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Satisfaction with the NHS: what is it and can we measure it?

MOST of us are familiar with the sight of politicians dismissing the results of unfavourable opinion polls. It is perhaps a little surprising, therefore, that our political masters who are so ready to dismiss one form of satisfaction survey should be keen to introduce measures of consumer satisfaction into the NHS. Indeed, there are plans for such surveys of hospital and general practitioner services.[1,2] General practitioners will have to face the family practitioner committee, albeit in confidence, to discuss the results of patient surveys. These plans are all part of the government's policy of making the NHS more responsive to patients' views. In addition, patient satisfaction is seen as one form of outcome that can be used to measure the quality of services provided.

At first glance measuring satisfaction seems a relatively simple task. But closer examination of the concept reveals a number of difficulties which are of major importance if such surveys are to be used as a form of imposed external audit.

The first difficulty, and one which may be ignored in the rush to start satisfaction surveys, is: what is satisfaction, how is it defined and what does it mean to different people? Human satisfaction is a complex concept that is related to a number of factors including lifestyle, past experiences, future expectations and the values both of the individual and society.[3] The involvement of all these factors means that satisfaction is likely to be defined very differently by different people and by the same person at different times. An understanding of how experience affects satisfaction helps to explain why older patients who can remember the pre-NHS days are more satisfied with the NHS than those who have never known anything but the NHS.[4,5] This in turn means that the general practitioner with a large number of old people on his list will be more likely to get a good satisfaction rating than the doctor whose practice is composed mainly of students. Similarly, the doctor who practises what he believes to be good quality medicine may get a poor satisfaction rating because a number of his patients do not share his belief about what constitutes good quality medicine. An example that many general practitioners will be familiar with is that of the new patient who, because of past experience, continues to expect antibiotics for a sore throat despite explanation as to why they are unnecessary.

The second difficulty relates to methodology. Variations in who is interviewed, the timing of the interview, the type of questionnaire used and how satisfaction is rated have a major influence on the results and make comparisons extremely difficult.[3,6] It is important that satisfaction surveys are applied to relevant populations who actually consume health services. In the hospital service this may not be too difficult, but the choice of whom to survey in a general practice population may prove to be much more complicated. If a random sample of patients is drawn from the practice list, this may include patients who have seen the doctor 10 times in the last year and people who have not seen him for 10 years. Do these people have equivalent status as consumers and should their opinions carry equal weight? On the one hand people who have not seen their doctor for many years may give outdated or stereotyped responses to enquiries about satisfaction, while on the other hand those who see their family doctor very regularly (predominantly the old and chronically sick) may be less likely to complain because of their continuing dependence on and/or loyalty to their doctor.[3]

The timing of surveys may also be of critical importance. The longer the gap between use of services and interview the greater the chances of recall bias, of people overlooking matters that affected them during the episode of care and of changes in their appreciation of services. Such considerations led Rees and Wallace to conclude that factors relating to the timing of research interviews 'make it difficult to interpret the "meaning" of the results and once again suggest caution in accepting some research conclusions about client satisfaction'.[7]

Perhaps the most important methodological consideration relates to the type of questionnaire used to acquire data. It is axiomatic that the questionnaire should not distort the consumers' view, but achieving this is not an easy task. There are two basic ways of surveying satisfaction, either through a closed structured questionnaire or through an open ended questionnaire which allows respondents to express their opinions more freely. With open unstructured questions respondents will only mention important aspects of care that occur to them at the time of interview while with direct questions respondents will have their attention drawn to specific aspects of the service. These will be aspects that are important to the researcher, a view that the respondent may not necessarily share. A review of previous questionnaire surveys shows that dissatisfaction ratings with the more open style are consistently lower than those obtained with closed questions.[3]

Having acquired the data the next problem arises when an attempt is made to rank satisfaction on a scale. Such ranking is of particular importance when different services are to be compared or when the same service is to be compared at different times. There are essentially three approaches to rating satisfaction: a global evaluation of the service to give an overall satisfaction score; a satisfaction measure for each aspect of care; or a composite score derived from satisfaction scores for each aspect of care. The advantages and disadvantages of each approach have been well documented[3] and Kincey and colleagues reported considerable differences in satisfaction scores between the three methods.[8]

The definition and measurement of satisfaction is fraught with difficulties but is still likely to be worthwhile, providing that those who commission such surveys know the limitations and hence the legitimate uses of the resulting data. If surveys are sufficiently comprehensive to include details of peoples' experiences and suggestions for change, they may quite reasonably be used to indicate aspects of the services that need to be modified. They may also be used to measure satisfaction before and after a service change.

Such surveys should not, however, be used alone as evaluations of the quality of care. If 90% of patients are satisfied with a service this observation only becomes a measure of quality if some agreed standard of excellence is available for comparison. Setting this standard is likely to be a difficult task. Who will decide for example, if 90% satisfaction with a particular general practitioner's service makes it a quality service? Will it be the family practitioner committees, the doctors or the public?

Ultimately, it is only worthwhile measuring consumer opinion if those who measure it are going to regard it as being of value. At best it could provide an indirect means by which patients could participate in policy development and decision-making in the NHS. Unfortunately, the many problems and pitfalls outlined above will mean that, like politicians dismissing opinion polls, those who want to will be able to discount the results of future surveys. Given these problems, a more appropriate way of increasing consumer participation in the NHS might be to allow the public greater representation on family practitioner committees, district and regional health authorities and the boards of self governing hospitals.

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Prescribing research: PACT to the future

IN the past, research into general practitioners' prescribing has consisted of a variety of descriptive studies, attempts to identify factors that influence prescribing behaviour, audit of patient management protocols, and latterly the development and evaluation of information feedback systems and general practice formularies. Now that the PACT (prescribing analyses and cost) information system has been installed, the government proposes to introduce indicative prescribing budgets for general practitioners, and to foster the production of agreed local formularies in an attempt to exert 'downward pressure' on drug expenditure.[1] While the government's motives can be debated, there is no doubt that these changes will have an effect on prescribing habits and on the future direction of prescribing research.

Less than a year after doctors received their first PACT reports, the government has indicated that a major enhancement of the system is needed for the operation of the indicative budget scheme. The PACT scheme had a long gestation. Full computerization of the Prescription Pricing Authority was recommended in 1977[2] but only completed in 1986. Before the PACT system began only a small minority of doctors requested analyses of their prescribing,[3] yet several studies had demonstrated that feedback to doctors can result in change in prescribing[4-6] though this change may disappear if the feedback ceases.[7]