Why are people dissatisfied with medical care services in Lithuania? A qualitative study using responses to open-ended questions

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Abstract

Objectives. To identify and describe the main sources of dissatisfaction with medical services among the population in Lithuania.

Design. Analysis of written responses to an open-ended question as a part of a questionnaire survey.

Participants. A randomly selected group of 25–64-year-old men and women from the Utena and the Kaisiadorys regions of Lithuania. Of the 1395 survey respondents, 357 persons (25.6%) answered the question regarding the dissatisfaction with health care services.

Main outcome measures. Identification of the sources of dissatisfaction with medical care services among study participants.

Results. Twelve categories of dissatisfaction were identified that were related to three levels: shortcomings in the health care system (systemic level), deficiencies in provision and quality of services (institutional level) and deficiencies in physicians’ attitudes, skills and work (individual level).

Conclusion. Consumers’ perceptions of medical care quality can be analysed by using information obtained from simple survey material and can be used to improve the quality of service. The causes of dissatisfaction with medical service can be traced to the development of the health care delivery system and patients’ rights in a country.

Keywords: dissatisfaction, general population, medical services, qualitative study, physicians’ skills and attitudes

Over the past 20 years, the quality of health care services has become an important issue and consumer satisfaction has been recognized as a factor that contributes to quality of care. In spite of agreement on the importance of consumers’ opinions for efforts to improve the quality of health care, there is still limited evidence concerning the mechanisms that most effectively measure views about health care quality. One method used in Western industrialized countries is patients’ satisfaction studies, which have been used to evaluate processes in health care in order to develop a ‘customer-oriented service culture’ [1].

Lithuania inherited the soviet model of health care provision, which is characterized by the dominance of bureaucracies over a whole society. In the soviet context, physicians assumed control over patients, and there was no movement for patients’ rights. Patients felt compelled to make informal payments to physicians and other medical personnel [2]. As a result, present Lithuania faces problems in terms of patients’ perceived quality of health care. Lithuania has been affected by the regional restructuring of health care, and over the last 10 years has undergone profound changes in health care. Available state revenue for the health sector has decreased due to an economic recession in the early 1990s, which had a negative impact on the development of the health sector. Since 1996 the health care system in Lithuania has been in the process of moving away from an integrated bureaucratic model towards a contractual model. Major changes in the system have been driven by the appearance of a third-party payer in the form of a statutory health insurance system and enforcement of legislation re-defining property rights and the status of health care institutions [3]. In addition, health care reform in Lithuania has...
aimed to increase patients' choice, strengthen patients' rights and increase quality of care while maintaining accessible health care for consumers [4].

Traditionally users' views of health care have been evaluated through satisfaction studies. Researchers have tended to use questionnaires to assess satisfaction, but many questionnaires have been seen as problematic. As Whitfield and Baker pointed out, 'poor questionnaires may limit the opportunity of patients to express their concerns about different aspects of care' [5]. A strictly formulated questionnaire might miss important aspects of the service experience. From the methodological point of view there seem to be two problems: (1) using a questionnaire to measure satisfaction may result in obtaining answers only to the questions we have asked, and (2) asking about satisfaction might result in high scores for general satisfaction but might ignore perceptions of negative experience with services. Because of these limitations, several authors have advocated alternatives for questionnaire-based satisfaction studies.

A number of authors have recommended devoting more attention to qualitative methodologies to assess the whole satisfaction–dissatisfaction phenomenon in a comprehensive and patient-oriented way, because good and validated quantitative methods are still lacking [6,7]. For example, Pichert et al. reported a qualitative analysis of 12,000 patient complaint narratives, where the reasons for complaints were classified into six categories. In this way the material could be sorted and elaborated to yield very practical advice for quality improvement [8].

The concept of 'satisfaction' and the use of it in studies are problematic. Publication of satisfaction studies reached their peak in 1994, reflecting the changes in service management in the US and the UK [1]. A meta-analysis of over 100 studies showed that results of satisfaction should be interpreted carefully due to the lack of theoretical foundations on which the concept of 'satisfaction' and its 'measurement' are based. The validity and reliability of many studies of health care consumers' satisfaction have been questioned [9]. Measurement and interpretation of patients' satisfaction reveal several problems. Williams and colleagues identified the problems inherent in the term 'satisfaction' [10]. They argue that the model for satisfaction is more complex than an expression of fulfillment of expectations. Satisfaction—and dissatisfaction—result in a process in which expectations, service experience and 'culpability' of the service provider are involved. The authors demonstrated that even those service users whose needs were not met by the service would frequently express satisfaction with the service. In their study, dissatisfaction was only expressed when the following factors were present: the needs of the patient were unmet; the patient perceived the request as a 'duty' of the service; the service was perceived as 'culpable' of not meeting the need; and there were no mitigating factors for this 'culpability' [11]. According to Williams et al. [11], dissatisfaction levels may be of more use as an indication of a negative experience, which high reported levels of satisfaction do not capture.

From the practical point of view of quality improvement, studying dissatisfaction might also be more important than studying satisfaction in the identification of system malfunctions. As Coyle pointed out, studying expressions and the meaning of dissatisfaction will provide us with information on lay beliefs about health care functioning and bases of criticism [12].

We wanted to explore the opinions about health care services among citizens in Lithuania. In this study we aimed to assess what reasons the inhabitants give for their dissatisfaction with health care services. The topic has been very little studied in Lithuania where the health care system has been extensively reorganized since 1991. To be able to describe the phenomenon with concepts used by ordinary citizens, we chose to use qualitative methods to analyse the unstructured material derived from open-ended answers in a questionnaire. We wanted to create categories that could increase understanding of the phenomenon. This, in turn, would provide us with a means to understand and improve medical care services from the point of view of the health care consumer.

Materials and methods

The material for this study was collected as a part of a larger survey on self-reported health and determinants of health within two administrative regions of Lithuania, Utena and Kaisiadorys, covering a population of more than 90,000 [13]. These administrative regions were chosen based on significantly different average life expectancy figures between them—the former region with a higher average life expectancy than that of the latter. Questionnaires were mailed in 1998 to a random representative sample of 2000 inhabitants of both genders of working age (25–64 years of age). The response rate was 69.7%. Of the 1395 respondents, 32% responded negatively to the question on satisfaction, worded as follow: 'Are you mostly satisfied with medical care?'. The question was followed by an open-ended question requesting the respondent to provide reasons for any dissatisfaction with medical care services ('If you are not satisfied, what are the reasons for this?'). There were 357 responses (25.6% of all respondents) to this question. These responses formed the material for this analysis.

An interpretational approach was used for qualitative analysis of the open-ended answers. The aim was to generate categories of reasons for dissatisfaction by using content analysis of the data [14]. Each response was written on a separate piece of paper and read through. If the response included two or more different statements of reasons for dissatisfaction it was cut into pieces accordingly to form the separate statements. There were 443 statements in total and each statement was considered as one unit of analysis.

An initial sample of 80 statements was read through and organized into categories of reasons. Categories were named using the respondents' own expressions where possible. Two researchers read all of the statements in the initial sample and carried out this analysis separately. This initial analysis generated almost identical sets of categories. The categories were discussed and finally a set of 12 categories was composed
Table 1. Reasons for dissatisfaction and the number of answers

<table>
<thead>
<tr>
<th>Reasons for dissatisfaction with health care services</th>
<th>Example</th>
<th>Number of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systemic level: deficiencies in the health care system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction with health care reform</td>
<td>“Health care reform is ‘pushing people to despair’”</td>
<td>55</td>
</tr>
<tr>
<td>Bureaucracy</td>
<td>‘Excess paper work’</td>
<td>6</td>
</tr>
<tr>
<td>Difficulty in getting to a specialist</td>
<td>‘There are lots of problems in getting to the specialist needed’</td>
<td>14</td>
</tr>
<tr>
<td>High cost of services</td>
<td>‘I do not have money to buy medications’</td>
<td>27</td>
</tr>
<tr>
<td>Institutional level: deficiencies in provision and</td>
<td></td>
<td>73</td>
</tr>
<tr>
<td>quality of service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long queues, waiting</td>
<td>‘You have to wait a lot to get to the doctor’</td>
<td>33</td>
</tr>
<tr>
<td>Lack of medical equipment</td>
<td>‘Lack of diagnostic equipment’</td>
<td>15</td>
</tr>
<tr>
<td>Inadequate health care service quality</td>
<td>‘Services are not good quality and they are provided in a hurry’</td>
<td>25</td>
</tr>
<tr>
<td>Individual level: deficiencies in physicians’ attitudes,</td>
<td></td>
<td>315</td>
</tr>
<tr>
<td>skills and work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of competency</td>
<td>‘Health care is not professional, not of good quality’</td>
<td>84</td>
</tr>
<tr>
<td>No money—no service</td>
<td>‘Not having a lot of money, nobody cares about you’</td>
<td>38</td>
</tr>
<tr>
<td>Doctors’ indifference, lack of attention, rudeness</td>
<td>‘Doctors are lacking tolerance, attentiveness and willingness to help’</td>
<td>149</td>
</tr>
<tr>
<td>Lack of responsibility, negligence</td>
<td>‘I am not satisfied with health care due to doctors’ negligence’</td>
<td>11</td>
</tr>
<tr>
<td>Lack of information</td>
<td>‘Lack of information about the treatment of disease and lifestyle, any care or advice after operations’</td>
<td>33</td>
</tr>
<tr>
<td>Number of respondents</td>
<td></td>
<td>443</td>
</tr>
</tbody>
</table>

Based directly on the respondents’ statements. This classification of reasons for dissatisfaction was then reviewed using knowledge and experience of the Lithuanian health care system, thus the categories were further grouped into three different classes, now with an operational content. Finally, all 443 statements were counted according to these categories to obtain a quantitative description of the whole material.

Results

The initial analysis of 443 statements generated 12 categories of reasons for dissatisfaction with health care (Table 1). A further grouping of these categories was carried out reflecting the context of the Lithuanian health care system. This stage of analysis produced three main categories, which describe dissatisfaction with health care at three different levels of responsibility for health services health care: (1) the systemic level, (2) the institutional level and (3) personal or individual level. Main categories and subcategories are described in detail below. For the purpose of understanding the causes of dissatisfaction, the main emphasis is on the qualitative analysis of the data. The numbers of responses in each subcategory are given to indicate the magnitude, but this type of material does not give a possibility for further quantitative analysis.

Deficiencies of the health care system

The statements expressing dissatisfaction with the way the health care services are organized were categorized as ‘system level’ dissatisfaction. These statements reflect respondents’ dissatisfaction with a perceived dysfunction of the whole system or a part of it and included perceived problems in the regulation of the health care system, legislation and implementation of it or costs of services. These reasons for dissatisfaction were grouped into four distinctive groups.

Dissatisfaction with health care reform (six responses). The majority of complaints classified in this category were general statements on health care reform as a source of dissatisfaction without providing further explanation. Some statements blamed health care reform as a cause of ill treatment. ‘Health care reform is bad’; ‘Health care reform is pushing people to despair’; ‘Cannot choose the doctor’; ‘Health care reform is bad: patients are waiting at their doctors’ (GP) office, and only later they are referred to the specialist. This is how the time of doctor and patient is wasted’.
Bureaucracy (eight responses). The statements in this category described dissatisfaction with bureaucratic features of the health care system or services—usually in the form of excess paper work. The dissatisfaction was expressed as a general statement on bureaucracy or a description of the negative effects on service:

‘Too much bureaucracy’;
‘Doctors fill in many papers; instead they could use this time to communicate with patients’.

Difficulty in getting to a specialist (14 responses). The main object of the dissatisfaction in these responses was the perceived difficulty in getting to a specialist, but the cause of this constraint was seen in the system. In Lithuania, a person usually needs a referral from a family doctor to see a specialist.

‘Doctors often try to ‘keep’ the patient in their regions; they do not want to give referrals to other clinics’;
‘There are lots of problems in getting to the specialist needed’.

High cost of services (27 responses). The problems identified here involved the cost of health care services or medication as a source of dissatisfaction. Some respondents reported that the cost of medical care created a barrier to obtaining needed treatment.
‘I do not have the money to buy medications’;
‘Too many charged medical care services, one has to pay for medications’;
‘We have to pay for the dental treatment, lack of money; it is not possible to buy more expensive medications’.

Deficiencies in provision and quality of service at the institutional/organizational level

A group of statements expressed dissatisfaction with the health care or service at the institutional level. These statements described problems that appear on the level of the actual provision of care, but are seen as a dysfunction or fault of the organization. The respondents indicated problems that were either deficiencies of the structure (equipment, facilities) or the process (queues, actual service). We grouped these statements into three categories accordingly.

Long queues, waiting (33 responses). Long lines and waiting times for service and care were mentioned in 33 statements. The respondents described it as ‘a waste of time’ or gave a description of the detrimental effects on health.
‘It is difficult to get to the doctor; you have to wait behind the door half of a day’;
‘Long queues, bad doctors, often it is too late to do something’;
‘Long registration procedure, it is not possible to plan the time, because sometimes we have to wait for 2–3 hours at the doctor’s office’.

Lack of medical equipment (15 responses). The equipment that was used or was available for practitioners seemed to affect the level of satisfaction with medical services. People also described how the lack of equipment is reflected in services, especially diagnostic services.

‘Lack of diagnostic equipment’;
‘Bad and old medical equipment, very often it is too late to do something’.

Inadequate health care service quality (25 responses). A number of respondents expressed dissatisfaction with service because they considered that service was of ‘not good quality’ or that quality is ‘poor’. The poor service might here mean either professional quality or the quality of how people are treated: hurried and even a ‘poor service culture’ were identified by some respondents.
‘Services are not good quality and they are provided in a hurry’;
‘Health care is not professional, not of good quality’.

Deficiencies in physicians’ attitudes, skills and work

The overwhelming majority of analysed statements on dissatisfaction described perceived deficiencies of individual practitioners. The expressions covered basically all aspects of practice: knowledge, skills, behaviour and attitudes. Some presented a general mistrust towards doctors without specifying the exact cause thereof. Although these categories of expressed dissatisfaction are somewhat overlapping, we made a distinction in the analysis between statements on deliberate negligence or rudeness and a more passive lack of attention as well as quite different qualities like greed (‘no money—no service’), lack of competence and unwillingness to inform patients.

Lack of competency (84 responses). ‘Competency’ or the lack of it was understood in this category as a lack of appropriate professional knowledge or skills needed by a practitioner. In the statements this was expressed more or less directly as the respondent’s opinion on the subject. Most of the statements were very general, and did not provide more details on how this perceived incompetence was manifested.
‘Doctors are lacking competence’;
‘Doctors do not care about their knowledge and competence’;
‘Doctors do not know anything about the disease’.

No money—no service (38 responses). The responses in this category described quite explicitly the practicality of having to pay extra to get proper service. Different labels were given to this phenomenon such, as ‘bribery’, or ‘additional payment’, or ‘pocket money’. The cause of dissatisfaction here was seen on the level of individual practitioners. Interpreted from the point of view of respondents, it could be very clearly distinguished from the perceived systemic level dissatisfaction with health care costs. However, it does not exclude the possibility of interrelations between these two causes of dissatisfaction at different levels.
‘If one does not pay extra [money], then they [doctors] behave in a rude manner and they are not interested in disease’;
‘Treatment depends on the financial status [of the patient]’;
‘Not having a lot of money, nobody cares about you’.

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Doctors’ indifference and lack of attention, rudeness (149 responses). Indifference or lack of attention was described as a feature of physicians who did not pay enough attention to patients. The patients perceived this as a kind of nonchalance or lack of motivation to listen carefully, and a lack of willingness to help. This characteristic of doctors’ communication and behaviour with patients was the most prevalent cause of dissatisfaction among respondents. Rudeness is a more active conduct than mere nonchalance. Respondents described physicians’ disrespectful behaviour or perceived lack of compassion.

‘Doctors are lacking tolerance, attentiveness, and a willingness to help’;
‘The number of examinations is not sufficient, medical examination is superficial, communication is not sincere’;
‘Doctors are not always willing to talk with persons and to listen to them, only prescribed medications won’t help’;
‘Doctors are rude and they rarely propose different medications’;
‘Absence of compassion’.

Lack of responsibility, negligence (11 responses). Negligence or a lack of responsibility was considered as a reason for dissatisfaction by a number of respondents. Negligence was mentioned often without further explanation. Professional negligence and lack of responsibility may lead to legal consequences. Because of a different connotation, these comments were codified in a separate category from indifference (lack of attention).

‘Doctors’ negligence’;
‘[Doctors’] attitudes towards work are not responsible enough’;
‘Doctors are not responsible for poor treatment and they have forgotten the Oath of Hippocrates’;
‘It is necessary to have good psychological contact. If you go to the public services, most often doctors are not working responsibly, you can feel as if you are disturbing them’.

Lack of information (33 responses). A shortage of information was mentioned as a source of dissatisfaction by numerous respondents. In the statements, this complaint is reflected either as a general lack of information or as a lack of a specific type of information. Typically, it is mentioned that patients do not get enough information on their illnesses and medication, or appropriate advice to take care of themselves.

‘There is no information provided to the person about disease, causes, perspective, and way of treatment. While treating one disease, there is no attention paid to other diseases’;
‘They [doctors] say nothing concrete’;
‘Doctor could suggest/advise healthier nutrition, healthier lifestyle, but they propose the strongest medications and operations’;
‘[Doctors] not always explain clearly enough the use of medications’.

Discussion

In this study we have generated a classification of the main reasons for dissatisfaction with medical care among the general population in Lithuania. The qualitative analysis yielded 12 distinctive categories of reasons for dissatisfaction. Our study supports some findings of other researchers that the quality, satisfaction and dissatisfaction with medical services are determined by such variables as good relations between doctor and patient, time used for the consultation and information given during consultation and waiting times [1,15,16]. We have also recognized categories that do not come about in satisfaction studies, but have been demonstrated by Prichert et al. in a qualitative study of patient complaints [8], namely bad attitudes, discrimination, billing and payment problems. However, we believe that our findings revealed classes of dissatisfaction, which were not clearly distinguished in those previous studies such as bribery, negligence and rudeness of practitioners. Also, our material demonstrated some systemic-level reasons for dissatisfaction, which have not been pointed out in earlier satisfaction studies.

The difference between this and previous studies can be explained by two factors. First, our study produced explicit statements on reasons for dissatisfaction that were not obtained in most previous satisfaction studies. The use of open-ended questions and the large size of the study population yielded qualitatively rich data.

Secondly, results of this study must be seen in the context of the health care in Eastern Europe. Lithuania has been going through not only a transition of the health care system, but a transition of the society as a whole, from a state of the former Soviet Union to an independent state. Soviet society was characterized by strict hierarchy and bureaucracy, and Soviet physicians have been criticized for their rudeness, callousness and an irresponsible attitude toward the fulfilment of professional duties [2]. During the soviet period, the medical profession carried prestige although generally with a low income. Although there officially was ‘free medical care’, it was compromised by corruption of medical and allied personnel [2]. The soviet culture and working habits are most probably still present in the functions of the health care system and practicing individuals. One previous study has reported high levels of patients’ satisfaction with health care in Europe in general, but patients in Eastern and Southern Europe reported lower satisfaction with health care compared with those in Northern and Western Europe [17]. Even if the interpretation and comparison of the results of this survey are difficult because of the validity problems of satisfaction studies mentioned earlier, we assume that the lower levels of satisfaction in Eastern European countries as well as findings of our study can be attributed to some specific features of the service provision still remaining from the soviet period.

Respondents of this study assessed health care services from various perspectives. Some of their statements mirrored a citizens’ perspective (‘health care reform is bad’), others were related to personal experience leading to disappointment with practitioners’ behaviour (e.g. ‘not having a lot of money, nobody cares about you’). There are three main groups of
actors in the health care system: consumers, payers and providers. Consumers are probably the least capable of seeing the complexity of the health care system and its challenges. Because they are not directly involved in the management of the system, they only face the consequences of this process.

The results of this study showed that respondents were able to perceive and express their concerns in relation to various components of the health care system. Respondents’ ability to identify the causes of medical care dysfunction and their willingness to express it is a useful source of information when reformers turn to the task of enhancing the quality of medical care. This also gives some hope for more active participation of users in the decision-making process in the future. In addition, respondents made a clear distinction between practitioners’ attitudes and their negligence. Wording like ‘professional negligence’ and ‘professional responsibility’ was not widely used in the Lithuanian health care context until recently. The use of these terms might imply that health care users consider doctors’ work as having legal implications.

The material for this analysis was essentially qualitative. However, the large number of responses may provide an opportunity for some quantitative conclusions. In this study, the magnitude of statements related to the improper behaviour, negligent or negative attitudes, and incompetence of individual practitioners is striking and strengthens the argument that these form an important phenomenon in Lithuanian medical care. Referring to the satisfaction framework provided by Williams et al. [11], we might have captured those persons who have had negative experiences of services and have not had their expectations met, but still thought that meeting their needs was the duty of the service.

The analysis produced three main groups of reason for dissatisfaction with medical care. These three groups (systemic, institutional and individual) indicate the level of the responsibility for issues to be addressed.

At the systemic level there is a need to understand what makes consumers hostile to health care reform. Perhaps the changes in health sector do not support the values of society or there is not enough clear information about how the changes affect patients.

At the institutional level, the perceived dissatisfaction with service delivery (long queues, lack of equipment, bad service) should challenge health care managers to engage in quality of service improvement. It is possible to improve service and reduce waiting through structural changes in the institutions.

Although the results of our study do not directly show what actually happens during consultations, the attitudes, skills and behaviour of individual practitioners seem to need special attention in the Lithuanian context. To change these in order to cause less dissatisfaction among health care consumers would require measures by physicians themselves, by those responsible for basic and postgraduate education, by remuneration systems and possibly also by patients. This would create pressure for respecting the rights of patients, an issue on which Lithuania already has advanced legislation. The process might be slow, for ‘a physician is not simply any trained person who applies the universal knowledge of medical science uniformly, he or she is also the product of the culture, the tradition, the history, and the personal life course in the social setting in which he and she applies that knowledge’ [2].

We can therefore conclude that the results of our study could help to direct actions and further research on determinants of dissatisfaction. These findings should also have implications for the development of health care policy in Lithuania. The quality of health care is a priority issue in the majority of health policy documents in the country. Patient satisfaction could be considered an indicator of quality of care from the patient’s perspective [18]. The results of the study show that the analysis of free-form expressions of consumer perceived dissatisfaction could provide valuable information in this process.

References


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