</td>
<td>4.3 (14.3/85.7)</td>
<td>11 (2/9)</td>
<td>3.5 (18.1/81.9)</td>
</tr>
<tr>
<td>Alytus</td>
<td>93 (19/74)</td>
<td>4.8 (20.4/79.6)</td>
<td>15 (4/11)</td>
<td>4.7 (26.7/73.3)</td>
</tr>
<tr>
<td>Panevėžys</td>
<td>141 (19/122)</td>
<td>7.3 (13.5/86.6)</td>
<td>27 (3/24)</td>
<td>8.5 (11.1/88.9)</td>
</tr>
<tr>
<td>Šiauliai</td>
<td>179 (34/145)</td>
<td>9.2 (19.0/81.0)</td>
<td>28 (4/23)</td>
<td>8.9 (14.3/85.7)</td>
</tr>
<tr>
<td>Tauragė</td>
<td>51 (12/39)</td>
<td>2.6 (23.5/76.5)</td>
<td>15 (2/13)</td>
<td>4.7 (13.3/86.7)</td>
</tr>
<tr>
<td>Telšiai</td>
<td>76 (20/56)</td>
<td>3.9 (26.3/73.7)</td>
<td>11 (3/8)</td>
<td>3.5 (27.3/72.7)</td>
</tr>
<tr>
<td>Utena</td>
<td>73 (15/58)</td>
<td>3.8 (20.1/79.9)</td>
<td>10 (0/11)</td>
<td>3.2 (0/100)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1947 (287/1660)</strong></td>
<td><strong>100 (14.7/85.3)</strong></td>
<td><strong>316 (49/267)</strong></td>
<td><strong>100 (15.5/84.5)</strong></td>
</tr>
</tbody>
</table>
More detail information about the respondents in 1994 and 2004 surveys is reflected in Figure 3.1.1. There were 595 total number of district doctors in 1994 survey: 40% (232) were pediatricians and 60% (363) were internists. There were 316 questionnaires of family physicians in 2004 survey; therefore 6 of them have been eliminated (more than half of the questions were not answered). So 310 total number of family physicians’ were included in 2004 survey; they were grouped according family physicians’ background to: former pediatricians 16.8% (52), former internists – 60% (186), physicians after FM residency – 23.2% (72).

Figure 3.1.1. Physicians’ surveys samples in 1994 and in 2004

Physicians’ study instrument. The same questionnaire has been used for district and family physicians. The questionnaire was developed in NIVEL with the aim – to detect the differences in task provision between general practitioners and was used in international survey [12]. The questionnaire was in English language and the translation took place in successive steps. Backward-forward translations were produced under the responsibility of BMTI and KMU. Later it was compared with independent translations, made by official translators in the Netherlands, coordinated by NIVEL. There were some discrepancies in the translation detected. So the discussion between researchers (NIVEL, BMTI and KMU) was provided and the common solution was presented. There were following sections in the questionnaire:

- physicians’ personal information (age, gender, workload and qualification items);
- practice information (availability and acceptability aspects; organizational structure);
• provision of medical-technical procedures;
• activity in acute and chronic disease management;
• fulfillment in screening and preventive care;
• job satisfaction.

Respondents were asked to answer on four-point scale ranging from “(almost) always” to “seldom/never” indicating the extent to which specific health problems were presented to them and the extent to which specific therapeutic interventions were made by them. The fourth area concerned prevention: involvement in screening for hypertension, blood cholesterol, cervical cancer, as well as giving health education was measured by means of other types of questions. The answers have been dichotomized, distinguishing between preventive approaches and more incidental approaches. Involvement in health education was measured as prevention when special sessions were providing to deal with nutrition habits, smoking cessation and alcohol consumption.

The questionnaire in the second survey was supplemented with the series questions about Lithuanian family physicians opinion on current health care and their position on it.

3.2. The patients’ attitudes surveys

Study design. According to literature recommendations it is very important to assess health care from different point of view: users, providers and stakeholders [139]. This came up to the idea to use a parallel survey in 2004 and evaluate patients’ attitudes. The patients’ attitudes were measured by the questionnaire which was presented by NIVEL researchers. The anonymous questionnaire was used with the aim – to evaluate patients’ views about their family physician, community nurse, PHC setting and health care in general. The patients have been questioned in PHC settings. To ensure higher response rate and objectivity questionnaire were handed out by the trained observers from KMU in each selected family practice. All the patients were informed about the purpose of the study, anonymity and possibility of refusing to participate. They were asked to fill in the questionnaire during waiting time before the consultation of their family physician. It was decided to group the patients according a list of a particular family physician’s in different PHC settings. PHC settings have been selected according urbanization level (city, town, rural area) and PHC centers’ type (private, public). So at the same time two surveys (patients and family physicians) supplemented each other in 2004. There was a great outcome: the researches got a
possibility to compare patients’ views according different characteristics: patients, family physicians and PHC settings as well (Figure 3.2.1).

* – the 30 patients were questioned from the selected physicians’ list.

**Figure 3.2.1. The patients’ survey design in 2004**

**Sample size of patients’ attitudes survey in 2004.** The selected patients sample was 3000. The selected number of family physicians was 328. According to the sampling of family physicians, there was a needed to question 30 patients from selected physician’s list in different 10 Lithuanian regions (10 regions. sample size – 3000, so 300 patients from each of the region). In order to obtain representative data stratified random sample of different PHC centers have been selected. In selected regions of Lithuania PHC practices were stratified according to the area of urbanization (larger cities. towns. and rural areas) and the practice type (private and public). The selection of practice and family physicians was made using national data of Lithuanian health information centre. Selected practices and each questionnaire had got a unique code, which was written in the questionnaire by the field worker. The patient survey started with the pilot study in Šiauliai region. The pilot study didn’t reveal any limitations to continue the survey in national level [105].

Patients have been questioned in the PHC centers before family physicians consultation by independent researchers. Each patient was purposely selected according the particular family physicians’ list and was personally asked to fill up the questionnaire. The purpose of the study was explained and the anonymity was guaranteed. For older people the questioners were read and explained if the patient asked for it. The response rate was 89%. The patients who disagreed to participate in the study or didn’t return the questionnaire were included to the no respondents group. The total number of respondents were 2670, though 41 questionnaires have been eliminated because there were unfilled more then 50% of the answers), so the total number were 2629.

**Patients’ attitudes questionnaire.** The questionnaire was developed by NIVEL experts and BMTI researchers of the project. Part of the questions has been derived from existing instruments, such as the QUOTE and the GPAS [136]. Backward – forward translations were produced under the responsibility of KMU. Later it was compared with independent translations
made by official translators in the Netherlands, coordinated by NIVEL. Some questions about evaluation of PHC have been supplemented by BMTI researchers. The questionnaire was divided into different sections:

- evaluation of PHC setting (availability, accessibility and organization items);
- cooperation with family physician (relation and communication, provision of relevant information, health care items);
- cooperation with community nurse (relation and communication, provision of relevant information);
- evaluation of PHC in general;
- personal information (age, gender, employment, and education level as well as utilizations frequency of family physician within last 12 month).

There were used a 5-point Likert scale with the answers labeled “yes”, “rather yes”, “do not know”, “rather no”, and “no”.

**Measurements of reliability and validity of patients’ view questionnaire.** The psychometric properties of the instrument have been measured. The internal reliability (also internal consistency) of the patients’ attitude questionnaire was evaluated using the Cronbach’s alpha coefficient. It is required that this coefficient would be not less than 0.7 for good internal scale consistency [55]. With the exception of the two domains (cooperation and health care), all Cronbach’s alpha coefficients were above the 0.7 criteria suggested for group comparisons, and these scales indicate excellent internal consistency (Table 3.2.1). The Cronbach’s alpha of the cooperation and health care domains were alpha=0.618 and alpha=0.551 respectively.
Table 3.2.1. The measurement of internal reliability for different domains of patients’ attitudes questionnaire

<table>
<thead>
<tr>
<th>Domains</th>
<th>N of items</th>
<th>Cronbach’s alpha</th>
<th>Range of Cronbach’s alphas if individual items deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total scale</td>
<td>43</td>
<td>0.842</td>
<td>0.832–0.859</td>
</tr>
<tr>
<td>Total scale without “negative” items</td>
<td>38</td>
<td>0.887</td>
<td>0.881–0.891</td>
</tr>
<tr>
<td>PHC centre</td>
<td>9</td>
<td>0.723</td>
<td>0.686–0.723</td>
</tr>
<tr>
<td>Family physician</td>
<td>16</td>
<td>0.880</td>
<td>0.868–0.879</td>
</tr>
<tr>
<td>General practice nurse</td>
<td>4</td>
<td>0.835</td>
<td>0.733–0.820</td>
</tr>
<tr>
<td>Cooperation</td>
<td>5</td>
<td>0.618</td>
<td>0.500–0.646</td>
</tr>
<tr>
<td>Health care</td>
<td>4</td>
<td>0.551</td>
<td>0.326–0.619</td>
</tr>
</tbody>
</table>

The convergent and discriminant validity were also measured. Each item should be more correlated to its own scale (convergent validity) than to the other scales (discriminant validity) and our results satisfy previously mentioned condition (Table 3.2.2.).

Table 3.2.2. The inter-item correlation between different domains of patients’ questionnaire

<table>
<thead>
<tr>
<th>Domains related to</th>
<th>Convergent Validity</th>
<th>Discriminant Validity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean r*</td>
<td>Min</td>
</tr>
<tr>
<td>PHC center</td>
<td>0.236</td>
<td>0.025</td>
</tr>
<tr>
<td>Family physician</td>
<td>0.349</td>
<td>0.150</td>
</tr>
<tr>
<td>General practice nurse</td>
<td>0.574</td>
<td>0.492</td>
</tr>
<tr>
<td>Cooperation</td>
<td>0.271</td>
<td>0.152</td>
</tr>
<tr>
<td>Health care</td>
<td>0.257</td>
<td>0.111</td>
</tr>
</tbody>
</table>

r* – correlation.

3.3. Statistical analysis

Statistical data analysis was performed using two main software packages: SPSS 13.0 for Windows and STATISTICA 8. Different statistical methods and grouping of variables for following objectives were used.
Family physicians workload and task profiles. The mean values of the qualitative variables were compared between two (ex. internists in 1994 and internists in 2004) and three (former internists, former pediatricians and family physicians after FM residency) groups of the respondents. For qualitative variables we used Chi square test. In addition the differences between various groups were performed Z test. For quantitative variables (age, working hours) the hypothesis concerning normal distribution was checked using Kolmagorov Smirnov test. The normality was denied, so two independent samples were compared using Mann Whitney test and three samples – Kruskal-Wallis test.

Family physicians’ job satisfaction. Family physicians satisfaction with their job and health care was measured using several statistical methods. Family physicians expressed their attitude using 6 statements regarding their job satisfaction and 10 statements regarding their opinion about the health care. There was used 5 point Likert scale with following categories: “strongly agree”, “agree”, “rather agree and rather disagree”, “rather disagree” and “disagree”. Family physicians job satisfaction was compared during PHC reform between district and former district physicians. Family physicians attitudes about the health care were also compared according family physicians background in 2004. The descriptive statistics was used: there were summarized median and percentiles. The differences between the mentioned groups were investigated using non-parametric tests: Mann-Whitney test (for two unrelated samples) and Kruskal-Wallis test (for three samples).

The satisfaction with the job and the health care between family physicians were analyzed. Firstly, aiming to reveal physician satisfaction there were described depended variables: family physicians who agreed with the statements (“strongly agree” conjoint with “agree”) and physicians who had other opinion (conjoint three groups of the answers: “rather agree and rather disagree”, “rather disagree” and “disagree”). The series qualitative and quantitative independent variables were selected from family physicians questionnaire and they were dichotomized. The qualitative variables were: family physicians age (younger 49/ older 50 years old), gender (male/ female), qualification type (after FM residency and those who were retrained), urbanization (urban/ rural conjoint with towns), PHC centre type (private/public), working type (working in solo practice/ together with other physicians). Physicians’ ability to work with an appointment schema were grouped into two categories: “working without appointment” (all non acute patients or less then half of the patients visit family physician without early appointment), “working with appointment” (all non acute patients or
more then half of the patients visit family physician with early appointment). Face to face meetings with other family physicians, specialists, pharmacists, social workers were grouped into “non frequent meetings” (rare or never and less then 3 times a year) and “frequent meetings” (every 1–3 months and more then once a month). Family physicians involvement in health education (regarding smoking, eating, alcohol consumption) as well their activity in other services (routine antenatal care, immunization of children, children care till 4 years old, consultations about family planning, homeopathic medicine) were divided into two categories as: “involved” and “uninvolved”.

There were selected series quantitative variables such as physicians’ number of working hours in main and additional positions, patients’ number on the list, patients’ number on the office per day, number of home visits per day, number of consultations by phone and number of hours for CME.

Secondly, possible relations between dependent and independent variables were analyzed. For this reasons two main statistical tests have been used: for quantitative data – Mann-Whitney test and for qualitative – Chi square test; value $p \leq 0.05$ were considered as statistical significant.

Thirdly, the logistic regression model was used to measure the likelihood that family physicians attitude will be influenced by different characteristics. For this reason, all the independent variables were dichotomized. The grouping of qualitative variables was discussed above. Therefore the quantitative variables were divided into two groups according their distribution in the sample: below and above the median. Most of the quantitative variables such as number of working hours in main and additional positions, patients’ number on the list, patients’ number on the office per day, number of home visits per day, number of consultations by phone and number of hours for CME were dichotomized into two groups: "low” and “high” (e.g. low number of patients on the list and high number of the patients on the list).

**Patient’s attitudes.** Main characteristics of the patients’ sample are presented in the Table 3.3.1. Patients’ attitudes towards PHC performance, health care, family physician and community nurse were measured using descriptive statistics. The patients’ attitudes were compared according 7 different characteristics: age, gender, employment status, education, frequency of services use, PHC centre type (private, public) and urbanization area (city, town, rural area). Likert scale answers were grouped into two groups: “yes” with “rather yes” and “no” with “rather no” with “don’t know”. The Chi square was used to reveal the statistical differences and $p \leq 0.05$ was considered as statistical significant. The Z test was used to detect statistically significant differences between groups.
Patients’ satisfaction according different family physicians characteristics (workload, gender, age and etc.) were also compared. Due to study design and specifically coding of family physicians and patients questionnaires, we could select 30 patients of particular physician. Secondly, we selected the questions indicating patients’ satisfaction with the family physicians and PHC from patients’ questionnaires. The answers were scored according Likert scale into two groups: “satisfied” and “dissatisfied”. After statistical analyses, majority of the patients were satisfied with all the statements. Further analyses aiming to compare the patient's satisfaction between “satisfied” and “dissatisfied” groups was impossible.

**Table 3.3.1. Characteristics of the patients’ sample (absolute numbers, valid percentages)**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Percentage (absolute numbers) Total n=2629</th>
<th>Characteristics</th>
<th>Percentage (absolute numbers) Total n=2629</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC centre type:</td>
<td></td>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>65.9 (1718)</td>
<td>Man</td>
<td>32.9 (865)</td>
</tr>
<tr>
<td>Private</td>
<td>34.1 (911)</td>
<td>Woman</td>
<td>67.1 (1764)</td>
</tr>
<tr>
<td>Urbanization:</td>
<td></td>
<td>Frequency of services use:</td>
<td></td>
</tr>
<tr>
<td>Cities</td>
<td>44.7 (1174)</td>
<td>Rare</td>
<td>23.7 (624)</td>
</tr>
<tr>
<td>Towns</td>
<td>40.3 (1059)</td>
<td>Moderate</td>
<td>31.6 (830)</td>
</tr>
<tr>
<td>Rural areas</td>
<td>15.0 (396)</td>
<td>Usually</td>
<td>44.7 (1175)</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td>Employment status:</td>
<td></td>
</tr>
<tr>
<td>Till 25</td>
<td>12.7 (335)</td>
<td>Employed</td>
<td>48.5 (1275)</td>
</tr>
<tr>
<td>24–49</td>
<td>45.6 (1197)</td>
<td>Students</td>
<td>9.4 (247)</td>
</tr>
<tr>
<td>50–59</td>
<td>16.5 (435)</td>
<td>Unemployed</td>
<td>9.1 (245)</td>
</tr>
<tr>
<td>60–(–69)</td>
<td>15.1 (397)</td>
<td>Disable</td>
<td>6.2 (169)</td>
</tr>
<tr>
<td>Above 70</td>
<td>10.1 (265)</td>
<td>Housewife</td>
<td>5.8 (157)</td>
</tr>
<tr>
<td>Employment status:</td>
<td></td>
<td>Retired</td>
<td>21.0 (536)</td>
</tr>
<tr>
<td>Education:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>10.4 (274)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary school</td>
<td>40.0 (1051)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>20.1 (529)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. RESULTS

4.1. Physicians’ workload and task profiles

4.1.1. Changes in physicians’ workload

Family physicians workload according their background in 2004 is reflected in the Table 4.1.1.1. The comparison of workload between former pediatricians (2004) and pediatricians’ (1994) as well as the former internists (2004) and internists (1994) are presented in the Tables 4.1.1.2–4.1.1.3.

Median number of family physicians total working hours per week in 2004 were 58: working hours in main position – 40 and in additional – 18. In 2004 physicians’ median number of CME hours per month was 10. The statistically significant changes have been noticed during PHC reform: the working hours in main position increased between former internists and internists, while working hours in additional position increased between former pediatricians and pediatricians. Hours for CME hours were lower between former internist and internists ($p \leq 0.05$).

Median number of patients on the list was 1600 in 2004. During the health care reform, number of patients increased between former pediatricians, while between former internists decreased. Comparing the situation between physicians in 2004, the lowest number of the patients had family physicians’ after FM residency ($p \leq 0.05$). Median number of patients in the office per day was 25 in 2004; comparing to the year 1994 the number of consultations increased 1.6 times ($p \leq 0.05$). The highest number of visits in the office per day had former district doctors, therefore family physicians after FM residency had the lowest ones ($p \leq 0.05$).

Number of home visits decreased after 10 years between former internists and internists and was highest between former pediatricians ($p \leq 0.05$). Median number of consultations by phone was 5 per day in 2004 and was highest between former district doctors vs. those who graduated FM residency ($p \leq 0.05$). In addition number of consultations by phone statistically increased in 2004: former pediatricians and former internists used them more often then pediatricians and internists in 1994.
Table 4.1.1. Family physicians' workload according their background in 2004

<table>
<thead>
<tr>
<th>Items related to family physicians’ workload</th>
<th>Former pediatricians (n=52 (16.8%))</th>
<th>Former internists (n=186 (60%))</th>
<th>After FM residency (n=72 (23.2%))</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working hours in main position per week</td>
<td>Median 40, P_{25}, P_{75} 35, 40</td>
<td>Median 40, P_{25}, P_{75} 36, 40</td>
<td>Median 40, P_{25}, P_{75} 35, 40</td>
<td>0.54</td>
</tr>
<tr>
<td>Working hours in additional position per week</td>
<td>20, 15.5, 24</td>
<td>17.8, 12, 20</td>
<td>15, 10, 21</td>
<td>0.2</td>
</tr>
<tr>
<td>Hours for CME per month</td>
<td>Median 10, P_{25}, P_{75} 8, 10</td>
<td>Median 10, P_{25}, P_{75} 8, 20</td>
<td>Median 10, P_{25}, P_{75} 8, 20</td>
<td>0.98</td>
</tr>
<tr>
<td>Number of patients on the list</td>
<td>Median 1500, P_{25}, P_{75} 1120, 1900</td>
<td>Median 1800, P_{25}, P_{75} 1500, 2000</td>
<td>Median 1100*, P_{25}, P_{75} 725, 1500</td>
<td>0.00</td>
</tr>
<tr>
<td>Number of patients in the office per day</td>
<td>Median 25, P_{25}, P_{75} 20, 30</td>
<td>Median 25, P_{25}, P_{75} 20, 30</td>
<td>Median 20***, P_{25}, P_{75} 16, 25</td>
<td>0.00</td>
</tr>
<tr>
<td>Number of home visits per day</td>
<td>Median 4**, P_{25}, P_{75} 2, 5</td>
<td>Median 2, P_{25}, P_{75} 2, 3</td>
<td>Median 2***, P_{25}, P_{75} 1, 3</td>
<td>0.00</td>
</tr>
<tr>
<td>Consultations by phone per day</td>
<td>Median 5, P_{25}, P_{75} 2, 6, 3</td>
<td>Median 5, P_{25}, P_{75} 3, 6</td>
<td>Median 3.5*, P_{25}, P_{75} 2, 5</td>
<td>0.01</td>
</tr>
</tbody>
</table>

P_{25} = 25^{th} percentiles; P_{75} = 75^{th} percentiles; p ≤ 0.05 – * statistical significant difference between physicians after FM residency and former internists; p ≤ 0.05 – ** statistical significant difference between former pediatricians and former internists; p ≤ 0.05 – *** statistical significant difference between physicians after FM residency and former district doctors.
Table 4.1.1.2. The comparison of workload between internists and former internists (1994–2004)

<table>
<thead>
<tr>
<th>Items related to family physicians’ workload</th>
<th>Internists, 1994 (n=363)</th>
<th>Former internists, 2004 (n=186)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>P_{25}, P_{75}</td>
<td>Median</td>
</tr>
<tr>
<td>Working hours in main position per week</td>
<td>38 *</td>
<td>32, 40</td>
<td>40</td>
</tr>
<tr>
<td>Working hours in additional position per week</td>
<td>15</td>
<td>10, 20</td>
<td>17.8</td>
</tr>
<tr>
<td>Hours for CME per month</td>
<td>18.5*</td>
<td>10, 25.3</td>
<td>10</td>
</tr>
<tr>
<td>Number of patients on the list</td>
<td>1912*</td>
<td>1721, 2175</td>
<td>1800</td>
</tr>
<tr>
<td>Number of patients in the office per day</td>
<td>16*</td>
<td>13, 19</td>
<td>25</td>
</tr>
<tr>
<td>Number of home visits per day</td>
<td>2.8*</td>
<td>2, 4</td>
<td>2</td>
</tr>
<tr>
<td>Consultations by phone per day</td>
<td>3*</td>
<td>2, 4</td>
<td>5</td>
</tr>
</tbody>
</table>

P_{25} – 25^{th} percentiles; P_{75th} – 75^{th} percentiles; p ≤ 0.05 – * statistical significant difference between internists and former internists.
Table 4.1.1.3. The comparison of workload between pediatricians and former pediatricians (1994–2004)

<table>
<thead>
<tr>
<th>Items related to family physicians’ workload</th>
<th>Pediatricians, 1994 (n=232)</th>
<th>Former pediatricians, 2004 (n=52)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>P_{25}, P_{75}</td>
<td>Median</td>
</tr>
<tr>
<td>Working hours in main position per week</td>
<td>38</td>
<td>34, 40</td>
<td>40</td>
</tr>
<tr>
<td>Working hours in additional position per week</td>
<td>12*</td>
<td>9, 19</td>
<td>20</td>
</tr>
<tr>
<td>Hours for CME per month</td>
<td>12</td>
<td>8, 22.3</td>
<td>10</td>
</tr>
<tr>
<td>Number of patients on the list</td>
<td>739*</td>
<td>630, 830</td>
<td>1500</td>
</tr>
<tr>
<td>Number of patients in the office per day</td>
<td>15*</td>
<td>12, 17</td>
<td>25</td>
</tr>
<tr>
<td>Number of home visits per day</td>
<td>5*</td>
<td>4, 6</td>
<td>4</td>
</tr>
<tr>
<td>Consultations by phone per day</td>
<td>3*</td>
<td>2, 5</td>
<td>5</td>
</tr>
</tbody>
</table>

P_{25} – 25th percentiles; P_{75} – 75th percentiles; p ≤ 0.05 – * statistical significant difference between pediatricians and former pediatricians.
Family physicians were asked to assess some organizational aspects: working on the appointment schema, possibility of pre-registration and reflect their assistance by laboratory workers, community and register nurses. The results reflected, that most of the family physicians were using pre-registration in 2004: 63.5% of respondents noted that all or more then half of non acute cases were pre-registered. Comparing to the situation in 1994, patients’ pre-registration between districts physicians were significantly less popular then in 2004 between retrained district physicians (Figure 4.1.1.1).

![Graph showing comparison between district and former district physicians in 1994–2004 (%)](image)

- $p \leq 0.05$ – * statistical significant difference between pediatricians and former pediatricians; $p \leq 0.05$ – ** statistical significant difference between internists and former internists.

**Figure 4.1.1. Working with pre-registration schema in PHC centers: the comparison between district and former district physicians in 1994–2004 (%)**

Comparing the use of early pre-registration according family physicians background in 2004, there were no significant differences detected (the pre-
registration schema was used in all of the non acute cases by former pediatricians – 23.1%, by former internists – 32.2%, by physicians after FM residency – 30.6%; more then half of the patients were pre-registered – 28.8%, 30.6%, 43.1%; less then half of the patients were pre-registered – 23.1%, 15.3%, 13.9%; idn’t work with pre-registration at all – 25%, 21.9%, 12.5% respectively).

Most of family physicians were assisted by register (79.8%), community nurses (99%) and laboratory workers (74.1%) in 2004. There were no significant differences regarding the assistance and family physicians background in 2004. Few significant differences during health care reform were detected: former pediatricians in 2004 were more frequently assisted by laboratory workers (90.3%) then ten years ago (69.2%). The opposite situation was between internists and former internists: assistance by laboratory workers in 1994 were – 94.5% and in 2004 – 78.9%, p ≤ 0.05. The assistance by community nurse between internists in 1994 were 98.3% and in 2004 – 98.9% (p = 0.59); between pediatricians – 98.1% and former pediatricians – 99.1% (p = 0.51). The assistance by register nurse between the internists in 1994 were 74% and in 2004 – 80.4% (p = 0.09); between pediatricians – 78.8% and former pediatricians – 77.1% (p =0.79).

The respondents also have been questioned about the frequency of face to face meetings with the other family physicians, medical specialists, pharmacists and social workers. Most frequent meetings (at least more then once a month) in 2004 were with family physicians (72.8%), less frequently with other medical specialists (50.8%) and pharmacists (49%) and least frequently with the social workers (16.4%). Evaluating the frequency of the meetings according physicians background in 2004, there were detected statistically significant differences. Family physicians after FM residency had least frequent meetings with social workers vs. former district doctors (50% of physicians after FM residency, 31.8% former internists and 41.7% former pediatricians stated that they didn’t have any meetings with the social workers, p ≤ 0.05).

The frequency of meetings was also compared during the health care reform. Former internists in 2004 were having less frequent meetings with the medical specialists (i.e. more then once a month) then they used to in 1994, respectively 52.4% and 73.7%; though there were more frequent meetings with social workers, respectively 18.4% and 8.6% and other family physicians, respectively 71.8% and 50.4% (p ≤ 0.05). The same tendency was noticed between former pediatricians and pediatricians in 1994: meetings once a month with the social workers in 2004 – 14.6% and in 1994 – 5.2%, respectively with the family physicians – 71.2% and 47%, medical specialists – 43.1% and 64.7% (p ≤ 0.05).
Summarizing results, family physicians’ workload statistically increased during ten years of the PHC reform. There were more working hours per week in main or additional positions, more patients’ consultations on the office per day and consultations by phone.

The organizational aspects during health care reform had some changes. Family physicians started to use pre-registration more often in their practice. The elements of team work were presented, though the assistance by community and register nurses were the same as 10 years ago and didn’t reflect any changes. The hours for CME were decreasing during health care reform.

The working conditions between former pediatricians and former internist became more similar vice versa they were in 1994. Number of the patients on the list increased between pediatricians and decreased between internists, number of working hours and number of patients at the office per day and number of consultations by phone per day were similar as well.

Frequency of the meetings with other medical professionals differed. During health care reform the meetings with the medical specialist decreased and meetings with the family physicians increased. The meetings with the social workers were higher in 2004 comparing with situation in 1994, unfortunately they still were very low (14.5%).

4.1.2. The use of equipment

The respondents have been questioned about the ability to use different kind of medical equipment in their PHC centre. According to Lithuanian description of the Family physicians’ professional norm, the equipment were divided in two groups:

(1) compulsory / recommended: hemoglobin meter, blood glucose test, cholesterol meter, blood cell counter, ophthalmoscope, otoscope, eye tonometer, peak flow meter, ECG, blood pressure meter, urine catheter, set for minor surgery, suture set, disposable syringes;

(2) additional / other: proctoscope, gastroscope, sigmoidoscope, X-Ray, ultrasound for abdomen / fetus, microscope, audiometer, bicycle ergometer, spirograph, coaguliometer, defibrillator.

The data analyses revealed that the usage of additional / other equipment decreased after 10 years of PHC reform. Former pediatricians used additional / other equipment (such as proctoscope, gastroscope, sigmoidoscope, X-ray, microscope, audiometer, coaguliometer, spyrograph) less often then pediatricians in 1994 (p ≤ 0.05). The former internists also used less additional / other equipment (such as: proctoscope, gastroscope, sigmoidoscope and X-ray) then internists in 1994 (p ≤ 0.05).
The use of major compulsory equipment increased after 10 years of PHC reform: former internists and former pediatricians were using compulsorily equipment more frequently then they did it ten years ago. More detailed comparison of compulsory equipment is presented in the Figures 4.1.2.1–4.1.2.3. Former internists stated that they more often used 3.8 times blood glucose test (89.9%), disposable syringes (87.4%), 2.8 times cholesterol meter (91.2%), above 1.5 time otoscope (90.1%) and urine catheter (55.5%) neither internists in 1994 (p \leq 0.05). Retrained pediatricians 8 times more often used disposable syringes (86.5%), 2 times cholesterol meter (80.8%), above 1.5 times suture set (65.4%) and otoscope (92.3%), p \leq 0.05. The usage of minor surgery set decreases 1.1 times between former internists (75.8%) and 1.3 times between former pediatricians (69.2%).

The former internists in 2004 used hemoglobin meter, X-Ray, urine catheter more often then physicians after FM residency, they used gastroscope, sigmoidoscope, blood cell counter more often then former pediatricians and physicians after FM residency (p \leq 0.05). Physicians after FM residency were most frequently using blood glucose test and ophthalmoscope (p \leq 0.05).
Figure 4.1.2.1. The use of compulsory equipment between internists and former internists in 1994–2004 (%)

- Disposable syringes: 23.3% (2004) vs 87.4% (1994), *statistically significant differences*
- Set for minor surgery: 75.8% (2004) vs 86.1% (1994), *statistically significant differences*
- Urine catheter: 55.5% (2004) vs 35.5% (1994)
- Blood pressure monitor: 71.8% (2004) vs 97.3% (1994), *statistically significant differences*
- ECG: 97.8% (2004) vs 95.8% (1994)
- Peak flow meter: 63.3% (2004) vs 34.1% (1994)
- Eye tonometer: 89.1% (2004) vs 84.1% (1994)
- Otoscope: 90.1% (2004) vs 54.8% (1994)
- Ophthalmoscope: 83.0% (2004) vs 61.2% (1994)
- Blood cell counter: 79.1% (2004) vs 69.4% (1994)
- Blood glucose test: 89.9% (2004) vs 23.6% (1994)
- Hemoglobinometer: 87.4% (2004) vs 80.0% (1994)

p ≤ 0.05 – *statistically significant differences between internists and former internists.

Figure 4.1.2.1. The use of compulsory equipment between internists and former internists in 1994–2004 (%)
52

Figure 4.1.2.2. The use of compulsory equipment between pediatricians and former pediatricians in 1994–2004(%)
p ≤ 0.05 – * statistical significant differences between former internists and former pediatricians, physicians after FM residency; p ≤ 0.05 – ** statistical significant differences between physicians after FM residency and former district physicians.

Figure 4.1.2.3. The use of compulsory equipment by family physicians according their background in 2004 (%)
4.1.3. Involvement in the medical procedures

The detailed comparison of involvement in application of medical procedures between district physicians and family physicians are reflected in Figures 4.1.3.1–4.1.3.2.

Remarkable changes have been noticed between former internists and internists. Former internists were most active in setting up an intravenous infusion (71%), strapping an ankle (43.3%), fundoscopy (30.1%), wound suturing (21%) and less active in wedge resection of the ingrowing toenail (12.9%), insertion of IUD (12.9%), applying a plaster cast (10.2%), and excision of warts (6.5%). The involvement of the former internists statistically significantly increased in the mentioned procedures during health care reform. The activity of former internists in cryotherapy, paracentesis, maxillary sinus puncture, joint injection, removal rust spot form cornea were very low in 1994 and 2004 as well. Though involvement in the rest of procedures by former internists increased and it was 2–4 times comparing with internists in 1994.

The former pediatricians stated that they were most active in setting up an intravenous infusion (58.8%), strapping an ankle (33.3%) and fundoscopy (19.6%) in 2004, the provision of the mentioned procedures statistically increased after 10 years. Assessing the rest of the medical procedures, we may conclude that involvement of former pediatricians was very low (6% in average) in 2004 as it used to be 10 years ago.

The involvement in medical procedures was also compared between family physicians according to their background in 2004. The highest activity family physicians noted in setting up an intravenous infusion, strapping an ankle, fundoscopy, wound suturing, insertion of IUD, wedge resection of ingrown toenail and applying a plaster cast. Physicians’ involvement in removal of subcutaneous cyst or rusty spot from cornea, maxillary sinus puncture, paracentesis and cryotherapy were lower 7%. Few statistical significant differences have been regarding physicians’ activity according their background: the former internists were more involved in wound suturing then former pediatricians, while former pediatricians were more involved in applying a plaster cast vs. physicians after FM residency.
\[ p \leq 0.05 - * \text{statistical significant differences between internists and former internists;} \]
\[ p \leq 0.05 - ** \text{statistical significant differences between pediatricians and former pediatricians.} \]

**Figure 4.1.3.1. Involvement in medical procedures district and former district physicians 1994–2004 (％)**
p ≤ 0.05 – * statistical significant differences between former pediatricians and former internists; p ≤ 0.05 – ** statistical significant differences between former pediatricians and physicians after FM residency.

**Figure 4.1.3.2. Involvement in the medical procedures between family physicians according their background in 2004 (%)**
4.1.4. Involvement in the treatment of the diseases

The data reflects changes between internists and former internists regarding their involvement in the treatment of 17 different diseases (Figure 4.1.4.1). In 11 of cases involvement of former internists in treating of diseases increased: more then 5 times in the treatment of salpingitis, hordeolum, 3 times treating herniated disc lesion, concussion of the brain, Parkinson’s disease and from 1.1–2.3 times in treating hyperthyroidism, peritonsilar abscess, diabetes II type, depression, peptic ulcer, rheumatoid arthritis (p < 0.01). The activity in the treatment of ulcerative colitis and myocardial infarction decreased in 2004 (p < 0.01). There were no significant changes revealed in the treatment of chronic bronchitis, acute cerebro-vascular accident, congestive heart failure, pneumonia.

Involvement of pediatricians and former pediatricians in the treatment of 17 different diseases are reflected in Figure 4.1.4.2. There were revealed statistically significant differences in 12 cases: treatment of salpingitis and Parkinson disease increased 20 times, of myocardial infarction and herniated disc lesion – 10 times, diseases such as hyperthyroidism, hordeolum, peptic ulcer, acute cerebro-vascular accident, congestive heart failure, uncomplicated type II diabetes, rheumatoid arthritis, depression increased 2 times in average. There were no significant changes in the treatment of 5 diseases: chronic bronchitis, pneumonia, peritonsilar abscess, ulcerative colitis, concussion of the brain.

Involvement in treatment of different diseases according family physicians background was also compared (Figure 4.1.4.3). Former internists were most active in treating of major diseases. They treated chronic bronchitis, Parkinson’s disease more frequently then former pediatricians as well as physicians after FM residency. Former internists were more also active in herniated disc lesion, congestive heart failure, ulcerative colitis treatment then former pediatricians; and more active then physicians after FM residency treating depression and myocardial infarction (p < 0.05).
p ≤ 0.05 – * statistical significant differences between internists and former internists.

**Figure 4.1.4.1.** Involvement in the treatment of the diseases between internists and former internists in 1994–2004 (%)
$p \leq 0.05$ – * statistical significant differences between pediatricians and former pediatricians.

**Figure 4.1.4.2. Involvement in the treatment of the diseases between pediatricians and former pediatricians in 1994–2004 (%)**
\[ p \leq 0.05 - \text{* statistical significant differences between former internists and former pediatricians}; \ p \leq 0.05 - \text{** statistical significant differences between former internists and physicians after FM residency}; \ p \leq 0.05 - \text{**** statistical significant differences between former pediatricians and FM residency}.\]

**Figure 4.1.4.3. Involvement in the treatment of the diseases according family physicians’ background in 2004 (%)**
4.1.5. Preventive care

The results regarding preventive care and health education are reflected in Figures 4.1.5.1–4.1.5.2. Involvement in the measurement of blood pressure and cholesterol between internists and pediatricians were quite high in 1994; similar situation was in 2004. Though there were some important changes. Former pediatricians and former internists checked blood pressure and measured blood cholesterol more often routinely in their practice then they used to do that 10 years ago (p ≤ 0.05). To compare the measurement of cervical smears was impossible between district physicians and family physicians, because there were no such question in 1994 questionnaire.

Cervical smear was performed least frequently in 2004: 19.7% of respondents indicated that there was no possibility to measure it. Physicians after FM residency statistically significantly checked blood cholesterol more often for patients with relevant conditions or on requires vs. former district physicians.
BLOOD CHOLESTEROL:

- No such measures:
  - Former internists, 2004: 6.9%
  - Former pediatricians, 2004: 28.8%
  - Internists, 1994: 36.8%
  - Pediatricians, 1994: 21.6%

- For patients invited for this purpose:
  - Former internists, 2004: 13.9%
  - Former pediatricians, 2004: 8.2%
  - Internists, 1994: 21.6%
  - Pediatricians, 1994: 36.8%

- Routinely during regular patients’ visits:
  - Former internists, 2004: 4.3%
  - Former pediatricians, 2004: 3.5%
  - Internists, 1994: 19.6%
  - Pediatricians, 1994: 28.9%

- In connection with relevant clinical conditions or on requires:
  - Former internists, 2004: 57.2%
  - Former pediatricians, 2004: 56.9%
  - Internists, 1994: 59.4%
  - Pediatricians, 1994: 57.2%

BLOOD PRESSURE:

- For patients invited for this purpose:
  - Former internists, 2004: 2.1%
  - Former pediatricians, 2004: 6.2%
  - Internists, 1994: 19.2%
  - Pediatricians, 1994: 19.2%

- Routinely during regular patients’ visits:
  - Former internists, 2004: 86.1%
  - Former pediatricians, 2004: 72.4%
  - Internists, 1994: 84.3%
  - Pediatricians, 1994: 84.3%

- In connection with relevant clinical conditions or on requires:
  - Former internists, 2004: 11.8%
  - Former pediatricians, 2004: 8.4%
  - Internists, 1994: 15.7%
  - Pediatricians, 1994: 15.7%

\( p \leq 0.05 \) – *statistical significant differences between former pediatricians and pediatricians; \( p \leq 0.05 \) – **statistical significant differences between former internists and internists.

**Figure 4.1.5.1. Measurement of cholesterol and blood pressure between district and former district physicians in 1994–2004 (%)**

62
Figure 4.1.5.2. Family physicians involvement in the measurement of blood pressure, cholesterol and cervical smears according their background in 2004 (%)
Health education usually was provided only in normal patients’ contacts: more than 80% of former internists, former pediatricians and family physicians were educating their patients about smoking cessation, nutritional behavior and alcohol consumption. The involvement in group education was low: 8% of respondents noted that they were involved in group education and that there were no activity in health education between pediatricians stated 9% of physicians in 2004. Comparing the activity between pediatricians and former pediatricians regarding health education there were no significant changes detected. Though former internists were less involved in smoking cessation and nutritional behavior during normal patients’ contacts in 2004 rather internists in 1994 (p < 0.01). There were few significant differences between family physicians involvement in health education according their background: family physicians after FM residency were least involved in education about alcohol consumption vs. former pediatricians and former internists.
p ≤ 0.05 – * statistical significant differences between former internists and internists.

**Figure 4.1.5.3.** The involvement in health education between district and former district physicians in 1994–2004 (%)
4.1.6. Involvement in particular services

Family physicians in 2004 were most frequently involved in immunization program for children (71.6%), pediatric care till 4 years old (67.1%), while routine antenatal care and family planning were less popular (54.8% and 54.8% respectively) (Figure 4.1.6.2). The involvement in particular services increased during health care reform (figure 4.1.6.1). The involvement in routine antenatal care increased 4 times, in family planning-8 times and 2 times in homeopathic medicine between former pediatricians in 2004 vs. pediatricians in 1994 (p < 0.01). There were no significant changes in the activity regarding immunization program for children and children care till 4 years between former pediatricians. The involvement in immunization with children and pediatric care between former internists increased 5 times, in family planning – 6 times, 3 times in routine antenatal care and 1.5 times in homeopathic medicine vs. internists in 1994 (p < 0.01). The physicians after FM residency activity in particular services seemed to be higher vs. district physicians.
$p \leq 0.05$ – * statistical significant differences between former pediatricians and pediatricians; $p \leq 0.05$ – ** statistical significant differences between former internists and internists.

**Figure 4.1.6.1. Involvement in particular services between district and former district physicians 1994–2004 (%)**
Figure 4.1.6.2. Involvement in particular services between family physicians according their background in 2004 (%)
frequently strongly agreed with the statement then internists in 1994 (p ≤ 0.05). Despite the mentioned above, physicians strongly agreed, that their work still interests them as it ever did, and more or less agreed that they find real enjoyment in their work. Former internist more frequently disagreed with the previous statements when internists in 1994 (p ≤ 0.05). With the statement “if the payment conditions were similar I would do non medical work” disagreed most of physicians, but in 2004 former district physicians more frequently stated that they were not sure about it. “In my work there is good correspondence between effort and reward”, more or less disagreed majority of physicians, though former internists were least critical about it (p ≤ 0.05).

Family physicians attitude towards their work was compared according their background in 2004, though there were no statistical significant differences detected.

The associations between family physicians attitudes regarding their job satisfaction were measured according series characteristics. The statistical significant associations are reflected in Tables 4.2.1.1– 4.2.1.2. Majority of family physicians disagreed that some parts of their work do not make sense. Family physicians from public PHC centers and those who were working without appointment schema disagreed with the statement more frequently then physicians from private PHC centers, those who were working with the appointment schema (p ≤ 0.05). Work is overloaded with unnecessary administrative details disagreed most of the respondents, especially physicians from private PHC centre, those who had nonfrequent meetings with pharmacists, medical specialists and social workers, those who were involved in the immunization and children care till 4 years old (p ≤ 0.05). Physicians were satisfied with their work, though more satisfied were aged below 50 years old and those who were having frequent meetings with medical specialists, pharmacists and social workers, those who were involved in homeopathic medicine and had higher number of CME hours (p ≤ 0.05). Most of physicians find real enjoyment in their work, but those who were having frequent meetings with social workers and were involved in particular services such as routine antenatal care, immunization of children and their care till 4 years old, consultations about family planning agreed more often with the statement. The frequent meetings with the family physicians were associated with the lower satisfaction (p ≤ 0.05). Family physicians’ opinion about the possibility to change their work “if pay and conditions were similar” were ambiguous; physicians who had frequent meetings with the pharmacists and social workers, had higher number of CME hours more often agreed with the statement (p ≤ 0.05). “In my work there is a good correspondence between effort and reward” more often agreed physicians who had a higher number of the patients on the list and higher consultations by phone per day (p ≤ 0.05).
Table 4.2.1.1. Statistical significant associations between different qualitative characteristics and family physicians' attitudes towards their job satisfaction

<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Strongly, more or less agreed, n (%)</th>
<th>Didn’t know, more or less, strongly disagreed, n (%)</th>
<th>$\chi^2$ value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that some parts of my work do not really make sense</td>
<td><strong>PHC centre type:</strong> Private</td>
<td>18 (20.9)</td>
<td>68 (79.1)</td>
<td>6.233</td>
<td>0.013</td>
</tr>
<tr>
<td></td>
<td>Public</td>
<td>23 (10.2)</td>
<td>202 (89.8)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>Working with appointment schema:</strong> Without appointment</td>
<td>6 (5.4)</td>
<td>106 (94.6)</td>
<td>10.377</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>With appointment</td>
<td>37 (18.4)</td>
<td>164 (81.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My work still interests me as much as it ever did</td>
<td><strong>Age:</strong> Bellow 49 years old</td>
<td>35 (97.2)</td>
<td>1 (2.8)</td>
<td>5.359</td>
<td>0.021</td>
</tr>
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<td></td>
<td>Above 50 years old</td>
<td>230 (82.1)</td>
<td>50 (17.9)</td>
<td></td>
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<tr>
<td></td>
<td><strong>Meetings with medical specialist:</strong> Nonfrequent meetings</td>
<td>40 (74.1)</td>
<td>14 (25.9)</td>
<td>5.310</td>
<td>0.021</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings</td>
<td>214 (86.6)</td>
<td>33 (13.4)</td>
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<td></td>
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<td></td>
<td><strong>Meetings with pharmacists:</strong> Nonfrequent meetings</td>
<td>65 (76.5)</td>
<td>20 (23.5)</td>
<td>4.925</td>
<td>0.026</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings</td>
<td>186 (86.9)</td>
<td>28 (13.1)</td>
<td></td>
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<td></td>
<td><strong>Meetings with social workers:</strong> Nonfrequent meetings</td>
<td>139 (78.5)</td>
<td>38 (21.5)</td>
<td>8.775</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings</td>
<td>108 (91.5)</td>
<td>10 (8.5)</td>
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<td></td>
<td><strong>Homeopathic medicine:</strong> Involved</td>
<td>178 (87.3)</td>
<td>26 (12.7)</td>
<td>4.899</td>
<td>0.027</td>
</tr>
<tr>
<td></td>
<td>Not involved</td>
<td>87 (77.7)</td>
<td>25 (22.3)</td>
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</table>
### Table 4.2.1.1 continued

<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Strongly, more or less agreed, n (%)</th>
<th>Didn’t know, more or less, strongly disagreed, n (%)</th>
<th>$\chi^2$ value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>My work is overloaded with unnecessary administrative details</strong></td>
<td><strong>PHC centre type:</strong></td>
<td>2 (2.3) 20 (8.9)</td>
<td>84 (97.7) 205 (91.1)</td>
<td>4.077</td>
<td>0.043</td>
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<tr>
<td>Private</td>
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<td>Public</td>
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<td><strong>Meetings with pharmacists:</strong></td>
<td></td>
<td>2 (2.4) 19 (8.9)</td>
<td>83 (97.6) 195 (91.1)</td>
<td>3.967</td>
<td>0.046</td>
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<td>Nonfrequent meetings</td>
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<tr>
<td>Frequent meetings</td>
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<td><strong>Meetings with medical specialist:</strong></td>
<td></td>
<td>0 (0.0) 23 (9.3)</td>
<td>54 (100) 224 (90.7)</td>
<td>5.444</td>
<td>0.002</td>
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<tr>
<td>Nonfrequent meetings</td>
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<td>Frequent meetings</td>
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<td><strong>Meetings with social workers:</strong></td>
<td></td>
<td>7 (4.0) 14 (11.9)</td>
<td>170 (96) 104 (88.1)</td>
<td>6.699</td>
<td>0.010</td>
</tr>
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<td>Nonfrequent meetings</td>
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<tr>
<td>Frequent meetings</td>
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<tr>
<td><strong>Immunization of children:</strong></td>
<td></td>
<td>11 (4.8) 12 (13.6)</td>
<td>217 (95.2) 76 (86.4)</td>
<td>7.305</td>
<td>0.007</td>
</tr>
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<td>Involved</td>
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<tr>
<td>Not involved</td>
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<tr>
<td><strong>Children care till 4 years old:</strong></td>
<td></td>
<td>10 (4.7) 13 (12.6)</td>
<td>203 (95.3) 90 (87.4)</td>
<td>6.464</td>
<td>0.011</td>
</tr>
<tr>
<td>Involved</td>
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<tr>
<td>Not involved</td>
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<tr>
<td><strong>Assuming that payment and working conditions were similar I would do non medical work</strong></td>
<td><strong>Meetings with pharmacists:</strong></td>
<td>46 (54.1) 143 (66.8)</td>
<td>39 (45.9) 71 (33.2)</td>
<td>4.223</td>
<td>0.004</td>
</tr>
<tr>
<td>Nonfrequent meetings</td>
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<td>Frequent meetings</td>
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<tr>
<td><strong>Meetings with social workers:</strong></td>
<td></td>
<td>104 (58.8) 83 (70.3)</td>
<td>73 (41.2) 35 (29.7)</td>
<td>4.092</td>
<td>0.043</td>
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</table>
Table 4.2.1.1. continued

<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Strongly, more or less agreed, n (%)</th>
<th>Didn’t know, more or less, strongly disagreed, n (%)</th>
<th>$\chi^2$ value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I find real enjoyment in my work</td>
<td>Meetings with other family physicians:</td>
<td>11 (78.6)</td>
<td>3 (21.4)</td>
<td>5.509</td>
<td>0.019</td>
</tr>
<tr>
<td></td>
<td>Nonfrequent meetings</td>
<td>123 (46.4)</td>
<td>142 (53.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequent meetings</td>
<td>71 (40.1)</td>
<td>106 (59.9)</td>
<td>7.899</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings</td>
<td>67 (56.8)</td>
<td>51 (43.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meetings with social workers:</td>
<td>96 (54.9)</td>
<td>79 (45.1)</td>
<td>8.587</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>Nonfrequent meetings</td>
<td>54 (38.3)</td>
<td>87 (61.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequent meetings</td>
<td>120 (52.6)</td>
<td>108 (47.4)</td>
<td>8.753</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings</td>
<td>30 (34.1)</td>
<td>58 (65.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routine antenatal care:</td>
<td>114 (53.5)</td>
<td>99 (46.5)</td>
<td>9.601</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>Involved</td>
<td>36 (35)</td>
<td>67 (65)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not involved</td>
<td>93 (53.1)</td>
<td>82 (46.9)</td>
<td>5.064</td>
<td>0.024</td>
</tr>
<tr>
<td></td>
<td>Not involved</td>
<td>57 (40.4)</td>
<td>84 (59.6)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Table 4.2.1.2. Statistical significant associations between different quantitative characteristics and family physicians’ attitudes towards their job satisfaction**

<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Strongly, more or less agreed</th>
<th>Didn’t have opinion, strongly disagreed, more or less disagreed</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>P_{25}, P_{75}</td>
<td>Median</td>
<td>P_{25}, P_{75}</td>
</tr>
<tr>
<td>My work still interests me as much as it ever did</td>
<td>Number of hours for CME</td>
<td>10</td>
<td>8, 20</td>
<td>10</td>
</tr>
<tr>
<td>Assuming that payment and working conditions were similar I would do non medical work</td>
<td>Number of hours for CME</td>
<td>10</td>
<td>8, 20</td>
<td>10</td>
</tr>
<tr>
<td>In my work there is a good correspondence between effort and reward</td>
<td>Number of patients on the list</td>
<td>1800</td>
<td>1500, 2000</td>
<td>1600</td>
</tr>
<tr>
<td></td>
<td>Number of consultations by phone a day</td>
<td>5</td>
<td>3, 8</td>
<td>5</td>
</tr>
</tbody>
</table>

P_{25} – 25th percentiles, P_{75} – 75th percentiles.

**4.2.2. Family physicians’ attitudes regarding health care in Lithuania**

Family physicians assessed different items about the health care. Unfortunately the comparison during health care reform was impossible because, there were no questions about the health care in 1994 survey. In general physicians’ attitudes according their background varied between the statements. Family physicians strongly agreed that with the statements: physicians and nurses should be better paid, with rising costs the co-payments for patients are available, and their patients should have more influence. Physicians more or less agreed that health care premises and equipment are better then 5 years ago, that PHC would be more effective if physicians would work together with the nurses, family physicians and nurses have good skills.

73
Physicians are accepted by patients as their personal doctors. Majority didn’t know if the health care in Lithuania was better then 5 years ago and more or less disagreed, that family physicians who work privately are better then publicly employed.

There were few significant differences detected according family physicians background (Supplements, Table 2). Former pediatricians more often disagreed, then others, that patients should have more influence in their management and they are able to cope with their simple diseases without a doctor. Former pediatricians also less often stated then former internists that physicians and nurses have good knowledge and skills and that health care is better then it was 5 years ago. Physicians after FM residency more often stated that they should be better paid then former district physicians.

The statistical significant associations between different characteristics and family physicians’ attitudes regarding the health care in Lithuania are reflected in the Tables 4.2.2.1–.4.2.2.2. Majority of family physicians stated that they are accepted as personal doctors, especially those who were working with other physicians ($p \leq 0.05$). The changes during last 5 years in health care, equipment and premises were evaluated positively by majority of respondents, but the most satisfied were physicians from private PHC centers, who were having frequent visits with specialists and social workers, were having more hours of CME ($p \leq 0.05$). The equipment and premises were evaluated better by publicly working physicians, those who had frequent meetings with the specialists and had higher number of CME hours ($p \leq 0.05$). The co-payments were acceptable for physicians who were working together with other physicians ($p \leq 0.05$). Privately working physicians were not evaluated better then publicly employed physicians and most disagreed with the statement physicians from public centers and those who weren’t involved in particular services ($p \leq 0.05$). That family physicians and nurses should be better agreed most of the respondents, but most often agreed those who were involved in particular services (children care, immunization for children) and had higher number of consultations by phone per day. “Patients should have more influence on the management of their health care” significantly more often stated physicians with the higher patients number on the list. “If patients would know more about dealing with simple diseases they would not need to visit their family physicians so quickly in such cases” agreed most of the respondents, though most often from rural areas or towns, who were not involved in the particular services and higher number of patients on the list and at the office per day ($p \leq 0.05$).
Table 4.2.2.1. Statistical significant associations between different qualitative characteristics and family physicians' attitudes towards the health care

<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Strongly, more or less agreed, n (%)</th>
<th>Didn't have opinion, more or less, strongly disagreed, n (%)</th>
<th>$\chi^2$ value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients accept me as their personal doctor</td>
<td><strong>Working type:</strong> Working alone Working with other physicians</td>
<td>38 (76.0) 246 (92.8)</td>
<td>12 (24.0) 19 (7.2)</td>
<td>13.428</td>
<td>0.000</td>
</tr>
<tr>
<td>At present health care in Lithuania is better than it was five years ago</td>
<td><strong>PHC centre type:</strong> Private Public</td>
<td>52 (60.5) 94 (42.0)</td>
<td>34 (39.5) 130 (58.0)</td>
<td>8.537</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td><strong>Meetings with medical specialists:</strong> Nonfrequent Frequent</td>
<td>13 (24.5) 130 (52.6)</td>
<td>40 (75.5) 117 (47.4)</td>
<td>13.816</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td><strong>Meetings with the social workers:</strong> Nonfrequent Frequent</td>
<td>71 (40.3) 68 (57.6)</td>
<td>105 (59.7) 50 (42.4)</td>
<td>8.468</td>
<td>0.004</td>
</tr>
<tr>
<td>Nowadays health care premises and equipment in Lithuania are much better than they were five years ago</td>
<td><strong>PHC centre type:</strong> Private Public</td>
<td>77 (89.5) 168 (74.7)</td>
<td>9 (10.5) 57 (25.3)</td>
<td>8.227</td>
<td>0.004</td>
</tr>
<tr>
<td></td>
<td><strong>Meetings with the medical specialists:</strong> Nonfrequent Frequent</td>
<td>33 (61.1) 203 (82.2)</td>
<td>21 (38.9) 44 (17.8)</td>
<td>11.624</td>
<td>0.001</td>
</tr>
<tr>
<td>With rising costs of health care it is acceptable that there are copayments a</td>
<td><strong>Working type:</strong> Working alone Working together with other physicians</td>
<td>40 (80.0) 245 (92.1)</td>
<td>10 (20.0) 21 (7.9)</td>
<td>6.971</td>
<td>0.008</td>
</tr>
</tbody>
</table>
Table 4.2.2.1. continued

<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Strongly, more or less agreed, n (%)</th>
<th>Didn’t have opinion, more or less, strongly disagreed, n (%)</th>
<th>$\chi^2$ value</th>
<th>p value</th>
</tr>
</thead>
</table>
| Family physicians who work privately are usually better than family physicians who are publicly employed | **PHC centre type:**  
Private | 28 (32.6) | 58 (67.4) | 9.772 | 0.002 |
| Public | 37 (16.4) | 188 (83.6) | | |
| **Immunization for children:**  
Involved | 55 (24.1) | 173 (75.9) | 6.326 | 0.012 |
| Not involved | 10 (11.4) | 78 (88.6) | | |
| **Children care till 4 years old:**  
Involved | 51 (23.9) | 162 (76.1) | 4.553 | 0.033 |
| Not involved | 14 (13.6) | 89 (86.4) | | |
| **Consultations about family planning:**  
Involved | 44 (25.1) | 131 (74.9) | 5.020 | 0.025 |
| Not involved | 21 (14.9) | 120 (85.1) | | |
| Family physicians and nurses should be better paid | **Immunization for children:**  
Involved | 225 (98.7) | 3 (1.3) | 6.947 | 0.008 |
| Not involved | 82 (93.2) | 6 (6.8) | | |
| **Children care till 4 years old:**  
Involved | 210 (98.6) | 3 (1.4) | 4.895 | 0.027 |
<p>| Not involved | 97 (94.2) | 6 (5.8) | | |</p>
<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Strongly, more or less agreed, n (%)</th>
<th>Didn’t have opinion, more or less, strongly disagreed, n (%)</th>
<th>$\chi^2$ value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>If patients would know more about dealing with simple diseases they would not need to visit their family physicians so quickly in such cases</td>
<td><strong>Urbanization:</strong> Cities</td>
<td>118 (75.2)</td>
<td>39 (24.8)</td>
<td>3.847</td>
<td>0.050</td>
</tr>
<tr>
<td></td>
<td>Rural/towns</td>
<td>132 (84.1)</td>
<td>25 (15.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Routine antenatal care:</strong> Involved</td>
<td>130 (74.3)</td>
<td>45 (25.7)</td>
<td>7.242</td>
<td>0.007</td>
</tr>
<tr>
<td></td>
<td>Not involved</td>
<td>122 (86.5)</td>
<td>19 (13.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Immunization for children:</strong> Involved</td>
<td>174 (76.3)</td>
<td>54 (23.7)</td>
<td>5.967</td>
<td>0.015</td>
</tr>
<tr>
<td></td>
<td>Not involved</td>
<td>78 (88.6)</td>
<td>10 (11.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Children care till 4 years old:</strong> Involved</td>
<td>161 (75.6)</td>
<td>52 (24.4)</td>
<td>7.002</td>
<td>0.008</td>
</tr>
<tr>
<td></td>
<td>Not involved</td>
<td>91 (88.3)</td>
<td>12 (11.7)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4.2.2.2. Statistical significant associations between different quantitative characteristics and family physicians’ attitudes towards the health care

<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Strongly, more or less agreed</th>
<th>Didn’t have opinion, strongly disagreed, more or less disagreed</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>P₂₅, P₇₅</td>
<td>Median</td>
<td>P₂₅, P₇₅</td>
</tr>
<tr>
<td>PHC would be more effective if family physicians would work together with nurses who provide real nursing care</td>
<td>Number of patients on the list</td>
<td>1650</td>
<td>1200, 2000</td>
<td>1500</td>
</tr>
<tr>
<td>Nowadays health care premises and equipment in Lithuania are much better than they were five years ago</td>
<td>Number of hours for CME</td>
<td>10</td>
<td>8, 20</td>
<td>10</td>
</tr>
<tr>
<td>Family physicians and nurses should be better paid</td>
<td>Number of consultations by phone a day</td>
<td>5</td>
<td>3, 6</td>
<td>2</td>
</tr>
<tr>
<td>Patients should have more influence on the management of their health care</td>
<td>Number of patients on the list</td>
<td>1600</td>
<td>1225, 2000</td>
<td>1335</td>
</tr>
<tr>
<td>If patients would know more about dealing with simple diseases they would not need to visit their family physicians so quickly in such cases</td>
<td>Number of patients on the list</td>
<td>1700</td>
<td>1300, 2000</td>
<td>1509</td>
</tr>
<tr>
<td></td>
<td>Number of patients on the office per day</td>
<td>24.5</td>
<td>20, 25</td>
<td>25</td>
</tr>
</tbody>
</table>
Logistic regression analyses was provided aiming to assess the likelihood that family physician will be satisfied with his job and health care as well. The results are presented in the Tables 4.2.2.3–4.2.2.4.

The results reflected that family physicians satisfaction with his work depended on the several characteristics such as: PHC type, age, working on the appointment schema, frequency of the meetings with the social workers, medical specialists, pharmacists, other family physicians, also involvement in particular services (children care till 45 years old, immunization program, consolation about the family planning). The mentioned variables were also important evaluating family physicians satisfaction with the health care, additionally the urbanization, family physicians’ background, solo or group practice were also important for physician satisfaction.

The likelihood that physicians will be satisfied with the working conditions (that all the parts of the work make sense and the work is not overloaded with the administrative details) was increasing if physicians was form the private PHC centre, was working with the appointment schema and had frequent meetings with the medical specialist; and was decreasing if he was involved in children care and immunization. The likelihood that family physicians was interested in his work and was enjoying it was increasing if he was older 50 years old, had frequent meetings with the social workers and was involved in particular services (homeopathic and children care. consultations about the family planning). Frequent meetings with the pharmacists and social workers were increasing the likelihood that physician won’t change his profession even if there offered better working conditions.
Table. 4.2.2.3. The likelihood that family physician will agree with the statements related to their job satisfaction according different characteristics

<table>
<thead>
<tr>
<th>Items related to job satisfaction</th>
<th>Significant variables</th>
<th>Beta coefficient</th>
<th>Odds ratio</th>
<th>Confidence Intervals 95 %</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no parts of the work that don’t make sense</td>
<td>Private PHC centre type (vs. public)</td>
<td>0.957</td>
<td>2.605</td>
<td>1.282–5.293</td>
<td>0.008</td>
</tr>
<tr>
<td></td>
<td>Working with appointment schema (vs. without appointment)</td>
<td>1.019</td>
<td>2.77</td>
<td>1.242–6.182</td>
<td>0.013</td>
</tr>
<tr>
<td>My work still interests me as much as it ever did</td>
<td>Aged above 50 years old (vs. younger 49)</td>
<td>0.488</td>
<td>1.629</td>
<td>1.015–2.613</td>
<td>0.043</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings with social workers (vs. nonfrequent meetings)</td>
<td>1.222</td>
<td>3.393</td>
<td>1.633–7.049</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Involvement in homeopathic medicine (vs. uninvolved)</td>
<td>0.801</td>
<td>2.227</td>
<td>1.201–4.128</td>
<td>0.011</td>
</tr>
<tr>
<td>There are no unnecessary administrative details in my work</td>
<td>Frequent meetings with medical specialist (vs. non frequent meetings)</td>
<td>1.827</td>
<td>6.218</td>
<td>0.881–16.792</td>
<td>0.028</td>
</tr>
<tr>
<td></td>
<td>Involved in immunization of children (vs. not involved)</td>
<td>–1.099</td>
<td>0.333</td>
<td>1.044–5.875</td>
<td>0.013</td>
</tr>
<tr>
<td></td>
<td>Involved in children care till 4 years old (vs. uninvolved)</td>
<td>–1.101</td>
<td>0.333</td>
<td>0.138–0.799</td>
<td>0.014</td>
</tr>
<tr>
<td>Assuming that payment and working conditions were similar I still would not change my medical work</td>
<td>Frequent meetings with pharmacists (vs. non frequent meetings)</td>
<td>0.611</td>
<td>1.843</td>
<td>1.128–3.010</td>
<td>0.015</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings with social workers (vs. non frequent meetings)</td>
<td>0.570</td>
<td>1.768</td>
<td>1.094–2.857</td>
<td>0.002</td>
</tr>
<tr>
<td>I feel real enjoyment in my work</td>
<td>Frequent meetings with social workers (vs. non frequent meetings)</td>
<td>0.866</td>
<td>2.513</td>
<td>1.429–4.421</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Involved in children care till 4 years old (vs. uninvolved)</td>
<td>0.922</td>
<td>2.513</td>
<td>1.429–4.421</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Involved in consultations about family planning (vs. uninvolved)</td>
<td>0.685</td>
<td>2.193</td>
<td>1.190–3.618</td>
<td>0.009</td>
</tr>
</tbody>
</table>
The likelihood that family physician was feeling as a personal doctor was increasing if he was working together with the other physicians and his background was a former district doctor vs. physician after FM medicine. The probability that family physician will assess changes in the health care system, premises and equipment positively was increasing if he was from the private PHC centre, had frequent meetings with the medical specialists and social workers. The likelihood that physician will agree that PHC would be more effective if physicians will work together with the nurses who provide real nursing care was increasing if physician had frequent meetings with the social workers. The agreement with co-payments was increasing if family physician was working together with other physicians and was decreasing if he was from the city. That physician should be better paid the likelihood was increasing if he was involved in particular services (children care, immunization). The likelihood that physician will agree with the statement that patients should be involved more in their treatment were increasing if family physician was uninvolved in children and antenatal care, but was involved in homeopathic care.
Table 4.2.2.4. The likelihood that family physician will agree with the statements about the health care according different characteristics

<table>
<thead>
<tr>
<th>Items related to health care</th>
<th>Significant variables</th>
<th>Beta coefficient</th>
<th>Odds ratio</th>
<th>Confidence Interval 95%</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients accept me as their personal doctor</td>
<td>Working together with other physicians (vs. working alone)</td>
<td>1.492</td>
<td>4.446</td>
<td>2.038–9.700</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Family physicians retrained from former pediatricians or internists (vs. physicians after FM residency)</td>
<td>0.760</td>
<td>2.138</td>
<td>1.06–4.312</td>
<td>0.034</td>
</tr>
<tr>
<td>At present health care in Lithuania is better than it was 5 years ago</td>
<td>Private PHC centre type (vs. public)</td>
<td>0.785</td>
<td>2.192</td>
<td>1.251–3.841</td>
<td>0.006</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings with medical specialists (vs. not frequent)</td>
<td>0.807</td>
<td>2.241</td>
<td>1.088–4.616</td>
<td>0.029</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings with the social workers (vs. not frequent)</td>
<td>0.629</td>
<td>1.875</td>
<td>1.113–3.161</td>
<td>0.018</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings with the social workers (vs. not frequent)</td>
<td>0.698</td>
<td>2.009</td>
<td>1.050–3.845</td>
<td>0.035</td>
</tr>
<tr>
<td>Nowadays health care premises and equipment in Lithuania are much better than they were 5 years ago</td>
<td>Private PHC centre type (vs. public)</td>
<td>1.106</td>
<td>3.023</td>
<td>1.353–6.752</td>
<td>0.007</td>
</tr>
<tr>
<td></td>
<td>Frequent meetings with the medical specialists (vs. not frequent)</td>
<td>0.918</td>
<td>2.503</td>
<td>1.361–4.603</td>
<td>0.003</td>
</tr>
<tr>
<td>With rising costs of health care it is acceptable that there are co-payments</td>
<td>Working together with other physicians (vs. working alone)</td>
<td>1.467</td>
<td>4.336</td>
<td>1.903–9.882</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Urbanizations cities (vs. towns and rural areas)</td>
<td>-0.844</td>
<td>0.430</td>
<td>0.187–0.991</td>
<td>0.048</td>
</tr>
<tr>
<td>Items related to health care</td>
<td>Significant variables</td>
<td>Beta coefficient</td>
<td>Odds ratio</td>
<td>Confidence Interval 95%</td>
<td>p value</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------------------------------</td>
<td>------------------</td>
<td>------------</td>
<td>--------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Privately physicians are better then publicly employed</td>
<td>Private PHC centre type (vs. public)</td>
<td>0.749</td>
<td>2.114</td>
<td>1.161–3.849</td>
<td>0.014</td>
</tr>
<tr>
<td>Family physicians and nurses should be better paid</td>
<td>Involved in children care till 4 years old (vs. uninvolved)</td>
<td>1.414</td>
<td>4.114</td>
<td>1.031–16.418</td>
<td>0.045</td>
</tr>
<tr>
<td></td>
<td>Involved in immunization of children (vs. uninvolved)</td>
<td>1.625</td>
<td>5.080</td>
<td>1.261–20.463</td>
<td>0.022</td>
</tr>
<tr>
<td>If patients would know more about dealing with simple diseases they would not need to visit their family physicians so quickly in such cases</td>
<td>Uninvolved in children care till 4 years old (vs. involved)</td>
<td>1.099</td>
<td>3.002</td>
<td>1.004–8.975</td>
<td>0.049</td>
</tr>
<tr>
<td></td>
<td>Uninvolved in routine antenatal care (vs. involved)</td>
<td>0.642</td>
<td>1.901</td>
<td>1.002–2.609</td>
<td>0.049</td>
</tr>
<tr>
<td></td>
<td>Involved in homeopathic medicine (vs. involved)</td>
<td>0.939</td>
<td>2.558</td>
<td>1.448–4.519</td>
<td>0.001</td>
</tr>
</tbody>
</table>
Summarizing the paragraph, there were revealed several characteristics are associated with physicians’ attitudes about their job and health care. The satisfaction with the job was increasing if family physician was older 50 years old, from private PHC centre, was having frequent meetings with the social workers/ medical specialists, was involved in particular services, especially in children care. Therefore if family physicians were involved in children care and their immunization they stated more often that their work is overloaded with unnecessary administrative details and wanted to be paid better. The co-payments were very important for those physicians who were working with other physicians. Working together with the other physicians and family physician background made physicians feel that they are accepted by patients as the personal doctors. The health care system, premises were also assessed more positively by physicians form the private PHC centers and by those who were having frequent meetings with the social workers and other specialists.

4.3. Patients’ attitudes

Patients were evaluating four PHC aspects related to the PHC performance (accessibility, waiting times, premises and staff, working hours of the PHC centre); health care in general (patients’ attitudes towards health care in Lithuania, knowledge of physicians and community nurses, co-payments, patients involvement in health care and etc.); family physician and community nurse (satisfaction with their work, cooperation, and provided information).

Patients’ attitudes were compared according their different characteristics: patients’ age (till 25, 25–49, 50–59, 60–69, above 70), gender (men and women), education status (primary school, secondary school, higher professional, university), employment status (employed, in education, unemployed, disable, home workers or retired), PHC type (private or public), urbanization area (cities, towns, rural area), frequency of the services use (rare, moderate, usually).

4.3.1 Patients attitudes about the different health care aspects in general

Patients’ evaluations on the performance of PHC settings’

Majority of the respondents’ evaluated all 10 statements, related to the performance of PHC settings’, very positively (more then 85% of respondents), except in two cases: “my family physician has sufficient medical
“equipment” (60.5%) and “waiting time to see my family physician is usually too long” (49%) (Figure 4.3.1.1).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes (%)</th>
<th>Rather Yes (%)</th>
<th>No (%)</th>
<th>Rather No (%)</th>
<th>Don't Know (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am satisfied with the opening hours of my PHC centre</td>
<td>94</td>
<td>4.4</td>
<td>0</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>I am well informed about the opening hours</td>
<td>85.7</td>
<td>11.6</td>
<td>0</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>During the consultation no other persons except family physician and myself</td>
<td>88.6</td>
<td>10.6</td>
<td>0</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>My family physician has sufficient medical equipment</td>
<td>60.5</td>
<td>17.7</td>
<td>0</td>
<td>21.8</td>
<td></td>
</tr>
<tr>
<td>The family physician's consultation room is convenient</td>
<td>93.5</td>
<td>4.1</td>
<td>0</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>The waiting time to see my family physician is usually too long</td>
<td>49</td>
<td>48.9</td>
<td>0</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>The waiting room for patients is convenient</td>
<td>91.2</td>
<td>8.8</td>
<td>0</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Staff at the reception desk is kind and helpful</td>
<td>93.2</td>
<td>5.4</td>
<td>0</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Waiting times are short at the reception desk</td>
<td>87.4</td>
<td>11.4</td>
<td>0</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>My PHC centre is well accessible</td>
<td>93.9</td>
<td>5.9</td>
<td>0</td>
<td>0.2</td>
<td></td>
</tr>
</tbody>
</table>

Figure 4.3.1.1. Patients’ attitudes about the performance of PHC settings (%)
Patients’ attitudes about the health care in Lithuania

The assessment on health care is reflected in Figure 4.3.1.2. Most of the patients (above 80%) stated that “physical and technical environment of health care are much better than five years ago”, “Lithuanian family doctors and nurses have good skills and knowledge”, “family doctors and nurses should be better paid”, “if I would know more about the simple diseases I wouldn’t visit my family physician so quickly in such cases”. The statement “health care in Lithuania is better than it was five years ago” was rated lower then the previous ones (agreed two thirds of respondents). Most of the respondents wanted to “have more influence on the management of PHC centre” and that ”with the rising cost of health care it is acceptable that there are co-payments” agreed just more then half of the patients. The patients’ attitudes towards family physicians who work privately were ambiguous: less then half of the respondents evaluated them positively, one third disagreed and one third didn’t have an opinion about it.
Figure 4.3.1.2. Patients’ attitudes about the health care in Lithuania (%)
Patients’ attitudes about their family physician

Family physicians were evaluated very positively (Figure 4.3.1.3) Majority of respondents (above 90%) stated that family physicians takes sufficient time to talk to patients and is well listening to them; is thoroughly asking about the symptoms and always keeps promises; gives clear explanation about prescribed drugs, illness or health problem, results of investigations. Family physicians also will refer patients to a specialist if they would ask for it. After the consolation patients’ questions are usually answered and patients feel able to cope better with their health problem or illness.

Patients were most critical about the following statements: “my family physician knows my work and home situation” (answered “yes” and “rather yes” 73.8%), my family physician is not just available for my medical problems but also for my other personal problems or worries” (62.5%), ”my family physician will visit me at home if would ask for it” (84.7%).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes (%)</th>
<th>Rather Yes (%)</th>
<th>Neither (%)</th>
<th>No (%)</th>
<th>Don't Know (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My family physician is a good family doctor</td>
<td>91.7</td>
<td>3</td>
<td></td>
<td></td>
<td>5.2</td>
</tr>
<tr>
<td>After a visit to my physician I feel able to cope with my health problem</td>
<td>91.2</td>
<td>3.2</td>
<td></td>
<td></td>
<td>5.6</td>
</tr>
<tr>
<td>If I leave my physician's office my questions are usually answered</td>
<td>94.3</td>
<td>4</td>
<td></td>
<td></td>
<td>1.7</td>
</tr>
<tr>
<td>Physician will visit me at home if would ask for it</td>
<td>84.6</td>
<td>2.4</td>
<td></td>
<td></td>
<td>12.8</td>
</tr>
<tr>
<td>Physician will refer me to a specialist if would ask for it</td>
<td>92.6</td>
<td>1.4</td>
<td></td>
<td></td>
<td>5.8</td>
</tr>
<tr>
<td>Physician clearly explains the results of investigations</td>
<td>94.1</td>
<td>4.2</td>
<td></td>
<td></td>
<td>1.7</td>
</tr>
<tr>
<td>Physician clearly explains about my illness</td>
<td>94.5</td>
<td>4.1</td>
<td></td>
<td></td>
<td>1.4</td>
</tr>
<tr>
<td>Physician gives clear explanation about prescribed drugs</td>
<td>94.2</td>
<td>3.8</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Physician is available for solving my personal problems</td>
<td>62.5</td>
<td>19.5</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>Physician always keeps to promises</td>
<td>93.2</td>
<td>3</td>
<td></td>
<td></td>
<td>3.8</td>
</tr>
<tr>
<td>Physician is thoroughly asking about my symptoms</td>
<td>95.2</td>
<td>3.6</td>
<td></td>
<td></td>
<td>1.2</td>
</tr>
<tr>
<td>Physician is listening well to me</td>
<td>95.9</td>
<td>2.5</td>
<td></td>
<td></td>
<td>1.6</td>
</tr>
<tr>
<td>Physician takes sufficient time to talk with me</td>
<td>93.7</td>
<td>4.9</td>
<td></td>
<td></td>
<td>1.4</td>
</tr>
<tr>
<td>Physician knows my medical problems in the past</td>
<td>85.9</td>
<td>19.4</td>
<td></td>
<td></td>
<td>4.7</td>
</tr>
<tr>
<td>Physician knows my work and home situation</td>
<td>73.8</td>
<td>21.1</td>
<td></td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>Physician knows me</td>
<td>89.8</td>
<td>6.9</td>
<td></td>
<td></td>
<td>3.3</td>
</tr>
</tbody>
</table>

Figure 4.3.1.3. Patients’ attitudes about their family physician (%)
Patients’ attitudes about their community nurse

Majority of patients’ assessed community nurse positively (Figure 4.3.1.4).

<table>
<thead>
<tr>
<th>My community nurse is a good nurse</th>
<th>82.7</th>
<th>2.4</th>
<th>14.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>My community nurse clearly explains about my illness</td>
<td>76</td>
<td>14.4</td>
<td>9.6</td>
</tr>
<tr>
<td>My community nurse takes sufficient time to talk with me</td>
<td>79.8</td>
<td>11.5</td>
<td>8.7</td>
</tr>
<tr>
<td>My community nurse knows me</td>
<td>78.4</td>
<td>11.3</td>
<td>10.3</td>
</tr>
</tbody>
</table>

Figure 4.3.1.4. Patients’ attitudes about their community nurse (%)

4.3.2 Patients’ attitudes according their different characteristics

Patients’ attitudes were measured according their different characteristics and there were found several significant associations. More detail analyses regarding statistical significant cases are reflected on the Figures 1–12, (Supplements).

Patients’ attitudes according their age

**PHC accessibility.** Majority of younger respondents (until 50 years) noted that PHC centre is easy accessible, while most dissatisfied were patients above 70 years old ($p \leq 0.05$). Reversible findings were regarding the satisfaction and information about the opening hours of PHC centre: older 60 years patients were more satisfied then younger 50 years old ($p \leq 0.05$). There were no other statistical significant changes according age groups and patients evaluations.

**Family physician.** Almost in all the cases family physician was most positive evaluated by older 60 years old patients vs. the younger ones; most critical were aged below 24 years old patients ($p \leq 0.05$).
**Community nurse.** Nurses were most positive evaluated by older than 60 years old patients vs. the younger ones, the same tendencies were detected in all the statements assessing community nurse (p ≤ 0.05).

**Health care.** The health care, premises and equipment, privately employed family physicians were more positively assessed by patients below 50 years old, p ≤ 0.05 (Figure 4.3.2.1). Younger patients also more frequently agreed with the co-payments (p ≤ 0.05). Patients older 50 years more frequently stated that family physicians’ should be better paid and wanted to have more influence on the management of PHC centre.
Figure 4.3.2.1. Statistical significant associations between patients' assessments about the health care in Lithuania and their age
Patients’ attitudes according their gender

PHC accessibility. There were no statistical significant differences found on respondents’ evaluations according their gender assessing PHC accessibility.

Family physician. The associations between patients and their evaluations about family physicians according gender were also rare, though women statistically significantly more often than men stated that their family physician knows them (respectively 74.9%, 70.6%), gives clearly explanations (respectively 93.6%, 90.1%) and he also would refer them to the specialist (respectively 93.6%, 90.1%).

Community nurse. Gender was an important characteristic assessing nurses. Women in all of the cases assessed nurses more positively than men ($p \leq 0.05$). That nurse was evaluated as good by 84.2% of women and 80.3% of men, respectively – the nurse clearly explains the illness – 77.1% and 73.1%, takes sufficient time to talk – 81.6%, 76.2%, knows the patient – 80.2%, 75.1%.

Health care. Women evaluated premises and equipment more positively vs. men (respectively 82.7%, 78.4%), also they wanted to have more influence on PHC centre’s management (respectively 71.7%, 66.4%), agreed that family physicians and nurses should be better paid (respectively 85.8%, 82.7%) and the co-payments were acceptable (respectively 59.9%, 55.0%).

Patients’ attitudes according their education

PHC accessibility. There were few significant differences detected evaluating PHC accessibility according patient’s education: with the university education, physicians more often stated that the PHC centre is easy accessible (96.1%) vs. with primary school education (87.2%), $p \leq 0.05$. With the higher professional education were most satisfied with opening hours of PHC centre (96.1%) vs. those with the primary one (87.2%).

Family physician. Respondents with higher professional education most usually agreed that family physician knows them vs. with secondary school education ($p \leq 0.05$). Primary school educated more frequently stated that family physician would visit them at home if they would ask; also that physician is available for personal problems vs. secondary school and higher professional education ($p \leq 0.05$). Therefore with university education stated more often vs. secondary one that they will be referred to the specialist if they would ask for it.

93
Community nurses. With primary school education were more satisfied with the nurses and most positively assessed them vs. those with the secondary education and the university education (p ≤ 0.05).

Health care. Most positive attitudes were related to those who had higher professional education and most negative attitudes had with primary and secondary school education. With secondary school education stated most often that physicians in private PHC center are better then publicly employed (p ≤ 0.05). With higher professional education evaluated most positively premises and equipment, they also wanted to have more influence on the management of
PHC centers (p ≤ 0.05). That family physicians should be better paid most frequently agreed patients with university education (p ≤ 0.05).

Figure 4.3.2.3. Patients' attitudes about the health care in Lithuania according their education
Patients’ attitudes according their employment status

**PHC accessibility.** Employed and patients in education were most satisfied with the PHC accessibility vs. others, but they were most dissatisfied with the opening hours of PHC centre and the information about them (p ≤ 0.05). There were no more statistical differences revealed.

**Family physician.** Retired patients were most satisfied with the family physicians and most critical about them were respondents in education and/or employed (p ≤ 0.05). Unemployed seemed to be also happy with the family physicians, though they less frequently agreed that family physician knows them or they will visit them at home.
p ≤ 0.05 – * statistical significant difference between retired and employed, in education, disable, housewife/men; p ≤ 0.05 - ** statistical significant difference between housewife/men and in education; p ≤ 0.05 – *** statistical significant difference between retired and employed, in education, housewife/men; p ≤ 0.05 – **** statistical significant difference between retired and employed, unemployed, in education, housewife/men.

**Figure 4.3.2.4.** Patients’ attitudes about the cooperation with family physician according their employment status (part 1)
Patients' attitudes about the cooperation with family physician according their employment status (part 2)

Figure 4.3.2.5. Patients' attitudes about the cooperation with family physician according their employment status (part 2)
Community nurse. Retired patients and unemployed were most satisfied with the nurses, most critical were respondents who were employed or in education ($p \leq 0.05$).

Health care. The HC in general was most positive assessed by patients staying at home (housewife/men) and those who were in education; they also agreed with co-payments. Most critical about the mentioned statements were retired respondents ($p \leq 0.05$). Disable and housewife/men stated more frequently that privately working physicians are better vs. publicly employed. Disable most positively assessed premises; most critical about it were retired ($p \leq 0.05$). Those family physicians should be better paid more frequently agreed retired and unemployed ($p \leq 0.05$). The management on their PHC centre wanted to have disable or unemployed.
100

$p \leq 0.05$ – * statistical significant difference between unemployed, disable and employed, in education; $p \leq 0.05$ – ** statistical significant difference between retired and employed, in education, disable, housewife/men; $p \leq 0.05$ – *** statistical significant difference between housewife/men, disable and employed and unemployed, retired; $p \leq 0.05$ – **** statistical significant difference between housewife/men and unemployed, disable, retired; $p \leq 0.05$ – ***** statistical significant difference between unemployed, disable and retired; $p \leq 0.05$ – ****** statistical significant difference between disable, housewife/men and retired.

**Figure 4.3.2.6. Patients’ attitudes about the health care in Lithuania according their employment status**
Patients’ attitudes according their PHC centre type

**PHC accessibility.** In all the cases except one patients from private PHC centers were more satisfied with the PHC performance items vs. from the public ones ($p \leq 0.05$). Though patients from private PHC centers indicated more frequently that “waiting time to see their family physicians is usually to long” (56.1%) vs. those from the public PHC centers (45.5%), $p \leq 0.05$.

**Family physician.** There were no significant differences found regarding this characteristic; except one case: that family physician will refer the patient to the specialist most frequently stated the patients from the private PHC centers (94.9%) vs. from the public ones (91.2%), $p \leq 0.05$.

**Community nurse.** Patients from the public PHC centers assessed nurses more positively in all the cases ($p \leq 0.05$).

**Health care.** Most of the patients from private PHC centers were more satisfied with the current HC, equipment and premises; they also stated that family physicians are better in the private PHC centers ($p \leq 0.05$). Family physicians who work privately more positively were evaluated by patients from private PHC centers ($p \leq 0.05$). Patients from the public PHC centers more frequently indicated that they want to have more influence on the management on PHC centers, and agreed with co-payments ($p \leq 0.05$).
Patients’ attitudes according their urbanization

PHC accessibility. PHC centre as accessible was assessed by patients from towns vs. patients from cities or rural areas (p ≤ 0.05). Respondents from rural areas vs. from the cities and towns, were more satisfied with the convenience of waiting rooms, short waiting times at reception desk and with the staff at reception (p ≤ 0.05); they also more frequently stated that during consultation there were no other persons except their family physicians (p ≤ 0.05). Respondents from the rural areas were more dissatisfied with the waiting times to see their family physicians vs. those from cities and towns (p ≤ 0.05). Family physicians consultation room as convenient was most usually evaluated by patients from towns vs. from rural areas (p ≤ 0.05).
**Family physician.** Family physician was most positive evaluated by patients from rural areas vs. respondents from the cities and towns in majority of the questions assessing family physicians: family physician is a good doctor, takes sufficient time to talk with him, he would visit patients at home and refer for the specialist if they would ask for it, he clearly explains about the illness and drugs, is available for solving of personal problems (p ≤ 0.05).

**Community nurse.** Nurses were most positive evaluated in all the statements by patients from rural areas and most critical were patients from cities (p ≤ 0.05).

**Health care.** The positive changes during last 5 years of PHC regarding health care, premises and equipment were assessed better by patients from towns; they also wanted to have more influence on PHC centers’ management and evaluating private working physicians more positive (p ≤ 0.05). Patients from rural areas most frequently noted that PHC providers have good knowledge and skills and agreed that family physicians and nurses should be better paid (p ≤ 0.05).
Figure 4.3.2.8. Patients’ attitudes about the accessibility of the PHC centre according urbanization
People should have more influence on the management of health centers

- Patients from cities: 70.9%
- Patients from towns: 74.4%
- Patients from rural areas: 64.8%

Family physicians and nurses should be better paid

- Patients from cities: 87.3%
- Patients from towns: 82.4%
- Patients from rural areas: 86.3%

Family physicians who work privately are usually better than family physicians who are publicly employed

- Patients from cities: 34.8%
- Patients from towns: 45.6%
- Patients from rural areas: 43.7%

Premises and equipment is better than they were 5 years ago

- Patients from cities: 73.5%
- Patients from towns: 86.5%
- Patients from rural areas: 78.3%

Lithuanian family physicians have good knowledge and skills

- Patients from cities: 89.4%
- Patients from towns: 87.9%
- Patients from rural areas: 84.4%

At present health care in Lithuania is better than it was five years ago

- Patients from cities: 62.1%
- Patients from towns: 72.5%
- Patients from rural areas: 62.1%

$p \leq 0.05$ – * statistical significant difference between patients from cities and rural areas, towns; $p \leq 0.05$ – ** statistical significant difference between patients towns and rural areas, cities; $p \leq 0.05$ – *** statistical significant difference between rural areas and towns, cities.

**Figure 4.3.2.9. Patients' attitudes about the health care in Lithuania according urbanization**
Patient attitudes according their frequency of the PHC services use

PHC accessibility. In all the other statements usually users evaluated PHC centre very positively. The most critic evaluations were presented by rare users except one case- they most frequently revealed that PHC centre is well accessible vs. moderate and usually users (p ≤ 0.05).

Family physicians. Usually users’ evaluated family physicians better then others in all of the cases and most dissatisfied with them were patients from the cities (p ≤ 0.05).

Community nurses. In all the cases statistically significantly usually users evaluated nurses better and rare users were least satisfied with them.

Health care. Lithuanian family physicians have good knowledge and skills and they should be better paid most frequently agreed usually services’ users (p ≤ 0.05). Rare users more often agreed with the co-payments and evaluated privately working family physicians better (p ≤ 0.05).
Summarizing patients’ evaluations important findings must be underlined. The patients’ evaluations were compared according to 7 characteristics: PHC centre type, urbanization, patients’ gender, age, frequency of the service use, employment status and education. Positive patients’ evaluations (“yes” and “rather yes”) statistically significantly differed according to different characteristics. The different characteristics were dominating evaluating different health care aspects. Some statistically significant findings should be emphasized more in detail. The accessibility of PHC centre most positively was assessed by respondents younger than 50 years old, employed or in education, from towns and usually users of PHC services. The opening
hours were most positively assessed by older 60 years old respondents, retired or disable, private PHC centers, patients from rural areas and usually users of the services. Family physician was assessed most positively by older 60 years old, retired or disable, from rural areas and by frequent services users. Community nurses were assessed most positively by older 60 years old, women, and primary school education, retired or disable, from public PHC centers, rural areas and by frequent services users. With possible co-payments most frequently agreed younger 50 years old, women, and housewifes, employed or in education, from public PHC centers, rare PHC services users. More influence on the management of the health care centers wanted older 50, women, higher professional education, unemployed or disable, from public PHC centers and towns. The changes during health care reform most positively evaluated younger 50 years old, women, with higher professional education, in education or housewives, from private PHC centers and patients from towns. Privately working physicians were evaluated more positively by younger 50 years old, with higher professional education, disable and housewifes, from towns and rare users of PHC services. That family physicians should be better paid most frequently stated older 60, women, with higher professional and university education, retired and unemployed, from cities and rural areas, usually PHC services users. Family physicians and community nurses have good knowledge and skills more often stated with primary school education, from cities and towns, rare or moderate users of the services.
5. DISCUSSION

There were a lot of different PHC aspects assessed in our survey. There were evaluated the main changes between district and family physicians’ regarding their workload, task profiles and job satisfaction during ten years of PHC reform. In addition patients’ evaluated performance of PHC centers, their family physician and community nurse and health care in general. All the mentioned aspects will be discussed in three sections:
1. physicians’ workload and task profiles;
2. family physicians’ job satisfaction;
3. patients’ attitudes towards PHC.

All the mentioned sections will contain three main paragraphs: main findings, methodological limitations and the comparison of findings in the light of the other studies’ results.

5.1. Physicians’ workload and tasks

Main findings. The family physicians’ workload statistically increased during ten years of the health care reform and their task profiles became wider. In addition the services in 2004 provided by family physicians’ retrained from pediatricians and internists were more related to Lithuanian description of the Family physicians’ professional norm (the opposite situation was in 1994). The organizational aspects during health care reform were developed better, but the cooperation with other medical professionals seemed to be low (especially with social workers). Family physicians lack activity in health education and involvement in the medical procedures. Family physicians after FM didn’t provide a larger scope of medical services vs. former district physicians.

Methodological limitations. There were some limits related to the family physicians’ survey questionnaire. The questionnaire was used in the international survey in 1994, so the questions were adopted for the European PHC level. To adopt the questionnaire according Lithuanian physicians’ professional norms were impossible, because the comparison during health care reform was impossible as well. Few problems regarding the mentioned above should be discussed.

Firstly, tasks profiles of family physicians are different in Lithuania and other European countries. For instance, acute cerebro – vascular accident, peritonsilar abscess, ulcerative colitis, acute myocardial infarction are not uniform task of the family physicians’ in Lithuania [148, 149]. The removal of sebaceous cyst from the hair scalp, excision of warts, removal of rusty...
spot from cornea, joint injection, sinus puncture, paracentesis, cryotherapy are not included in Lithuanian description of the family physicians professional norm as well.

Secondly, we are judging about management of diseases on self-reported rating scales. Due to formulation of some statements some misunderstandings were available. For example, in the statement about myocardial infarction treatment or follow up there was no explanation if the process was acute or chronic. This is very important, because acute myocardial infarction is treated in the tertiary level and chronic in the primary settings. Thirdly, respondents were asked about the possibility to use equipment, provide medical procedures, treat the diseases in their PHC centre, therefore there were no specification of these questions, if physicians were providing the services by themselves or by specialists’ help. Our results reflected a high involvement of former internists in the mentioned services and this might be an arguable finding if they provided the services by themselves? Major of the former pediatricians and former internists in 2004 were from the public PHC centers (74% and 78% respectively) and possibly were working together with other specialists. These could make an impact on the higher activity of former internists.

Our findings in the light of other studies. Our survey reflected the increase of family physicians’ workload. What are the (dis)advantages? First of all it proves that family physicians took over the gatekeeping function: they are the first contact physicians. This also was revealed by other researchers. Plieskis et al. assessed the restructuring process in PHC level for the year 2002–2006; number of private PHC centers, patients on the list and consultation rate were statistically significantly increasing (average annual changes were 6.9%, 22.2%, 27.2% respectively); as well as the proportion of patients’ registered with the family doctors and the number of visits to family doctors were significantly increasing during reform (average annual changes were 22.5%, 27.2% respectively) [117]. Another study in 2005 showed that 69% of all visits were to primary physicians, while to specialist were 43.4% of all patients’ visits a year [190].

Therefore there is disadvantage of the increased workload. The high workload influence negatively on job motivation and satisfaction: physicians with higher workload experience burn out and suffer from emotional stress, chronic fatigue symptoms [160]. Norwegian researchers detected that working hours were closely related to patients’ list length and indicated that job satisfaction were lower when physicians were having a heavy workload and full patients’ list [60]. Physicians in our survey also revealed low job satisfaction. May we do a precondition that the workload of Lithuanian family physicians is heavy with 1600 of patients on the list,
25 office consultations per day and total 58 working hours per week? This question needs more evidence based research in the future with more detailed evaluations: “isn’t the contemporary workload heavy?”, “isn’t the working environment fulfilled with bureaucracy, absence of a team work, lack of e-health”?

The changes in family physicians involvement in the different health care services was reflected during ten years period. We can conclude that with some aspects there were marked improvements. Family physicians in 2004 showed higher clinical activities and provided a wider range of services. The exceptional former district physicians’ activity was noticed in the treatment of eye, gynecological, various of chronic diseases. The findings also revealed that former district physicians were more involved in routine antenatal care and former internists were more involved in children immunization program and their health care. This proves that during ten years of reform retrained district doctors were shift towards the family physicians’ tasks.

The similar findings were presented in the family physicians survey for the year 1999–2006 provided by Jankauskienė et al.: the activity in the treatment of eyes, otorhinolaringology diseases increased between family physicians in 2006 comparing with the situation in 1999; therefore the involvement of physicians in minor surgery statistically decreased during the health care reform (53% in 1999, 28.1% in 2006). There were also detected that 17% of family physicians provided children care in 1999; while in 2006 majority (87%) of family physicians’ were taking care with the children [68]. Raila presented similar findings: family physicians were having integrated communities and they provided services for adults and children as well (2002) [124].

Our survey reflected that former internists were statistically significantly more active in the treatment of series diseases (chronic bronchitis, herniated disc lesion, congestive heart failure, ulcerative colitis, Parkinson disease, depression, myocardial infraction) vs. former pediatricians and physicians after FM residency. Raila also assessed family physicians activity according their background and reflected that family physicians after FM residency were more active in gynecology and neurology, while former internists in minor surgery and internal medicine; former pediatricians in children care, skin disorders, otorhinolaringology and inflectional diseases [124]. How we may explain our findings? Firstly, it may be due to uncompleted separation of primary and secondary health care levels in public PHC centers. Also possible bias of the survey instrument could influence on the higher activity of former internists. Our data revealed that physicians after FM residency were more involved vs. former district physicians in the use of blood
glucose test and ophthalmoscope (p ≤ 0.05), but somehow their involvement in fundoscopy and treatment of diabetes or eye disorder (hordeolum) didn’t differ? Thirdly, the survey instrument was the questionnaire, based on the physician’s answers and attitudes, the survey didn’t reveal the actual performance of the services (example: assessments of the outcomes and statistical data). Summarizing we may conclude that the primary and secondary health care levels are not completely separated and it is possible to argue with the survey results former internists by themselves or with the help of medical specialists?

Some assumptions should be added regarding family physicians’ face to face meetings with different groups of medical professionals: social workers, pharmacists, family physicians and medical specialists. Majority of family physicians were having meetings more then once a month with other family physicians, every second with medical specialist and pharmacists, and every sixth with social workers. Are the number of meeting sufficient is not easy to answer. One precondition may be presented – cooperation may be very helpful for the better patient’s outcomes and for family physicians job motivation. The importance of personal relationships between family physicians and specialist were related to family physicians’ intention to learn from the specialists [153]. The main motives were shared responsibility and care for the patients, extending the degree of collaboration would serve the patient’s interest, particularly of serious ill and the elderly [11].

Vladičkienė and Petrauskienė (1999) evaluated physicians’ attitudes towards the cooperation with other medical professionals and revealed that majority of family physicians were ready for cooperation [163]. The survey by Jokimaitis et al. (1998) detected that family physicians preferred to cooperate with medical specialist and wanted to assess with them prevention programs, treatment and diagnostic of most common diseases; while medical specialists preferred to cooperate with authorities and with the other specialist [71].

Vladičkienė (1999) was also assessing family physicians’ motivation and reflected that partnership in PHC was very important; physicians had a higher impact on job motivation regarding their cooperation with specialists. The findings that physician’s job satisfaction was low, the precondition may be that the current frequency with the specialists seems to be low. Another regrettable finding was the lack of cooperation between social workers. The same findings were in the previously mentioned studies: family physicians cooperate with social workers rare [72]. This finding indicates the disintegration between the social and health care institutions. According to the mentioned findings of our and other surveys is not completely clear if family physicians attribute the collaborative function? What are the
obstacles to ensure this function? More assessments are needed in future with some suggestions about new collaboration models.

The provision of preventive care is a core value in the PHC level. May we conclude from our survey, that physicians are involved in preventive services? Our survey is unable to answer completely to the question. There were just few questions regarding preventive care: physicians’ involvement in measuring blood pressure, cholesterol, cervical smears; and the physicians seemed to be active in the mentioned services. Physicians were also questioned about their activity in health education: majority (above 80%) provided education in normal patient’s contacts, every tenth were having group education and every tenth were not involved in health education. Though the European survey revealed that in the mentioned preventive services Lithuanian patients were significantly less involved vs. European level [31]. Is this situation critical should be answered in the future? One is clear that physicians should be involved in preventive services. Armonaité and Andrijauskas proved that health education and prevention in communities are more effective as well as in the cities or rural areas [4, 5]. It was also proved that family physicians during ordinary consultation may reduce patients’ alcohol consumption and may be very helpful for patients informing how to quit smoking (starting from some motivated conversations about smoking cessation and continuing to individual or specialized therapy: use of Fagerstrom questionnaire, nicotine therapy) [162]. What are the possible reasons regarding inefficient health education; unfortunately, there are no evident data. Of course it might be due to high workload, lack of motivation. Additional payment is very helpful in increasing family physicians activity in preventive care, a nice example was the recognition of incentive services in national level since 2004–2005. Family physicians were extra paid according their activity in prostate, cervical, breast cancer screening, and as the result of that – the significant increase of the mentioned services in every day practice.
5.2. Family physicians job satisfaction

**Main findings.** Family physicians’ satisfaction with their work was ambiguous and the satisfaction with their work was decreased during 10 years of PHC reform. Physicians in 2004 more frequently agreed that some parts of their work do not make sense and there are a lot of administrative details in their work, they were lacking correspondence between their efforts and reward.

Therefore some positive facts were presented: majority of respondents indicted that their work still interests them and their patients accept them as their personal doctor. Family physicians attitudes in 2004 towards health care were ambiguous: premises and equipment, knowledge of physicians and nurses were assessed positively by majority of physicians, while with the statement “health care in Lithuania is better than it was five years ago” agreed half of the respondents. Family physicians preferred better payment and agreed with co-payments, wanted their patients to be more involved in the health care.

Family physician’s attitude was influenced by different characteristics. Most critical attitude of family physicians were related to high workload, young physician’s age, lack of face to face meetings with social workers and specialists.

**Our findings in the light of other studies.** Family physicians’ job satisfaction decreased during health care reform and physicians were more often ready to change their work to non medical one, if the working conditions were offered similar. There were other survey assessing physicians’ satisfaction in Lithuania and the results also were not quite positive. The survey in 1999 reflected that just 55.1% of family physicians were happy about their profession [164], in 2003–2005 survey 67.2% of family physicians were satisfied with their profession and in 2004 – 56.7% of doctors in primary and secondary health care levels stated that they were happy with the working conditions [77]. Lack of satisfaction could be influenced with series problems in Lithuanian health care. The inappropriate professional recognition was proved in 2002 survey, where 60.7% of medical residents and 26% of physicians intended to leave for the EU and other countries; the major reasons for leaving were higher salary, better professional possibilities, and better quality of life [141]. There were presented several reasons related to family physicians’ dissatisfaction: inefficient payment, excessive paperwork and other unnecessary administrative details, high workload, insufficient sharing of information between doctor and authorities, lack of professional training [77, 164].
There were proved that family physicians job satisfaction was also related to their motivation; in addition physicians with higher motivation spend more time for self education, and they tend to achieve their goals more often [43, 103]. The results presented by Vladičkienė survey (1999) reflected several factors influencing job motivation: health status and lifestyle of family physicians (higher motivated physicians evaluated their health status better), professional factors (future guarantees, interesting work, monetary award, age had the most impact on physicians’ level of motivation), partnership in PHC (for older physicians the cooperation with physicians had a higher impact on job motivation). There were emphasized some factors influencing family physicians’ dissatisfaction with their profession: low salary, inappropriate working conditions (excessive paperwork), insufficient sharing of information between doctor and authorities, lack of professional training. Glumbakaitė revealed that doctors with longer duration in practice more frequently answered that job satisfaction, good relations with patients, possibility to improve qualification, financial guarantees, good working conditions had much bigger influence for their work motivation vs. those who had less duration [43].

Insufficient sharing of information between doctor and authorities influenced negatively on family physicians satisfaction with their work [164]. Some authors admit that family medicine was covered by negativism and lack of respect from specialist colleagues and lack of cooperation may influence negatively to job motivation and satisfaction [80, 152]. Consequently our findings proved the importance of more frequent meetings with other medical workers to more positive attitude of family physicians. Family physicians prefer to cooperate with the specialists, because the possibility to change the information is very important to them and unfortunately they indicate lack of such meetings and information transfer [164].

There were proved that family physician (dis)satisfaction is influenced by stressors such as age, high workload, time limitations, competency issues, challenges of documentation and practice management, limited resources, lack of support from specialists, feeling undervalued, and financial concerns [91]. The findings of our survey are similar. More critical attitude were related to younger physician’s age, higher workload, lack of assistance and face to face meetings with social workers and specialists. More positive attitude depended on the higher physician’s involvement in particular services and more CME hours.
5.3. Patients’ attitudes towards PHC

Main findings. Patients’ assessed different health care aspects (performance of PHC, health care in general, cooperation with family physician and community nurse) very positively. Evaluating PHC performance, respondents were most critical with the long waiting times to see their family physician and less frequently agreed that their physician have sufficient equipment. With the statement that health care is better then five years ago agreed just two thirds of respondents. Therefore, patients wanted to have more influence on the PHC centre and one third of them disagreed with possible co-payments. Regarding family physicians evaluations most critical attitude were towards the following statements: “my family physician knows my work and home situation”, my family physician is not just available for my medical problems but also for my other personal problems or worries”.

Different patients’ characteristics were dominating evaluating four aspects. Patients’ evaluations differed according age. The differences regarding patients’ evaluations on the performance of PHC centre according age were least frequent. Younger patients assessed the accessibility of PHC centers most positive; though older were happier with the working hours. The exceptional importance regarding this characteristic was related to patients’ evaluation about family physician and community nurse. Most positive evaluations were provided by patients above 60 years old vs. younger 50 years old. The evaluations of health care according age varied between the statements: younger 50 years respondents more often agreed with co-payments and evaluated changes during health care reform more positive vs. vs. older ones.

Gender was most important characteristic assessing community nurses. In all the cases women’s attitudes were more positive then men’s’. Education seemed to be least important characteristics to patients’ assessments regarding PHC centre performance. With lower education patients were happier with psychological support of the physicians (helps to cope with the problems even with the personal ones), with university education were happier with the fact that physician will refer them to the specialist if they would ask for it. There were a lot of significant differences assessing community nurse according the education: with primary school education were more satisfied vs. with the university and/or secondary school education. The education varied between the statements assessing health care in Lithuania.

There were few differences assessing PHC performance according employment status. The accessibility was evaluated most positively by
employed respondents and in education, though with opening hours the happiest were retired. Employment status was very important assessing family physician and community nurse: retired and unemployed were most satisfied. The evaluations of health care according employment varied between the statements.

The PHC centre type seemed to be important in the patients’ evaluations regarding the following aspects: PHC performance (patients from the private PHC centers assessed PHC performance more positively vs. form public ones except waiting times), community nurse (patients from the public PHC centers assessed them more positively vs. private PHC centers) and health care (PHC center’s type varied regarding the question).

Patients’ evaluations were different according urbanization. Most satisfied were patients from rural areas assessing all 4 health care aspects and most critical were respondents from the cities.

Patients’ evaluations according the frequency of the services use most often revealed that most satisfied with all the aspects were by usually users of PHC services.

**Multidimensionality of “patient satisfaction” concept.**

Terminological misunderstanding might cause a lot of confusion to researches. Patients’ views surveys are described differently in the literature: patient satisfaction, expectation, experience, evaluation. So what is the difference between these terms and what should be measured?

Dictionary definitions attribute the term “satisfaction” to the Latin root satis, meaning “enough”. Something that satisfies will adequately fulfill expectations, needs or desires. Usually “satisfaction” refers to an emotional response to whole experience, while the term “evaluation” suggests a cognitive process in which specific aspects of care are assessed. Pascoe describes patient satisfaction as the result of a cognitive evaluation and emotional reaction to the structure, process and outcome [112]. Williams et al. describe that satisfaction is based on the fulfillment of expectations [177]. Parasurman et al. presents a similar view: he suggests evaluate expectations and experiences, because usually (dis)satisfaction results if expectations have been met or not [111].

According to Wensing and Elwyn, the methods used to determine patients’ views can be divided into three types: measures of preferences, evaluations by users, and reports of health care. The authors suggest these definitions: (a) preferences are ideas about what should occur in healthcare systems, preference is often used to refer to individual patients’ views about their clinical treatment. and the term priorities is used to describe the
preferences of a population; (b) evaluations are patients reactions to their experience of health care (for example, whether the process or outcome of their care was good or bad); (c) reports represent objective observations of organization or process of care by patients, regardless of their preferences or evaluations [170]. It was proved by a study, that patients clearly distinguish their preferences from their evaluations of PHC. Aspects of PHC, whether important or not, can be evaluated positively or negatively. Patients’ preferences and evaluations are, however, both influenced by the length of the time elapsed since the consultation: the longer the period after consultation, the lower was the mean percentage rated as “good” in the evaluation questionnaire and higher was the means percentage of all the aspects rated as “very important” [73].

In nowadays a new concept was presented. Patient satisfaction is defined as the extent to which services satisfy the desires of patients regarding structure, process, outcome dimensions and characteristics; and patient satisfaction is understood as a multidimensional concept, based on a relationship between experiences and expectations [136]. The new concept was also presented by Zastowny et al. based on three qualities of care dimensions: performance, importance and impact [189]. Performance relates to the actual experience of the use of health care services (rather than a patient satisfaction judgment), which is in line with recent developments within health services research. Importance refers to the fact that people see some features of health services as more significant than others. They reflect what people see as desired qualities in health care. This approach avoids problems with conceptualizing people’s evaluations of health care in terms of satisfaction (usually high levels of satisfaction, not specific enough to be used in quality improvement) and expectations (ambiguous relations between expectations and actual experiences) [52].

In conclusion of the described above, it is certainly clear, that traditional satisfaction measures are ambiguous. Achieving quality improvement, patient surveys must probe beyond simplistic to ask the patient indicate their level of satisfaction. It is more valuable asking the patient to evaluate the specific item and to find out what is most important. For example: long waiting times not necessarily means dissatisfaction with the health care services, because more important for the patient is the time spent during the consultation [178].

Therefore, it is very important to assess different dimensions of the health care. It was established that patients’ judgments are related to different aspects of the health care system, and therefore measuring instruments should reflect the multidimensionality of care giving process [56]. Also it will help to find a tiny limit between patient satisfaction and dissatisfaction if the different
dimensions would be analyzed [23]. The following dimensions are recommended in the literature: availability (opportunity to choose a physician); accessibility (waiting times, telephone consultations, financial and physical accessibility); organization and cooperation (premises, continuity, Cooperation); medical care (effectiveness, competence); doctor patient relation (humaness, patient’s privacy, time for a patient. involvement in decisions); information (provision of relevant information); counseling and support (attention for patients psychological problems, stimulating self-help) [34, 74].

Though some studies added some important issue – that some aspects (especially those that requires a qualified evaluation) can’t rely alone on patients’ assessments; e.g.: the evaluation of technical quality should be also measured using practice records, because patients are unable to assess them [126].

Selection of the trial method and instrument. It was proved, that trial method makes an influence on the study results, though the selected study method directly lead to the accuracy of study results [130, 131]. In general patient view surveys methods are classified as Quantitative and Qualitative. Quantitative methods basically are: (1) ranking (simple ranking or conjoint analysis); (2) rating (Likert. Guttman scales. SERVQUAL); (3) choice based techniques (simple or conjoint analysis choice and etc. [130]. The Qualitative methods identified as: (1) individual (one to-one interview); (2) group-based (focus groups, citizens’ juries, consensus panels and public meetings) [130]. Quantitative approaches are very popular because gives an opportunity to compare patients views in different HC centers, countries and etc.; the data are easier to analyze. Qualitative approaches usually based on interview approach, usually orientated towards focus groups, the questions are open ended. These types of surveys give an ability to target specified sample of respondents; reveal the most important questions and problems to the patients; provides a possibility to get a lot of information during short period of time [25]. The disadvantages are: lack of anonymity, the coordinator might influence self-determination of the patient; it is difficult to interpret study results. Studies confirmed that data for qualitative studies are more time consuming and costly, but these methods yield a more detailed account of peoples perceptions of their care [92]. Open ended questions can generate more negative comments then closed questions, although the responses may lack detail [45]. Some researches recommend cooperating qualitative and quantitative data together. It is recommended to start the study using open ended questions’ with the intention to reveal most important and actual problems. A quantitative questionnaire should be constructed according to the previous findings [1, 35]. Many applied health (service) researchers argue that qualitative and quantitative methods can and
should complement each other. Pope and Mays highlighted three ways in which this could be done: (1) many quantitative researchers are familiar with the idea of using qualitative methods in order to prepare their quantitative techniques; for example, using interviews and/or focus groups to determine the questions for a postal questionnaire, the content of an outcome indicator, or the criteria to include in a CA study; (2) qualitative techniques can be used in parallel with quantitative ones, either to help explain quantitative findings or to enlarge on such findings; or as part of triangulation; whilst quantitative techniques tell us that the public prefer local clinics or do not want resources to be allocated to certain social groups; qualitative methods can help us understand the reasons behind such preference structures. Using both types of techniques in parallel can be part of a validation process, as in a triangulation exercise whereby the different techniques address the same issue from a slightly different direction; (3) finally, qualitative methods may be used to explore “complex phenomena or areas not amenable to quantitative research” [119].

Another problematic area – which scale to use in the questionnaire? It was proved that in dichotomous questions (yes / no), respondents are more usually to use the answer “yes”, and in the Likert type scale from very – satisfied to dissatisfied, the respondents more frequently will use: “satisfied” [14]. It may be due to “social desirability bias”. In addition respondents may avoid using extreme response categories (central tendency bias) and this also may lead to distortion of the results. Other researches argue about patients’ reports or ratings (Table 5.3.1).
Table 5.3.1. The comparison of patients’ ratings and reports

<table>
<thead>
<tr>
<th>Patients reports</th>
<th>Patients ratings</th>
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<tbody>
<tr>
<td>e.g.: “How often does GP inform you about healthy life style?” (Never. Sometimes. Usually. Always)</td>
<td>e.g.:” How do you evaluate if GP informs you about healthy life style?” (Very poor. Poor. Fair. Good. Very good)</td>
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- Instruments that measure experiences using patient reports require patients to recall and estimate the frequency of certain events [29].
- Judgments based on patients reports are facility centered, not patient centered [88]. This method should be used if data are required about patient’s pathway through different healthcare institution [170].
- Patient reports simply assess the number of problems regardless of the importance of the issues to patients; reports are intentionally more factual and objective [167].
- Questions asking for “reports” tend to reflect better quality of care and are more interpretable and actionable for quality improvement purposes than ratings of satisfaction or excellence [19].

In addition a lot of arguments are related to Likert scale statistical analyses. The typical question is the data collected on “ordinal scale” (not equidistant) or “interval type” (equidistant). If the Likert scale fall within the ordinal level of measurement it may be analyzed it two ways: using frequencies/percentages of response in each category or scored as ordinal data that should employ the median or mode as the measurement of central tendency (the mean and standard deviation are inappropriate for ordinal data). Therefore some researchers use Likert-type categories as interval scales, but it must be considered at the design stage and it may be used when the summed scores are normally distributed [123]. The Likert scale might be analyzed reducing the scale to the nominal level by combining all “agree” and “disagree” responses into two categories of “accept” and “reject”; in this case the chi square test, Cochran Q or Mc-Nemar tests are common statistical procedures.
Summarizing must be admitted, that researchers still argue which is the best way to assess patients’ view. Was the assessment of patients’ satisfaction correct in our study? Some critics would suspect the survey because of the very positive survey's results. High levels of satisfaction: a lack of study validity? Some authors doubt on the ability of such surveys to detect real differences in patients’ opinions [17, 34]. Our patients’ survey presents some negative and positive facts. Firstly, patients were questioned in the PHC centers and it may be related to higher levels of positive evaluations. The place and the methods (interview or mail) where the patients are being questioned make an influence on patients’ evaluations. If patients would be questioned in the health care center such methods have a higher satisfaction vs. postal surveys [58. 84]. The differences between hands out and mailed patient satisfaction surveys showed: that handout surveys yielded higher satisfaction scores then mailed surveys [51]. Fitzpatrick explains high levels of satisfaction are typically recorded by at least 80% of respondents to satisfaction surveys and possible reasons for this include the reluctance of patients to express negative views about their healthcare [33]. Secondly, there were used rating technique it the questionnaire, though some authors recommend to use open ended and smaller scale in satisfaction studies, because they are more likely to report areas of criticism than large-scale (postal) questionnaire surveys [21]. Though Ross et al. found that global measures and very-dissatisfied to very satisfied scales were inferior to multidimensional evaluations that assessed several aspects of patients’ care” [131].

Our findings in the light of other studies. Are there any similar finding regarding high levels of satisfaction? High levels of satisfaction in Eastern EU countries have been proved by several studies. Patient’s satisfaction with PHC in Slovenia was shown to be relatively high: 58.2% rated the level of care received as excellent. Waiting time in the waiting room was evaluated poorestly (26%). Participants were also less satisfied with the time perceived during the consultation (51.6%), feeling that family physician showed interest in their personal situation (46.5%), family physician made easy to explain problems (49.1%). The confidentially of medical records was evaluated high 77% as the listening capacity of family physician – 69.4% [83]. The level of satisfaction were high: 88.3% of respondents rated items of the questionnaire excellent or good and only 3.7% of respondents rated them poor or very poor. Patients evaluated PHC implementation positively in Estonia as well: during five year period most of Estonian population has accepted new PHC system and the satisfaction rate increased: out of all the respondent who have had a contact with their family doctor during the last 12 months 87% were satisfied with his work [118].
The overall satisfaction with the family doctor depended on perceived competence of the physician, understanding the patient’s problem; punctuality of the physician, location of the PHC centre [118].

Patients’ satisfaction with the family physician behavior (empathy, competence, expertise) in Croatia was also very high – 85.3% of respondents were satisfied. Differences in answers were found regarding gender, age, education level, reason for encounter (acute or other). Younger patients, whose reason for encounter was an acute condition, were less satisfied with the physician consultation [82]. Patients in our survey assessed the PHC aspects differently. Patients were not satisfied with the waiting times and this finding was inline with the other surveys [76, 78]. Patients’ from private PHC centers, rural areas, indicated more frequently that “waiting time to see their family physicians is usually to long” vs. from the public PHC centers and cities and towns. Other surveys revealed the opposite results; most dissatisfied with the waiting times were patients from the cities, public PHC centers [115]. This finding is difficult to explain, and need more evidence if the waiting times in rural and/or private PHC centers are really longer?

The territorial accessibility was positively evaluated by younger (24 – 29) patients, rare users, living in towns and by respondents in education or already with university education. The similar findings were presented by other authors [67].

The interesting finding was that patients’ characteristics influencing their attitudes towards family physicians’ and nurses were different. The PHC centre type (from public PHC settings patients were happier vs. from private ones) seemed to be important factor in general nurse assessments, but not for family physicians. Why? Possibly the reason is that family physicians were evaluated in public PHC centers as well as in the private ones. Therefore the nurses could be evaluated well in public PHC centers because family physicians work together with them more frequently rather in the private ones. It is obvious that in the private PHC centers the authorities are more “economical” and they are less assisted with general practice nurses.

Patients were happier with the information provided by family physicians rather by community nurse. Zagurskienė in her theses assessed the information provided for patients and reflected that information for patients was provided 90.4% by doctors and 17.1% by nurses, physicians were indicated to be the main source of health information in most cases; nurses more often than patients noted that information provided by them was adequate [188].

Patients evaluated health care positively in our survey and similar findings were presented in the other surveys. Giedrikaitė in her thesis
compared the opinions of physicians and patients about confidence and confidentiality in healthcare institutions. Nearly all patients (94.2%) stated that they trusted their physician. There were no differences between the physicians’ and the patients’ opinions in this respect. Cooperation between patients and physicians were positively assessed by patients. Respectful communication is one of the preconditions for confidence between a physician and patient. Another study also proved that majority of patients were confident with family physicians, but not with the healthcare system. Gender and education level had impact on patient’s confidence in healthcare.

Summarizing the patients’ attitude we may conclude that patients evaluate family medicine and its different aspects very positively. These positive assessments are in line with other studies. The high satisfaction may be criticized, the survey instrument have some solid arguments about its relevance:

1. The instrument is reliable (all Cronbach’s alpha coefficients were above the 0.7 criteria suggested for group comparisons, and these scales indicate excellent internal consistency) and valid (each item in the questionnaire should be more correlated to its own scale (convergent validity) than to the other scales (discriminant validity and our results satisfy previously mentioned condition) [55, 39].

2. Patients’ were assessing different PHC aspects and this helped us to reveal their different attitudes; using multidimensional surveys in which patients evaluate specific aspects of their care episode reduces positive bias and identifies more opportunities for quality improvement [178].

3. The questionnaire was based on two questionnaires, which were already proved as appropriate instruments for health care quality assessments QUOTE and GPAS [136, 125].
CONCLUSIONS

1. A number of important changes in the task profiles of family physicians were observed: after ten years of PHC reform they performed a gatekeeper’s function and provided a wider range of services (including care for children, antenatal and adult care) and were more oriented towards the Lithuanian description of a family physicians professional norm.

2. Organizational aspects of health care changed during PHC reform: the workload increased, and an appointment schema was more frequently used and elements of teamwork were observed. Family physicians activity in health education, application of medical procedures and cooperation with social institutions were low. The hours used for continues medical education were reduced.

3. Family physicians’ job satisfaction had decreased during ten years of PHC reform: the majority of physicians were unsatisfied with the feedback between their efforts and reward; they experienced a lot of unnecessary administrative details, wanted better payment and agreed to co-payments from the patients. They furthermore wanted their patients to be more actively involved in the health care. One fifth of physicians were ready to change their profession if they were offered better financing guarantees and working conditions outside PHC.

4. Family physician’s attitudes were related to the following characteristics: PHC type, physicians’ gender and age, workload, involvement in provision of medical services, and the frequency of meetings with social workers and medical specialists. Critical attitudes were foremost related to high workload, rare face to face meetings with social workers and specialists, young physician’s age and working in public PHC centre.

5. Patients’ attitudes were very positive in the assessment of the performance of PHC, family physicians, community nurses and Lithuanian health care as such. The majority of patients wanted to participate in the management and performance of their PHC centre. The most critical patient’s attitudes were related to long waiting times and insufficiency of medical equipment. One third of patients disagreed with possible co-payments.
Patients’ assessments of family physicians and community nurses were related to their age, gender, education, employment status, PHC type, urbanization, and frequency of the service use: the most positive were older, lower educated, retired, from rural area patients and the more frequent users of PHC services.
RECOMMENDATIONS

For PHC policy makers and authorities

1. The health care policy should be based on continues monitoring of the ongoing health care reform: it helps to identify contemporary problems, provide some suggestions for solutions and to reflect about the outcome.

2. The legislations regulating Lithuanian family physicians’ professional norm, especially regarding physicians’ workload, work scope and remuneration should be reconsidered by authorities.

3. Family physicians activity differs according to their background; further qualification should be continued especially with regard to children health, antenatal care, treatment of diseases, and provision of medical procedures.

4. One of the main principles of PHC institution, i.e. primary diseases prevention and health education, is missing. Additional encouragement is needed. The reduction of excessive workload and the increasment of motivation might be helpful.

5. The workload of family physicians may be reduced in several ways: the integration of e-health should be continued; community nurses should be more involved in the provision of PHC services (they should be specialized in health care education, preventive services, provision of information for patients’); social institution should work in line with the family physicians, new collaboration models between the mentioned institutions may be reconsidered in future.

6. Lack of family physicians satisfaction with their work is a major concern for the future of family medicine institution. The appropriate workload, remuneration, cooperation with other medical personnel, increased hours for CME, the extension of private PHC may be the solutions how to increase family physicians’ job satisfaction.
For future researchers

1. The health care services research should ensure: continuity, instant feedback to authorities and comprehensive approach (to assess the attitudes of health care providers and their users).

2. The use of valid and reliable instruments and methods, certified in international level in health care research may be beneficial.

3. Evidence based data is missing regarding family physicians teamwork, work environment, provision of preventive services and health education. Further surveys are needed to assess physicians’ task profiles in relation to the Lithuanian description of the family physicians professional norm.

4. Patients’ attitudes surveys regarding health care quality assessments should include different health care aspects. It would be also valuable to distinguish patients’ experiences using PHC services from their needs.
LIST OF PUBLICATIONS

Regarding PhD thesis

Presentations
Others


REFERENCES

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188. Zagurskienė D, Misevičienė I. The comparison of patients’ and nurses’ attitudes to health education and nurses’ participation in this process. Medicina (Kaunas) 2008;44:885-94.


p ≤ 0.05 – * statistical significant difference between respondents younger 49 years old respondents and older 60 years; p ≤ 0.05 – **statistical significant difference between respondents younger 49 years old respondents and older 50 years; p ≤ 0.05 – *** statistical significant difference between respondents younger 49 years old respondents and older 70 years respondents.

Figure 1. Patients’ attitudes about the accessibility of the PHC centre according their age
p ≤ 0.05 – * statistical significant difference between respondents younger 49 years old respondents and older 50 years; p ≤ 0.05 – **statistical significant difference between respondents younger 49 years old respondents and older 60 years.

**Figure 2. Patients' attitudes about the cooperation with family physician according their age (part 1)**
p ≤ 0.05 – * statistical significant difference between respondents younger 49 years old respondents and older 50 years; p ≤ 0.05 – **statistical significant difference between respondents younger 49 years old respondents and older 60 years; p ≤ 0.05 – ***statistical significant difference between respondents younger 49 years old respondents and aged 50–69 years; p ≤ 0.05 – ****statistical significant difference between respondents younger 24 years old respondents and older 25.

Figure 3. Patients' attitudes about the family physician according their age (part 2)
Figure 4. Patients' attitudes about the accessibility of the PHC centre according their employment status

$p \leq 0.05$ – * statistical significant difference between retired and employed, in education, disable, housewife/men; $p \leq 0.05$ – ** statistical significant difference between retired and employed, in education, disable; $p \leq 0.05$ – *** statistical significant difference between employed and unemployed, housewife/men.
Figure 5. Patients’ attitudes about their cooperation with community nurse according their employment status

<table>
<thead>
<tr>
<th>Statement</th>
<th>Employed</th>
<th>in Education</th>
<th>Unemployed</th>
<th>Disable</th>
<th>Housewife/Men</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>My community nurse is a good nurse</td>
<td>90.0</td>
<td>84.5</td>
<td>70.8</td>
<td>80.1</td>
<td></td>
<td></td>
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<tr>
<td>My community nurse clearly explains about my illness or health problem</td>
<td>82.8</td>
<td>74.8</td>
<td>87.1</td>
<td>78.5</td>
<td>84.9**</td>
<td>73.1</td>
</tr>
<tr>
<td>My community nurse takes sufficient time to talk with me</td>
<td>87.5****</td>
<td>78.8</td>
<td>84.7</td>
<td>85.4</td>
<td>68.3</td>
<td>77.1</td>
</tr>
<tr>
<td>My community nurse knows me</td>
<td>88.1****</td>
<td>78.1</td>
<td>81.6</td>
<td>84.9</td>
<td>64.2</td>
<td>75.4</td>
</tr>
</tbody>
</table>

p ≤ 0.05 – * statistical significant difference between unemployed and employed, in education, housewife/men; p ≤ 0.05 – ** statistical significant difference between and employed, in education, disable, housewife/men; p ≤ 0.05 – *** statistical significant difference between retired and employed, in education, housewife/men; p ≤ 0.05 – **** statistical significant difference between retired and employed, in education, disable, housewife/men.
p ≤ 0.05 – *statistical significant difference between usually users of PHC services and rare users; p ≤ 0.05 – ** statistical significant difference between usually users of PHC services and moderate, rare users; p ≤ 0.05 – *** statistical significant difference between moderate users of PHC services and rare users.

Figure 6. Patients' attitudes about the accessibility of the PHC centre according the frequency of the PHC services use
Figure 7. Patients’ attitudes about the cooperation with family physician according the frequency of the PHC services use (part 1)

- **p ≤ 0.05** – *statistical significant difference between usually users of PHC services and rare users;
- **p ≤ 0.05** – **statistical significant difference between usually users of PHC services and rare, moderate users;
- **p ≤ 0.05** – ***statistical significant difference between moderate users of PHC services and rare users.
p ≤ 0.05 – *statistical significant difference between usually users of PHC services and rare users; p ≤ 0.05 – ** statistical significant difference between moderate users of PHC services and rare, moderate users; p ≤ 0.05 – *** statistical significant difference between usually users of PHC services and moderate, rare users.

**Figure 8. Patients' attitudes about the cooperation with family physician according the frequency of the PHC services use (part 2)**
p ≤ 0.05 – * statistical significant difference between usually users of PHC services and rare, moderate users; p ≤ 0.05 – **statistical significant difference between moderate users of PHC services and rare users

**Figure 9. Patients’ attitudes about their cooperation with community nurse according the frequency of the PHC services use**
<table>
<thead>
<tr>
<th>Items related to physicians satisfaction</th>
<th>Pediatricians (n=232)</th>
<th>Former pediatricians (n=52)</th>
<th>p value</th>
<th>Internists (n=363)</th>
<th>Former internists (n=186)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median P&lt;sub&gt;25&lt;/sub&gt;, P&lt;sub&gt;75&lt;/sub&gt; Median P&lt;sub&gt;25&lt;/sub&gt;, P&lt;sub&gt;75&lt;/sub&gt;</td>
<td>Median P&lt;sub&gt;25&lt;/sub&gt;, P&lt;sub&gt;75&lt;/sub&gt;</td>
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<td>Median P&lt;sub&gt;25&lt;/sub&gt;, P&lt;sub&gt;75&lt;/sub&gt;</td>
<td>Median P&lt;sub&gt;25&lt;/sub&gt;, P&lt;sub&gt;75&lt;/sub&gt;</td>
<td></td>
</tr>
<tr>
<td>I feel that some parts of my work do not make sense</td>
<td>2, 1, 3</td>
<td>2, 1, 3</td>
<td>0.06</td>
<td>2**</td>
<td>1, 3</td>
<td>1, 1, 2</td>
</tr>
<tr>
<td>My work still interests me as much as it ever did</td>
<td>1, 1, 2</td>
<td>1, 1, 2</td>
<td>0.76</td>
<td>1**</td>
<td>1, 3</td>
<td>1, 1, 2</td>
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<tr>
<td>My work is overloaded with unnecessary administrative details</td>
<td>2, 1, 3</td>
<td>1, 1, 2</td>
<td>0.18</td>
<td>2**</td>
<td>1, 3</td>
<td>1, 1, 2</td>
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<tr>
<td>Assuming that pay and working conditions were similar I would do non medical work</td>
<td>5*</td>
<td>5, 5</td>
<td>0.00</td>
<td>5**</td>
<td>5, 5</td>
<td>4, 3, 5</td>
</tr>
<tr>
<td>I find real enjoyment in my work</td>
<td>2, 1, 3</td>
<td>2, 2, 3</td>
<td>0.53</td>
<td>2**</td>
<td>1, 3</td>
<td>3, 2, 3</td>
</tr>
<tr>
<td>In my work there is a good correspondence between effort and reward</td>
<td>4, 3, 5</td>
<td>4, 3, 5</td>
<td>0.78</td>
<td>5**</td>
<td>3, 5</td>
<td>4, 3, 5</td>
</tr>
</tbody>
</table>

P<sub>25</sub> – 25th percentile, P<sub>75</sub> – 75<sup>th</sup> percentile; the coding of the Likert scale: 1 – strongly agree; 2 – more or less agree; 3 – don't know; 4 – more or less disagree; 5 – disagree; p ≤ 0.05 – * statistical significant difference between pediatricians and former pediatricians; p ≤ 0.05 – ** statistical significant difference between internists and former internists.
Table 2. The comparison of family physicians satisfaction with the health care according their background in 2004

<table>
<thead>
<tr>
<th>Items related to physicians satisfaction</th>
<th>Family physician’s background (n =310)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Former pediatricians, n=52 (16.8%)</td>
<td>Former internists, n=186 (60%)</td>
<td>After FM residency, n=72 (23.2%)</td>
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<td>Median</td>
<td>P_{25}, P_{75}</td>
<td>Median</td>
<td>P_{25}, P_{75}</td>
<td>Median</td>
<td>P_{25}, P_{75}</td>
<td></td>
</tr>
<tr>
<td>Lithuanian family physicians and nurses have good knowledge and skills</td>
<td>2*</td>
<td>2, 2</td>
<td>2</td>
<td>1, 2</td>
<td>2</td>
<td>1, 2</td>
<td>0.04</td>
</tr>
<tr>
<td>Health care premises and equipment are much better than they were 5 years ago</td>
<td>2*</td>
<td>1, 3</td>
<td>2</td>
<td>1, 2</td>
<td>2</td>
<td>1, 2</td>
<td>0.03</td>
</tr>
<tr>
<td>Physicians and nurses should be better paid</td>
<td>1</td>
<td>1, 2</td>
<td>1</td>
<td>1, 2</td>
<td>1**</td>
<td>1, 1</td>
<td>0.02</td>
</tr>
<tr>
<td>Patients should have more influence on the management of their PHC centre</td>
<td>1***</td>
<td>1, 2</td>
<td>1</td>
<td>1, 1</td>
<td>1</td>
<td>1, 1</td>
<td>0.00</td>
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</tbody>
</table>

P_{25} – 25th percentile, P_{75} – 75th percentile, the coding of the Likert scale: 1 – strongly agree; 2 – more or less agree; 3 – don’t know; 4 – more or less disagree; 5 – disagree; p ≤ 0.05 – * statistical significant difference between former pediatricians and former internists; p ≤ 0.05 – ** statistical significant difference between physicians after FM and former district physicians; p ≤ 0.05 – *** statistical significant difference between former pediatricians and physicians after FM, former internists.
Apie sveikatos priežiūrą

1. Lietuvos sveikatos priežiūros šiuo metu yra geromė neįgalų
   priežiūros metu

2. Lietuvos bendroviečių praktikos gydymo ir sklaustų
   žinios ir gūžtis yra geri

3. Lietuvos sveikatos priežiūros, atstogos ir medicininė
   veikla šiuo metu yra daug geromė neįgalų priežiūros metu

4. Švarku, kad dėdės ir sveikatos priežiūros didėti, kai
   jų (pačių) būtų vaikų niekų atsakomybė padidėt

5. Prašome dirbantį bendroviečių praktikos gydymo yra
   geromė neįgalų dirbtuvės vaikų ir neįgalų veiklą

6. Bendroviečių praktikos gydymo ir sklaustų atlyginimo
   tvirtai būtų didėti

7. Gyventojų ataskaita sveikatos centrų turėtų būti didesnė

8. Jeigu ar dėdės žmogus rugęs reikšmiškas ligomis (pvz. porinimu ar asmenų gėlės (daugumos), tiksli
   atsakymas atitiktų mokėjimą į savo bendrovičių praktikos gydymą

Informacija apie savę

1. Kokį kartą jūs atkelkės pas savo bendroviečių praktikos
   gydymą per pastarus 12 mėnesius? (nelygys)

2. Kokį kartą jūs atkelkėt pas savo bendroviečių praktikos
   sklaustą per pastarus 12 mėnesius? (nelygys)

3. Kuris iš žinomų pasikušés ligų jums geriausiai tink?
   (pažymykite tik vieną langtelį)
   - Dėža
   - Nefitima
   - Dėžo
   - Prižiūrą namų
   - Širmi
   - Mokėjimai
   - Nefitima
   - Nefitima ir kitokos
   - Personinės

4. Jūsų dara pasikvietimas (pažymykite tik vieną langtelį)
   - Pradinė
   - Vykdomas
   - Aktyviai
   - Aktyvia

5. Lytis
   - Vyriaus
   - Moteris

6. Gimimo metai (nelygys)

Nevalgykite dėkojame, kad pildote anketa!
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<tr>
<th>Įvai požiūrininko/sveikatos centro pradžios/</th>
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<tr>
<td>10. Aš esu gera informuota apie požiūrinę darbo terapiją. (Šviesu)</td>
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<td>13. Mano bendrosios praktikos gynybos pradžios</td>
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<td>su mano darbo ir namų sąlygomis</td>
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<td>14. Mano bendrosios praktikos gynybos pradžios</td>
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<td>žinoma, jog įmonė buvo auksčiaus sveikatos problemas</td>
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<td>ir ligos</td>
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<td>15. Mano bendrosios praktikos gynybos pradžios</td>
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<td>16. Mano bendrosios praktikos gynybos pradžios</td>
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<td>17. Mano bendrosios praktikos gynybos pradžios</td>
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<td>19. Į savo bendrosios praktikos gynybos pradžios</td>
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<tr>
<td>galu krentis ne tik dienos sveikatos, bet ir kitų atsiradimų pobūdžio terapijai</td>
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<td>20. Mano bendrosios praktikos gynybos pradžios</td>
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<td>sveikatos problemas</td>
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<tr>
<td>23. Kai aš paprastai, bendrosios praktikos gynybos pradžios</td>
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<td>mane, pasiūrus pas specialistą</td>
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<td>24. Kai aš paprastai, mano bendrosios praktikos gynybos</td>
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<td>25. Po atsaky SMP pas bendrosios praktikos</td>
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<td>33. Aš galiu griežtai patikėti pas specialistą, kai mane</td>
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<td>34. Specializuotas naikins ir medicinos consulta</td>
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<td>mano bendrosios praktikos gynybos</td>
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<td>35. Kartas mane konsultuoja mano bendrosios praktikos</td>
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<td>gynybos ir mano nėščių ir šiuos kūno gynybos</td>
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<td>36. Mano bendrosios praktikos gynybos ir sklaugtojų</td>
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</table>
Mielas gydytojau,

Atliekant respublikinį šeimos gydytojų tyrimą, norėtume paprašyti Jūsų bendradarbiavimo. Per pastaruosius dešimt metų sveikatos priežiūros srityje įvyko daug pasikeitimų.

Ši studija skirta įsiaiškinti kokiame lygme pirminė sveikatos priežiūra yra dabar, ir koki koks lygio yra realizuoti sveikatos priežiūros politika ir liūdesiai. Šiuo tikslu Lietuvos šeimos gydytojų prašome užpildyti šią ankėtą.

Ši apklausa yra paruošta Kauno Medicinos Universiteto, artimai bendradarbiuojant su NIVEL – sveikatos priežiūros tyrimų institutu iš Olandijos, kuris dalyvavo pradiname Lietuvos sveikatos priežiūros projekte nuo 2001 m. Ši studija yra dalis Olandų remiamo projekto.


Norime pabrėžti, kad ši anketa yra anoniminė, todėl Jums vardo, pavardės nurodyti nereikia. Taip pat užtikriname, kad Jūsų anketojų nebus rodomos Jūsų kolegoms ar viršinininkams. Šio tyrimo rezultatai ir išvados bus pateikiamos publikacijose.

Esame nuoširdžiai dėkingi už Jūsų dalyvavimą ir indėlį į Lietuvos sveikatos reformą.

Kauno medicinos universitetas
Šeimos medicinos klinikos bendradarbiai
Atsakingas asmuo: gydytoja-asistentė I.Juodrytė
mob. tel.: 868752929
1. DUOMENYS APIE ASMENĮ IR DARBĄ

1.1 Kuriais metais Jūs gimėte?  
Gimimo metai: 19_____

1.2 Jūsų lytis:  
☐ vyraus  
☐ moteris

1.3 Ar Jūs dirbate privačiai ar esate etatinių darbuotojas? Jei dirbate daugiau, nei vienose pareigose, pagrindinės yra tos, kuriose praleidiate daugiausiai laiko, kitoje yra antracilei.

 mano pagrindinės pareigos yra:  
☐ etatines pareigos  
☐ privati praktika (pagal sutartį su sveikatos ar draudimo tarnyboje)

 mano antracilei pareigos yra:  
☐ nedirbu apmokėmo antracilei darbo  
☐ etatines pareigos  
☐ privati praktika (pagal sutartį su sveikatos ar draudimo tarnyboje)

1.4 Kiek valandų per savaitę Jūs paprastai praleidiate darbe (nuolatinio darbo, clubies pagalbos ar išsivietimų)?

 darbo valandos pagrindinėse pareigose 
vidutininkai_________valandų per savaitę

darbo valandos antracilese pareigose 
vidutininkai_________valandų per savaitę

1.5 Kiek valandų vidutininkai per mėnesį skiriate kvalifikacijos kėlimui (profesinės literatūros skaitymui, pasiūlymus kursams, moksliniams darbams ir t.t.)?

 kvalifikacijos kėlimui skiria 
vidutininkai_________valandų per mėnesį

1.6 Kada pradėjote dirbti gydytojui (pediatru ar terapeutu) ir kada persikvalifikuote į šeimos gydytoją?

 gydytojo pradėjau dirbti 19______metais

 pradėjau dirbti  
☐ pediatru  
☐ terapeutu

 šeimos gydytojo pradėjau dirbti  
☐ nuo 19______metaų  
☐ šeimos gydytoja įsidirbė

1.7 Koks yra atstumas nuo Jūsų pagrindinės darbovietais iki artimiausios bendro profilio ar universiteto giminės?

 atstumas iki artimiausios giminės yra:  
☐ mažiau nei 5 km.  
☐ nuo 5 iki 10 km.  
☐ nuo 10 iki 15 km.  
☐ daugiau kaip 15 km.

1.8 Ar Jūs dirbate vienas, ar dalinės pataislomis su kitais šeimos gydytojais ir/iar su kitais medicinos specialistais (iš vienos atskyrimų):

☐ dirbuti vienas  
☐ kartu su kitais šeimos gydytojais______ (įrašyti kelią)  
☐ kartu su kitais medicinos specialistais______ (įrašyti kelią)  
☐ kartu su kitais šeimos gydytojais ir medicinos specialistais______ (įrašyti kelią)
1.9 Kiek Jūs turite pacientų (įrašykite skaičių)?

1.10 Įrašykite apytikrį pacientų skaičių, kuriuos Jūs priimate kabinete, aplankote namie per dieną:

priimate kabinete per dieną____ (įrašykite skaičių)
aplankote namuose per dieną____ (įrašykite skaičių)

1.11 Kiek vidutiniškai kartų per dieną Jūs telefonu konsultuojate pacientų ar duodate jiems patarimą?

telefoninių konsultacijų per dieną____ (įrašykite skaičių)

1.12 Kokia dalis pacientų užsiregistruoja iš anksto (pvz.: telefonu)?

☐ nėra išankstiniu užsiregistravimo
☐ mažiau kaip pusė nežininių ligonių užsiregistruoja iš anksto
☐ daugiau kaip pusė nežininių ligonių užsiregistruoja iš anksto
☐ beveik visi nežininiai ligonių užsiregistruoja iš anksto

1.13 Ar Jums padaeda žemiau išvardintas personalas:

registratorė, administratorė
slaugystė
laborantė

☐ taip ☐ ne
☐ taip ☐ ne
☐ taip ☐ ne

1.14 Ar dažnai Jūs sustipinate ar diskutojate su šiais specialistais?

☐ šeimos gydytojais
☐ gydytojais specialistais
☐ farmaciniškas
☐ socialiniai darbuotojai

☐ retai ar siekada ☐ rečiau kaip 3 kartus per mėn. ☐ 1-3 mėn. ☐ dažniau negu kartą per mėn. ☐ netinkamas klausimas

1.15 Priklausomai kokia aparatūra naudojate Jūs ar Jūsų personalas (“taip”, jei galite naudotis bendra centre/poliklinikoje esančia aparatūra):

laboratorinė
viziai
funkcijos
kita

☐ hemoglobino metr
☐ ofalhoskopas
☐ audiometras
☐ katecriašį slapčių

☐ bet koks cholesterino
☐ gastroskopas
☐ pneumotachometras
☐ komplektą žūdžių sužinomų

☐ kiekis
☐ ultrazvukinis aparatas
☐ elektrokardiografas
☐ vienkartiniais svirkstais

☐ kiekis
☐ pilvo ar vaisiaus tyrimai
☐ ir hipertenzijos
☐ defibrilatorius

☐ kiekis
☐ plaučių matavimai
☐ arterijų tonometris
☐ srdžo tonometris

☐ kiekis
☐ kraujo lapelių skaičius
☐ rektoskopas
☐ HUG aparatūra

☐ kiekis
☐ proktoskopas
☐ ir rektoskopas
☐ siropografas
☐ minimalios chirurgijos

☐ kiekis
☐ kraujošūpūžio matavimo aparatas
☐ miniatūrų siropografas
☐ komplektas

1.16 Kokiu tikslu darbe naudojate kompiuterį?

☐ kompiuterio nėra
☐ registruojama
☐ administracijoje

☐ ligonų kortelių prašymai
☐ receptų prašymai
☐ moksliniam tyrimams, auditu
### 2. MEDICININIŲ PROCEDŪRŲ ATLIKIMAS

<table>
<thead>
<tr>
<th>Intervencijos</th>
<th>beveik visada</th>
<th>dažnai</th>
<th>kartais</th>
<th>retai ar niekada</th>
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<td>2.3 Zaizdos susidavimas</td>
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<td>2.4 karpų ekscizija</td>
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<td>2.8 sapario punkcija</td>
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<td>2.9 makuliarišnio sinaso punkcija</td>
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<td>2.10 paracentezė</td>
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<td>2.11 gipso ubejimas</td>
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<tr>
<td>2.12 kulkšnių sutvarstymas</td>
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<td>2.14 intraveninė infuzija</td>
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</table>

### 3. LIGŲ GYDYMAS

**Ar Jūs gydote ir skakė savo apylinkės gyventojus, sergančius žemiau išvardintomis ligomis?** Pz.: jei leitinio bronchitui sergančius savo apylinkės pacientus paprastai gydote Jūs, pažymėkite atitinkamą langelį.

#### Aš gydau, sekų:

<table>
<thead>
<tr>
<th>beveik visada</th>
<th>paprastai</th>
<th>kartais</th>
<th>retai, niekada</th>
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<tr>
<td>3.1 Tyrotopiksikoze</td>
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<td>3.2 Lėtinis bronchitas</td>
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<td>3.3 Miežis</td>
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<td>3.4 Peptinė opa</td>
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<td>3.5 Stūburo disco išvarža</td>
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<td>3.6 Ūminis smegenų kraujotakos sutrikimas</td>
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<td>3.7 Lėtinis širdies nepakankamumas</td>
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<td>3.8 Pneumonija</td>
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<td>3.10 Ulcerozinis kolitas</td>
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<td>3.11 Salpingitas</td>
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<td>3.12 Smegenų sutrenkimas</td>
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<td>3.13 Parkinsonos liga</td>
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<td>3.14 Nekomplikuotas II tipo cukrinis diabetas</td>
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<td>3.15 Reumatooidinis artritas</td>
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<td>3.16 Depresija</td>
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<td>3.17 Miokardo infarktas</td>
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4. PROFILAKTINĖ IR KITA VEIKLA

4.1 Kokiais atvejais Jūs ar Jūsų personalas matuoja kraujospūdį?
☐ esant atitinkamai klinikinei būklei ar pacientui prašant
☐ visiems suaugusiems apsilankiusiems kabinete (nepriklausomai nuo atvykimo priežasties)
☐ suaugusiems, pakviestiems šiau tikslu

4.2 Kokiais atvejais Jūs ar Jūsų personalas tiria cholesterolio kiekį kraująje?
☐ esant atitinkamai klinikinei būklei ar pacientui prašant
☐ visiems suaugusiems apsilankiusiems kabinete (nepriklausomai nuo atvykimo priežasties)
☐ suaugusiems, pakviestiems šiau tikslu

4.3 Kokiais atvejais Jūs ar Jūsų personalas daro ccrvikalinį tepinėlį dėl vėžio?
☐ esant atitinkamai klinikinei būklei ar pacientei prašant
☐ visoms apsilankiusioms kabinete moterims su padidinta rizika
☐ moterims, pakviestoms šiau tikslu
☐ toks profilaktinis tyrinimas neatliekamas

4.4 Kaip Jūs dalyvaujate sveikatos mokyme-rūkymo, mitybos ir alkoholio vartojimo įpročių korekcijoje?

<table>
<thead>
<tr>
<th>nedalyvauji</th>
<th>dirbų tik su apsilankėiais ligonais</th>
<th>dirbų taipogi specialiuose grupiniuose užsiėmimuose ar programose</th>
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<tbody>
<tr>
<td>-rūkymo</td>
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<td>-mitybos</td>
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4.5 Ar atliekate žemiau išvardintus darbus?

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<tr>
<th>atlieku</th>
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<td>-vaikų iki 4 metų sekinas</td>
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<td>-seimų planavimas/kontracepcija</td>
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<td>-homeopatinė medicina</td>
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5. PASITENKINIMAS DARBU

Ar Jūs sutinkate su žemiau pateiktais pasitenkinimo darbui vertinimais?

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<tr>
<th>Numatytas</th>
<th>Visiškai sutinku</th>
<th>Daugiau nei sutinku</th>
<th>Nei taip, nei ne</th>
<th>Daugiau nei neįsivaizdu tikriausiai</th>
<th>Visiškai neįsivaizdu tikriausiai</th>
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</tbody>
</table>

DEKOJAME!

164
I am truly grateful to my Teachers for sharing their knowledge and time, humanity and warmth, for advices in my scientific and personal life:

Irena Misevičienė
Žemyna Milašauskienė
Leonas Valius
Wienke GW Boerma
Jakob Kragstrup
Gediminas Urbonas

and

to my Family … for believing in me