Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

INSIGHT 07

Health and Social Services in Ireland – a survey of consumer satisfaction

Researched and compiled by

UCD DUBLIN

LANSDOWNE MARKET RESEARCH

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ACKNOWLEDGEMENTS

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The School would like to thank Dr. Liam Delaney, UCD Geary Institute, Mr. Richard Waring and Mr. David Hamill of Lansdowne Market Research, who managed the fieldwork.

The HSE Consumer Affairs Department would like to thank and acknowledge the work of: The Steering Group for Consumer Research and Ms. June Boulger, Project Manager.

FOREWORD

This independent study of consumer satisfaction with the health and social care services was commissioned by the Health Service Executive (HSE) and carried out by the School of Public Health and Population Science in University College Dublin in partnership with Lansdowne Market Research.

This is the first time a study of this scale has been undertaken among a nationally representative sample of people who have used the HSE's hospitals and community services.

It involved detailed face-to-face interviews with 3,517 people across the country who were asked about their experience of the public health and social care services.

Consulting with patients and clients and asking them about their experience is important if we are to achieve our ambition which is to create a health and social care service that is easy to access, in which the public has confidence and which staff are proud to provide.

The information gathered during this study will enable us to establish and improve how we communicate with our patients; determine whether all patients are treated with dignity and respect; whether their preferences are respected as well as a range of other important factors which can influence the quality of their overall experience.

The study is part of a wide range of initiatives being developed by the HSE's Consumer Affairs Department to involve consumers and communities more actively in health service design, delivery and evaluation.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Complaints Policy and Procedures Manual

your service
your say

The HSE is committed to making it easy for people to make comments, suggestions and complaints. It has established a national programme, 'your service…your say' to provide fair and timely responses to comments, suggestions and complaints. It ensures that comment and complaint forms, websites and other literature are highly visible, accessible, easy to use and suitable for everyone, thus contributing to the HSE's Transformation Programme 2007–2010. The Transformation Programme represents the organisation's ambition for the future, which is that: *'Everybody will have easy access to high quality care and services that they have confidence in and staff are proud to provide'.*

Comments, suggestions and complaints can be made in a range of different ways:

- by completing a 'your service …your say' comment/complaint form
- verbally face-to-face to any member of staff
- by letter or fax
- by emailing **yoursay@hse.ie**
- by telephone communication (1850 24 1850).

For more information on how to make a comment, suggestion or complaint about the service provided by the HSE, visit: **www.hse.ie.**

We would like to take this opportunity to thank all of those who gave their time so generously to participate in this study and to the School of Public Health and Population Science in University College Dublin, authors of the report.

Mary Culliton
Head of Consumer Affairs

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EXECUTIVE SUMMARY

BACKGROUND

The Health Service Executive (HSE) is committed to providing health and social care services in Ireland. This country is presently in a stage of considerable social and economic transition, there have been major reforms and re-structuring of the health services in very recent years. Policy documents have repeatedly stressed the importance of equity and access, particularly for the most disadvantaged, and the need to promote client centred and empowering models of care.

Central to the success of the Irish healthcare transformation process is the role of patients or healthcare consumers in influencing change, and the HSE corporate plan 2005–2008 identified as the first of four corporate objectives, the improvement of people's experience of health and social services and their outcomes.

It is important to undertake a national consumer satisfaction survey to understand the views and attitudes of the general public as to how health care services are delivered as well as to consult those who are service users on their actual experience of these services.

A key component in meeting this objective is reliable and nationally representative information in order to plan effectively for the future and monitor whether stated aims and objectives are being met. Accordingly, the HSE commissioned the UCD School of Public Health and Population Science and Lansdowne Market Research to undertake a national survey that would measure, for the first time, consumer perspectives and experiences of all aspects of the health care system, both in hospital settings and in primary, community and continuing care (PCCC).

There is now a good understanding in the international literature that satisfaction with a service is a subtle and multi-dimensional concept, reflecting a person's own social and psychological circumstances as well as the experience of a service in itself. Accordingly individuals should be asked not just to rate their satisfaction but to recount whether or not certain processes or events occurred during a particular visit. In that sense what occurred is as important as the evaluation of what occurred and this is what needs to be captured.

METHODOLOGY

This survey is based on a nationally representative quota sample of Irish adults, balanced equally for the four HSE areas and augmented to include 500 extra respondents aged over 50 years as these are relatively more frequent service users. The final attained sample was 3,517 respondents. Fieldwork commenced on 13th November 2006 and continued through to 9th March 2007.

Interviews were conducted face to face, in respondents' own homes, taking about 25 minutes on average. In developing the questionnaire instrument for this survey, best practice was reviewed in the literature and a stakeholder consultation process was also undertaken.

The final questionnaire included information on socio-economic circumstances, measures of self-rated health and well-being, and history of utilisation of the health services in the 12 months preceding the survey. Knowledge of, and attitudes to, health services were also assessed.

A detailed interview covering an experience of at least one service, either as hospital inpatient, or as hospital outpatient, or in general practice or in any other community service was undertaken with respondents who had experience of one such service in the 12 months preceding the survey.

Eight dimensions of that experience were explored with respondents:

1 Fast access to reliable services,

2 Effective treatment delivered by a trusted professional,

3 Involvement in decisions and respect for preferences,

4 Clear, comprehensive information and support for self care,

5 Attention to physical and environmental needs,

6 Emotional support, empathy and respect,

7 Involvement and support for family carers,

8 Continuity of care with smooth transitions.

Analysis included basic descriptive presentation, tests for significance respondents eligible for General Medical Services (GMS) and those not eligible (non GMS) and those under and over 50 years with chi squared or to test as appropriate. Finally a number of multivariate statistical models were used to profile patterns of non-users and predictors of satisfaction with hospital outpatient services in particular.

RESULTS

Profile and Utilisation Patterns

The final attained sample reflects the sampling methodology, giving a representative national sample, 52% women and 48% men; 13% were in social category AB, 31% in C1, 26% in C2, 16% in D, 8% in E and 7% farmers. Those over 50 years were more likely to have primary school education only (27% versus 3%) and less likely to have third level education (9% versus 19%). A majority of respondents were married (52%).

Overall 64% of respondents had consulted a general practitioner (GP) in the last year, 30% had a hospital experience, 21% had a community experience and 27% were reported non-users of any service. This pattern was strongly age related, with rates of GP utilisation rising from 59% of under 50s to 75% of over 50s, hospital experience from 27% to 39%, and community service users from 19% to 25%. The main overlap in utilisation pattern was between the GP and other services, the overlap between the hospital and the community without involvement of a GP was very low at 1% and just 2% of respondents reported experience of community services only.

Measures of self reported health were positive among respondents, but showed a strong age pattern, with for instance 33% of those under 50 years old rating their health as excellent, compared to 13% of those over 50. There was also an association with GMS status for self reported health, so that amongst those over 50 years of age 8% of GMS eligible respondents rated their health as excellent, compared to 19% of those non-eligible for GMS. Non-users of the health services in the last year tended to be male, younger, have better self reported health and higher levels of education; conversely those retired or with permanent sickness or disability were more likely to be users. Distance to GP, hospital or access to a car did not affect utilisation.

The GP was cited as the most important source of information by 82% of respondents; the next most cited source was family or friends (28%), followed by internet (18%) and the media (18%), with official health services sources at 9% and helplines used by only 1%. There was an age pattern in that 22% of under 50s compared with 8% of over 50s cited the internet as an information source. Whilst most respondents knew what the HSE is (66%), 81% did not know what the letters PCCC stood for. Most respondents were in favour of county-level services (96% for emergency and 84% for acute hospitals) but a majority (76%) would also favour treatment in a specialist or concentrated service, even if it meant concentrating services in fewer centres, and 70% of respondents rated ease of access to services as very important to them.

Smoking and the 2004 Ban

A clear majority (89%) of respondents agreed or strongly agreed with the implementation of the smoking ban in workplaces in March 2004 and 59% would agree with the implementation of a total site ban in healthcare facilities, including the outdoor grounds. However total smoking rates at 29% have not fallen in the population since the introduction of the ban.

Experience of Services

There were 2,758 service experience interviews completed, the remainder being non-users. The most frequently recorded interview experience was GP services (n=1,732, 63% of user interviews), followed by hospital outpatient (n=470, 17% of user interviews), hospital inpatient (n=344, 13% of user interviews) and the least frequent community health services (n=212, 8% of user interviews).

Fast Access to Reliable Services

Generally speaking, respondents reported reasonably prompt access to services. The wait from the time inpatient respondents were told they had to be admitted was immediate for 76% of inpatients, up to one month for a further 11%, up to three months for 4%, up to six months for 1% and six months or greater for 4% of patients. There was no difference in waiting time according to GMS status. Of those with a recent outpatient experience, 23% were seen on time, 44% were seen within 30 minutes, but 18% waited more than an hour and 7% for two hours. For GP services, 31% were seen without an appointment, 38% received a same day appointment and 3% had to wait more than two working days to be seen.

Encounter with the Health Professional

Ratings were overall generally highly positive for all the dimensions associated with the health professional encounter: 78% of inpatients, 67% of outpatients, 86% of GP patients and 78% of community services patients expressed definite or complete trust in the health professional they encountered. Most respondents, 70% of inpatients and 57% of outpatients, felt the healthcare professional at the initial encounter had all the necessary information. Most respondents, 80% of inpatients, 79% of outpatients and 86% of GP patients felt the amount of information they were given was about right. A majority of respondents, 67% of inpatients, 52% of outpatients and 72% of GP patients agreed completely that they were involved in decision making about their care and treatment. A majority of all groups, 83% of hospital inpatients, 79% of outpatients, 90% of GP patients and 77% of those receiving community services, felt that they had been treated with dignity and respect at all times.

Physical and Environmental Needs

A majority, 63%, of hospital inpatients thought the adequacy/cleanliness of hospital public toilets was good or very good and 78% thought ward facilities generally were of a clean standard. Of outpatients, 83% thought the department was very or fairly clean. For GP patients, 72% thought the surgery was very clean and a further 24% that it was fairly clean.

Overall Ratings of Quality of Care

General ratings of quality of care were very positive in all four service settings. Rating their overall quality of care as excellent or very good were 64% of inpatients, 58% of outpatients, 84% of GP patients and 76% of other community services; a further 26% of inpatients, 27% of outpatients, 13% of GP patients and 13% of community patients rated services as good. Just 9% of inpatients, 13% of outpatients, 3% of GP and 11% of other community service patients rated the experience as fair or poor. A majority, 83% of inpatients, 73% of outpatients, and 90% of GP patients would recommend the service to someone else.

For outpatients other than emergency department (ED), both waiting time greater than 15 minutes and a perception that all necessary arrangements were not made to continue care influenced overall satisfaction levels.

SECTION 2

AUTHORS' INTERPRETATION OF FINDINGS

This is the first large-scale, representative survey of consumer satisfaction undertaken by the Health Service Executive (HSE). By contrast with smaller-scale surveys, it is not focused on a particular client group or setting, but seeks to address all the major areas of health and social care and provides us, for the first time with a solid snapshot of patterns of utilisation and direct recent experience of a given service.

It was conducted as a 25 minute household interview and so offered an opportunity to reflect knowledge, attitudes and experience as well as the more conventional measures of satisfaction.

The information from this survey can provide opportunities for learning, which will assist the HSE in planning responses in areas which matter to the users of the services and which can shape the direction and emphasis of the HSE Transformation Programme

DIMENSIONS OF SATISFACTION

Generally speaking a majority of respondents report strong satisfaction with the health care services and a high degree of confidence and trust in health professionals. Emerging from the results are areas which are positive for health service provision and the HSE; a majority of respondents were admitted to hospital in a timely manner; there is relatively little evidence of any GMS/non GMS divide in experience as reported by respondents in this survey; the level of confidence and trust in the care received in hospital and community settings is rated highly; there is a public perception of good hygiene in healthcare settings, although there is an age effect evident, which suggests that younger users of the services are less tolerant of poor hygiene.

Overall ratings of quality of care were mainly highly satisfactory. There were some variations in rated satisfaction within settings. The GP setting is rated most positively. Within the acute setting those whose experience was in the ED were less satisfied than other outpatients. Where dissatisfaction does exist, particularly in this much publicised outpatient or ED setting, there are clear reasons related to established dimensions of care. Satisfaction was also lower where all these dimensions of care were not met. Further in-depth analyses are in train to assess those dimensions of care in the other settings also and these will be presented in the final report.

UTILISATION PATTERNS

The survey provides the HSE with knowledge, for the first time at national level, of the utilisation rates for different areas of service use within the population. It finds that one third of the population has had some contact with the hospital system in the 12 months preceding the survey; almost two thirds have been in contact with their GP; and one fifth report contact with community services other than GP.

A snapshot survey like this cannot give information on direction of flow between services – it is not evident where contact was initiated and what direction people moved from there – but the survey does show that the GP is the busiest point and around half of those who see the GP have also used services in hospital. The GP is confirmed as the most frequently consulted point of the health service with most interaction with other services and is the best rated service. The number who have used services both in the hospital and the community without involvement of a GP is much lower, about 1%. In this sample, 2% reported using community services only.

This pattern of service use, which shows high utilisation of GP services, coupled with the fact that the vast majority of respondents stated that they got their health information from the GP, reinforces the central part primary care plays in the promotion, provision and maintenance of health. Putting primary care at the frontline to meet the public's health needs is in line with the HSE Transformation Programme and the Primary Care Strategy and the findings of this survey support that strategy.

The analysis of those who report not using any services in the past year indicates that in Ireland men are less likely to avail of health services than women and that utilisation rises steeply with age. Those who rate their health as excellent are more likely to be in higher social positions and they use services less. Those with GMS eligibility use the services more and are more likely to report that their health is poor. These findings support international evidence of the inter-relationship between social, economic and gender factors and health and are a reminder of the need to design services and campaigns that reflect the needs and use patterns of specific groups.

KNOWLEDGE, ATTITUDES AND BELIEFS

The information from the survey suggests that the public are as yet unfamiliar with Primary Community and Continuing Care (PCCC), the HSE organisational structure which manages health and social services outside the acute hospitals, and do not relate or associate services provided in non-acute settings, apart from the GP service, as a core part of overall health care provision. There are proposals by the HSE to meet local health needs through a combination of enhanced health promotion and public health measures, minor trauma units, primary care teams, home care, step-down and rehabilitation facilities. These will support the work of centres of excellence for the treatment and management of conditions requiring acute hospitalisation.

A large majority of respondents stated that they believe that acute hospital services should be provided in every county. However, seven out of ten respondents also indicated a preference to be treated at a specialist or concentrated acute centre where there is evidence that this will provide the best outcome for them. Nonetheless ease of access remains very important to most respondents.

These findings indicate a need to drive and shape communication with communities around HSE plans to meet their health needs by enhancing non-acute services provision hand in hand with the provision of acute and specialist services. The profile of the new service structure must be raised with the general public.

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SMOKING: HEALTH PROMOTION AND POLICY

There are health policy initiatives, such as the smoking ban, which can impact on overall health status and service usage but may not be associated by the public with direct health service experience. This direct link between public health policy and health service usage need not be explicit to the public, but there is a need for public support to make health policy a priority within overall health planning.

Among this survey group, the vast majority supported the smoking ban and a smaller majority indicated that they would support an outright ban on smoking on hospital sites. The aim of the ban is to protect people from passive smoking in the workplace and other studies have shown it to be successful in meeting this aim. However, this survey indicates that, while attitudes may have changed, the prevalence of smoking remains the same as before the ban and supports such as the smokers' quit line may not be well used by smokers. This needs to be considered by service providers.

In conclusion, these survey findings provide a positive basis for HSE for the immediate and long-term future.

SECTION 3

OBJECTIVES

The Health Service Executive commissioned the UCD School of Public Health and Population Science and Lansdowne Market Research to undertake a national survey of consumer satisfaction in November 2006. This report presents preliminary results of the survey. This project has been identified as a priority by the HSE's Chief Executive Officer's Office, facilitated through Consumer Affairs, with a Steering Group comprised of representatives of Population Health, Primary Community and Continuing Care, National Hospitals Office, Quality and Risk, Communications, Patients' Bodies, Strategic Planning and Reform, Human Resources and the Department of Health and Children.

The survey had the following key objectives:

- To create a national profile of service users, their characteristics, and their patterns of utilisation
- To provide the baseline measurements for health service utilisation and consumer satisfaction so that future studies can examine trends over time
- To examine a representative sample of adults, living in 188 randomly selected electoral divisions, who are users of acute hospital services and of a broad range of PCCC services
- To assess new HSE policy initiatives and their effect on satisfaction levels
- To inform the development of survey instruments and methods for future location and service specific research, for example, patients' experiences of acute hospital, disability and mental health services
- To create a benchmark that can be used to compare HSE Ireland with the equivalent European and other international services
- To assess geographic variation within Ireland as the study was conducted in the HSE's four administrative areas – Dublin Mid-Leinster, Dublin North East; West, and South
- To inform the implementation of the National Complaints Framework for the HSE
- To analyse the relevance of internationally documented key determinants of patient satisfaction to identify the most important aspects of health service provision as seen by consumers in Ireland.

SECTION 4

BACKGROUND AND LITERATURE REVIEW

Central to the success of the Irish healthcare transformation process is the role of patients or healthcare consumers in influencing change. It is increasingly acknowledged that the most successful approach to building a safer and higher quality healthcare system is when the health services work together with patients and communities. This collaboration ensures more appropriate and consumer-centred care – care that reflects the needs, wants and preferences of consumers and that leads in the long-term to sustainable quality improvements. A momentum for change has been gathering within the HSE during the past two years, change which, if effective, will ultimately lead to better care and service for patients, clients and carers.

Consumer participation in better healthcare services delivery requires a multi-faceted approach, part of which entails the measurement and evaluation of consumers' experience with the healthcare services. Enabling consumer participation was highlighted as a priority in "Quality and Fairness: A Health System for You" (2001), the national health strategy policy document that governs the totality of the health system in Ireland. More recently, the HSE has identified this as the first of four corporate objectives:

"We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice".

(HSE Corporate Plan 2005-2008)
Similarly, following wide consultation with HSE staff during 2006, the HSE Transformation Programme sets out the following mission statement:

"It is clear that we provide much more than quality services. We provide care, comfort, support, expertise, help, hope, encouragement, protection and a lot more. Providing quality services is therefore simply the means by which we achieve our fundamental purpose which is in essence – To enable people to live healthier and more fulfilled lives. By expressing our purpose or mission in this way, it is easy to see that what matters most is the positive impact we have on the lives of others. It also recognises the role people have to play in maintaining their own health".

(HSE Transformation Programme 2007-2010)
A number of key initiatives by the Department of Health and Children and the HSE are already underway and are likely to have influence on satisfaction levels. For example, 65,000 patients have received treatment under the National Treatment Purchase Fund to date. GPs, patients and families can access the Patient Treatment Register, an online service that provides information about waiting times for inpatient and day-case hospital procedures in public hospitals in Ireland. The HSE has tackled issues within hospitals on a national basis, such as significant increases in hygiene standards, and reductions in Emergency Department waiting times. Community Intervention Teams will enable people who are ill to live independently, avoiding a stay in an acute hospital. Locally based multidisciplinary Primary Care Teams are being rolled out across the country. There is expanded access to comprehensive out-of-hours GP services at treatment centres throughout Ireland, for example, the Shannon Doc service in the Mid-western area, and D-DOC and Care Doc in County Dublin. The increase in income guidelines announced in June 2006 resulted in wider eligibility for the medical card under the GMS, while the new GP Visit Card enables more people to visit their Family Doctor free of charge.

A successful health service recognises the role of the patient and the HSE's corporate plan includes the objective of improving people's experience of its services. The HSE Survey of Consumer Satisfaction measures consumer experience of the Irish health services in the past year (2006) across a representative national sample of inpatients (including day-patients), outpatients (including accident and emergency patients), patients of GPs, and PCCC service users.

Previous research was largely focused on hospital services. This survey reports on a representative sample of adults, living in 188 randomly selected electoral divisions, across the four HSE areas of Ireland, both users and non-users of hospital and PCCC services. The questionnaire design tests specific dimensions of satisfaction with health care as documented internationally to ascertain their relevance to HSE service users. Dimensions having a bearing on HSE service user decisions and experience are included as well as demographic information. The results from this survey will form the basis of future studies which are likely to be location and service specific. This research will contribute to the development of further studies to examine experiences of acute hospital, disability and mental health services, and to measure health service utilisation trends over time. The results will also be used to inform the implementation of complaints policies and indicate the profile of HSE service usage nationally and within the four administrative areas.

4.1 SOURCES FOR QUESTIONS INCLUDED IN THE CURRENT RESEARCH

The survey designers incorporated validated items previously used in other Irish and international studies. Studies such as the national Survey on Lifestyles, Attitudes and Nutrition (SLAN, 2002), the Patients' View study by the Irish Society for Quality in Healthcare (2004) and numerous Picker Institute studies carried out on behalf of the Healthcare Commission and the National Health Service (UK) were important in the development of questionnaire items. Examples of items asked in Picker Institute UK-wide surveys addressing hospital, GP and community health services included:

- The ease with which patients felt they could ask questions about their treatment and condition
- The general appearance of hospital wards and surroundings
- How medical staff treated the patient
- Patients' perceptions of outpatient and emergency department facilities and staff
- How patients felt about waiting times in a wide range of health settings
- How patients felt about the respect they were shown
- How patients felt about transitions from one service to the next if this was necessary
- How patients felt about the levels of information they received from medical professionals.

Coulter's (Picker Institute, 2005) research addressed how patients felt staff training, health advice and trustworthiness could be improved, whether patients felt enough involvement in decisions affecting their health, whether patients had access to emotional support and post discharge care, whether patients had adequate time with health professionals as well as whether they believed appointments occurred at times suiting them. The Donegal Mental Health Services study (2006) focused on communication, medication, hospital facilities and food, accommodation and security. Their questionnaire addressed patient feelings of boredom, their satisfaction with visiting times, bedroom/ bathroom facilities and other patients' behaviour.

4.2 DEFINITIONS OF SATISFACTION

The concept of satisfaction is easy to understand but hard to define as it overlaps with happiness, contentment and quality of life (Crow *et al,* 2002; Coulter, 2005). Satisfaction with a particular service does not imply its superiority; rather, that an acceptable standard was achieved from it. Patient satisfaction is an attitude as well as a person's general orientation towards a total experience of health care. Other important factors include literacy levels, intellectual and physical/sensory disability levels and cultural diversity. Satisfaction is also conflated with user's knowledge and expectations, rather than with the quality of the service provided (Crow *et al*, 2002). There is also a need to separate feelings of satisfaction from those related to the outcome of the service. Data on satisfaction cannot be interpreted independently of the knowledge the user has of the service. It is also interesting that not all people will readily admit to dissatisfaction as to do so would somehow reveal a fault or inferiority in themselves. Research into patient satisfaction should not simply ask patients to rate their satisfaction; rather, they should be asked whether or not certain processes or events occurred during a particular visit, or over a specified number of visits. What occurred is more important than the patient's evaluation of what occurred.

4.3 DIFFERENCES BETWEEN PUBLIC AND PATIENT PERCEPTION

There is often a difference between the perception of the public and that of patients actually using health services. The public's perception is often more negative than that of patients who personally experience the services. Research conducted in 2004 by the MORI Social Research Institute explored public attitudes towards and perceptions of the NHS in the UK. The public's perception is based largely on the media portrayal of health services, and the public often have different priorities than service users. The views of users are generally more positive than those of the public as a whole, and this was felt to clearly illustrate that improved communications can play a role in improving public perceptions of the health services.

While improved service delivery was found to be central to increasing public confidence and improving the patient experience, communication messages aimed at linking 'local' provision (i.e. in the community) to the 'national' system were identified as key, as would demonstrating that real service improvements 'on the ground' reflected improvements in the system across the country.

Looked at from another perspective, patient experience as reported by thousands of patients themselves (through the NHS trusts' annual surveys of patients) requires that specific areas be targeted for service improvement, and these areas may be different from the priorities for action generated by public opinion as a whole. The Picker Institute's report, 'Patient involvement in Health Care', found that the greatest potential benefits from involving patients, as distinct from the public, would lie in improving the effectiveness of care and treatment through transforming the interaction between patients and health professionals. Engaging patients in treatment decisions and in managing their own health care has been shown to improve the appropriateness of care, to lead to better and more cost-effective health outcomes, to reduce risk factors and prevent ill-health, to improve safety and to reduce complaints and litigation. Engaging patients in treatment and self-care requires a change in culture and the move towards a partnership approach in which patients are supported to engage in shared decisions. Key elements of the partnership approach include upgrading the communication skills and training of doctors, nurses and other health professionals, providing comprehensible information which patients can trust, and which can be personalised to them, creating an environment in which patients, their families and carers feel comfortable and welcomed, and an approach to planning patients' care which accommodates and supports them with taking more responsibility for and managing their conditions.

4.4 OVERVIEW OF IRISH RESEARCH IN PATIENT SATISFACTION

No certification or licensing procedure exists for the establishment of a hospital in Ireland. The Independent Hospital Association of Ireland, however, has given its commitment to an accreditation system for hospitals. The Excellence Ireland Quality Association (EIQA) was originally established as the Irish Quality Association to promote quality development in Irish industry. This new excellence model has given rise to much interest from the healthcare sector but has not been widely implemented. In recent years, the Patients' Charter addressed the quality of service and accountability to patients and required the establishment of a complaints procedure. The Joint Commission of Accreditation of Health Care Organisations (JCAHCO, 1994) embraced patient satisfaction as a valid indicator and mandated in its 1994 standards for accreditation that 'the organisation gathers, assesses, and takes appropriate action on information that relates to patient/client satisfaction with service provided.' The Irish Health Services Accreditation standards also seek evidence of a client and community focus and ask the question 'do we know what our patients/clients think of us?' There is an increasing recognition that quality healthcare must take account of the outcomes which are important to people.

In 2000, the first national patient perception survey was conducted by the Irish Society for Quality and Safety in Healthcare (ISQSH) to investigate patient perception of the quality of their care received during a hospital stay. The questionnaire examined specific aspects of the quality of service experienced by 5,000 patients in 26 hospitals nationwide.

This report found that while 93% of patients were quite satisfied with the care they received while in hospital, areas requiring improvement were the communication practices of staff, hospital environment (noise, cleanliness and privacy) and the responsiveness of staff when called.

The second ISQSH report, National Patient Perception, was undertaken in 2002 in 10 hospitals around Ireland. Almost 93% of patients said they were satisfied with the quality of care they received while in hospital. However, as in the previous 2000 study, some patients did complain about the lack of communication with them, particularly when they first entered hospital. There was concern that a number of patients rarely or never saw their consultant while in hospital. Public patients were also more likely than their private counterparts to have to wait longer for admission to hospital from a waiting list. The concerns raised in this report focused on privacy, information about treatment and teaching/research. The Patients' Charter which states that patients must be asked for permission when a consultant wants to have a student present, and is entitled to privacy whenever their condition or treatment is discussed.

The first ever HSE survey among a nationally representative sample of people who have attended EDs was undertaken in late 2006. It was carried out by the Irish Society for Quality and Safety in Healthcare, in partnership with the Royal College of Surgeons in Ireland and Ipsos MORI Ireland. Interviews were carried out by telephone with 1,600 people who attended an ED and the results showed 93% of respondents said they were treated with respect and dignity, 76% reported that they were satisfied with the overall service they received and 86% said they would return to the same emergency department if they needed care in the future.

4.5 OVERVIEW OF LITERATURE FROM ABROAD

4.5.1.Who is using the Health Services and how often?

In every population, health services are used by only a fraction of that population (Centre for Health Services and Policy Research, July 2003). Researchers in British Columbia wanted to understand why a particular group used a disproportionate number of health resources. One question is whether or not this group of users has an unusual burden of illness. To see how services and service costs could be improved for regular users, this research chose GP services as a measure of use because patients are believed to have some influence over their use of GPs. In British Columbia, GPs are also the 'gateway' to other medical services. Almost three million adults were registered in their Medical Services Plan in 1997; 126,000 of these were noted as 'high users.' These users visited more than three times as many different doctors as other users and accounted for 18% of all visits to GPs and 30% of all hospitalisations.

4.5.2 Patient Experiences of Hospital

In an innovative study, Gyntelberg *et al* (2006) examined how Danish nurses and doctors evaluated the hospital care given to their relatives and their own experiences when they had to be patients themselves. A cross-sectional questionnaire was sent to 1,995 doctors and 1,472 nurses, 27% of whom had been hospitalised within the past five years. A majority (85%) of them said they were satisfied with the care they received while 15% were dissatisfied with aspects of facilities, care and treatment. The study revealed areas for improvement in the Danish health care system: better physical facilities, improved patient information and continuous surveillance of errors.

Larson *et al* (USA, 1996) determined that there is an association between meeting patients' information needs and their overall satisfaction with care and their general health status outcomes. Meeting information needs was significantly associated with patients' satisfaction measures and quality of life. The results suggest that care providers should ensure that they meet the information needs of patients as their perceptions of care quality are associated with the clinicians' ability to transfer key information.

4.5.3 Satisfaction and Emergency Services

Based on an analysis of Medline literature from 1976 to 2005, Vukmir (2006) found that there was a lack of objective data correlating customer service objectives, patient satisfaction and quality of care. It was found that patients largely presented for emergency care because it was more convenient to do so. Satisfaction was expressed in terms of timing and quality of care. Boudreaux and O'Hea (2004) also conducted a review of literature on patient satisfaction in EDs. The most robust predictor of global satisfaction was found to be the quality of personal interactions with the emergency care provider. It was also found that perceived waiting times were more closely associated with satisfaction than actual waiting times.

4.5.4 Satisfaction and Waiting Times

Pothier and Frosch (2006) found that time spent waiting to see a doctor is a source of considerable dissatisfaction to most patients. The authors presented patients with information sheets and then questionnaires asking them to rate their levels of satisfaction with various experiences in the outpatient department on a score from one to five. They found that patients given the information sheets were more likely to be satisfied with waiting times. No verbal complaints were received in clinics at which the information sheets were given out. The authors believe that information sheets would be a useful and cost-effective method of improving patient satisfaction in primary care and outpatient hospital settings.

4.5.5 Mental Health Services

A Mental Health Statistics Improvement Programme (MHSIP) study, conducted in the USA (2006), addressed consumer perception of good access to mental health service, the quality and appropriateness of services, positive change, and consumer participation in treatment planning. The Washington Institute for Mental Illness Research and Training conducted an Adult Consumer Survey (2006) to examine quality issues related to the delivery of state-funded mental health services. The survey consisted of 32 items pertaining to the respondent's perceived general satisfaction with service, appropriateness of service, perceived outcomes and access to service. Demographic items were included.

4.6 OVERVIEW OF THE UK LITERATURE

Attention to consumer views in the UK was first triggered in 1983 by the Griffiths Report which recommended that the NHS give more attention to the views of health service users. Crow *et al* (2002) also note that the 1990s witnessed the introduction of clinical audit systems in the UK. Not all professionals welcome the prospect of patient involvement; it is believed by some that patients cannot judge technical aspects of their care and that their knowledge extends no further than cleanliness of facilities and interpersonal skills.

4.6.1 Measuring Patient Satisfaction

In the United Kingdom, Wilson et al (2006) piloted a questionnaire amongst patients and staff in order to measure patient satisfaction with intermediate care. Analysis identified six factors: general satisfaction, affective response, cognitive response, timing of discharge, coordination after discharge, and access to pain relief. In the UK, various methods of assessing satisfaction have been used:

- Experience of care
- Overall satisfaction with care
- What did or did not happen during a visit to a particular service?
- Asking the individual to rate their satisfaction with various aspects of care.

4.6.2 Engaging People with their own Healthcare

A national telephone survey of 3,000 patients conducted by Ellins and Coulter (Picker Institute, 2005) found that many patients want more involvement in decisions about their care as well as greater support from professionals in achieving self-care. The authors found that little is understood about the capacity of patients to be successful managers of their own health issues. The authors used a "Patient Activation Measure" to assess people's knowledge, confidence and skills for self-management. They identified a four-stage model of patient activation: 1) Believing the patient role is important; 2) Having the confidence and knowledge necessary to take action; 3) Taking action to maintain and improve one's health; 4) Staying the course when under stress. Patients who were elderly, had low education attainment, or were of lower socio-economic status had low levels of confidence and knowledge. Those with poor health also had poor knowledge and expertise. The authors found that while 60% of those with good education had good knowledge and confidence, only 30% of those who were more disadvantaged had less knowledge and confidence. It was also found, however, that over 90% of all people surveyed said they understood their illness and the purpose of their medication.

Among various initiatives undertaken in the UK, the most noted is the Expert Patients Programme, a community-based education course which imparts the skills and knowledge necessary to allow patients to be fully engaged in self-management of health care. A three-year programme was put in place aiming to improve patient access to high quality health information. Recent NHS patient surveys found that 59% of mental health patients, 47% of inpatients and 39% of heart disease patients would have liked more input into their care (Picker Institute, 2005).

Another Picker Institute report in 2005, 'How engaged are people in their health care?', confirmed the importance of initiatives to improve patients' involvement in their health care. Certain groups need more support in order to become more active participants in their healthcare. As stated earlier, this group tends to include the elderly, those from lower social grades, the less educated and the chronically ill. 'Ownership' of healthcare is encouraged through patients' active involvement in clinical decisions and collaborative relationships with health professionals. Almost all respondents acknowledged the importance of taking an active role in managing their health problems. Many felt sufficiently confident in taking appropriate action where necessary. However, a significant number of patients interviewed lacked the knowledge, skills and motivation to look after themselves effectively.

4.7 CONCLUSIONS

The literature on satisfaction with health services shows consistent results – there is a high level of satisfaction with service in most Western countries, higher amongst users than non-users. Satisfaction has many elements, some of which are identified in the dimensions reported on below. More important than measurement, is the development of methods of empowering staff and users to work together to improve service delivery.

SECTION 5

METHODOLOGY

This HSE consumer satisfaction survey uses a questionnaire designed to capture and evaluate nationally representative baseline information that measures consumers' experience of Irish health services. The survey design was based on evidence of best practice and surveys used in other health services research internationally. Its focus is on the general public's experience and satisfaction with hospital services and PCCC. To be nationally representative, it was conducted face-to-face in the four HSE areas of Dublin Mid-Leinster; Dublin North East the West and South. The interview consisted of a comprehensive set of questions which capture not only a profile of service use, but also information related to demographics, health status and health service knowledge, all of which are factors that influence the respondent's perception of the health services.

Taking a cross-sectional adult population living in the community, the aim of the survey was to measure satisfaction with four services:

- Inpatients (including day patients)
- Outpatients (including ED patients)
- GP services
- Other PCCC services - 25 specific community health services, including the mental health service. (See Appendix 1 for list).

5.1 THE EIGHT DIMENSIONS OF SATISFACTION

The survey was designed to incorporate as many as possible of similar measures of satisfaction using eight dimensions of satisfaction (Table 5.1) within each service in order to allow comparisons of users' experiences across the services.

TABLE 5.1

Eight dimensions of satisfaction – used to construct questionnaire

Dimensions of satisfaction	
1	Fast access to reliable health services
2	Effective treatment delivered by trusted professionals
3	Involvement in decisions and respect for preferences
4	Clear, comprehensive information and support for self-care
5	Attention to physical and environmental needs
6	Emotional support, empathy and respect
7	Involvement of and support for family carers
8	Continuity of care and smooth transitions

Key expertise and information from HSE stakeholders at the survey design stage informed the selection of the questions relating to service utilisation, knowledge about the health services and the appropriate questions for each of the dimensions of satisfaction. The health status, demographics and smoking questions were used previously in the national Survey on Lifestyle, Attitudes and Nutrition (SLAN 1998, 2002).

The introduction of anchoring vignettes (Section G) was designed to improve the interpretation of self-reported measures of health by detecting and adjusting for different expectations of health across individuals and areas. The vignette is used increasingly in the social psychology literature. By using hypothetical individuals described in short 'stories' set in a health service context, vignettes are used to identify differences in health expectation across age groups and other variables, and to make self reports more comparable. The vignettes were selected with assistance from Dr. Liam Delaney of the UCD Geary Institute (http://geary.ucd.ie/), currently conducting several projects in the area of health behaviour and risk. The respondent can identify with the experience of the person described and express their attitude to the situation. In the present survey four individuals are described, based on Harvard University developed models (http://gking.harvard.edu/vign/eg/involved.shtml). 'Vincent's' situation reflects getting involved in decisions, 'Patricia's' situation explores privacy/respect, 'Dora's' situation relates to family contact and 'Thomas's' situation to communication.

Research using anchoring vignettes has grown tremendously in recent years. Vignette questions have been applied in recent work on international comparisons of health (King *et al,* 2004 and d'Uva *et al,* 2006), political efficacy (Salomon *et al,* 2004), work disability (Kapteyn *et al,* 2007), job satisfaction (Kristensen and Johansson, 2005), and life satisfaction (Kristensen *et al,* 2006). Anchoring vignettes are used extensively now in major health survey research and are an important part of the World Health Organisation's survey strategies. In the context of the present study of health satisfaction, the use of these vignettes will allow survey measures of satisfaction with health services to be refined. In particular, it will be possible to ascertain whether different groups interpret satisfaction questions differently and whether this has implications for how the experiences of these groups are compared. This is the first time that such a methodology has been used in the Irish context despite its increasing prevalence in the global literature. It will thus add greatly to the stock of knowledge in this area. The analysis of the vignettes will appear as a separate report.

5.2 PREPARATION AND DESIGN

The research team conducted a systematic literature review of service-specific surveys undertaken previously both nationally and internationally. A first design brief meeting with the HSE study team focussed on the choice of study instrument and most appropriate survey method: a face-to-face interview, not more than 25 minutes in duration. Issues that were addressed included: content and appropriateness of the instrument, sampling issues, and how to raise awareness and support for the fieldwork stage of the survey. A brief two-stage Delphi consultation process was conducted to refine our level of consensus and a detailed agreement was reached on the specific order and content for the instrument.

The proposed instrument, using primarily pre-validated questions, was circulated, together with a selection of recent papers on the measurement of patient perceptions of healthcare services. At a second stakeholder meeting, the specifications were refined and consensus was reached on the exact deliverables, and subsequently some new domains related to patient engagement were developed.

5.3 ETHICAL CLEARANCE PROCEDURES

The main ethical issues relating to the conduct of this study were confidentiality, and consent. It was agreed that the respondents' names, addresses, and telephone numbers (essential to enable back-checking of interviewer performance) would be recorded separately from the questionnaire to maintain complete confidentiality.

Hospital numbers and other personal identifiers were not recorded. All information recorded was held securely within Lansdowne Market Research and UCD. Ethical approval was obtained from the UCD ethics committee. Respondents were not offered incentives for their participation.

5.4 DATA COLLECTION/ FIELDWORK

The fieldwork was carried out by Lansdowne Market Research, and quality control checks included postal and telephone back-checking of interviewer performance, consistent editing procedures and intensive interviewer supervision. Lansdowne's fieldwork processes are in accordance with the guidelines on interviewing quality proposed and supported by the Association of Irish Market Research Organisations (AIMRO). Fieldwork commenced on 13th November 2006 and continued until 9th March 2007.

5.5 SAMPLE SIZE AND SAMPLING

The agreed design objectives of the study were 1) to secure a demographically representative national sample of the adult population 2) to examine those over 50 years in more depth and hence to supplement or augment the sample with an additional 500 interviews with respondents aged over 50. It is well established that rates of morbidity or ill health, and hence utilisation, begin to rise steeply after the age of fifty years (Kelleher *et al,* 2002).

A national sample of 3,000 was selected based on the required precision of estimate and practical considerations. This sample size is sufficient, with 95% confidence, to measure a 50% positive response to any given question with precision +/-1.8% at National level and +/- 3.6% in each of the four HSE areas.

To achieve this, a sampling technique was developed using a quota controlled method, based on quotas for age, sex and social class, within each of the four HSE areas. This was based on the 2002 census population composition, as the 2006 census data were not available at the time of starting fieldwork. The Joint National Readership Survey was used to set quotas for social class. Separate quotas were set for each HSE Area. The overall quotas are shown in Table 5.2.

Interviewees were identified at 188 sampling points randomly selected from around the country, and a total of 16 face-to-face interviews were to be completed for each point.

TABLE 5.2
Quotas and intended sample sizes for the nationally representative sample

Group	Census	Census %	Sample	Sample %			
Male	1,426,681	49.1%	1,479	49.2%			
Female	1,477,491	50.9%	1,529	50.8%			
Total	2,904,172	100%	3,008	100%			
Male							
Age					**Social group**	**Sample**	**Sample %**
18-24	230,266	16.1%	237	16.0%	AB	232	15.7%
25-34	308,477	21.6%	319	21.6%	C1	378	25.6%
35-49	404,812	28.4%	418	28.3%	C2	392	26.5%
50-64	293,971	20.6%	302	20.4%	DE	326	22.0%
65+	189,155	13.3%	203	13.7%	F	151	10.2%
Total	1,426,681	100%	1,479	100%		1,479	100%
Female							
Age					**Social group**	**Sample**	**Sample %**
18-24	225,653	15.3%	233	15.2%	AB	191	12.5%
25-34	308,892	20.9%	320	20.9%	C1	456	29.8%
35-49	407,682	27.6%	421	27.5%	C2	327	21.4%
50-64	288,418	19.5%	299	19.6%	DE	449	29.4%
65+	246,846	16.7%	256	16.7%	F	106	6.9%
Total	1,477,491	100%	1,529	100%		1,529	100%

5.6 QUESTIONNAIRE DESIGN

Questionnaire design was based on the findings of the literature review. As far as possible questions were re-used or slightly adapted from existing instruments. A major practical issue that had to be addressed early in the design phase was the issue of respondent burden. While some interviewees were expected to have no contacts with health services, and most only one or two, a small number of respondents were expected to have had many contacts, possibly with many different services. Attempting to ask this latter group detailed questions about satisfaction with each experience would have posed an unacceptable burden on them. Nor was it possible to estimate in advance what the utilisation pattern might be, since this was an outcome of the survey in itself. Accordingly a random selection process was employed to ensure as far as possible a balanced sample, and that all users would describe at least one experience in depth.

Each respondent was asked about service utilisation in the preceding year. Four sets of questionnaires were produced with different colour-coded covers, but otherwise identical in content.

Depending on which questionnaire colour was used, and on their responses to the utilisation questions, respondents were asked in detail about only one experience as a hospital inpatient, as a hospital outpatient, as a GP patient, or any other community based service in random order, according to the sequence presented in Table 5.3.

TABLE 5.3

Colour-coded surveys used to ensure equal distribution among service users.

Blue (25% respondents)	Pink (25% respondents)	Yellow (25% respondents)	Green (25% respondents)
Ask first about hospital inpatient experience, if none, then proceed to outpatient, then GP then other community health service	Ask first about hospital outpatient experience, if none, then proceed to GP then other community health service, then hospital inpatient	Ask first about GP then other community health service experience, then hospital inpatient, then hospital outpatient	Ask first other community health service experience, if none then ask about hospital inpatient, then outpatient, then GP

This process yielded the following sample:

TABLE 5.4

Questionnaires completed by respondents: national and national augmented samples

		National quota sample (n=3,032)		National augmented sample (n=3,517)	
Section	Service Experience	n	%	n	%
C	Hospital inpatients	277	9%	344	10%
D	Hospital outpatients	414	14%	470	13%
E	General Practitioner (GP)	1,467	48%	1,732	49%
F	Community Services	186	6%	212	6%
	Non-Users	688	23%	759	22%
	Total	3,032	100%	3,517	100%

5.7 ARCHIVING

It is envisaged that in agreement with the HSE, UCD will archive the data dictionary, the data set, and the instruments, and also the procedures manuals and the codes used in analysis. A cleaned anonymised dataset in a format readily usable from any modern statistics package will be prepared for analysis along with full documentation. Following the initial analysis by UCD, the datasets will be made available to the HSE and with permission of the HSE will be archived with ISSDA, the Irish Social Sciences Data Archive at UCD, which responds to requests for appropriate access to the archived datasets (http://www.ucd.ie/issda).

5.8 STATISTICAL ANALYSIS

The data are reported throughout in the following ways:

- First the report focuses on the national quota sample (n=3,032), which in effect is designed to be representative of the national and area populations, overall and according to GMS status. All summary statistics in the body of the report are based on the national quota sample.
- For comparisons of those under and over 50 years the national augmented sample (n=3,517), which has the extra respondents over 50 years of age, is used. Respondents were asked to state their exact age in years. For ease of presentation, these are labelled as ‘Under 50s’ and ‘Over 50s’. The Under 50s category comprises those who are 50 years and under, the Over 50s category comprises those who are 51 and upwards.
- Basic descriptive data are presented for utilisation patterns for the national quota sample (n=3,032), sub-analysis for under 50s and over 50s (n=3,517) and for GMS and non GMS.
- Chi square or independent t tests were conducted as appropriate for comparison purposes, between groups and p values < 0.05, ≤ 0.01, ≤ 0.001 as applicable are indicated.
- Valid responses to each question are given. The figures were adjusted to remove non-responses for given questions.

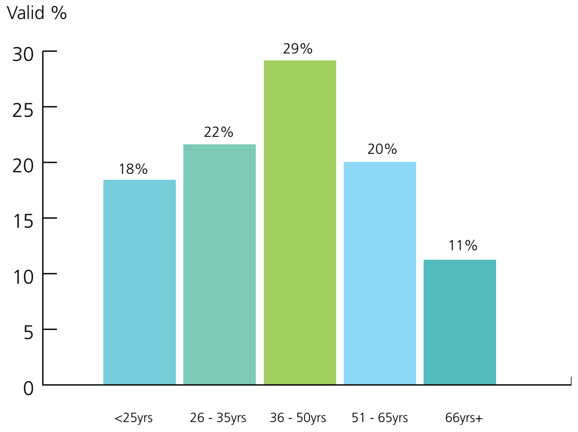
SECTION 6

RESULTS

6.1 DEMOGRAPHICS AND SOCIAL CLASSIFICATION

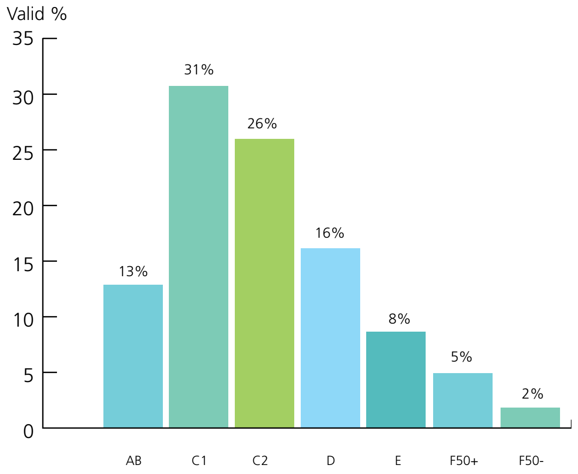
The aim was to recruit at least 3,000 respondents balanced for region and to undertake an additional 500 interviews in those over 50 years. This was achieved (see Table 5.4), the balanced national sample was 3,032 respondents and the final national national augmented sample of 3,517 increases the number of respondents in the over 50s category by 50%, 2,102 under 50 years and 1,415 over 50. The sample was balanced for gender (48% men, 52% women) with an age range up to 92 years. The national sample was weighted to reflect the population age (Figure 6.1) and sex distribution and this is therefore reflected in the findings.

FIGURE 6.1
Age distribution of respondents: national quota sample (n=3,032)



The social classification, according to the Market Research Scale, also gives the expected representation of the population (Figure 6.2).

FIGURE 6.2
Social classification of respondents: national quota sample – Market Research Scale (n=3,032)



The education level achieved by respondents for the national quota sample (Figure 6.3) and in the national augmented sample for respondents under and over 50s (Figure 6.4) is also given.

FIGURE 6.3
Education level of respondents: national quota sample (n=3,032)

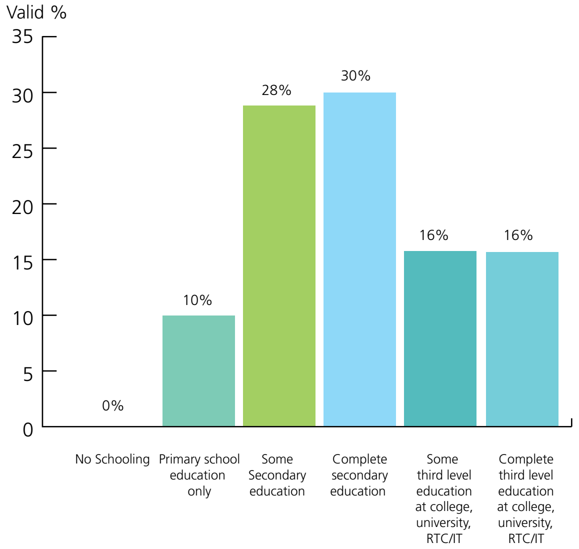
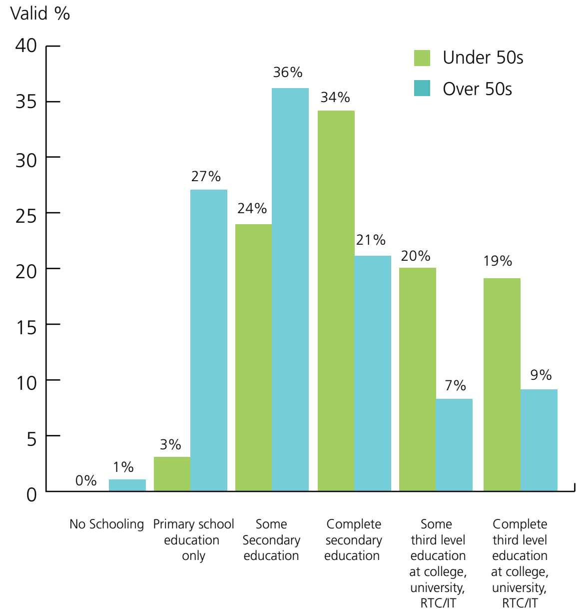


FIGURE 6.4

Education level of respondents: national augmented sample (n=3,517)

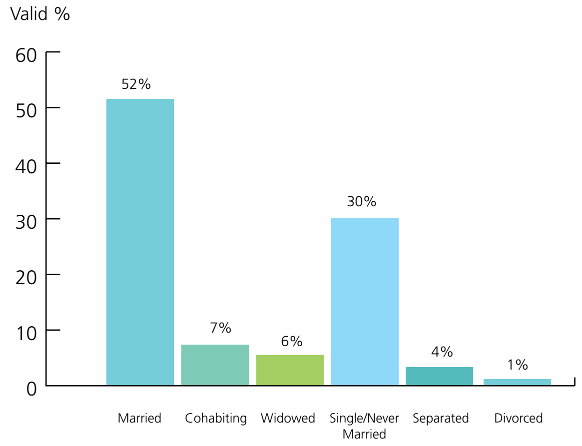


There is a clear effect of age on level of education [p<0.001]; 27% of respondents over 50 years of age had primary school education only, compared with just 3% of those under 50 years of age. Conversely, just 9% of those over 50 had completed third level education, compared with 19% of those under 50. This pattern reflects the impact of the introduction of free second level education in Ireland in 1966.

A majority of respondents were married (Figure 6.5) and 6% of respondents were not of Irish nationality.

FIGURE 6.5

Marital status: national quota sample (n=3,032)



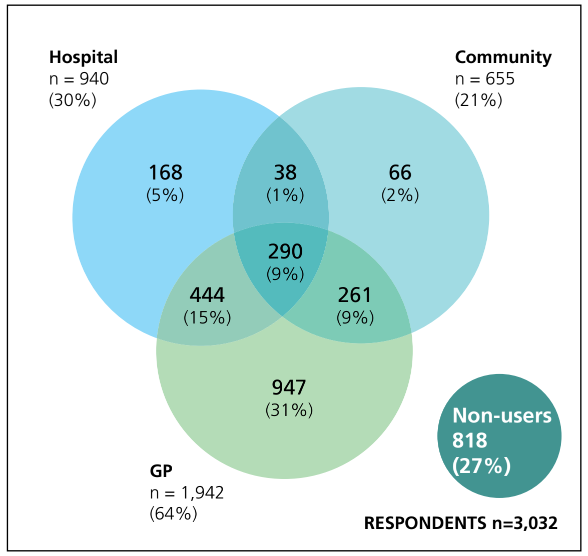
6.2 PROFILE OF HEALTH SERVICE USERS IN THE 12 MONTHS PRECEDING THE SURVEY

The utilisation profile of service users was examined in the national quota sample (n=3,032) and for under and over 50s in the national augmented sample (n=3,517). Nearly two-thirds (64%) of respondents had consulted a GP in the previous 12 months, 30% had attended a hospital and 21% had attended any kind of community service (Figure 6.6).

The overlap between utilisation patterns is presented in Venn diagram format. The interface with a GP was the most frequently reported. Around half of those attending a GP (51%) also reported attending another service. Just 9% of the total sample reported experience of all three categories of service. Very few respondents reported use of community services alone (2%), and very few of those with a hospital experience reported use of community services without interface with a GP (1%). Those reporting non-use of any service were appreciable, at 27%.

FIGURE 6.6

Service utilisation: national quota sample (n=3,032)



As might be anticipated, there is a clear age pattern, in that the over 50s were more likely to be service users than the under 50s and the rate of non-users is almost halved, from 31% to 17%, (Figures 6.7 and 6.8).

Those with contact with a hospital increases to 39% from 27% and those with contact with a GP increases from 59% to 75%. However contacts between hospital and community were low especially when the GP is excluded (1%).

FIGURE 6.7

Service utilisation by respondents aged under 50: national augmented sample (n=2,102)

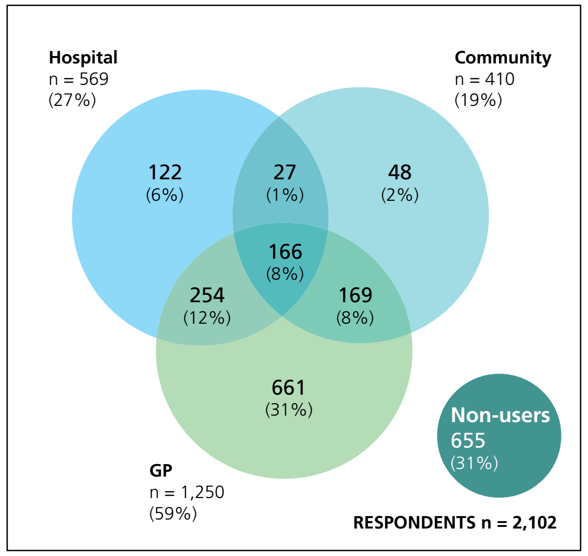
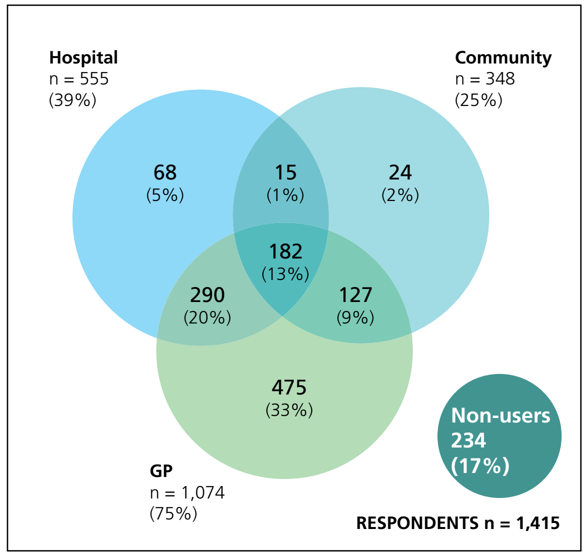


FIGURE 6.8

Service utilisation by respondents aged over 50: national augmented sample (n=1,415)



The type of community service consulted is presented in Table 6.1, according to age category. The two front running services were dental services and physiotherapy, and while this was meant to refer to public services only, it is possible some respondents were privately treated. The rates of utilisation were very low for some services.

TABLE 6.1

Community service utilisation by age category

Community Service	**18–25 yrs**	**%**	**26–35 yrs**	**%**	**36–50 yrs**	**%**	**51–65 yrs**	**%**	**66+ yrs**	**%**
Dental Services (Public only Not Private)	15	47%	17	44%	14	35%	5	13%	2	8%
Physiotherapist	6	19%	7	18%	5	13%	6	15%	4	16%
Community Welfare Officer	3	9%	–	–	1	3%	3	8%	–	–
Mental Health Services (including non-acute Psychiatric hospitals)	2	6%	3	8%	9	23%	3	8%	–	–
Public health nurse	2	6%	8	21%	3	8%	5	13%	4	16%
Chiropody\Podiatry	2	6%	–	–	2	5%	1	3%	4	16%
Occupational therapist	1	3%	–	–	–	–	1	3%	–	–
Audiology	1	3%	–	-	1	3%	1	3%	–	–
Psychology services	–	–	1	3%	2	5%	–	–	–	–
Social worker	–	–	1	3%	1	3%	–	–	–	–
Home Help Services	–	–	–	–	1	3%	–	–	5	20%
Drug\Alcohol Outreach Services	–	–	–	–	1	3%	1	3%	–	–
Speech Therapy	–	–	1	3%	–	–	–	–	–	–
Dietician	–	–	–	–	–	–	3	8%	1	4%
Ophthalmology	–	–	1	3%	–	–	5	13%	1	4%
Day services for older people	–	–	–	–	–	–	1	3%	–	–
Respite services for older people	–	–	–	–	–	–	1	3%	–	–
Home support for older people	–	–	–	–	–	–	–	–	2	8%
Residential services for the intellectual\physical or sensory disabled	–	–	–	–	–	–	–	–	1	4%
Day services for the intellectual\physical or sensory disabled	–	–	–	–	–	–	2	5%	–	–
Respite services for the intellectual\physical or sensory disabled	–	–	–	–	–	–	–	–	1	4%
Home support for the intellectual\physical or sensory disabled	–	–	–	–	–	–	1	3%	–	–
Totals	32	100%	39	100%	40	100%	39	100%	25	100%

6.3 PROFILE OF NON-USERS OF HEALTH SERVICES IN THE 12 MONTHS PRECEDING THE SURVEY

Table 6.2 indicates the profile of non-users of health services in the last year according to key demographic variables (n=818).

Men were more likely to be non-users than women. There is a strong inverse age gradient, with highest rates of non-use, at 36% in the youngest age category of those aged 25 and under, falling steadily across age brackets to 11% of those aged 66 and upwards.

Those GMS eligible were less likely to be non-users (19% compared to 32% not GMS eligible). Those on the lowest income were less likely to report non-use. Homemakers, the retired and those with permanent sickness were also less likely to be non-users. Conversely those with excellent self-rated health and those residing in the West had the highest levels of non-use.

There was no indication of a link between non-use and access to services, whether measured as ‘distance to nearest GP’, or ‘distance to hospital’ or ‘access to a car’. A multivariate logistic model, adjusting for age group and sex, indicated that all the characteristics above remained independent and significant predictors of non-use of health services.

TABLE 6.2

Profile of service users versus non-users: national quota sample

		Total	Non-users	% Non-Users	p
Gender	Male	1,466	487	33%	<0.0001
	Female	1,566	331	21%	
Age group	≤ 25 (21)	540	197	36%	<0.0001
range (median)	26-35 (31)	668	207	31%	
	36-50 (43)	865	240	28%	
	51-65 (57)	616	136	22%	
	66+ (72)	343	38	11%	
Nationality	Irish	2793	734	26%	0.0005
	Other	203	76	37%	
Medical card status	Medical card	1,034	192	19%	<0.0001
	No medical card	1,936	611	32%	
Health insurance	Insured	1,557	424	27%	0.91
	Not insured	1,401	379	27%	
Education	None/Primary	320	77	24%	0.28
	Secondary	1,700	445	26%	
	Tertiary	956	270	28%	
Social Class	AB	381	101	27%	<0.0001
	C1	925	252	27%	
	C2	776	243	31%	
	D	493	139	28%	
	E	240	28	12%	
	F50+	144	45	31%	
	F50-	72	10	14%	
Employment	Employee	1,356	427	31%	<0.0001
	Self-employed	366	126	34%	
	Homemaker	530	91	17%	
	Unemployed/seeking 1st job	111	31	28%	
	Student	234	93	40%	
	Retired	329	40	12%	
	Permanent sickness	51	3	6%	
	Other	29	5	17%	
Income (Euro per week)	< 320	556	125	22%	0.01
	320-950	1,197	346	29%	
	> 950	302	89	29%	

TABLE 6.2

Profile of service users versus non-users: national quota sample - continued

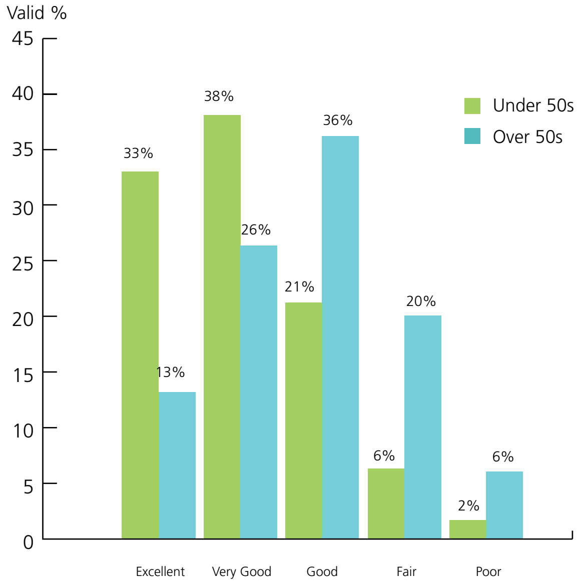
		Total	Non-users	% Non-Users	p
HSE Area	West	759	262	35%	<0.0001
	South	748	168	22%	
	Dublin North	781	204	26%	
	Dublin Mid Leinster	744	184	25%	
Marital status	Married	1,555	361	23%	<0.0001
	Cohabiting	224	76	34%	
	Widowed	182	17	9%	
	Single	903	325	36%	
	Separated/divorced	151	36	24%	
Smoking status	Current smoker	867	222	26%	0.3
	Non-smoker	2,090	574	27%	
Self-rated health	Excellent	792	317	40%	<0.0001
	Very good	1,029	307	30%	
	Good	783	150	19%	
	Fair	321	32	10%	
	Poor	79	6	8%	
Distance to GP	0-1 miles	1,519	407	27%	0.75
(nearest)	1-4 miles	707	186	26%	
	>= 4 miles	805	225	28%	
Distance to hospital	< 2 miles	518	150	29%	0.23
(nearest general)	2-5 miles	683	162	24%	
	5-12 miles	617	177	29%	
	12-20 miles	523	143	27%	
	>= 20 miles	691	186	27%	
Access to car	Yes	2,317	616	27%	0.38
	No	682	193	28%	

6.4 SELF-REPORTED HEALTH AND SMOKING STATUS

A majority of respondents reported their health as either excellent (26%) or very good (34%) and this shows a clear and positive age-related pattern, which was statistically significant [p<0.001] (Figure 6.9), with younger respondents much more likely to rate their health well.

FIGURE 6.9

Respondents' ratings for their general health: national augmented sample (n=3,517)



The level of self-reported health was generally high, 72% of respondents reported no problems with their physical health in the last month, 88% reported no problem with their mental health and 79% indicated that their usual activities were not affected by ill-health in the last month. However 10% of respondents reported that they had a long-term illness or disability that interfered with their usual work, which was age-related, rising from 6% in those aged under 50 to 20% of those aged over 50 years.

There is an observable pattern in the self-reported health status according to GMS status also, those GMS eligible being more likely to report fair or poor health, limitation or long-term disability [p<0.001]. Both reported quality of life and satisfaction with health are also related to age and GMS eligibility [p<0.001] (Figures 6.10 to 6.12).

FIGURE 6.10

Self reported health status in GMS eligible respondents according to age: national augmented sample (n=1,293)

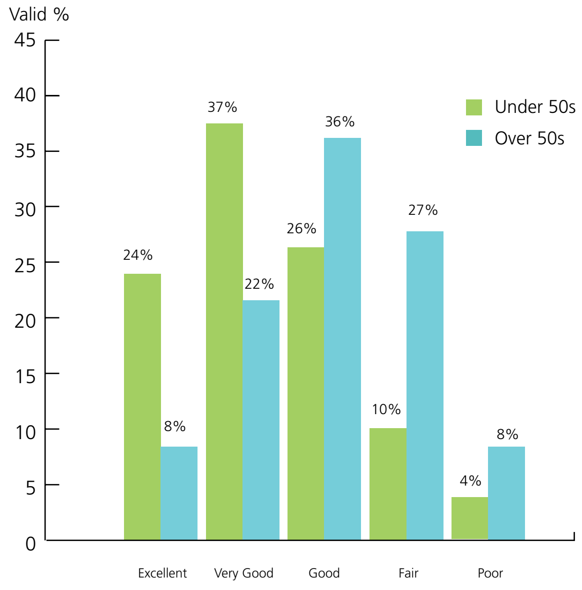


FIGURE 6.11

Self reported health status in non GMS eligible respondents according to age: national augmented sample (n=2,224)

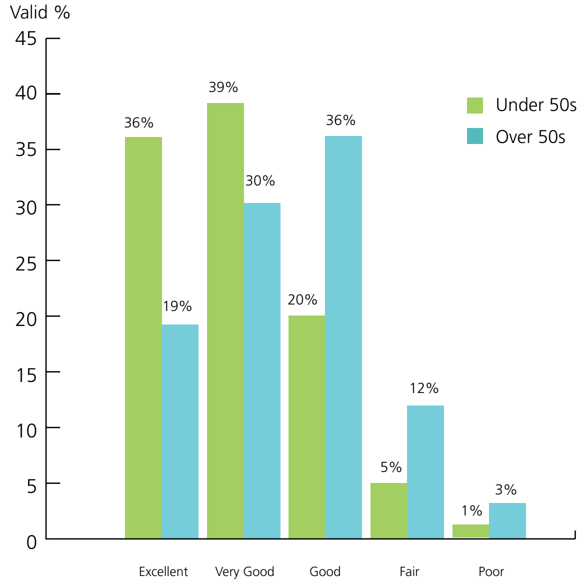
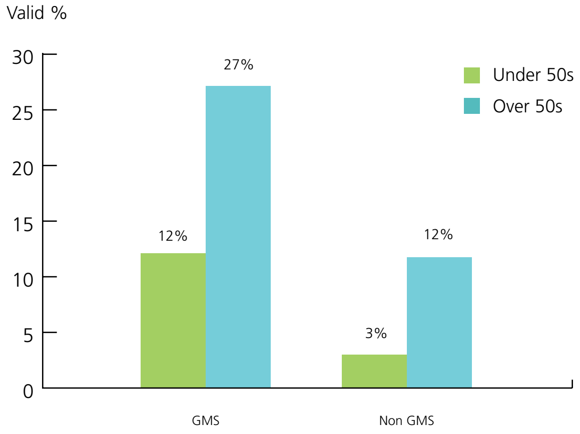


FIGURE 6.12

Respondents reporting daily activities or work limited by long term illness, according to age and GMS status: national augmented sample (n=411)



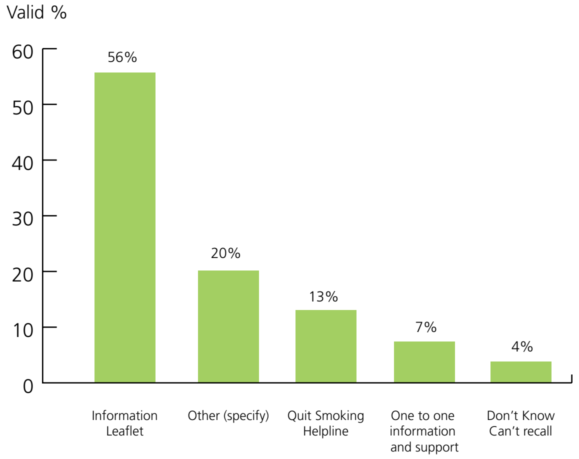
6.4.1 Smoking

Respondents were asked if they currently smoked cigarettes, cigars or a pipe; (29%, n=867) of respondents were current smokers. The majority of cigarette smokers were currently smoking 2 or more cigarettes a day regularly (90%, n=731).

All smokers were asked if they had ever received information on stopping smoking. The majority of smokers said they had not, (51%, n=358) while (49%, n=339) stated they had received information about stopping smoking. Sources of information are given in Figure 6.13.

FIGURE 6.13

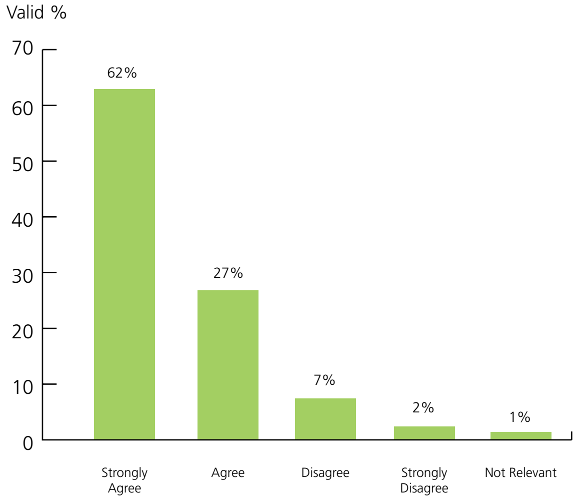
Source of smoking information for smokers: national quota sample (n=339)



All respondents were asked if they agreed or disagreed with the nationwide smoking ban, which was implemented in March 2004. The majority of respondents (62%) strongly agreed with the ban (n=1,863) and another 27% (n=828) stated they agreed (Figure 6.14).

FIGURE 6.14

Ratings given by all respondents regarding the national smoking ban implemented in March 2004: national quota sample (n=3,032)



Finally, respondents were asked if they agreed or disagreed with a total site ban on smoking in all healthcare facilities in Ireland, including the outdoor grounds. The majority (59%) of respondents were in favour of a total site ban in healthcare facilities: 35% (n=1,068) strongly agreed and 24% (n=730) stated that they agreed (Figure 6.15).

FIGURE 6.15

Views of respondents on the implementation of a total site ban on smoking in all healthcare facilities in Ireland, including outdoor grounds: national quota sample (n=3,032)

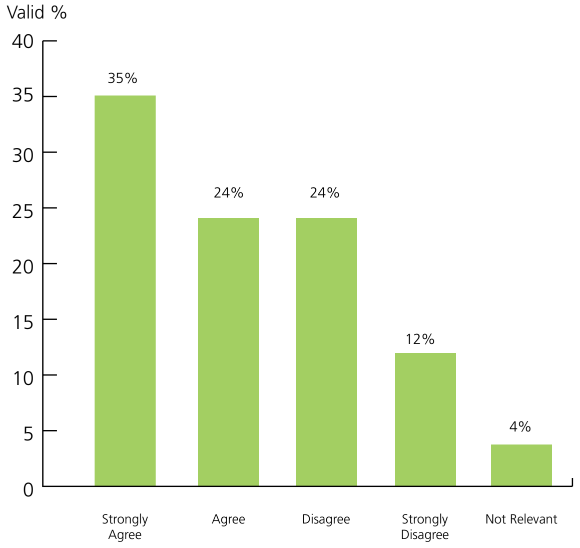
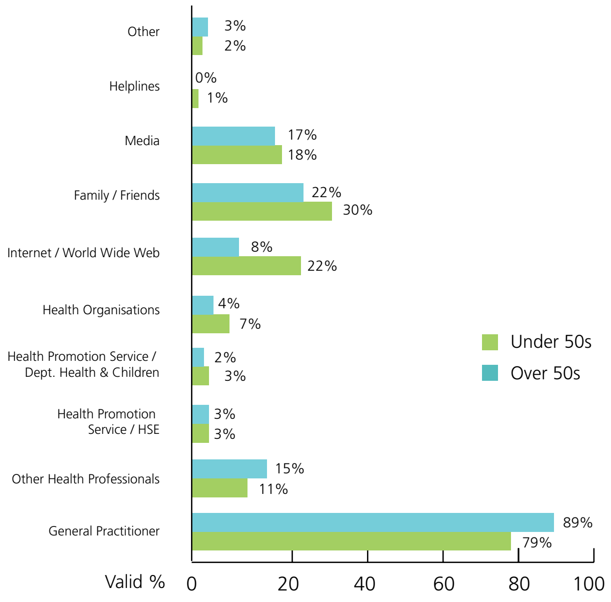


FIGURE 6.16

Sources of health information by age: national augmented sample (n=3,517)



6.5 KNOWLEDGE, ATTITUDES AND BELIEFS

Respondents were asked about sources of information about health. By far the most frequently cited source was the GP (82%). The GP was somewhat more important as a source of information among older respondents [$p<0.001$], (Figure 6.16) and in GMS eligible respondents [$p<0.001$] (Table 6.3). The next most frequently cited source was family or friends (28%). Newer sources of information, such as the internet, are increasingly popular (18%) but strongly age-related being cited by 8% of those over 50, rising to 22% of those under 50 years.

Knowledge about the structure of the HSE was variable. A majority (86%) of respondents were registered with a GP. Whilst most respondents knew what the letters HSE (Health Service Executive) mean (64%); knew that the HSE replaced the health board structure (66%); knew what the HSE does (66%) and what the Department of Health and Children is (66%); there was much lower recognition of the term PCCC (the new Primary, Community and Continuing Care services) stood for, with 82% saying they did not know what it stood for and just 11% getting it correct.

Most respondents were in favour of county level services being available, 96% of respondents thought emergency services should be provided in every county and 84% thought acute hospitals services should be provided in every county. When it was suggested to respondents that research evidence indicates that specialist or regional centres provided the best clinical outcome, 76% agreed that they would like to be treated in such a centre, and 16% were unsure. Ease of access was important to respondents, 70% stating that it was very important and a further 24% that it was somewhat important (Figure 6.17).

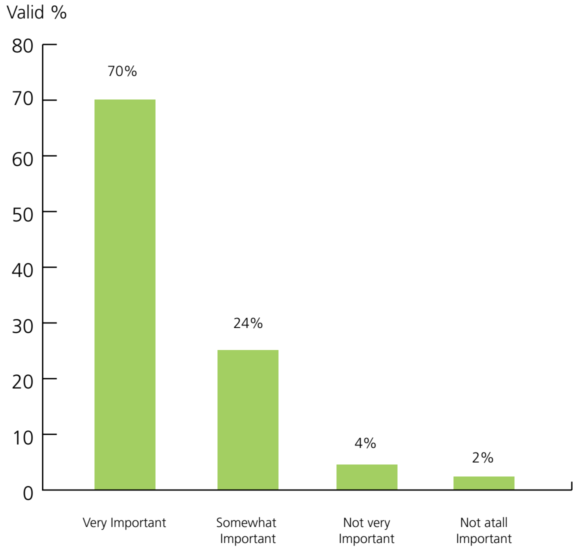
TABLE 6.3

Sources of health information according to GMS eligibility

Source of Health Information	GMS		Non GMS	
	%	n	%	n
GP	88%	910	79%	1,577
Family / Friends	23%	238	30%	605
Media	16%	160	19%	373
Other Health Professionals	14%	148	12%	241
Internet / World Wide Web	12%	125	21%	426
Health Organisations	4%	44	7%	145
Health Promotion Service / HSE	2%	25	3%	60
Health Promotion Unit/Dept of Health and Children	2%	24	3%	67
Other	2%	17	3%	50
Don't Know	1%	12	2%	40
Help lines i.e. National Information Helpline	1%	9	1%	23

FIGURE 6.17

Ratings for importance of ease of access to a specialist or regional centre: national quota sample (n=3,032)



Respondents were also asked to assess their own ease of access, compared to others in the community, for various services, 80% said it was about the same as everyone else for GP services, 70% for emergency services and 57% for mental health services.

Awareness of rights was also explored; 63% were aware that the Data Protection Act, 1988, protects information in medical records, 55% knew that the Freedom of Information Act, 1997, allows access to one's own patient records. However, knowledge about the various patient charters was very low with 77% being unaware of the original Patients' Charter, which sets out what patients should expect from their care experience. A majority (64%) were unaware of the complaints procedure within the care setting and 61% said that they would not know how to go about making a complaint.

While 81% said they had never wished to make a complaint about the health service, only 16% were aware of the new provision for a complaints procedure under the Health Act, 2003, rolled out in January 2007.

6.6 CONSUMER EXPERIENCES OF SERVICES

All respondents who reported experience of a service in the 12 months preceding the survey were asked in detail about one such experience. As indicated in the methodology section, respondents were asked at random and in rotating order about hospital inpatient, hospital outpatient, GP or community health service experience and asked to discuss one such service in particular. There were 2,758 service experience interviews completed, the remainder being non-users. The most frequently recorded interview experience was GP services (n=1,732, 63% of users), followed by hospital outpatient (n=470, 17% of users), hospital inpatient (n=344, 13% of users) and the least frequent community health services (n=212, 8% of users).

6.6.1 Overall Quality of Care Ratings by Service Users

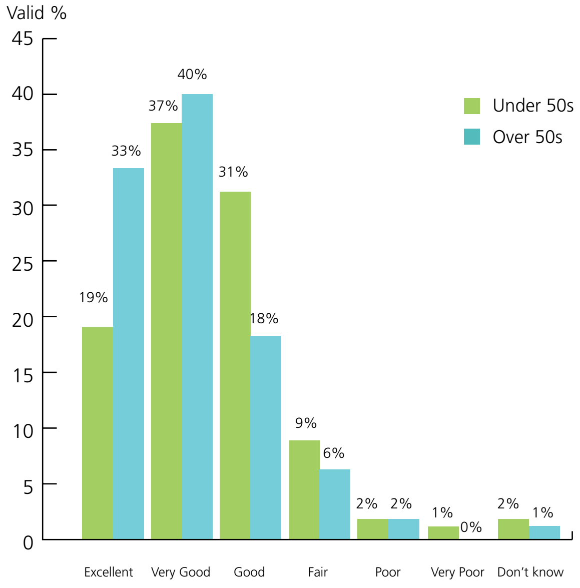
Respondents' assessment of quality of care was generally positive in all four settings, with GP rating best.

- Rating their experience as excellent or very good were 64% of inpatients, 58% of outpatients, 84% of GP patients and 76% of other community services;
- A further 26% of inpatients, 27% of outpatients, 13% of GP patients and 13% of community patients rated services as good.
- Just 9% of inpatients, 13% of outpatients, 3% of GP and 11% of other community service patients rated the experience as fair or poor.
- A majority, 83% of inpatients, 73% of outpatients, 90% of GP patients would recommend the service to someone else.

For inpatients, overall quality of care was rated more favourably by service users who were over 50 years of age, with 33% rating these services as excellent. In comparison, only 19% of the inpatients aged under 50 rated quality of care as excellent (Figure 6.18) [$p<0.05$].

FIGURE 6.18

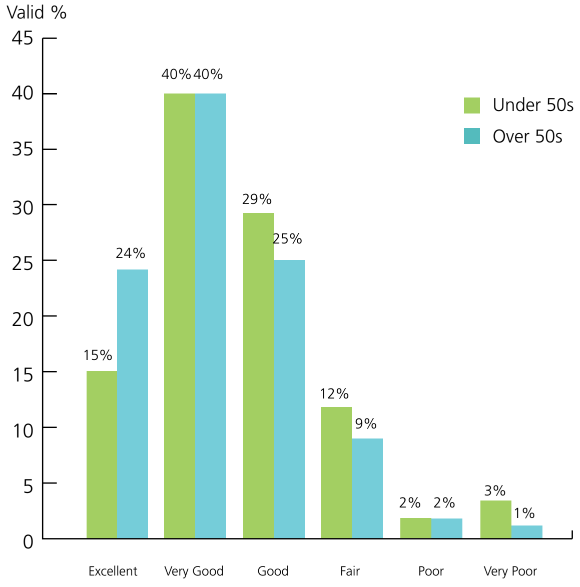
Inpatients' overall ratings for quality of care received while in hospital: national augmented sample (n=344)



Amongst outpatients, overall quality of care was also rated more favourably by service users who were over 50 years of age. 24% rated this service as excellent in comparison to 15% of the under fifties (Figure 6.19).

FIGURE 6.19

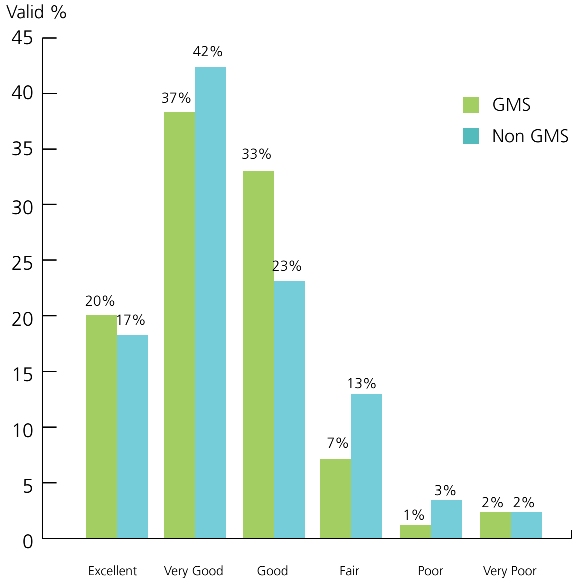
Outpatients' overall ratings for the quality of care received while at the outpatient or emergency department: national augmented sample (n=470)



For outpatients, overall quality of care was rated more favourably by GMS eligible respondents (90%) in comparison to those non GMS eligible (82%); 20% rated this service as excellent in comparison to 17% (Figure 6.20).

FIGURE 6.20

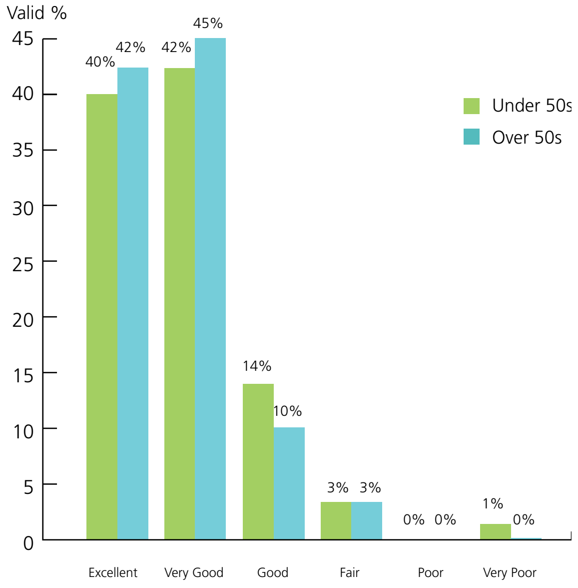
Outpatients' overall ratings for the quality of care received while at the outpatient or ED: national quota sample (n=414)



Ratings for the overall quality of care provided by the GP were similar according to age. 40% of GP service users under 50 and 42% of those over 50 rated the quality of care as excellent (Figure 6.21).

FIGURE 6.21

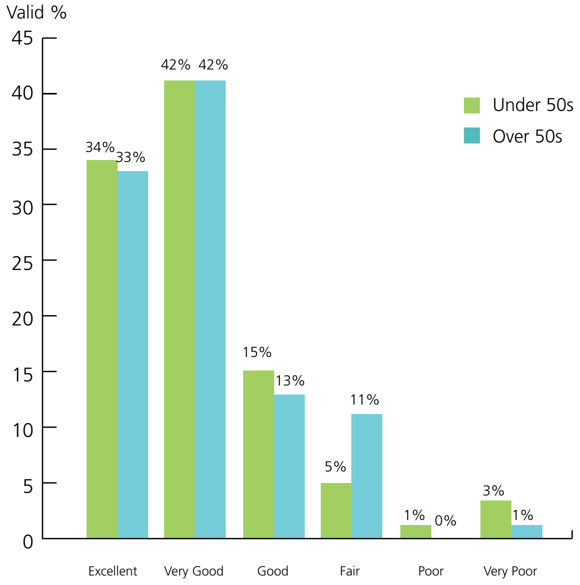
GP patients' overall ratings for quality of care received while at the GP surgery: national augmented sample (n=1,732)



Again, ratings for the overall quality of care provided to service users were similar for community services: 34% of service users under 50 and 33% of those over 50 rated the quality of care as excellent (Figure 6.22).

FIGURE 6.22

Community service users' overall ratings for quality of care received in the last 12 months: national augmented sample (n=212)



The following sections describe respondents' experience in each service, according to the eight dimensions explored in the interview.

6.6.2 Consumer Experience of Inpatient Services

6.6.2.1 Fast Access to Reliable Services
Generally speaking, hospital inpatient respondents reported reasonably prompt access to services. Inpatients were asked how they were admitted to hospital, a third (37%) came via GP referral, a third via emergency department (35%) and the remainder by means of other routes. A reported 22% of GMS and 36% of non GMS inpatients were admitted via the ED and younger respondents were more likely to report admission by that route. Indications for admission were varied, the most frequently mentioned reason (24%) was for an operation or procedure. The wait for admission from the time inpatient respondents were told they had to be admitted was immediate for 76% of inpatients, up to 1 month for a further 11% of patients, up to 3 months for 4% of patients, up to 6 months for 1% and 6 months or greater for 4% of patients. 65% of respondents were told why they would have to wait. There were no differences according to GMS status.

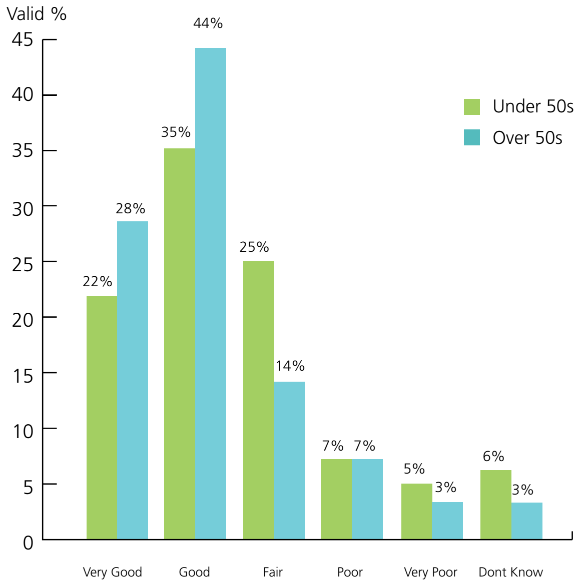
6.6.2.2 Effective Treatment by a Trusted Professional
Ratings were overall generally highly positive in this dimension: 70% of hospital inpatients thought the person to whom they were first referred had all the necessary information while 19% thought so to some extent, and 78% said they always had trust and confidence in the health professional treating them, with just 4% giving an outright no.

6.6.2.3 Involvement in Decisions and Respect for own Preferences
A clear majority of inpatients, 75%, were in complete agreement that they were given enough time to discuss their health or medical problem, and a further 20% indicated they were to some extent. Again most inpatients (67%) felt they were involved completely in decisions about their treatment and care and a further 20% agreed they were to some extent. Asked if given a choice about place of referral, half (51%) said not, but that they did not mind, a third (31%) said yes and 13% said no, but they would have liked a choice.

6.6.2.4 Clear Comprehensive Information and Support for Self-care
Most hospital inpatients (75%) received information about their condition or treatment verbally, rather than in writing, though 5% indicated they received none at all. While 80% felt they received the right amount of information, 13% did not receive enough and 3% felt they received too much. Of those who had an operation or procedure, 77% felt a staff member explained completely what would be done and a further 16% agreed to some extent. Notably 3% said they did not want an explanation.

6.6.2.5 Attention to Physical and Environmental Needs
In rating the adequacy or cleanliness of hospital public toilets, 25% of inpatient respondents overall thought them very good and a further 37% good. There was an age pattern: 22% of those inpatients under 50 thought they were very good, compared to 28% of those over 50, a significant difference [p<0.05] (Figure 6.23).

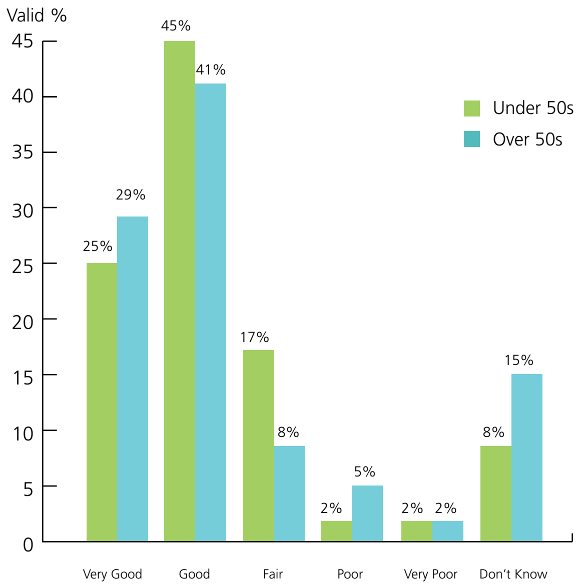
FIGURE 6.23
Inpatients' ratings for adequacy\cleanliness of hospital



public toilets: national augmented sample (n=344)

For inpatients, contact with the hospital by phone was rated as very good by 27%, good by 42%, fair by 12% and poor or very poor by 6%; again this showed an age pattern with younger respondents less satisfied (Figure 6.24) [p<0.05].

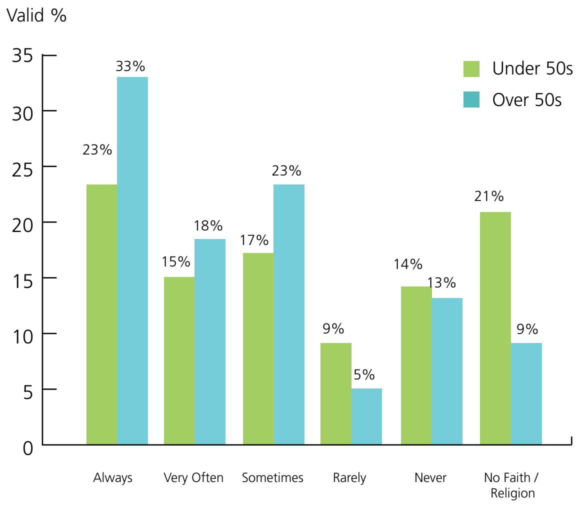
FIGURE 6.24
Inpatients' ratings for contacting the hospital by phone: national augmented sample (n=344))



Inpatient assessment of car-parking facilities was mixed: 18% said very good, 28% said good, but 30% thought them poor or very poor. A majority (74%) of respondents found the hospital easy to get around and 59% thought the shop services adequate.

6.6.2.6 Emotional Support, Empathy and Respect
A clear majority (83%) of hospital inpatients indicated that they were treated with respect and dignity. Overall 72% of hospital inpatients stated they were always given enough privacy when discussing their treatment or condition. Inpatients were asked if ministers or priests of their faith were available as frequently as required. Significant differences were observed between the responses of patients under and over 50 years [p<0.05], in that 21% of the under 50s stated they were of no faith or religion, in comparison to 9% of those aged over 50 (Figure 6.25).

FIGURE 6.25
Inpatients' ratings regarding availability of ministers or priests of their faith: national augmented sample (n=344)

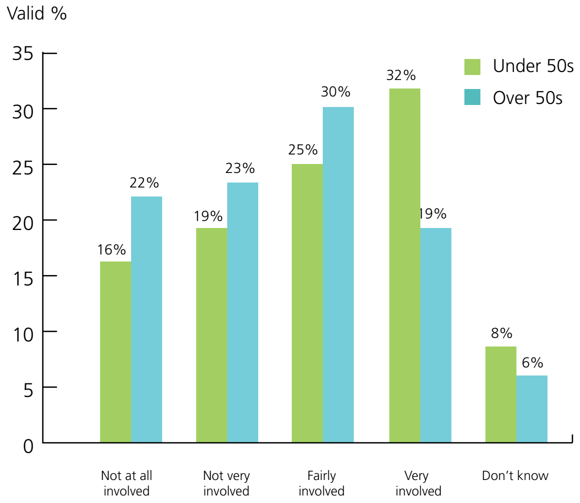


6.6.2.7 Involvement of and Support for Family and Carers
Many respondents felt that family members did not need to be involved. Most hospital inpatients (42% definitely and 18% to some extent) felt the healthcare team provided family or someone close with all the information they needed, though appreciable numbers (19%) felt either the family or they themselves did not want or need such information.

6.6.2.8 Continuity of Care with Smooth Transitions
There was evidence of an age pattern in involvement by inpatients in decisions regarding discharge from hospital (Figure 6.26), with 32% of those under 50 being very involved, compared to 19% of those over 50 [p<0.05]. There was similarly an age pattern in regard to continuity of care.

FIGURE 6.26

Inpatients' ratings regarding involvement in decision-making about their discharge from hospital: national augmented sample (n=344)



6.6.3 Consumer Experience of Outpatient Services

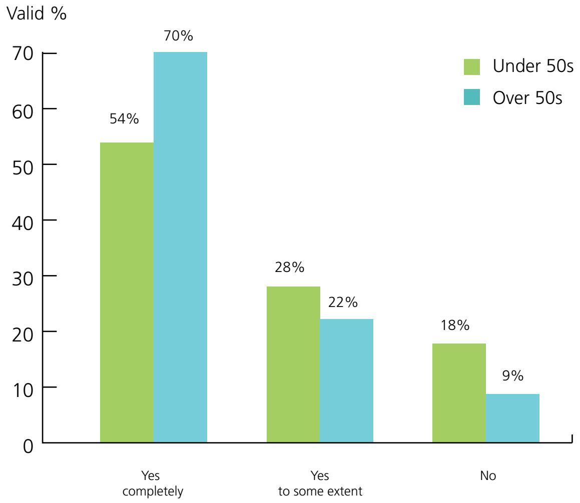
Of all respondents who reported experience of a service in the last year, 13% reported in detail on an outpatient experience. This section describes respondents' experience, according to the eight dimensions explored in the interview.

6.6.3.1 Fast Access to Reliable Services
Those with a recent outpatient experience reported being seen relatively quickly at the actual appointment, with 80% reporting that the original appointment was kept unchanged. Furthermore, 23% were seen on time or early, and 44% within 30 minutes. However, 18% waited more than an hour and a further 7% more than two hours. While 68% were not told how long they had to wait, the small number who were told were accurately informed. Significant differences in this pattern were not observed on the basis of GMS status.

6.6.3.2 Effective Treatment by a Trusted Professional
In the outpatient setting 57% thought the person to whom they were first referred had all the necessary information, 25% to some extent while 14% thought not. This pattern varied according to age (Figure 6.27), older people being more satisfied [$p<0.01$]. Again levels of trust were high, 67% definitely and a further 24% to some extent having confidence in those treating them, with just 6% stating not.

FIGURE 6.27

Outpatients: Did person to whom first referred have all necessary information about your condition\treatment: national augmented sample (n=470)



6.6.3.3 Involvement in Decisions and Respect for own Preferences
Among outpatients, 63% agreed completely that they were given enough time to discuss their health or medical problem and a further 26% agreed to some extent. Just over half of outpatients, (52%) felt complete involvement in decision-making about their care while a third felt they were involved to some extent. Again, half (50%), said they were not given a choice about location but did not mind, 28% indicated they were given a choice and 18% said they would have liked a choice, if offered.

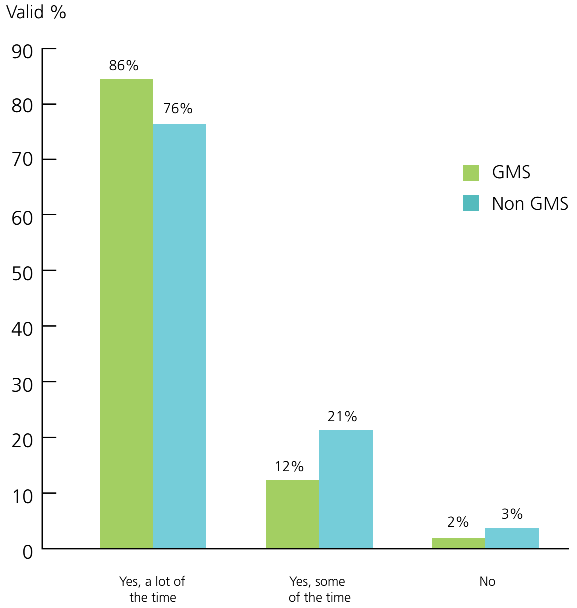
6.6.3.4 Clear Comprehensive Information and Support for Self-care
Among hospital outpatients, 77% of respondents felt the information given was about the right amount, while 19% felt it was not enough. Just 57% felt the healthcare team gave a complete explanation of the reasons for any treatment, a further 34% agreed to some extent and 6% said not. Respondents were asked if they had questions for the healthcare team, whether they got an answer they could understand: 60% said yes definitely, 32% to an extent, 4% got no opportunity and 4% said not.

6.6.3.5 Attention to Physical and Environmental Needs
Among outpatients, overall 41% thought the outpatient area or emergency department was very clean and a further 42% fairly clean, though there was again some age pattern. Nearly half (49%) of those aged over 50 considered the department or area to be very clean, as opposed to 39% of those aged 50 and under; and 39% of those aged over 50 considered the area to be fairly clean, as opposed to 45% of those aged 50 and under. Most outpatients (76%) found it easy to get around the department or area.

6.6.3.6 Emotional Support, Empathy and Respect
Overall 78% of hospital outpatients indicated they were treated with respect and dignity, with a difference between GMS and non GMS respondents [$p<0.05$] (Figure 6.28).

FIGURE 6.28

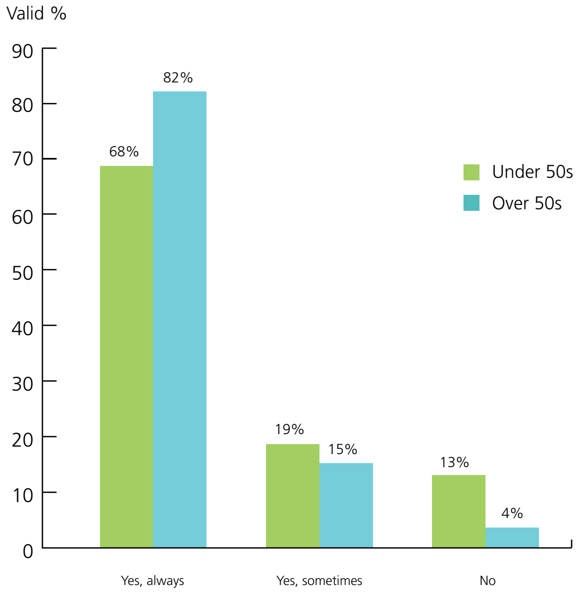
Outpatients' ratings for being treated with respect and dignity by healthcare professionals: national quota sample (n=414)



Overall 70% of hospital outpatients stated they were always given enough privacy when discussing their treatment or condition (Figure 6.29).

FIGURE 6.29

Outpatients' ratings for whether they were given enough privacy by healthcare professionals when discussing their treatment: national augmented sample (n=470)

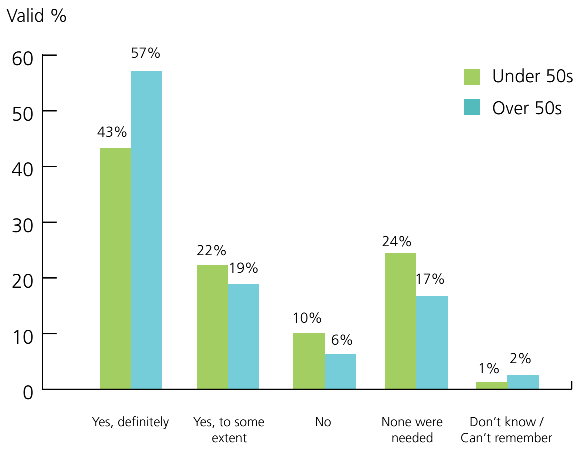


6.6.3.7 Involvement of and Support for Family and Carers
In the case of outpatients, 26% agreed definitely and 16% to some extent that family or close contacts received adequate information, though 21% had no family or friends involved and 25% did not want such information imparted. If family wanted to talk to a health professional 84% were afforded an opportunity to do so.

6.6.3.8 Continuity of Care with Smooth Transitions
Among outpatient respondents, 47% felt definitely and 20% to some extent that arrangements for continuing care were made and 20% felt none were needed, again showing an age pattern [$p<0.05$] (Figure 6.30).

FIGURE 6.30

Outpatients' ratings regarding arrangements made to continue care or treatment after they left outpatient or emergency department: national augmented sample (n=470)



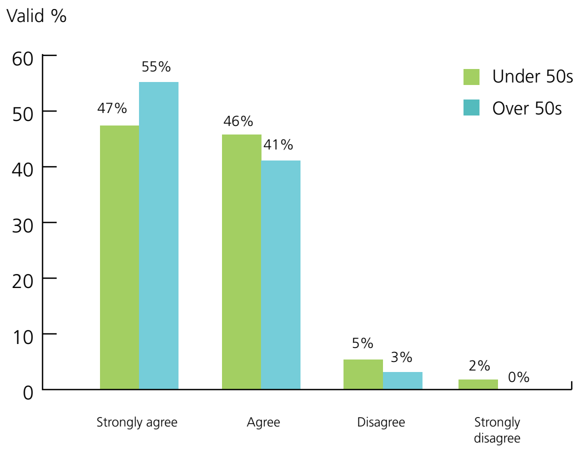
6.6.4 Consumer Experience of GP Services

6.6.4.1 Fast access to Reliable Services
In general practice, the top three reasons for a consultation were: a minor illness or ailment (44%), a routine check-up (23%) or a repeat prescription (23%). One third (31%) were seen without an appointment, 10% had a pre-planned appointment and a further 38% obtained a same day appointment. Just 3% had to wait more than two working days to be seen, significant differences were not observed based on GMS status. Two thirds (68%) of respondents said they were not put off going to their GP because surgery opening hours were inconvenient. However, 35% of respondents under 50 and 22% of those over 50 reported being put off often or sometimes being put off by GP opening hours, an age-related pattern that was significant [p<0.001].

6.6.4.2 Effective Treatment by a Trusted Professional
Of those with a GP experience, 50% overall strongly agreed and 93% overall agreed that they were confident that they could tell their doctor of their concerns, even if he or she did not ask [p<0.001], (Figure 6.31) with younger respondents less likely to agree.

FIGURE 6.31

GP patients' ratings for feeling confident about confiding in their doctor regarding their concerns: national augmented sample (n=1,732)

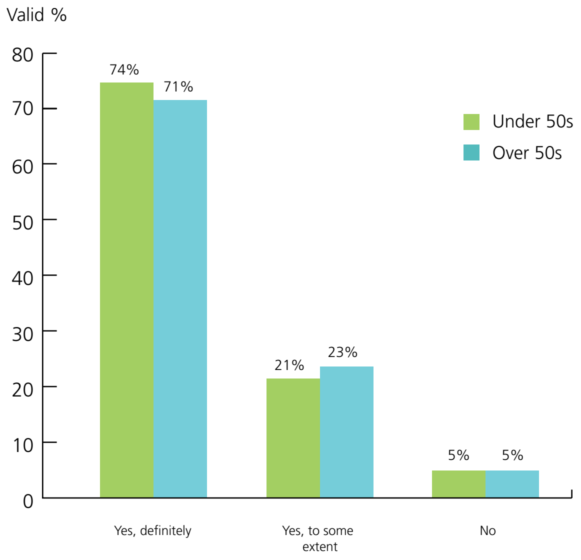


6.6.4.3 Involvement in Decisions and Respect for own Preferences
The majority (81%) of GP respondents felt definitely they were given enough time to discuss their health or medical problem and 72% (74% of those under 50 and 71% of those over 50) felt they were completely involved in decisions about their treatment and care (Figure 6.32). One fifth (22%) of GP patients had been referred to a specialist service by their doctor in the last year and of these 45% had been given a choice and 47% not. When the latter were asked if they would have liked a choice, a clear majority (70%) said they were happy for the GP to decide.

Just under half (49%) of GP patients were aware of letters exchanged between doctors about their health care. This sub-group was asked if they had been given a copy of the correspondence and almost three quarters (73%) replied not. Respondents were asked if in general they felt patients should receive such letters and a majority (57%) said yes. While 17% said no to this question, there were an appreciable number of respondents who did not know, 24%.

FIGURE 6.32

GP patients' involvement in decisions regarding their care and treatment: national augmented sample (n=1,732)

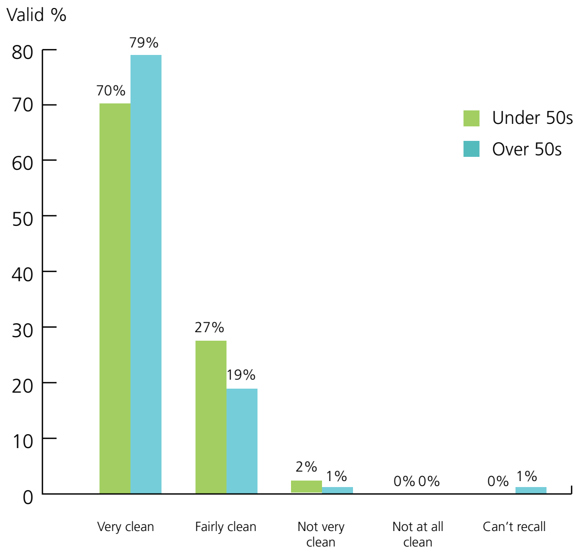


6.6.4.4 Clear Comprehensive Information and Support for Self-care
Of those with a GP experience, 69% of respondents agreed completely that the health professional explained the reasons for treatment in a way they could understand. Of those with questions, 74% received a definite answer they could understand, with 24% responding that this is true to an extent.

6.6.4.5 Attention to Physical and Environmental Needs
The GP surgery was thought to be very clean by 72% overall (70% of those under 50 and 79% of those over 50) and only 3 respondents (0.2%) rated it as not at all clean [p<0.001] (Figure 6.33).

FIGURE 6.33

GP patients' ratings for cleanliness of surgery: national augmented sample (n=1,732)

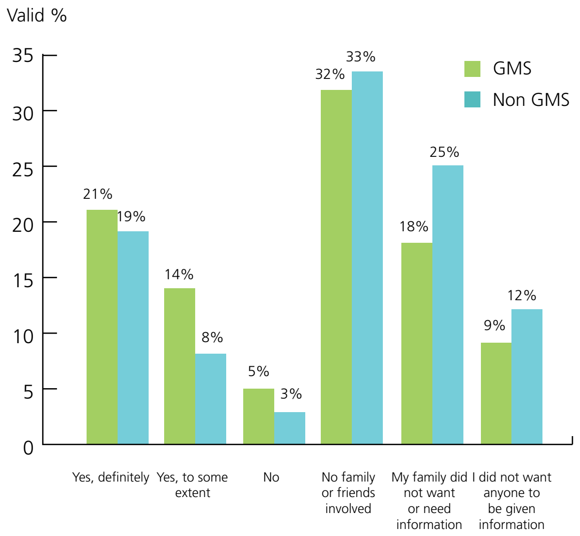


6.6.4.6 Emotional Support, Empathy and Respect
For this dimension there was a very positive response overall, with 97% of GP patients feeling that their privacy was respected.

6.6.4.7 Involvement of and Support for Family and Carers
Of GP patients 19% definitely and 10% to some extent felt families and close others were provided with adequate information, with 33% stating no family or friends were involved and 34% did not want such information. There was some variation according to GMS status, [p<0.001] (Figure 6.34).

FIGURE 6.34

GP patients' ratings for information received by family or friends from healthcare professionals: national quota sample (n=1,732)

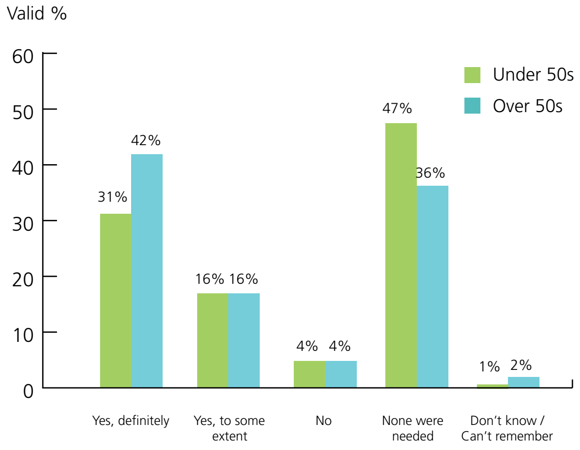


6.6.4.8 Continuity of Care with Smooth Transitions

For GP patients appropriate arrangements were definitely in place for 35% of respondents and to some extent for 16%, but none were needed for continuity of care for 42% and an age effect was again observed [p<0.001] (Figure 6.35).

FIGURE 6.35

GP patients' ratings regarding arrangements for continuity of care once they left the surgery: national augmented sample (n=1,732)



6.6.5 Consumer Experience of other PCCC Services

6.6.5.1 Fast Access to Reliable Services

The five most frequently used categories of community services were public-only dental services (25%) physiotherapy (16%), the public health nurse (14%), the mental health services (11%) and chiropody (6%), all the remainder were less than 3% each. Contact tended to be long-term, 70% of respondents in this category indicating they had been 2 years or more dealing with the relevant service. Overall, 39% were seen immediately on referral, a further 35% within a month and 11% within 3 months of referral. More than half (59%) were not told why they had to wait. While 52% of those who had to wait would have liked an appointment sooner, 40% thought it okay.

6.6.5.2 Effective Treatment by a Trusted Professional

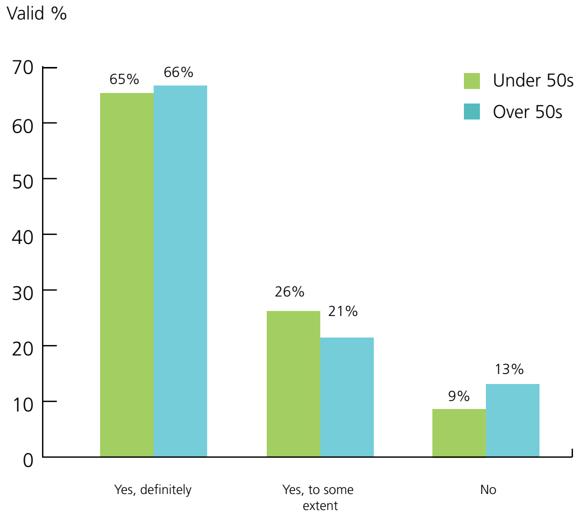
Ratings for this dimension were positive: 78% definitely had trust and confidence in the healthcare team, while 17% had to some extent.

6.6.5.3 Involvement in Decisions and Respect for own Preferences

In the community services setting, 62% were definite they had enough say in decisions about treatment and care, while 25% agreed with this to some extent. Almost three-quarters (73%) agreed completely that they were given enough time to discuss their health or medical problem. When asked if they had received copies of any letters sent from the person providing the service to their doctor, 42% said not and 33% did not know if any letters were sent.

FIGURE 6.36

Other PCCC service users' ratings of whether they had enough say in decisions regarding their care and treatment: national augmented sample (n=212)



6.6.5.4 Clear Comprehensive Information and Support for Self-care

In the community setting, 93% of the under 50s and 92% of those over 50 stated that they were given adequate information about the different treatment options for their condition.

6.6.5.5 Attention to Physical and Environmental Needs

In the community services setting, because services are delivered in such a diversity of environments, respondents were asked to rate the cleanliness of the rooms or clinics where the service was received. Overall 63% thought facilities were very clean and no age pattern was detected.

6.6.5.6 Emotional Support, Empathy and Respect

The majority (74%) of respondents availing of community services indicated that they were treated with respect and dignity.

6.6.5.7 Involvement of and Support for Family and Carers

Amongst community service respondents, 20% definitely agreed that family members or someone close had been given enough information, though 47% felt no such information was needed, and 10% did not want information given their to family.

6.6.5.8 Continuity of Care with Smooth Transitions

Overall 47% of community services respondents stated that everyone who needed to be informed (GP, other health professionals, family) received adequate information, and 10% to some extent. One fifth (21%) stated that they were involved in decisions about their discharge from the service, with 8% stating that they were involved to some extent.

SECTION 7

MODELS OF HEALTHCARE CONSUMER SATISFACTION

7.1 MODELS OF HEALTHCARE CONSUMER SATISFACTION

7.1 Demographic model

The following four figures illustrate the overall rating of quality of care for each setting according to region, Figures 7.1 to 7.4.

FIGURE 7.1
Overall rating of quality of care for inpatient services by HSE area: national quota sample (n=277)

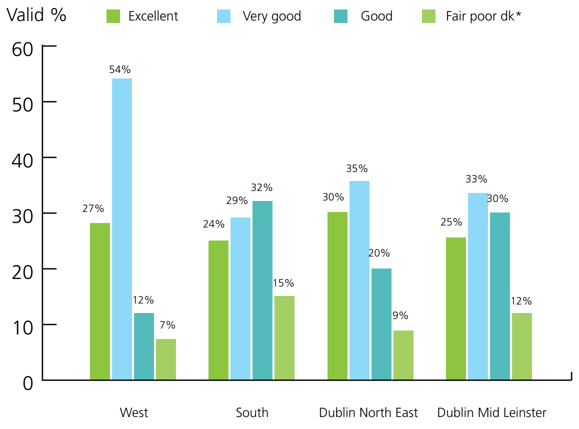


FIGURE 7.2
Overall rating of quality of care for outpatient services by HSE area: national quota sample (n=414)

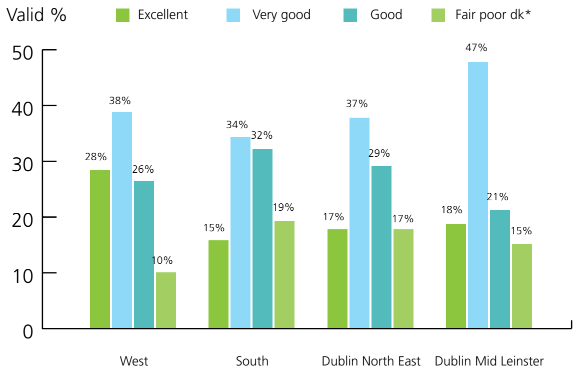


FIGURE 7.3
Overall rating of quality of care for GP services by HSE area: national quota sample (n=1,467)

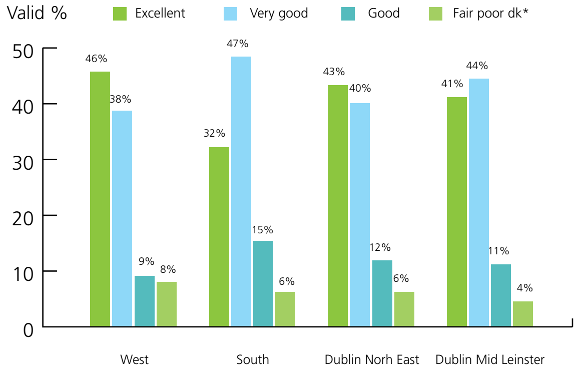
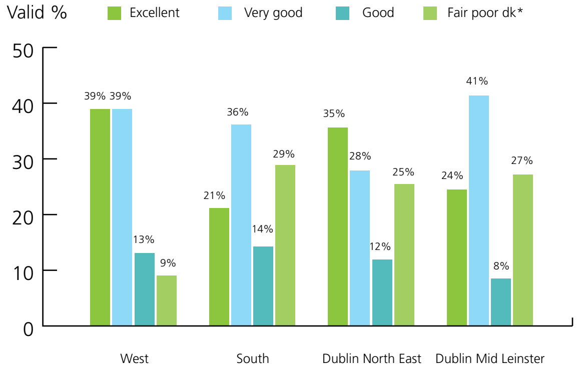


FIGURE 7.4
Overall rating of quality of care for community services by HSE area: national quota sample (n=186)



The first model that was examined in relation to consumer satisfaction related to demographic influences. In this model the relative association of age, sex, general medical services status, private health insurance status and residence in each of the four HSE administrative areas on satisfaction with inpatient services, outpatient services, general practice and community services were considered. Age, as already noted, was associated with satisfaction as a single variable, so this model was adjusted for that effect. There was no independent influence on degree of satisfaction according to general medical services eligibility or possession of private health insurance. There remains some variability by region.

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*dk = Don't know

7.2 MODEL OF OUTPATIENT SATISFACTION

The second model that was examined, for outpatient respondents only, was based on the approach taken by the Picker Institute in presenting the eight dimensions of quality of care. For each dimension the relative association with lower overall satisfaction with service experience was assessed (Table 7.1).

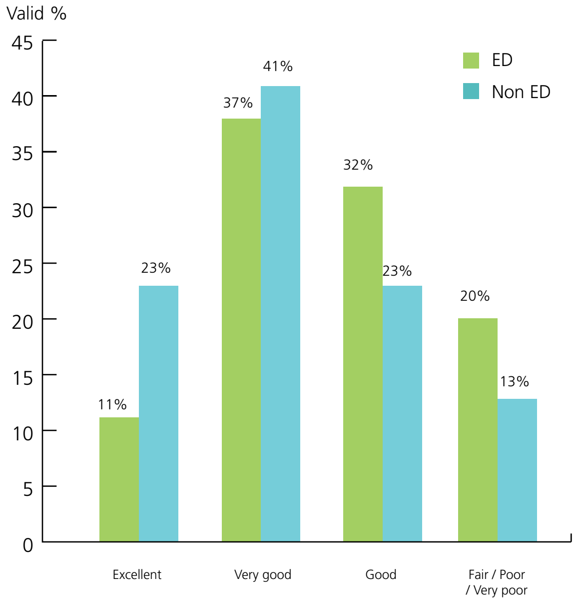
Respondents were asked to rank their overall satisfaction with the quality of care they had received as 'excellent', 'very goo'', 'good', 'fair', 'poor' or 'very poor'. For the purposes of analysis, the three lowest categories were grouped to construct a response variable having four ordered categories. Proportional odds models were fitted to predict the level of satisfaction in terms of covariates. The baseline category was taken to be the highest level of satisfaction (excellent) and the predicted odds for a covariate are the odds of a lower level of satisfaction given a unit change in the covariate – for instance the odds of satisfaction being very good, good or fair/poor/very poor versus excellent, or the odds of good or fair/poor/very poor versus excellent or very good, or the odds of fair/poor/very poor versus good, very good or excellent. Covariates included demographics (age, sex, area) and representative measures of each of the eight dimensions of satisfaction as identified by the Picker Institute. Individual questions were recoded to give binary covariates indicating the presence or absence of a problem, and problem scores calculated for each dimension. Models were fitted using SAS and S-Plus.

TABLE 7.1
Issues associated with each dimension considered in the multivariate satisfaction model

Outpatients - all
1. Access (only for non-ED)
Not given choice of appointment times and wanted choice
Before appointment, did not know what would happen during appointment
Appointment changed by hospital
Appointment started over 30 minutes late
Not told how long had to wait/ wait longer than told
Not told why had to wait / would have liked explanation
2. Effective Treatment
Person referred to did not have complete information on medical history etc
Did not definitely have confidence and trust in healthcare professionals examining and treating
3. Involvement in decisions
Not given a choice of hospital locations and would have liked choice
Not enough time to discuss problems with healthcare professionals
Not involved as much as wanted in decisions about care and treatment
4. Clear comprehensive treatment and support
Not given the right amount of information about condition/treatment
Did not completely understand healthcare team's explanations for treatment
Did not have opportunity to ask questions/ questions not answered understandably
5. Environment
Not easy to get into and around the outpatients department/ ED
Outpatients Department/ ED not clean
Toilets not clean
6. Emotional support, empathy, respect
Not always treated with respect and dignity by healthcare professionals
Not always given enough privacy when discussing condition or treatment
Not always given enough privacy when being examined or treated
7. Family
Family not given all the information needed to help recovery
Family did not have enough opportunity to talk to healthcare professionals
8. Continuity of care
All necessary arrangements were not made to continue care after hospital

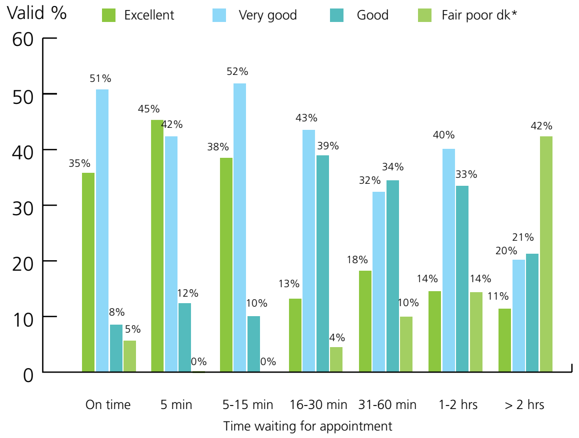
There is a significant difference in reported overall satisfaction between Emergency Department (ED) and other outpatient respondents (Figure 7.5). Among ED respondents, 11% reported excellent and 37% very good treatment compared to other outpatients, 23% of whom reported excellent and 41% very good treatment. Conversely 20% of ED patients compared with 13% of others reported fair or poor treatment [p=0.003].

FIGURE 7.5
Self-reported satisfaction with services in emergency department (ED) respondents compared to other outpatients (Non-ED): national quota sample (n=379)



Models for quality of care were developed for ED and other outpatients separately. Table 7.2 shows the odds ratios and 95% confidence intervals (CI) for lower reported quality of care in ED patients. Odds ratios compare the relative odds of a lower rating between groups, and this interpretation holds across the range of quality of care ratings ('excellent' to 'very poor/poor/fair'). The confidence interval gives the range within which the odds ratio is expected to lie. For instance, patients who did not have enough time to discuss problems with health care professionals were 2.36 times more likely to report a lower level of quality of care than those who did have sufficient time for discussions. The odds ratios are adjusted for the effect of the other significant issues.

FIGURE 7.6
Rating of quality of care of non-ED outpatients by waiting time: national quota sample (n=231)



Satisfaction ratings of outpatients were strongly influenced by waiting time, with a clear graduated pattern, satisfaction falling sharply after 15 minutes waiting (Figure 7.6).

Among outpatients, other than ED patients, some of the same factors were important, as was waiting time over 15 minutes and situations where all necessary arrangements were not made to continue care (Table 7.3). The remaining factors were not important problems after accounting for these.

*dk = Don't know

TABLE 7.2

Predictors of overall satisfaction for ED patients only

Problem	Odds Ratio	Lower 95% CI	Upper 95% CI	p
Person first seen did not have necessary information	2.63	1.25	5.55	0.01
Not enough time to discuss problems with health care professionals	2.36	1.02	5.45	0.04
No opportunity to ask questions/questions not answered	2.82	1.24	6.41	0.01
Not easy to get into and around the ED	2.52	1.10	5.76	0.04
Toilets not clean	4.17	1.74	10.01	0.002
Not always given enough privacy when being examined or treated	2.13	0.96	4.69	0.05

TABLE 7.3

Predictors of overall satisfaction for outpatients excluding ED

Problem	Odds Ratio	Lower 95% CI	Upper 95% CI	p
Waiting time in outpatients > 15 mins	3.68	1.79	7.59	0.0004
Person referred to didn't have all necessary information	1.93	1.05	3.53	0.03
Did not definitely have confidence and trust in healthcare professionals	2.91	1.43	5.92	0.003
Not given enough information about condition/treatment	3.12	1.57	6.22	0.001
Not easy to get into and around the outpatients department	3.16	1.56	3.70	0.001
Not always enough privacy when being examined or treated	2.80	1.27	6.20	0.01
All necessary arrangements were not made to continue care	3.54	1.77	7.06	0.0003

BIBLIOGRAPHY

1. Bender R and Benner A (2000). 'Calculating Ordinal Regression Models in SAS and S-Plus', *Biometrical Journal,* October 2000, 42: 677-699.

2. Boudreaux ED and O'Hea EL (2004). 'Patient Satisfaction in the Emergency Dept: a Review of the Literature and Implications for Practice', *J Emerg Med,* Jan 2004. Vol 26(1). Pp. 13-26.

3. Boudreaux ED, Cruz BL and Baumann B (2006). 'The Use of Performance Improvement Methods to Enhance Emergency Department Patient Satisfaction in the United States: A Critical Review of the Literature and Suggestions for Future Research' *Acad Emerg Med,* May 2006. Vol 13 (7). Pp 795-802.

4. CASPE Research (2004). Ireland, Summary Report.

5. Centre for Health Services and Policy Research (2003). *Why do some People use so much Health Care?* Vancouver, Canada.

6. Coulter, A (2005). *Trends in Patient Experience of the NHS*. Oxford: Picker Institute Europe.

7. Crow R, Gage H, Hampson S, Hart J, Kimber A, Storey L and Thomas H (2002). 'The Measurement of Satisfaction with Healthcare: Implications for Practice from a Systematic Review of the Literature', *Health Technology Assessment*, 2002. Vol 6(32).

8. Department of Health (2000). *The NHS Plan: A Plan for Investment, A Plan for Reform.* London: Department of Health.

9. Department of Health (2004). *Better Information, Better Choices, Better Health: Putting Information at the Centre of Health*. London: Department of Health.

10. D'Uva TB, Van Doorslaer ED, Lindeboom M, O'Donnell O and Chatterji, S (2006). *'Does reporting heterogeneity bias the measurement of health disparities?'* Tinbergen Institute Discussion Papers 06-033/3.

11. Gyntelberg F, Suadicani P, Rix BA, Skov P, Nielsen PE and Julh E (2006). 'Quality of Hospital Care evaluated by Danish Nurses and Doctors- based on Experience from their own or a close Family Member's Hospitalisation', *Danish Medical Bulletin,* August 2006. Vol 53 (3). Pp. 342-48.

12. Ellins J and Coulter A (2005). *How Engaged are People in their Health care?* Oxford: Picker Institute Europe.

13. Fallon, P (2002). *National Patient Perception of the Quality of Healthcare*. Dublin: Irish Society for Quality and Safety in Healthcare.

14. Healthcare Commission, NHS (2004). *Responses to the Healthcare Commission Consultation on Complaints*. NHS.

15. HSE Corporate Plan (2005-2008). HSE Publications (2005). http://www.hse.ie/en/Publications/HSEPublications (13/08/2007)

16. HSE Transformation Programme (2007-2010). HSE Publications (2007). http://www.hse.ie/en/Publications/HSEPublications (13/08/2007).

17. Irish Society for Quality and Safety in Healthcare (2003). *Measurement of Patient Satisfaction Guidelines: Health Strategy Implementation Project.* Dublin: Irish Society for Quality and Safety in Healthcare.

18. Irish Society for Quality and Safety in Healthcare (2004*). The Patients' View.* Dublin: Irish Society for Quality and Safety in Healthcare.

19. Kapteyn A, Smith JP, and Van Soest A (2007). 'Vignettes and Self-Reports of Work Disability in the United States and the Netherlands', *American Economic Review*, March 2007, Vol 97(1). Pp. 461-473.

20. Kelleher CC, Harrington J and Friel S (2002). 'Measures of self-reported morbidity according to age, gender and general medical services eligibility in the national survey of lifestyles, attitudes and nutrition', *Ir J Med Sci*. 2002 Jul-Sep;171(3):134-8.

21. King G, Murray CJL, Salomon JA and Tandon A (2004). 'Enhancing the Validity and Cross-cultural Comparability of Measurement in Survey Research', *American Political Science Review*, 94(1).

22. Kristensen N and Johansson E (2006), 'New Evidence on Cross-Country Differences in Job Satisfaction Using Anchoring Vignettes', Aarhus School of Business Department of Economics, Working Paper 06-1.

23. Larson CO, Nelson EC, Gustafson D and Batalden PB (1996). 'The Relationship between Meeting Patients' Information Needs and Satisfaction with Hospital Care and General Health Status Outcomes', *Int J Qual Health Care*, Oct 1996. Vol 8(5). Pp. 447-56.

24. Landefeld, C (1998). 'The Relation between Health Status Changes and Patient Satisfaction in Medical Patients', *Journal of General Internal Medicine*, March 1998. Vol 13. p. 223.

25. McBride D, Voss W, Waldron R, Villanueva T and Smith G (2006). Consumer Survey. The Washington Institute for Mental Illness Research and Training Western Branch.

26. McCardle, J (2006). *Patient Satisfaction Survey: Audit of Inpatients*, Oct 2005-06. Admission Unit, Donegal Mental Health Service.

27. Mental Health Statistics Improvement Programme (MHSIP) Consumer Survey. (2006) USA, February 2006.

28. MORI – Public Perceptions of the NHS (2003). Winter 2003 Tracking Survey.

29. Picker Institute Europe (2005). *Is the NHS getting Better or Worse?* Oxford: Picker Institute Europe.

30. Picker Institute Europe (2007). *Patient involvement in health care. Memorandum to the House of Commons Select Committee on Health: Inquiry into Public and Patient involvement in health care.* (2007).

31. Pothier DD and Frosch A (2006). 'Do Information Sheets improve Patient Satisfaction in the Outpatient Department?' *Ann R Coll Surg Engl*, Oct 2006. Vol 88(6). Pp. 557-61.

32. Salomon JA, Tandon A and Murray CJ (2004). 'Comparability of self rated health: Cross sectional multi-country survey using anchoring vignettes', *British Medical Journal*, 2004: 328; 258.

33. Kelleher C, NicGabhainn S and Friel S. *et al*. (2003). *The National Health and Lifestyle Surveys – Survey of Lifestyle, Attitudes and Nutrition (SLAN) & The Irish Health Behaviour in School-Aged Children Survey (HBSC).* University College Dublin and Centre for Health Promotion Studies, NUI Galway.

34.Venables WN and Ripley BD (2002). *Modern Applied Statistics with S.* New York: Springer.

35. Vukmir, RB (2006). 'Customer Satisfaction with Patient Care', *J Hops Mark Public Relations*, 2006. Vol 17(1). Pp. 79-107.

36. Wilson A, Hewitt G, Matthews R, Richards SH and Shepperd S (2006). 'Development and testing of a Questionnaire to Measure Patient Satisfaction with Intermediate Care', *Qual. Saf Health Care*, 2006. 15(5). Pp. 314-19.

APPENDIX 1: DETERMINING THE PROFILE OF HEALTHCARE SERVICE USERS

All respondents were asked:

Which, if any, of following services have you used in the last 12 months?

Acute Hospital Services	Not used	Used once	More than once
1. Hospital as an inpatient	1	2	3
2. Hospital as a day patient	1	2	3
3. Hospital as an outpatient	1	2	3
4. Emergency Department	1	2	3
PCCC Services			
5. GP (General Practitioner) services	1	2	3
6. Mental Health Services (including non-acute Psychiatric hospitals)	1	2	3
7. Public health nurse	1	2	3
8. Physiotherapist	1	2	3
9. Occupational therapist	1	2	3
10. Psychology services	1	2	3
11. Social worker	1	2	3
12. Community Welfare Officer	1	2	3
13. Home Help Services	1	2	3
14. Chiropody/Podiatry	1	2	3
15. Drug/Alcohol Outreach Services	1	2	3
16. Speech Therapy	1	2	3
17. Dietician	1	2	3
18. Ophthalmology	1	2	3
19. Audiology	1	2	3
20. Dental Services (Public only Not Private)	1	2	3
21. Palliative care (e.g. care of the dying)	1	2	3
22. Residential services for older people	1	2	3
23. Day services for older people	1	2	3
24. Respite services for older people	1	2	3
25. Home support for older people	1	2	3
26. Residential services for the intellectual/physical or sensory disabled	1	2	3
27. Day services for the intellectual/physical or sensory disabled	1	2	3
28. Respite services for the intellectual/physical or sensory disabled	1	2	3
29. Home support for the intellectual/physical or sensory disabled	1	2	3

APPENDIX 2: SURVEY RESPONSES BY AGE AND GMS STATUS

Summary Data Based on GMS Status (n=3032)

	Section A – General Health Status (Asked of All Participants)	GMS (n=1034)	Non GMS (n=1998)
A.1	Stated health status was excellent to very good	45.5%	67.6% ***
A.2	Poor physical health over the past 30 days.	36.4%	23.4% ***
A.3	Poor mental health over the past 30 days.	17.9%	9.0% ***
A.4	Poor physical or mental health hindered usual activities such as work or recreation over the past 30 days.	26.9%	17.0% ***
A.5	Daily activity or work limited by a long term illness, health problem or disability.	18.3%	5.8% ***
A.6	Information about health sourced from GP.	88.0%	78.9% ***
A.7	Participants who were unlikely or very unlikely to call a telephone help line such as the HSE National Information Line.	72.4%	69.3% **
A.8	Quality of life rated as good or very good.	74.7%	91.2% ***
A.9	Satisfied to very satisfied with health.	73.7%	88.6% ***

	Section C – Experiences of In / Day Patient Services (n=277)	GMS (n=128)	Non GMS (n=149)
C.1a	Most recent experience of hospital was as an inpatient.	57.0%	59.1%
C.1b	Spent between one to three nights in hospital on most recent admission.	42.4%	47.7%
C.3	Admitted to the hospital via the emergency department.	21.9%	36.4%
C.4	Not given an indication of the length of stay required in hospital.	58.9%	46.6%
C.5	Told they would be discharged on the day of discharge.	42.5%	55.7%
C.6	Admitted to hospital immediately.	75.3%	76.1%
C.7a	Were told why they had to wait.	75.0%	56.3%
C.7b	Did not require an explanation.	50.0%	57.1%
C.8	Healthcare team seemed to have all the necessary information about condition\treatment.	72.7%	67.8%
C.9	Had confidence and trust in the people/ health professionals treating them.	77.3%	78.5%
C.10	Not given a choice about where they were referred to, that is the location, but did not mind.	54.7%	48.3%
C.11	Given enough time to discuss their health/medical problem with the healthcare professionals.	78.1%	72.5%
C.12	Patients were involved in decisions about their care and treatment.	66.4%	67.1%

C.13 Received information verbally about condition/treatment.	78.1%	72.5%
C.14 Received the right amount of information about condition/treatment	81.3%	78.5%
C.15 Had operations or procedures in the hospital.	50.0%	49.0%
C.16 A member of staff explained what would be done during the operation or procedure.	79.7%	75.3%
C.17 Contacting the hospital by phone, rated as good to very good.	66.4%	71.8%
C.17 Availability of car parking facilities, rated as good to very good.	46.9%	46.3%
C.17 Ease of finding way around the hospital, rated as good to very good.	75.0%	72.5%
C.17 Adequacy/cleanliness of hospital public toilets, rated as good to very good.	63.2%	61.7%
C.17 Adequacy of shop facilities, rated as good to very good.	60.9%	56.4%
C.17 Wheelchair access, rated as good to very good.	60.9%	62.4%
C.18 Standard of food received in hospital rated as excellent to good.	49.2%	45.7%
C.19 Range of foods available in hospital rated as very satisfactory.	20.3%	20.1%
C.20 No special dietary requirements.	67.2%	68.5%
C.21 Participants agreed or strongly agreed that ward facilities (e.g. bed, wardrobe, room, bathrooms) were of a clean standard.	77.4%	77.8%
C.22 Healthcare team treated patients with respect and dignity.	85.9%	79.9%
C.23 Given enough privacy when discussing condition or treatment.	75.0%	69.8%
C.24 Ministers or priests of faith were always available as frequently as required.	25.8%	19.5%
C.25 Healthcare teams gave family, or someone close to patient, all the information they needed to help them recover.	68.9%	60.8%
C.26 If family wanted to talk to the healthcare team, had opportunity to do so.	58.5%	62.8%
C.27 Were very involved in decisions regarding discharge from hospital.	24.2%	24.8%
C.28 Good continuity of care and support was provided by the hospital.	55.0%	40.3%
C.29 Patients received support and advice from the hospital if illness/injury meant they were unable to work post discharge.	21.1%	24.2%
C.30 Quality of care received while in hospital rated as excellent to very good.	63.2%	60.4%
C.31 Would recommend the hospital where treated most recently to someone else.	85.9%	81.2%

P-Value * <0.05 ** ≤0.01 *** ≤0.001

Section D – Experiences of Outpatient Hospital Services (n=414)	GMS(n=153)	Non GMS (n=261)
D.1 Attended outpatient clinic 1 -3 times in the last 12 months.	70.6%	82.4% **
D.2 Were not given a choice of appointment times, but did not need or want a choice.	36.7%	44.6%
D.3 Before appointment, know what would happen during the consultation.	65.1%	64.2%
D.4 Most recent appointment was not changed to a later date by the hospital.	79.8%	79.7%
D.5 Waited between 16 minutes to an hour before appointment actually started.	23.8%	27.7%
D.6a Were not told how long they would have to wait.	67.5%	67.6%
D.6b Waiting time was about the same compared to what they were told.	53.8%	52.9%
D.7a Were told why they had to wait.	23.1%	52.9%*
D.7b Did not require an explanation.	66.7%	66.7%
D.8 Healthcare professional seemed to have all the necessary information about condition/treatment.	58.2%	
D.9 Had confidence and trust in the healthcare professionals treating them.	68.6%	66.3%
D.10 Given a choice about where referred for outpatient services - that is the location of the hospital.	24.8%	29.1%
D.11 Given enough time to discuss health\medical problem with the healthcare professionals.	61.4%	64.0%
D.12 Patients were involved in decisions about their care and treatment.	49.7%	52.9%
D.13 Received the right amount of information about condition/treatment.	78.4%	77.0%
D.14 Healthcare team explained the reasons for any treatment or action in a way that was understood.	52.9%	55.2%
D.15 If patients had questions to ask the healthcare team, they got answers they could understand.	61.4%	52.9%
D.16 Access to the Outpatient or Emergency Department, rated as easy to very easy.	81.0%	72.4%
D.17 The Outpatient or Emergency Department, rated as very clean.	40.5%	41.4%
D.18 Toilets in the Outpatient or Emergency Department, rated as very clean.	32.0%	28.7%

D.19 Healthcare professionals treated patients with respect and dignity.	84.3%	73.6% *
D.20 Given enough privacy when discussing their condition or treatment.	77.1%	66.3%
D.21 Given enough privacy when being examined or treated.	78.4%	70.9%
D.22 Healthcare professionals gave family or someone close all the information they needed to help them recover.	55.4%	51.5%
D.23 If family wanted to talk to a healthcare professional, they had the opportunity to do so.	56.4%	54.3%
D.24 Arrangements were made to continue care or treatment post discharge from Outpatient or Emergency Department.	48.4%	44.1%
D.25 Quality of care received while at the Outpatient or Emergency Department rated as excellent to very good.	55.5%	57.1%
D.26 Would recommend Outpatient or Emergency Department service, where treated most recently, to someone else.	80.4%	68.6% *

P-Value * <0.05 ** ≤0.01 *** ≤0.001

Section E - Experiences of GP Services (n=1467)	GMS (n=530)	Non GMS (n=937)
E.1 Visited GP one to three times in the last 12 months.	44.6%	72.0% ***
E.2 Visited GP as a private patient.	19.6%	75.5% ***
E.3: Visited GP for a minor ailment or condition.	38.3%	47.8% ***
E.4 An appointment was not required to visit the GP.	34.3%	29.0%
E.5 Were not put off going to GP because of opening hours.	72.8%	65.8% *
E.6 Were given enough time to discuss health\medical problems with the GP.	77.9%	83.2% *
E.7 Were involved in decisions about their care and treatment.	68.3%	74.1% *
E.8a Referred to a specialist in the last 12 months.	27.2%	19.0% ***
E.8b Felt they should have been referred.	1.8%	1.6%
E.8c Were not given a choice of referral.	56.3%	39.3% **
E.8d Would have liked a choice.	21.0%	35.7% *
E.9 Were not given a copy of any letters exchanged between doctors.	41.1%	33.2% ***
E.10 Feel that patients should receive such letters.	50.4%	60.7% ***
E.11 Participants agreed or strongly agreed they were confident they could tell their doctor concerns.	91.3%	94.0%
E.12 The healthcare professional explained reasons for any treatment or action in a way that was understood.	65.5%	70.3% ***
E.13 If had questions, received answers they could understand.	64.0%	70.4% *
E.14 Participants agreed or strongly agreed: Doctor or nurse gave help and advice on improving diet.	51.0%	41.9% **
E.14 Participants agreed or strongly agreed: Doctor or nurse gave help and advice on regular exercise.	53.4%	42.5% ***
E.14 Participants agreed or strongly agreed: Understood the nature and causes of their health problems or condition.	79.0%	79.9% ***
E.14 Participants agreed or strongly agreed: Knew about different medical treatments and self-treatment options for health problems or condition.	73.1%	71.5% ***
E.14 Participants agreed or strongly agreed: Confident they could follow through on medical treatments at home.	81.5%	79.2% **
E.14 Participants agreed or strongly agreed: Confident they could follow through on medical recommendations.	84.8%	81.7% ***
E.14 Participants agreed or strongly agreed: They were able to handle symptoms of their health (or chronic conditions) at home.	74.7%	73.3% ***
E.15 Privacy was respected by the doctor.	95.8%	97.3% *
E.16 Able to get a seat in the waiting room at your GP surgery.	68.3%	68.2%
E.17 Ease of access for people with disabilities to move around the GP surgery, rated very easy.	39.6%	34.6%
E.18 GP surgery rated as very clean.	72.8%	71.0%
E.19 Healthcare professional listened carefully to what they had to say.	83.6%	87.6% ***
E.20 Healthcare professional treated them with respect and dignity.	87.4%	90.2%
E.21 Had confidence and trust in the healthcare professional.	84.3%	86.8%
E.22 Healthcare professionals gave family or someone close, all the information they needed to assist recovery.	53.6%	63.2% ***
E.23 Family had the opportunity to talk to health care professionals.	58.7%	63.2% **
E.24 Arrangements were made to continue care or treatment after GP visit.	40.6%	31.1% ***
E.25 Main reason went to GP surgery was dealt with to satisfaction.	81.7%	85.8% *
E.26 Quality of care received at GP surgery, rated as excellent to very good.	80.6%	82.4%
E.27 Would recommend GP visited most recently to someone else.	90.6%	90.3%

P-Value * <0.05 ** ≤0.01 *** ≤0.001

	Summary Data Based on GMS Status Section F – Experiences of Community Health Services (n=175)	GMS (n=89)	Non GMS (n=86)
F.1	Visited dental services, public only not private in last 12 months.	26.3%	30.8% ***
F.2	In contact with community health services for one year or less.	19.1%	39.5% *
F.3	From the time first referred to service, had to wait up to a month for an appointment.	31.5%	39.5%
F.4	Were told why they would have to wait.	41.5%	29.8%
F.5	Did not require an explanation.	40.0%	78.1%*
F.6	Would have liked an appointment a bit sooner.	53.7%	27.7%*
F.7	Healthcare team listened carefully to patients.	70.8%	84.9%
F.8	Had confidence and trust in the healthcare team treating them.	74.2%	82.6%
F.9	Had enough say in decisions about care and treatment.	59.6%	65.1%
F.10	Given enough time to discuss health\medical problem with the person providing the service.	71.9%	74.4%
F.11	Did not receive copies of letters sent between the person providing the service and their doctor.	41.6%	41.9%
F.12	Received information about different medical treatments and self-treatment options for health problems or condition.	68.5%	66.3%
F.13	Received information verbally.	70.5%	66.7%
F.14	Received the right amount of information about condition or treatment.	80.3%	91.2%
F.15	The information was understood.	93.4%	93.0%
F.16	Privacy was respected by the person providing the service.	92.1%	96.5%*
F.17	Clinic or treatment area rated as very clean.	56.2%	68.6%
F.18	Had not attended day services in the last two months.	66.3%	75.6%
F.19	Day service users stated these services were helpful. GMS (n=27) Non GMS (n=15)	81.5%	80.0%
F.20	Day service users stated the person who provided the service listened carefully.	63.0%	80.0%
F.21	Day service users stated healthcare team treated patients with respect and dignity.	74.1%	73.3%
F.22	Family or someone close received enough information from service provider about the patient's health problems.	55.3%	53.8%
F.23	Family or someone close received enough support from the community health services, if support was needed.	44.7%	53.6%
F.24	Patients were involved in decisions about discharge from ongoing services.	22.5%	19.8%
F.25	Patients were satisfied that everyone who needed to be informed got adequate information.	63.5%	84.3% **
F.26	Community Service Users asked if they had used mental health services in last 12 months. GMS (n=14 of 89) Non GMS (n=3 of 86)	16.0%	3.0%
F.27	Participants who used mental health service stated counselling services were offered to them.	85.7%	66.7%
F.28	Participants who stated they used mental health services stated they were given a say in decisions about their care and treatment.	50.0%	66.7%
F.29	Participants who stated they used mental health services - stated they had taken medications for mental health problems in the last 12 months.	85.7%	100.0%
F.30	Participants who stated they used mental health services - stated they were given a say in decisions about the medication regimen.	21.4%	33.3%
F.31	All community service users completely agreed the main reason attended community health services was dealt with to satisfaction.	49.4%	59.3%
F.32	All community service users who rated services utilised as excellent to very good.	59.5%	62.8%

P-Value * <0.05 ** ≤0.01 *** ≤0.001

	Section H – Knowledge About Health Services Asked of All Participants (n=3032)	GMS (n=1034)	Non GMS (n=1998)
H.1a	Participants knew what the letters HSE meant.	54.4%	69.7% ***
H.1b	Participants knew what the HSE replaced.	59.6%	69.5% ***
H.1c	Participants knew what the HSE does.	57.3%	70.7% ***
H.2	Participants knew what PCCC stands for.	9.3%	11.7%
H.3	Participants knew what the Department of Health and Children is.	19.3%	27.6% ***
H.4	Registered with a GP.	93.5%	82.8% ***
H.5	Living less than five miles from nearest GP.	76.7%	73.3%
H.5	Living less than five miles from nearest Hospital.	36.9%	37.4%
H.7	Emergency Department hospital services should be provided in every county.	96.2%	95.5%
H.8	Acute hospital services should be provided in every county.	86.5%	82.2% ***
H.9	Had a preference to be treated at specialist centre.	72.1%	77.6% **
H.10	Ease of access to a specialist centre rated as very important.	66.3%	66.8%

H.11 Opportunities to access GP\primary care services rated as the same as everyone else.	80.7%	79.8% **
H.11 Opportunities to access accident and emergency services rated as the same as everyone else.	69.1%	70.8% **
H.11 Opportunities to access mental health services rated as the same as everyone else.	57.1%	56.5% *
H.12 Mental health services are just as accessible to service users and their families as other health services.	36.6%	35.3%
H.13 Aware that the Data Protection Act protects information about medical records.	55.2%	67.6% ***
H.14 Aware that the Freedom of Information Act allows patients to access their records.	47.4%	59.7% ***
H.15 Aware of the Patients' Charter.	18.0%	25.4% ***
H.16: Participants who were aware of the Patients' Charter, who had read Charters specific to hospitals in their area.	11.8%	14.6%
H.17 Aware of the complaints procedure within the hospital/GP practice/community health service.	31.5%	37.9% ***
H.18 Wanted to make a complaint about some aspect of the health service.	19.9%	18.1%
H.19 Knew how to make a complaint.	32.7%	41.3% ***
H.20: Would not make a complaint because they were concerned it would affect their health care.	18.7%	14.4% ***
H.21 Those who made a complaint about some aspect of the heath service who were fully satisfied with the outcome.	24.2%	27.8%
H.22 Participants who were not aware that, under the Health Act 2003, there is a provision for a complaints procedure.	87.1%	82.4% ***

P-Value* <0.05 ** ≤0.01 *** ≤0.001

Section J - Demographics and Social Classification **Asked of All Participants (n=3032)**	**GMS (n=1034)**	**Non GMS (n=1998)**
Age – Under 50s	26.0%	74.0% ***
Age – Over 50s	52.0%	48.0% ***
Male	40.9%	52.2% ***
Female	59.1%	47.8% ***
SOCIAL CLASS – C1	15.4%	38.3% ***
J.1 Left school between 16 to 18 years of age.	55.9%	62.7% ***
J.2 Completed third level education.	8.3%	19.9% ***
J.3 Married	44.6%	54.8% ***
Chief Income Earner	63.7%	59.0% *
J.17 Household net income per week, between 320 and under 950 Euro per week.	29.1%	44.8% ***
J.18 Irish nationality.	91.9%	92.2%
Accommodation		
J.4 Living in a semi-detached \ end of terrace house.	39.7%	40.3% ***
J.5 Home is owned with mortgage.	20.1%	44.9% ***
J.6 More than two people in household.	49.1%	66.0% ***
J.7a Children aged 15 years or under living in household.	29.7%	35.8% ***
J.7b Households with children under 15 yrs of age who have 1 or 2 children.	73.3%	81.0% *
Employment Status		
J.10 Employees.	25.6%	54.6% ***
J.11 Self employed.	5.5%	13.3% ***
J.12a Self employed, employs other people.	15.9%	41.6% ***
J.12b Self employed people with less than five employees.	40.0%	71.4%
J.13 Of participants who stated they were farmers (n=198), those with more than fifty acres.	39.7%	65.1% *
Health Insurance Status		
J.14b GP visit card holders.	25.3%	6.3% ***
J.15 Covered by private health insurance.	21.3%	66.9% ***
J.16 Access to transport.	60.7%	84.5% ***

Section J - Experiences of Smokers (n=987)	**GMS (n=336)**	**Non GMS (n=531)**
J.19a All participants who replied yes, they currently smoke cigarettes, cigars or a pipe.	32.5%	26.6% ***
J.19b Of respondents who currently smoke, people who smoke cigarettes now.	86.9%	89.3%
J.20a Smoke branded cigarettes between 11 to 20 per day.	47.3%	52.3%
J.20b Smoke hand rolled cigarettes between 11 to 20 per day.	2.7%	8.0%
J.21 Smoked cigarettes for between 5 - 10 years.	20.2%	24.7% ***
J.22 All participants were asked if they currently smoke cigars or cigarillos.	0.6%	1.8%
J.23 Smokers of cigars/cigarillos who smoke more than 10 per week.	33.4%	14.7%
J.24 All participants were asked if they currently smoke a pipe.	0.7%	0.3% **
J.26 Smokers who ever received information on stopping smoking.	37.5%	40.1%

J.27	Source of information on stopping smoking was an information leaflet.	63.5%	61.0%
J.28	Of all participants asked about the national ban on smoking in all indoor public areas implemented in Ireland in March 2004, agreed to strongly agreed.	86.3%	90.0% ***
J.29	All participants asked - Would you agree or disagree with a total site ban on smoking in all health care facilities in Ireland, including the outdoor grounds, rated agree to strongly agree.	60.8%	58.5% *

P-Value * <0.05 ** ≤0.01 *** ≤0.001

Summary Data Based on Age (n=3517)

Section A – General Health Status (Asked of All Participants)		Under 50 yrs (n=2102)	Over 50 yrs (n=1415)
A.1	Stated health status was excellent to very good	70.4%	38.0% ***
A.2	Poor physical health over the past 30 days.	23.6%	37.5% ***
A.3	Poor mental health over the past 30 days.	10.5%	13.9% **
A.4	Poor physical or mental health hindered usual activities such as work or recreation over the past 30 days.	17.3%	29.1% ***
A.5	Daily activity or work limited by a long term illness, health problem or disability.	6.0%	20.1% ***
A.6	Information about health sourced from GP.	79.4%	88.6% ***
A.7	Participants who were unlikely or very unlikely to call a telephone help line such as the HSE National Information Line.	67.5%	74.8% ***
A.8	Quality of life rated as good or very good.	90.1%	75.9% ***
A.9	Satisfied to very satisfied with health.	89.3%	71.0% ***

P-Value *<0.05 ** ≤0.01 *** ≤0.001

Section C – Experiences of In / Day Patient Services (n=344)		Under 50s (n=163)	Over 50 yrs (n=181)
C.1a	Most recent experience of hospital was as an inpatient.	60.1%	57.5%
C.1b	Spent between one to three nights in hospital on most recent admission.	55.1%	29.8% ***
C.2	In hospital during the last 12 months for an illness.	19.4%	30.8% ***
C.3	Admitted to the hospital via the emergency department.	36.1%	26.0% **
C.4	Not given an indication of the length of stay required in hospital.	45.9%	56.7%
C.5	Told they would be discharged on the day of discharge.	53.1%	42.3%
C.6	Admitted to hospital immediately.	76.5%	68.3%
C.7a	Were told why they had to wait.	61.1%	67.9%
C.7b	Did not require an explanation.	71.4%	55.6%
C.8	Healthcare team seemed to have all the necessary information about condition/treatment.	69.9%	67.4%
C.9	Had confidence and trust in the people/ health professionals treating them.	75.5%	81.2%
C.10	Not given a choice about where they were referred to, that is the location, but did not mind.	49.1%	53.6%
C.11	Given enough time to discuss their health/medical problem with the healthcare professionals.	75.5%	75.1%
C.12	Patients were involved in decisions about their care and treatment.	69.9%	65.7%
C.13	Received information verbally about condition/treatment.	76.1%	72.4%
C.14	Received the right amount of information about condition or treatment.	79.8%	80.7%
C.15	Had operations or procedures in the hospital.	46.6%	54.1%
C.16	A member of staff explained what would be done during the operation or procedure.	76.3%	78.6%
C.17	Contacting the hospital by phone, rated as good to very good.	70.0%	69.0%*
C.17	Availability of car parking facilities, rated as good to very good.	46.0%	44.2%
C.17	Ease of finding way around the hospital, rated as good to very good.	72.4%	77.9%
C.17	Adequacy/cleanliness of hospital public toilets, rated as good to very good.	57.1%	70.2%*
C.17	Adequacy of shop facilities, rated as good to very good.	54.0%	62.9%
C.17	Wheelchair access, rated as good to very good.	65.0%	61.8%
C.18	Standard of food received in hospital rated as excellent to good.	38.7%	56.9%*
C.19	Range of foods available in hospital rated as very satisfactory.	14.7%	26.5%**
C.20	No special dietary requirements.	73.0%	64.1%
C.21	Participants agreed or strongly agreed that ward facilities (e.g. bed, wardrobe, room, bathrooms) were of a clean standard.	77.3%	80.7%*
C.22	Healthcare team treated patients with respect and dignity.	79.8%	86.2%
C.23	Given enough privacy when discussing condition or treatment.	72.4%	73.5%

C.24 Ministers or priests of faith were always available as frequently as required.	20.2%	28.7% *
C.25 Healthcare teams gave family or someone close to patient all the information they needed to help them recover.	58.9%	68.0%
C.26 If family wanted to talk to the healthcare team, had opportunity to do so.	58.0%	61.7%
C.27 Were very involved in decisions regarding discharge from hospital.	30.1%	17.7% *
C.28 Good continuity of care and support was provided by the hospital.	46.0%	56.4%
C.29 Patients received support and advice from the hospital if illness/injury meant they were unable to work post discharge.	25.8%	21.5% ***
C.30 Quality of care received while in hospital rated as excellent to very good.	54.6%	71.2% *
C.31 Would recommend the hospital where treated most recently to someone else.	81.0%	86.2%

P-Value *<0.05 ** ≤0.01 *** ≤0.001

Section D – Experiences of Outpatient Hospital Services (n=470)	Under 50 yrs (n=265)	Over 50 yrs (n=205)
D.1 Attended outpatient clinic 1–3 times in the last 12 months.	78.9%	77.6%
D.2 Were not given a choice of appointment times, but did not need or want a choice.	40.7%	41.2%
D.3 Before appointment, knew what would happen during the consultation.	66.4%	66.1%
D.4 Most recent appointment was not changed to a later date by the hospital.	82.1%	77.6%
D.5 Waited between 16 minutes to an hour before appointment actually started.	22.2%	34.5% *
D.6a Were not told how long they would have to wait.	66.0%	72.5%
D.6b Waiting time was about the same compared to what they were told.	66.7%	52.6%
D.7a Were told why they had to wait.	40.0%	36.8%
D.7b Did not require an explanation.	60.0%	80.0%
D.8 Healthcare professional seemed to have all the necessary information about condition/treatment.	52.8%	67.8% **
D.9 Had confidence and trust in the healthcare professionals treating them.	66.4%	70.2%
D.10 Given a choice about where referred for outpatient services – that is the location of the hospital.	31.3%	24.4% ***

D.11 Given enough time to discuss health/ medical problem with the healthcare professionals.	62.3%	65.9%
D.12 Patients were involved in decisions about their care and treatment.	52.1%	49.8%
D.13 Received the right amount of information about condition and treatment.	76.6%	81.5%
D.14 Healthcare team explained the reasons for any treatment or action in a way that was understood.	55.5%	52.5%
D.15 If patients had questions to ask the healthcare team, they got answers they could understand.	55.5%	57.1%
D.16 Access to the Outpatient or Emergency Department rated as easy to very easy.	73.6%	81.4%*
D.17 The Outpatient or Emergency Department rated as very clean.	38.5%	47.8%
D.18 Toilets in the Outpatient or Emergency Department rated as very clean.	27.9%	33.2%
D.19 Healthcare professionals treated patients with respect and dignity.	75.1%	82.9%
D.20 Given enough privacy when discussing their condition or treatment.	65.7%	80.0% ***
D.21 Given enough privacy when being examined or treated.	68.7%	83.4% ***
D.22 Healthcare professionals gave family or someone close all the information they needed to help them recover.	53.1%	57.5%
D.23 If family wanted to talk to a healthcare professional, they had the opportunity to do so.	54.3%	62.3%
D.24 Arrangements were made to continue care or treatment post discharge from Outpatient or Emergency Department.	41.5%	55.1% *
D.25 Quality of care received while at the Outpatient or Emergency Department, rated as excellent to very good.	53.5%	61.9%
D.26 Would recommend Outpatient or Emergency Department service, where treated most recently, to someone else.	70.6%	77.1%

P-Value * <0.05 ** ≤0.01 *** ≤0.001

Summary Data Based on Age

Section E – Experiences of GP Services (n=1732)	Under 50 yrs (n=977)	Over 50 yrs (n=755)
E.1 Visited GP one to three times in the last 12 months.	69.6%	47.0% ***
E.2 Visited GP as a private patient.	59.9%	42.9% ***
E.3 Visited GP for a minor ailment or condition.	48.0%	37.1% ***
E.4 An appointment was not required to visit the GP.	29.5%	34.7%

E.5	Were not put off going to GP because of opening hours.	64.4%	77.4% ***
E.6	Were given enough time to discuss health/ medical problems with the GP.	81.4%	81.6%
E.7	Were involved in decisions about their care and treatment.	72.6%	70.2%
E.8a	Referred to a specialist in the last 12 months.	19.7%	24.0% *
E.8b	Should have been referred.	1.4%	2.1%
E.8c	Were not given a choice of referral.	45.8%	51.9%
E.8d	Would have liked a choice.	31.8%	23.4%
E.9	Were not given a copy of any letters exchanged between doctors.	33.4%	39.7% *
E.10	Feel that patients should receive such letters.	60.1%	49.7% ***
E.11	Participants agreed or strongly agreed they were confident they could tell their doctor concerns.	92.2%	95.2% ***
E.12	The healthcare professional explained reasons for any treatment or action in a way that was understood.	67.6%	69.1%
E.13	If had questions, received answers they could understand.	67.2%	69.9%
E.14	Participants agreed or strongly agreed: Doctor or nurse gave help and advice on improving diet.	40.9%	53.1% ***
E.14	Participants agreed or strongly agreed: Doctor or nurse gave help and advice on regular exercise.	41.0%	57.3% ***
E.14	Participants agreed or strongly agreed: Understood the nature and causes of their health problems or condition.	77.2%	84.4% ***
E.14	Participants agreed or strongly agreed: Knew about different medical treatments and self-treatment options for health problems or condition.	69.7%	77.7% ***
E.14	Participants agreed or strongly agreed: Confident they could follow through on medical treatments at home.	77.6%	84.6% ***
E.14	Participants agreed or strongly agreed: Confident they could follow through on medical recommendations.	80.8%	86.1% **
E.14	Participants agreed or strongly agreed: They were able to handle symptoms of their health (or chronic conditions) at home.	71.3%	78.6% **
E.15	Privacy was respected by the doctor.	97.1%	97.0%
E.16	Able to get a seat in the waiting room at your GP surgery.	66.5%	72.2% *
E.17	Ease of access for people with disabilities to move around the GP surgery, rated very easy.	35.2%	41.3%
E.18	GP surgery rated as very clean.	69.3%	77.9% ***
E.19	Healthcare professional listened carefully to what they had to say.	85.1%	89.3% *
E.20	Healthcare professional treated them with respect and dignity.	88.6%	91.3% *
E.21	Had confidence and trust in the healthcare professional.	84.7%	89.1% *
E.22	Healthcare professionals gave family or someone close, all the information they needed to assist recovery.	57.9%	63.7%
E.23	Family had the opportunity to talk to healthcare professionals.	58.2%	69.4%
E.24	Arrangements were made to continue care or treatment after GP visit.	30.7%	40.7% ***
E.25	Main reason went to GP surgery was dealt with to satisfaction.	83.1%	85.3% **
E.26	Quality of care received at GP surgery, rated as excellent to very good.	80.4%	84.9%
E.27	Would recommend GP visited most recently to someone else.	89.6%	92.3%

P-Value * <0.05 ** ≤0.01 *** ≤0.001

Summary Data Based on Age

	Section F – Experiences of Community Health Services(n=201)	Under 50 yrs (n=114)	Over 50 yrs (n=87)
F.1	Visited dental services, public only not private in last 12 months.	38.3%	7.6%
F.2	In contact with community health services for one year or less.	31.6%	26.4%
F.3	From the time first referred to service, had to wait up to a month for an appointment.	36.8%	31.0%
F.4	Were told why they would had to wait.	33.3%	42.5%
F.5	Did not require an explanation.	69.4%	52.6%
F.6	Would have liked an appointment a bit sooner.	28.1%	55.0%*
F.7	Healthcare team listened carefully to patients.	76.3%	81.6%
F.8	Had confidence and trust in the healthcare team treating them.	76.3%	81.6%
F.9	Had enough say in decisions about care and treatment.	62.3%	65.5%
F.10	Given enough time to discuss health/medical problem with the person providing the service.	71.1%	78.2%
F.11	Did not received copies of letters sent between the person providing the service and their doctor.	42.1%	46.0%
F.12	Received information about different medical treatments and self-treatment options for health problems or condition.	69.3%	62.1%
F.13	Received information verbally.	67.1%	79.6%

F.14 Received the right amount of information about condition or treatment.	88.6%	85.2%
F.15 The information was understood.	94.9%	92.6%
F.16 Privacy was respected by the person providing the service.	93.9%	96.6%
F.17 Clinic or treatment area rated as very clean.	61.4%	63.2%
F.18 Had not attended day services in the last two months.	71.9%	69.0%
F.19 Day service users stated these services were helpful (n=24) Over 50s (n=23)	75.0%	91.3%
F.20 Day service users stated the person who provided the service listen carefully.	70.8%	69.6%
F.21 Day service users stated healthcare team treated patients with respect and dignity.	70.8%	82.6%
F.22 Family or someone close received information from service provider about the patients health problems.	50.0%	58.5%
F.23 Family or someone close received enough support from the community health services, if support was needed	37.5%	60.0%
F.24 Patients were involved in decisions about discharge from ongoing services.	18.4%	23.0%
F.25 Patients were satisfied that everyone who needed to be informed got adequate information.	71.6%	76.8%
F.26 Community Service Users asked if they had used mental health services in last 12 months. Under 50s (n=16 of 114) Over 50s (n=6 of 87)	14.0%	7.0%
F.27 Participants who used mental health service Stated counselling services were offered to them.	81.3%	83.3%
F.28 Participants who stated they used mental health services Stated they were given a say in decisions about their treatment.	43.8%	83.3%
F.29 Participants who stated they used mental health services Stated they had taken medications for mental health problems in the last 12 months.	87.5%	100.0%
F.30 Participants who stated they used mental health services Stated they were given a say in decisions about the medication regimen.	25.0%	16.7%
F.31 All community service users were asked if the main reason attended community health services was dealt with to satisfaction.	57.0%	54.0%
F.32 All Community Service Users who rated services utilised as excellent to very good.	61.4%	59.7%

P-Value * <0.05 ** ≤0.01 *** ≤0.001

Section H – Knowledge About Health Services **Asked of All Participants (n=3517)**	**Under 50 yrs (n=2102)**	**Over 50 yrs (n=1415)**
H.1a Participants knew what the letters HSE meant.	65.6%	64.0%
H.1b Participants knew what the HSE replaced.	65.1%	70.1% **
H.1c Participants knew what the HSE does.	66.7%	66.4%
H.2 Participants knew what PCCC stands for.	11.4%	10.0%
H.3 Participants knew what the Department of Health and Children is.	25.9%	22.7%
H.4 Registered with a GP.	84.6%	92.2% ***
H.5 Living less than five miles from nearest GP.	74.1%	73.5%
H.5 Living less than five miles from nearest Hospital.	37.7%	37.2% ***
H.7 Emergency Department hospital services should be provided in every county.	95.8%	96.3%
H.8 Acute hospital services should be provided in every county.	83.7%	85.4%
H.9 Had a preference to be treated at specialist centre.	75.8%	76.7%
H.10 Ease of access to a specialist centre rated as very important.	64.9%	71.7% ***
H.11 Opportunities to access GP\primary care services rated as the same as everyone else.	79.8%	80.8%
H.11 Opportunities to access accident and emergency services rated as the same as everyone else.	70.2%	70.5% *
H.11 Opportunities to access mental health services rated as the same as everyone else.	57.6%	56.0% **
H.12 Mental health services are just as accessible to service users and their families as other health services.	35.3%	38.0%
H.13 Aware that the Data Protection Act protects information about medical records.	65.3%	59.5% ***
H.14 Aware that the Freedom of Information Act allows patients to access their records.	56.9%	51.9% **
H.15 Aware of the Patients' Charter.	22.8%	21.9%
H.16 Participants who were aware of the Patients' Charter, who had read Charters specific to hospitals in their area.	14.2%	13.2%
H.17 Aware of the complaints procedure within the hospital\ GP practice\community health service.	35.5%	36.6%
H.18 Wanted to make a complaint about some aspect of the health service.	19.3%	18.4%
H.19 Knew how to make a complaint.	37.8%	40.8%
H.20 Would not make a complaint because they were concerned it would affect their health care.	15.2%	18.4% **
H.21 Those who made a complaint about some aspect of the heath service who were satisfied with the outcome.	27.2%	26.7%

H.22 Participants who were not aware that, under the health act 2003, there is a provision for a complaints procedure.	84.3%	82.3%

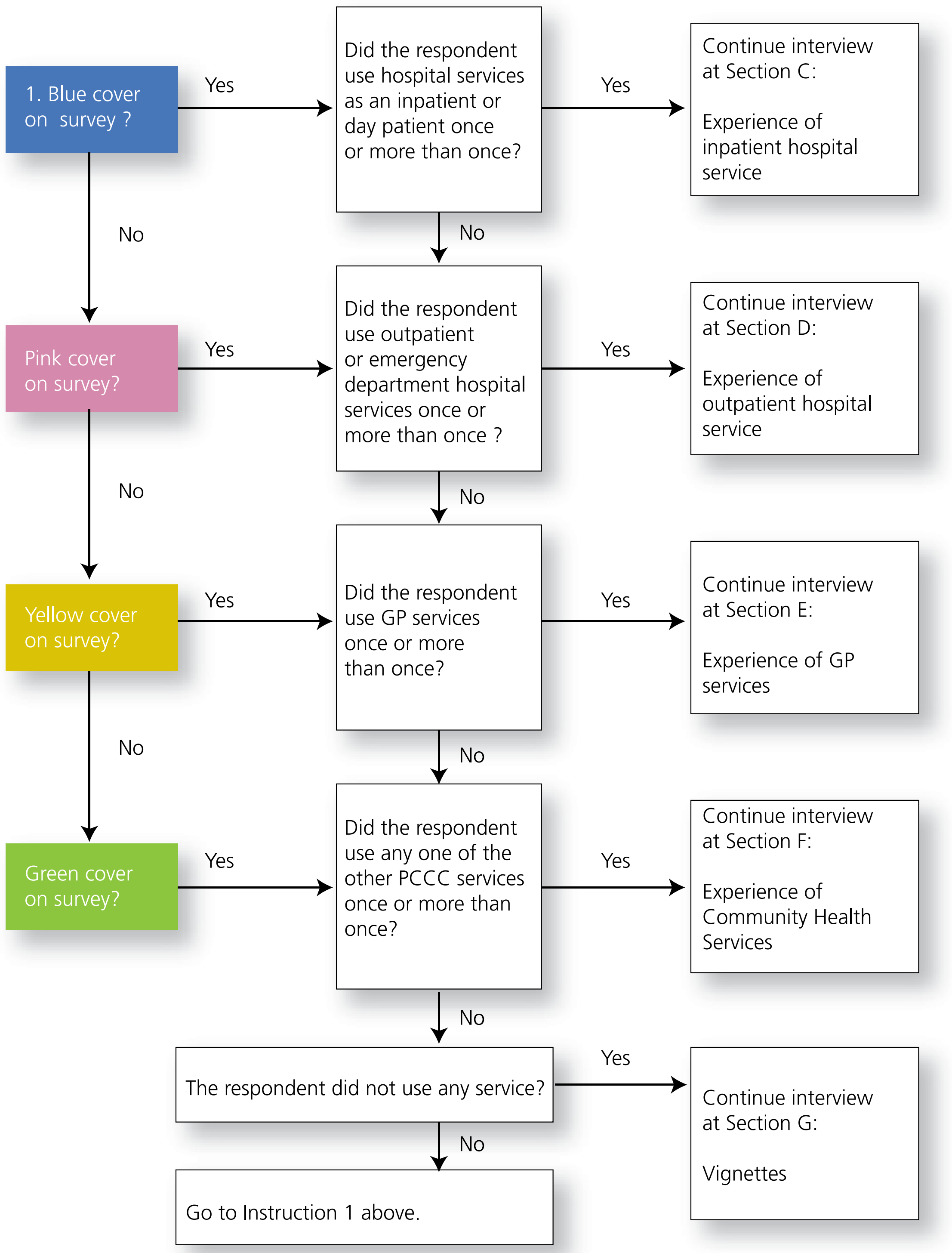
P-Value* < 0.05 - ** ≤ 0.01 - *** ≤ 0.001

Section J – Demographics and Social Classification **Asked of All Participants (n=3517)**	**Under 50 yrs (n=2102)**	**Over 50 yrs (n=1415)**
Age – Under & Over 50	59.8%	40.2% ***
Male	48.2%	48.5%
Female	51.8%	51.5%
SOCIAL CLASS – C1	34.0%	23.7% ***
J.1 Left school between 16 to 18 years of age.	64.8%	50.9% ***
J.2 Completed third level education.	18.7%	8.8% ***
J.3 Married	45.2%	63.3% ***
Chief Income Earner	57.7%	66.7% ***
J.17 Household net income per week, between 320 and under 950 Euro per week.	41.7%	32.0% ***
J.18 Irish nationality.	90.5%	95.7% ***
Accommodation		
J.4 Living in a semi-detached \ end of terrace house.	42.6%	34.6% ***
J.5 Home is owned with mortgage.	45.3%	18.0% ***
J.6 More than two people in household.	73.5%	31.3% ***
J.7a Children aged 15 years or under living in household.	45.4%	7.8% ***
J.7b Households with children under 15 yrs of age who have 1 or 2 children	78.0%	82.0% ***
Employment Status		
J.10 Employees.	55.2%	21.8% ***
J.11 Self employed.	9.8%	11.3% ***
J.12a Self employed, employs other people.	38.8%	35.4%
J.12b Self employed people with less than five employees.	71.3%	65.1%
J.13 Of participants who stated they were farmers (n=234), those with more than fifty acres.	52.8%	63.0%
Health Insurance Status		
J.14a Medical card holders.	25.9%	52.9% ***
J.14b GP visit card holders.	10.7%	16.5% ***
J.15 Covered by private health insurance.	53.1%	45.4% ***
J.16 Access to transport.	78.2%	70.8% ***

Section J – Experiences of Smokers (n=987)	**Under 50 yrs (n=665)**	**Over 50 yrs (n=322)**
J.19a All participants who replied yes, they currently smoke cigarettes, cigars or a pipe.	31.6%	22.8% ***
J.19b Of respondents who currently smoke, people who smoke cigarettes now.	90.4%	86.4% **
J.20a Smoke branded cigarettes between 11 to 20 per day.	50.5%	49.0%
J.20b Smoke hand rolled cigarettes between 11 to 20 per day.	1.4%	1.8%
J.21 Smoked cigarettes for between 5 - 10 years.	28.0%	3.7% ***
J.22 All participants were asked if they currently smoke cigars or cigarillos.	1.4%	1.3%
J.23 Smokers of cigars/cigarillos who smoke more than 10 per week.	14.3%	16.8%
J.24 All participants were asked if they currently smoke a pipe.	0.2%	0.8% ***
J.26 Smokers who ever received information on stopping smoking.	39.4%	43.8%
J.27 Source of information on stopping smoking was an information leaflet.	63.0%	58.2%
J.28 Of all participants asked about the national ban on smoking in all indoor public areas implemented in Ireland in March 2004, agreed to strongly agreed.	88.3%	89.7% *
J.29 All participants asked - Would you agree or disagree with a total site ban on smoking in all health care facilities in Ireland, including the outdoor grounds, rated agree to strongly agree.	59.1%	62.1% *

P-Value * <0.05 ** ≤0.01 *** ≤0.001

APPENDIX 3. FLOW DIAGRAM FOR INTERVIEWERS



Designed by BFK. WWW.BFK.IE

your service ...your say

Our 'your service ...your say' policy is designed to provide fair and timely responses to comments, suggestions or complaints about services provided by the HSE or voluntary service providers. We are committed to improving our services to address the wants, needs and preferences of all service users.

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Consumers Affairs Department
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