FACTORS INFLUENCING THE QUALITY OF PRIMARY CHILD HEALTHCARE

- A PARENTS' PERSPECTIVE -

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PREFACE

After a long period of studying I hereby present my master thesis to finalise my master education Health Sciences at the University of Twente. This research investigates which factors are important to the perception of parents looking for quality primary healthcare for their children.

I can look back at this challenging period of ups and downs with which I worked on this research with a good feeling. The execution of this research was therefore an interesting learning process for me. The end of the thesis is in sight and I would like to take this opportunity to thank some of the people who have supported me during this period.

First of all I would like to thank my supervisors, Janine van Til and Magda Boere-Boonekamp for their supervision and feedback during this period. Furthermore, I'd like to thank my colleagues, my friends, my family and Eelco, who have all showed their interest during this period and who have provided me with continuous motivation to follow through with this project.

Selma Mulder

NEDERLANDSE SAMENVATTING

ACHTERGROND

Een goede gezondheid van kinderen is van groot belang, aangezien de hedendaagse kinderen de werkers, burgers, ouders en verzorgers zijn van de toekomst. De zorg van kinderen hangt onder andere af van het aanwezige gezondheidssysteem in een land, maar ook van de beslissingen welke ouders nemen wanneer zij zorg zoeken voor hun kind(eren). Kinderen zijn namelijk vaak niet in staat om hun eigen zorgkeuzes te maken en vormen daardoor een kwetsbare groep binnen de samenleving. Bij de keuze voor zorg speelt de indruk die ouders krijgen van de kwaliteit hiervan een grote rol. Tot op heden kan er uit de literatuur worden afgeleid dat het onduidelijk is welk belang ouders hechten aan factoren ten aanzien van een goede kwaliteit van eerstelijnsgezondheidszorg voor hun kind. Daarnaast is niet duidelijk in hoeverre schaalmethoden of de zogenoemde Best-Worst Scaling (BWS) methode het beste kan worden gebruikt om het belang van deze factoren te onderzoeken. Vandaar dat het doel van dit onderzoek tweeledig is. Zo werd enerzijds onderzocht welke factoren van belang zijn voor de perceptie van ouders voor een goede kwaliteit van eerstelijnsgezondheidszorg voor hun kind. Ook werd nagegaan welke meetmethode hierbij het meest geschikt is.

METHODE

Er werd in dit onderzoek gebruik gemaakt van een gemengde methode. Factoren werden geïdentificeerd vanuit het bestuderen van de literatuur en interviews welke mogelijk invloed konden hebben op de zorgbeslissingen van ouders wanneer zij zorg zoeken voor hun kind(eren). Aan de hand van het literatuur onderzoek en de gehouden interviews werden twee enquêtes opgesteld om te meten welke factoren in de perceptie van ouders van belang zijn voor een goede kwaliteit eerstelijnsgezondheidszorg voor hun kind. Deze enquêtes bestonden uit drie delen, namelijk 1) eerdere ervaringen, 2) belang van factoren en 3) achtergrond vragen. Het belang van twintig factoren werd binnen deze twee enquêtes gemeten aan de hand van een vijf punts-schaal en de Best-Worst Scaling (BWS) methode. Ook werd gekeken naar welke methode in de context van dit onderzoek het meest geschikt is voor het meten van het belang van factoren. In totaal hadden tussen de periode van 17 december 2016 en 1 maart 2017, 138 respondenten meegewerkt aan dit onderzoek.

RESULTATEN

Uit dit onderzoek blijkt allereerst dat wanneer er wordt gekeken naar de belangrijkheid van de twintig factoren welke werden gemeten in de enquêtes, dat ouders de factoren deskundigheid van de zorgverlener (BWS=167, gemiddelde= 3,85, SD= 0,40) en serieus worden genomen door de zorgverlener (BWS=163, gemiddelde=3,74, SD=0,44) het meest belangrijk vinden voor een goede kwaliteit van zorg voor hun kinderen. In tegenstelling tot de meest belangrijke factoren, waren er ook factoren welke Nederlandse ouders het minst belangrijk vonden, namelijk: bij een afspraak aan de beurt op het afgesproken tijdstip (BWS=-143, gemiddelde=2,92, SD=0,97), de afstand tot de praktijk van de zorgverlener (BWS=-182, gemiddelde=2,95, SD=0,98) en openingstijden van de praktijk van de zorgverlener (BWS=-202, gemiddelde=2,77, SD=0,89). Verder bleek uit de resultaten van het praktijkonderzoek dat respondenten sterk verdeeld waren over het belang van betaalbaarheid van zorg (gemiddelde= 3,17, SD=1,03). Uit de resultaten van de enquêtes met de vijf punts-schaal en Best-Worst Scaling blijkt verder dat de Best-Worst Scaling methode in principe geschikter is dan de vijf punts- schaal, aangezien deze methode zorgt voor een sterkere discriminatie. Echter bleek dat er bij de ranking van de factoren tussen de vijf punts-schaal en Best-Worst Scaling geen grote verschillen aanwezig waren.

CONCLUSIE

Uit dit onderzoek komt naar voren dat factoren gericht op de service, zoals wachttijden en openingstijden minder van belang waren in de perceptie van ouders voor een goede kwaliteit van eerstelijnsgezondheidszorg voor hun kind dan factoren gericht op de deskundigheid en de relatie met de zorgverlener. Daarnaast kwam ook naar voren dat in de context van dit onderzoek de Best-Worst Scaling methode het meest geschikt is voor het onderzoeken van het belang van factoren.

SUMMARY

BACKGROUND

The health of children is of great importance, because the children of today will become the workers, civilians, parents and caregivers of tomorrow. The healthcare of children depends, among other things, on the healthcare system in a country, but also on the decisions the parents make when they look for healthcare for their child(ren). This is because children are often incapable of making their own healthcare decisions and are therefore a vulnerable group within our society. When choosing healthcare, the impression parents have on the quality of healthcare plays a large role in this. To this day, the surrounding literature does not make it clear which relative importance parents attach to factors regarding the quality of primary healthcare for their child. It is also unclear whether the scaling methods or the so-called Best-Worst Scaling (BWS) method is best to assess the importance of these factors. This is why this study is two-fold. On one hand, factors will be searched for that are of importance to the perception of parents regarding the quality of primary healthcare for their child. On the other hand, the most suitable assessment method will be investigated.

METHOD

A mixed method study was performed. Factors were identified by studying literature and interviews that possibly influence the healthcare decisions of parents when they are looking for healthcare for their child(ren). Through literature and the conducted interviews, two surveys were devised that will measure which factors are of importance to the perception of parents regarding the primary healthcare for their child. The surveys consist of three parts, namely 1) previous experiences, 2) the importance of factors and 3) background questions. The importance of twenty factors was measured with a five-point scale in one of the surveys and the other with the Best-Worse Scaling (BWS) method. Which of these two methods is most suitable, in the context of this research, to measure the importance of factors was also investigated. A total of 138 respondents participated in this research in the period of December 17th 2016 to March 1st 2017. **RESULTS**: First of all, this research shows when looking at the importance of twenty factors that were measured with the surveys, parents find the factors: the healthcare provider is professional (BWS=167, mean= 3.85, SD= 0.40) and the healthcare provider takes child's health seriously (BWS=163, mean=3.74, SD=0.44) the most important when it comes to quality healthcare for their child. Contrary to the most important factors, there were also factors that Dutch parents deemed least important, namely: helped through the healthcare provider at the agreed upon time (BWS=-143, mean=2.92, SD=0.97), distance to the practice of the healthcare provider (BWS=-182, mean=2.95, SD=0.98) and opening hours (BWS=-202, mean=2.77, SD=0.89). The results of the practical research also showed that the opinions regarding the affordability (mean= 3.17, SD=1.03) of healthcare varies strongly among the respondents. The results of the five-point scale and Best-Worst Scaling also show that the Best-Worst Scaling method is more suitable than the five-point scale, as this method created a stronger discrimination. However, when comparing the results (ranking) of the five-point scale and the BWS method, no large differences were found.

CONCLUSION

The main finding of this research is that factors oriented on the service, like waiting times and opening hours were deemed to be less important in the perception of parents than the professionalism and relationship with the healthcare provider, when evaluating the quality of primary care for their children. In addition, the results of the five point scale and BWS also show that the BWS-method is more suitable than the five-point scale, as this method created a stronger discrimination

Key words

Health care, child health, primary health care, quality care, patients priorities, parental decisions, Likert Scale and Best-Worst Scaling.

CONTENT

LIST OF ABBREVIATIONS

Abbreviation (Dutch)	Dutch name	English name
BWS		Best-Worst Scaling
EU	Europese Unie	European Union
GP	Huisarts	General practitioner
HBO	Hoger beroepsonderwijs	Higher Vocational Education
JGZ	Jeugdgezondheidszorg	Youth healthcare
MBO	Middelbaar beroepsonderwijs	Secondary vocational education
MOCHA		Models of Child Health Appraised
NZa	Nederlandse Zorgautoriteit	Dutch Health Care Authority
RIVM	Rijksinstituut voor Volksgezondheid en Milieu	National Institute for Public Health and the Environment
SD	Standaard Deviatie	Standard Deviation
WO	Wetenschappelijk onderwijs	Scientific education

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1 INTRODUCTION

1.1 MOTIVATION

The health of children is of great importance for the future of Europe. This is because the children of today are the workers, civilians, parents and caregivers of tomorrow (MOCHA, 2015; M. J. Rigby, Köhler, Blair, & Metchler, 2003). Children have the same rights as adults when it comes to receiving proper healthcare. When receiving healthcare, children are dependent on their environment, which consists of family, school, their daily care, the healthcare system, culture and their social lives. In finding appropriate healthcare, children are dependent on the choices made by their parents. This is because children themselves are often incapable of making independent healthcare decisions. Parents are thus regarded as the first point of contact and have the authority to make healthcare decisions for their children and they are ultimately responsible for the quality of care their children receive. The decision-making process of the parents is not the only factor that plays a large role in children's healthcare. The available primary healthcare system in the country is of importance as well. The impression parents have of the quality of healthcare plays a large role in choosing the care for their children (Dam, 2012; M. Rigby, 2005; M. J. Rigby et al., 2003; van Esso et al., 2010). It is therefore also important to gain a proper insight into the factors that influence parents their perception on the quality of primary healthcare.

A project involving thirty member states of the European Union (EU), *Models of Child Health Appraised* (MOCHA), is currently studying how to optimise the primary healthcare system for children in the fields of wellness and prevention. A key part of the project involves collecting the attributes of different child healthcare models and evaluating patient preferences. This raised a need for knowledge regarding the relevant factors that play a role in the perception parents have on the quality of the primary healthcare for their child. This research focusses on finding the answer to that question.

1.2 LITERATURE GAP

Research towards the factors that influence the perception patients have on the quality of healthcare is lacking, even more so when specifically looking for factors that influence the parents' perception on the quality of the healthcare of their child. The few studies that have been conducted in this area mainly focus on the general quality of healthcare provided by general practices from patients' perspectives. For example, Sixma, Kerssens, Campen, and Peters (1998) asked respondents in the Netherlands which factors are important to patients to determine whether or not a general practitioner offers quality healthcare and how the respondents would rate their general practitioner (GP). This study shows patients find it important that general practitioners cooperate with specialists regarding medicines, that they share their medical thoughts with patients during the consult and that they treat the concerns of patients seriously. Furthermore, this study demonstrates that patients who visit the general practitioner find waiting times and delivery of medication less important.

Similarly, Grol et al. (1999) conducted an international study and asking respondents about which aspects they find important to determine the quality of general practitioner healthcare. The results of this study indicate that patients value a quick GP response during emergencies, that the GP frees up enough time to talk during the consult to listen and to explain issues and that the GP handles patients' medical information with confidentiality. It was also found that patients attach the least importance to the GP being open to alternative treatment methods, the GP being aware of the costs of diagnoses and the GP provides the patient with written information about the clinic, such as the phone number.

Groenewegen conducted a similar study in 2005, involving respondents of nine different countries (Groenewegen, Kerssens, Sixma, van der Eijk, & Boerma, 2005). This research also looked at the performance of the general practitioner, based on the experiences of the respondents. This research indicates that factors regarding respectfulness have a larger importance to patients than service aspects. For example, patients find it important to be taken seriously by their GP, that the GP provides information regarding medicines in an understandable manner and that the GP has a proper overview of the patient's problems. Furthermore, the results of this research also indicated that patients attach the least importance to whether the GP can be reached by telephone. Also, according to this research patients attach less value to the coordination with other healthcare providers and the waiting times in the waiting room. There was also evidence of a positive relation between the performance and importance of factors.

Since 2005, however, no studies have been conducted in The Netherlands aimed at studying how patients experience or evaluate the quality of healthcare they received from the GP or other primary healthcare providers. There were no studies that specifically looked at the perception of parents regarding the quality of primary healthcare of their child and the relative importance parents attach to factors.

There have been some studies that asked patients how they experience healthcare in general and which aspects they find important. In 2007, for example, the Dutch Healthcare Authority (NZa) researched which factors play a decisive role for Dutch patients when looking for a healthcare provider (NZa, 2007). This study focused more on the process of choosing a healthcare provider and less so on how patients experience the quality of the healthcare they received. This study demonstrates that Dutch patients when they are looking for a healthcare provider are generally influenced by the relationship with the healthcare provider, travel times, financial impulses, quality, waiting times and GP advise.

In 2008, minister A. Klink of the Ministry of Health, Welfare and Sport ordered a study into the current state of the Dutch primary healthcare system and patients' opinions regarding this system (Klink, 2008). The results of this study indicate that Dutch patients find it important that the primary healthcare is close to home, well-coordinated, that there is a trust-based relationship with the healthcare provider, that they can choose which doctor to visit and that they are provided with safe and quality information. This study also indicates that Dutch patients find that primary healthcare could be more serviceable and flexible, such as telephonic reachability and opening hours.

None of the above mentioned studies offer an insight into how parents experience the quality of primary healthcare for their children and which factors play an important role in this experience. Furthermore, most of these studies only used scaling methods, while this research method has also been criticised by various researchers. For instance, according to Flynn and Marley (2014), with scaling methods, respondents are allowed to regard some factors as equally important. This creates a weak discrimination, in other words, differences between factors are unable to be properly mapped. That is why there is an increasing use of another measuring method in studies that focus on prioritizing factors, namely the Best-Worst Scaling (BWS) case 1 (object case), which was developed by Louviere (Marley, Flynn, & Australia, 2012). BWS case 1 forces respondents to choose, repeatedly during numerous rounds, the factors they deem most important and least important (Gené-Badia et al., 2007; Lancsar & Louviere, 2008; Wiegers, Hopman, Kringos, & Bakker, 2011). Contrary to the scaling methods, this prevents respondents from taking the easy way out and rating every outcome equally important. The BWS method allows the researcher to create a complete ranking, which results in a strong discrimination (Flynn & Marley, 2014).

In the context of this study and based on theory, it is assumed that the BWS methodology is the superior method to properly map the importance people attach to a certain factor. This is merely an assumption that requires further research. That is why the purpose of this study is twofold. Besides studying which factors are important for the perception of parents regarding the primary healthcare for their child, there will also be a comparison between the scaling method and the BWS method to determine which of these measuring methods is best suited for this task.

1.3 PROBLEM, OBJECTIVE AND RELEVANCE

It is unclear which factors influence the perception parents have of the quality of the primary healthcare provided to their children. The purpose of this study is to gain more insight into the quality indicators of the primary healthcare for children. This study is scientifically relevant as it provides more information on the advantages and disadvantages regarding the use of the BWS method as opposed to the scaling method. This research has a social relevance as well, because it provides insight into what parents experience to be quality healthcare for their child, which could be relevant for the optimization of the Dutch healthcare system in which the needs of the patient and especially the needs of children are central.

1.4 OUTLINE

To study the problem stated above, this report first presents the results of the literary study in the theoretical framework of chapter two. Among other things, an overview is provided of possible factors that could influence the perception of parents regarding the quality of primary healthcare for their children. This chapter also discusses the research question of this study. Chapter three then describes the research setup, where it becomes clear how the research question will be answered with a mixed method approach. Afterwards, chapter four presents the results of this study. Finally, chapter five answers the research question and concludes this paper with a discussion and numerous recommendations.

2 THEORETICAL FRAMEWORK

INTRODUCTION

The theoretical framework of this study will mainly focus on 1) the primary healthcare systems within the European Union (EU), 2) the primary healthcare system of The Netherlands, 3) models that map the primary healthcare system, 4) factors that can influence the perception of parents regarding the quality of the primary healthcare for their children, 5) the conclusion with the conceptual research model and 6) the research problem.

2.1 PRIMARY HEALTHCARE SYSTEM

2.1.1 EUROPEAN UNION

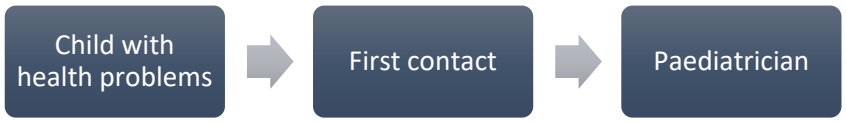
The primary healthcare is the first line of professional care, which can often be found in the neighbourhood of parents and their children. This is where parents and children can go when they need curative and preventive healthcare. Primary healthcare providers are, among other professions, general practitioners, dentists, physical therapists and the youth healthcare (Dam, 2012; Dionne S Kringos, Boerma, Bourgueil, et al., 2010; Zwakhals, 2014). A distinction can be made between preventive and curative healthcare needs. In the context of this research, prevention is defined as follows: "*prevention in the broad sense includes disease prevention, health improvement and health protection*" (Burgt, Mechelen-Gevers, & Lintel Hekkert, 2005). Curative healthcare is in the context of this study defined as: "*Medical treatment and care that cures a disease or relieves pain and promotes recovery"* (Organization, 2004)

Curative and preventive healthcare needs are organized in different manners in the independent member states of the European Union. Large differences can be observed between the countries in the areas of costs, quality, use and access to healthcare. However, most countries within the EU categorize prevention under primary healthcare. Within the EU, preventive activities are conducted by numerous types of healthcare providers, such as general practitioners, preventative care doctors, nurses or paediatricians. The organization of the curative primary healthcare can differ a lot between countries as well. Countries generally use one of the following three healthcare systems, namely 1) a paediatrician based system, 2) a general practice based system, or 3) a combined system (van Esso et al., 2010).

In a paediatrician based system, the paediatrician is responsible for offering primary healthcare to children with health complaints (see Figure 1). A paediatrician is a specialized doctor that offers medical care to children (paediatric care) (Cheng, 2004; van Esso et al., 2010).

Figure 1

Paediatrician based system



Furthermore, in a general practice based system, the general practitioner delivers first line care to children (see Figure 2). The general practitioner is a medical professional, and an easy accessible contact available for care questions, usually located within the neighbourhood (Klink, 2008; Dionne S Kringos, Boerma, Bourgueil, et al., 2010). General practitioners are functioning as gatekeepers to access specialized care. This means that patients only visit a paediatrician when this is deemed necessary by their general practitioner. Next to providing referrals to patients, the general practitioner needs to support patients in this process. Within this type of system, paediatricians are seen as specialists who deliver more complex care, while the general practitioner is perceived as being able to handle daily healthcare (Dionne Sofia Kringos, Boerma, Hutchinson, & Saltman, 2015).

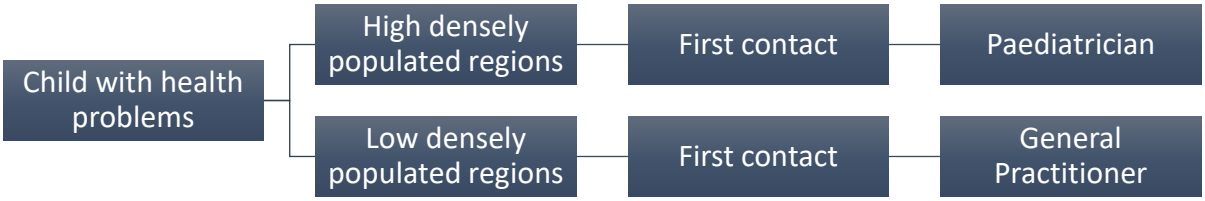
Figure 2

General practitioner system

Finally, in a combined system, primary child healthcare will be delivered as a mixture of systems (see Figure 3). This combined system consists of a general practice based system and a paediatrician based system. In such a system, whether the first line healthcare provider will be a paediatrician or a general practitioner depends on the living conditions of the child. For instance, children who are living in rural regions will generally be treated by general practitioners, while children living in densely populated regions are more likely to be treated by paediatricians (van Esso et al., 2010).

Figure 3

Combined system



2.1.2 THE NETHERLANDS

The Netherlands works with a general practice based system. This general practice based system is responsible for the first line care of more than 3,6 million children (van Esso et al., 2010; Van Weel, Schers, & Timmermans, 2012). Within the Netherlands parents visit general practitioners when their child is ill. Due to this general practitioner system, the accessibility to visit is higher. Patients only have access to specialized care, after receiving a referral from a general practitioner (Chapman, Zechel, Carter, & Abbott, 2004; Schellevis, Westert, & De Bakker, 2005; Van Weel et al., 2012).

In addition to the general practitioner, the Dutch healthcare system is characterized by a specialised organization for preventive child healthcare, the 'jeugdgezondheidszorg' (JGZ). Within the Netherlands, preventive child healthcare is sometimes described as the "nuldelijnszorg" (zero line care), which can be described as: "*when care is offered without a request"* (Mackenbach, 2008).

The JGZ has a widespread reach, especially in young children and parents. In the Netherlands, JGZ is accessible for children under 18 years (Dam, 2012; Hamberg-van Reenen & Meijer, 2014). The main function of JGZ is protecting the Dutch children and provide parents and children with easy access to preventive healthcare services. The JGZ is concentrating on monitoring and giving information and advice on social, psychological, cognitive and corporal developments of children. Parents and children are provided with information on healthy behaviours and are referred to the general practitioner if necessary. Dutch parents themselves are responsible for the participation of their child in preventive healthcare (NJC, 2016; Van Weel et al., 2012). The Dutch primary child healthcare system is described as efficient, strong and actively monitored, with respect to quality (Pelone, Kringos, Spreeuwenberg, De Belvis, & Groenewegen, 2013; Van Weel et al., 2012; Wiegers et al., 2011).

2.2 MODELS FOR MAPPING THE PRIMARY HEALTHCARE SYSTEM

In literature, numerous models can be found which can be used to describe the quality of a healthcare system of a country. Many of these models can also be applied to primary healthcare for children. These models include the model of Bronfenbrenner (Krishnan, 2010), the Health Policy Triangle (Buse, Mays, & Walt, 2012) and the Donabedian framework (Dionne S Kringos, Boerma, Bourgueil, et al., 2010). Each of these models serves a different purpose (see Table 1). The Bronfenbrenner model primarily looks at environmental factors which may influence the health development of children. The Bronfenbrenner model consists of multiple levels, namely: the microsystem, mesosystem, exosystem and microsystem. Factors on all these levels can exert an influence on the development of children, either indirectly or directly (Krishnan, 2010). The Health Policy Triangle, on the other hand, is a model which is aimed at describing the healthcare policy of a certain country. This model describes which factors can influence a healthcare policy. This framework mainly focusses on the content, processes, context and actors (participants) of a healthcare policy (Buse et al., 2012). The Donabedian, furthermore, offers a framework primarily to evaluate the quality of a healthcare system, and hence is especially relevant in the context of this research. This framework describes the quality of a healthcare system based on the structure, process and results of a healthcare system (Dionne S Kringos, Boerma, Bourgueil, et al., 2010).

Table 1

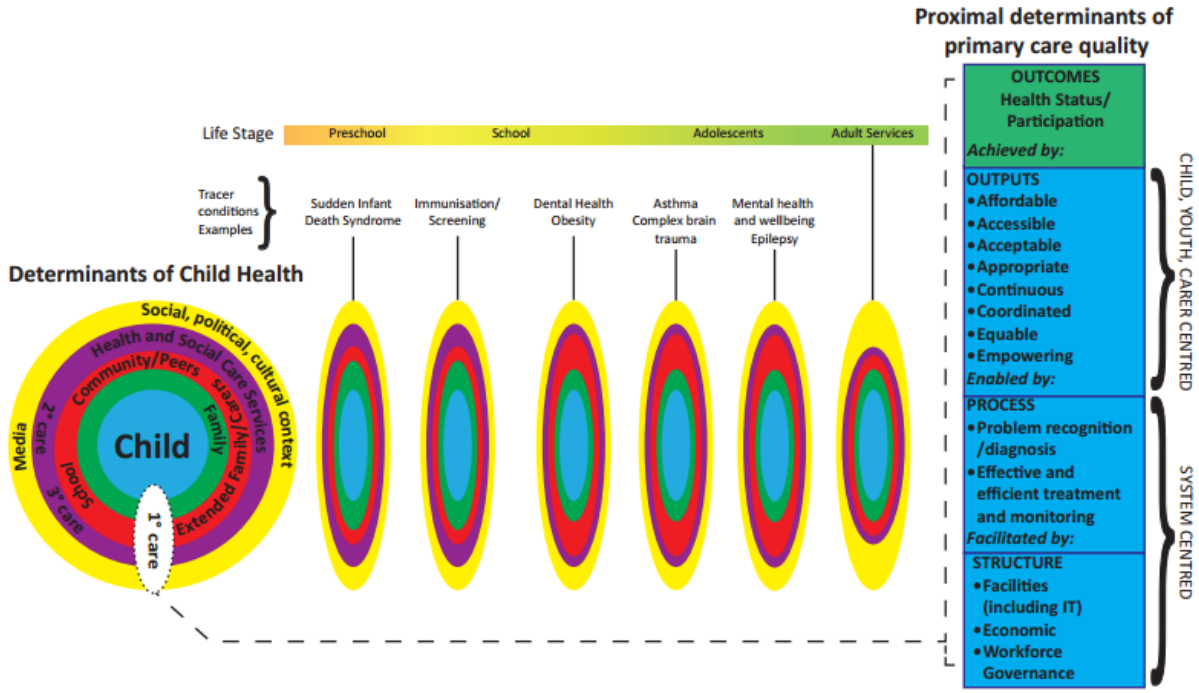
Overview Bronfenbrenner, the Health Policy Triangle and Donabedian model

Model	Purpose	Feature
Bronfenbrenner	Influence of environmental factors on health development of children	● *Microsystem* (family) ● *Mesosystem* (school and family relationship) ● *Exosystem* (school policy) ● *Macrosystem* (social, political and cultural factors)
The Health Policy Triangle	Analyzing the actors of healthcare policies	● *Actors* (individuals, organizations or groups) ● *Content (*content policy) ● *Process* (how policies are developed, communicated, evaluated and implemented) ● *Context* (situational, structural, cultural and international factors)
Donabedian	Investigating healthcare services and evaluating the quality of healthcare	● *Structure (*governance, economic conditions and workforce) ● *Process* (access, comprehensiveness, continuity and coordination) ● *Outcome* (quality, efficiency and equity)

In the context of the MOCHA-project this research is conducted for, it was decided to combine the Bronfenbrenner model with the Donabedian model into the so coined 'MOCHA-model' (see Figure 4). This combination was chosen, as it is assumed that the determinants as described by the Bronfenbrenner model will lead to a certain quality of the healthcare system, which in turn can be mapped by the Donabedian model. Using this combination, the MOCHA-model describes the determinants of a child's health, which is dependent on the age of the child and the different phases a child is in.

Figure 4

MOCHA working model (life course determinants of child health and primary care quality)



2.3 FACTORS

INTRODUCTION

This study focuses on factors that influence the perception parents have regarding the quality of primary healthcare for their children. That is why it is important to research which factors actually influence this. This paragraph describes the factors that were found through a literary study one by one.

2.3.1 TRANSPARENCY

The first factor that has an influence on the perception of quality of primary healthcare is, according to literature, the degree of transparency of healthcare providers. Transparency in this context refers to the degree to which a healthcare service or provider is open about their quality, cost structure, services and work method (Brabers & van Reitsma-Rooijen, 2011; Hanson, Yip, & Hsiao, 2004; Levesque, Harris, & Russell, 2013; NZa, 2007; Schäfer et al., 2010; van den Berg, Heijink, Zwakhals, Verkleij, & Westert, 2011). Numerous studies have shown that healthcare transparency can influence the perception patients have on the general quality of healthcare (Hanson et al., 2004; Klink, 2008; NZa, 2007; Schäfer et al., 2010; Zorgbalans, 2014). A study by Levesque et al. (2013) shows that healthcare transparency plays a key role when patients realise that they require healthcare and start researching the possibilities for available healthcare. Furthermore, a report from NZa (2007) shows that patients often look for information regarding the reputation and quality of a healthcare institution and its specialists.

However, a study by Wiegers et al. (2011) shows that transparency regarding healthcare providers and their performances is lacking. The problem could lie with the small scale of the Dutch primary healthcare system. The importance of transparency can be explained by the possibility that patients often engage in self-management and because they are involved in their medical decision-making process. This increases the need for transparent healthcare information (Levesque et al., 2013; Schäfer et al., 2010).

2.3.2 AVAILABILITY

Another factor that plays a role in the perception of the quality of care, according to literature, is the degree to which a healthcare provider is available to the patient. Availability of healthcare in the context of this research means whether or not the healthcare provider, from the parents' perspective, is able to provide healthcare within a reasonable timeframe and at a time that is convenient to the parents. Factors that play a role in this are waiting times, consultation times and opening times (Groenewegen et al., 2005; Grol et al., 1999; Levesque et al., 2013; NZa, 2007; RIVM, 2010; Sixma et al., 1998). The fact that availability could play a role is evident from studies that show that availability is generally an important factor regarding the quality of healthcare. One such study was conducted by Hanson et al. (2004). This research shows that patients who experience long waiting times (for an appointment) are more likely to switch healthcare provider (Hanson et al., 2004). From the report by NZa (2007) it becomes clear that patients do not appreciate waiting too long when they are trying to receive healthcare, which makes healthcare providers less appealing. However, studies by Grol et al. (1999); Sixma et al. (1998) and Groenewegen et al. (2005) shows that the waiting time in a physician's waiting room does not have a high priority among patients. The studies by Sixma et al. (1998) and Groenewegen et al. (2005), for example, show that this factor (waiting time <15 minutes) has the lowest priority when patients assess the quality of care provided by general practitioners. Similar results were found by the study conducted by Grol et al. (1999), which shows that the time patients have to wait in the waiting room when visiting a physician does not have a high priority. This study by Grol et al. (1999) also shows that the length of an appointment with the physician is categorised under the availability of care. It points out the fact that in general, patients find it very important for a physician to take his or her time with them, to listen and to explain aspects they find difficult to understand. Also, Dutch patients generally appear to attach a lot of importance to the ability to make short-term appointments with the general practitioner (Grol et al., 1999). Furthermore, the availability of healthcare is regarded as an important aspect of healthcare by the Donabedian framework as well (see paragraph 2.2) (Dionne S Kringos, Boerma, Bourgueil, et al., 2010). The numerous studies with varying results show that this factor is very important for the Donabedian framework, but availability as well. It is therefore interesting to research whether or not the availability of healthcare can influence the perception parents have regarding the quality of primary healthcare for their children.

2.3.3 ACCESSIBLITY

Another factor that possibly influences the perception of the quality of healthcare is the degree to which a healthcare provider is accessible, or reachable, to a patient. A distinction can be made between accessibility by phone and geographical accessibility. Telephone accessibility, in the context of this research, is the availability of the healthcare provider by phone (Groenewegen et al., 2005). Geographical accessibility includes the distance to a location, as well as the travel time and travel distance (Gené-Badia et al., 2007; Dionne Sofia Kringos et al., 2015; Dionne S Kringos, Boerma, Hutchinson, van der Zee, & Groenewegen, 2010; Levesque et al., 2013; NZa, 2007; RIVM, 2010; Schäfer et al., 2010; van den Berg et al., 2011). These two factors are further elaborated upon below.

TELEPHONE AVAILABILITY

Discussions are found in literature regarding the degree to which telephone availability of a healthcare provider influences the perception of the quality of healthcare. A study by Wiegers et al. (2011) shows that patients are often unsatisfied with the telephone availability of general practitioners. The increasing demand for healthcare from civilians could be an explanation for the lacking availability by telephone of general practitioners (Wiegers et al., 2011). The study by Sixma et al. (1998) and Groenewegen et al. (2005) also shows that Dutch patients attach great importance to the telephone availability of primary healthcare providers. However, this study also reveals that internationally, availability by phone is not considered to be important. Furthermore, the study by Grol et al. (1999) shows that Dutch patients do not find this factor very important when there is no urgency involved in the healthcare request.

GEOGRAPHIC ACCESSIBILITY

Numerous sources indicate that the geographic accessibility of a healthcare provider can play a major role in the patient's perception of the quality of healthcare. The report from the NZa (2007), for example, shows that the travel distance to a healthcare provider influences the choice of a patient who is looking for a healthcare provider. NZa (2007), Klink (2008) and van den Berg et al. (2011) all note that primary healthcare in The Netherlands is properly geographically accessible and can often be reached in a matter of minutes (by car). The distance patients are willing to travel to a healthcare provider, however, depends on the nature and level of urgency of the condition or illness of the patient (NZa, 2007). The study by Levesque et al. (2013) shows that the geographical accessibility influences the accessibility to healthcare and eventually the use of healthcare. Accessibility is also seen as an important factor of healthcare by the Donabedian framework (see paragraph 2.2) (Dionne S Kringos, Boerma, Bourgueil, et al., 2010).

2.3.4 AFFORDABILITY

Literature indicates furthermore that healthcare costs can also influence the patient's perception of the quality of healthcare, although this is a hotly debated topic. Healthcare costs in the context of this research include the costs attached to the use of a healthcare service, such as direct and indirect healthcare costs, the costs of healthcare insurance and a patient's deductible (amount of money that must be paid out of pocket by the patient, like the own risk for the basic healthcare insurance in the Netherlands).

The study by NZa (2007) shows that patients do consider the tariffs of a healthcare provider when they are looking for healthcare of which the costs are still covered by their deductible. This study also shows that patients in fictional situations will strongly react to financial triggers, like the deductible. On the other hand, numerous studies show that Dutch patients do not find the costs of healthcare very important. Groenewegen et al. (2005) shows, for example, that Dutch patients are not of the opinion that all medicine should be covered by the insurance companies. The study by Grol et al. (1999) indicated that patients are not actively aware of the costs of a treatment and that they also do not mind if their physician is not focussed on that. It should be noted, however, that this could be caused by the fact that most healthcare costs in The Netherlands are paid for by insurance companies and not by individual patients. The costs were also included by the Donabedian model (see paragraph 2.2) (Dionne S Kringos, Boerma, Bourgueil, et al., 2010). These insights say little about the degree to which healthcare costs play a role in the perception parents have on the quality of primary healthcare for their child when the healthcare costs are not to be paid for by the patient's deductible and are instead covered by insurance.

2.3.5 COORDINATION BETWEEN HEALTHCARE PROVIDERS

The literary study also shows that the degree to which a healthcare providers coordinates its actions with other healthcare providers could play a role in the parents' perception of the quality of primary healthcare for their child. Coordination in the context of this research involves the mutual cooperation between healthcare services, sectors and healthcare providers.

A report by the Zorgbalans (2014) shows that adult patients experience a lack of proper coordination between healthcare providers as a problem. Also, the study by Groenewegen et al. (2005) indicates that Dutch patients highly value a good cooperation within the healthcare system. However, this study, in which international differences between countries are examined, also reveals that the coordination is not considered to be very important by respondents in other countries. The study by Sixma et al. (1998) found that Dutch patients find a good coordination of healthcare reasonably important. The coordination of healthcare is also addressed by the Donabedian model (see paragraph 2.2), which can be used by regulators to measure the quality of a healthcare system (Dionne S Kringos, Boerma, Bourgueil, et al., 2010).

2.3.6 RELATIONSHIP WITH THE HEALTHCARE PROVIDER

Literature show furthermore that the relationship patients have with their healthcare provider could influence the perception patients have on the general quality of healthcare. In the context of this research, the relationship with the healthcare provider includes the relationship parents and their child have with their child's healthcare provider. The report from NZa (2007) that the expectation for a good relationship to develop with the healthcare provider plays an important role for patients when choosing healthcare providers. The study also shows that patients find it important that healthcare providers adhere to agreements that were made, take their time for their patients, explain situations in a way patients can understand, take the patient seriously, involve patients in decisions regarding their treatment and that they are friendly and helpful (Groenewegen et al., 2005; Grol et al., 1999; Hanson et al., 2004; Dionne Sofia Kringos et al., 2015; Levesque et al., 2013; RIVM, 2010; Sixma et al., 1998; Zorgbalans, 2014). The study from Grol et al. (1999) indicates that Dutch patients find it important that they are helped by the same physician for every visit to his or her office. The relationship between a patient and a healthcare provider is described as a property of continuity within healthcare in the Donabedian model (see paragraph 2.2) (Dionne S Kringos, Boerma, Bourgueil, et al., 2010).

2.3.7 QUALITIES OF THE HEALTHCARE PROVIDER

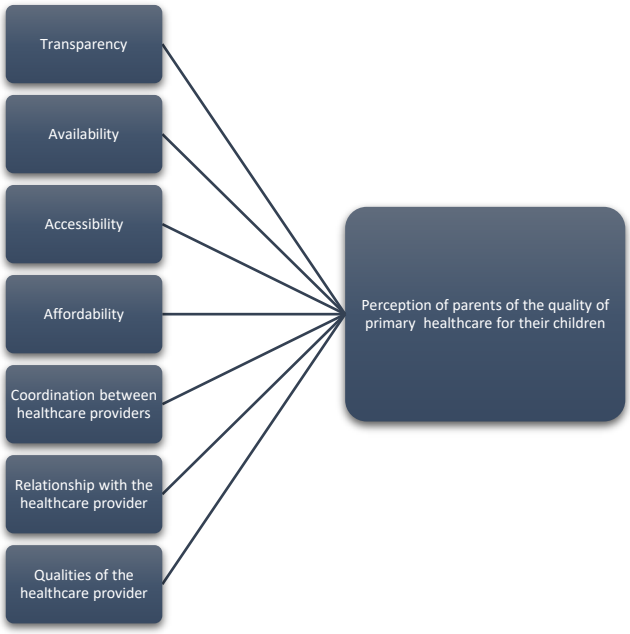
Finally, numerous sources also indicated that the qualities of a healthcare provider can influence the perception of parents regarding the quality of primary healthcare for their child. The qualities of a healthcare provider include the expertise, knowledge, reputation and experience of the healthcare provider (Klink, 2008; NZa, 2007; van den Berg et al., 2011). Research conducted by Hanson et al. (2004) shows that patients find this very important. A healthcare provider should also take care to provide the correct treatment and to make the correct diagnoses. Furthermore, the study by Grol et al. (1999) shows that patient find it important that their physician regularly follows courses regarding new medical developments. The quality of care is also an aspect of the Donabedian model (see paragraph 2.2) (Dionne S Kringos, Boerma, Bourgueil, et al., 2010).

2.4 CONCLUSION

The literature study, first of all, showed that there are numerous models that can map the quality of primary healthcare systems. However, these models are focussed on evaluating the quality of healthcare systems in general, they are not focussed on the patients' wishes. Based on the literature study, there are seven factors that can influence parents' perception of the quality of primary healthcare for their children, namely: 1) transparency, 2) availability, 3) accessibility, 4) affordability 5) coordination between healthcare providers, 6) the relationship with the healthcare provider and 7) the qualities of the healthcare provider (see Figure 5). The empiric section of this study will check the degree to which these factors influence parent's perception of the quality of primary healthcare for their child.

Figure 5

Conceptual model



2.5 RESEARCH QUESTION

Based on the results of the literature study which resulted in the conceptual model described in paragraph 2.4, the following research question and sub questions were formulated:

To what degree do the factors that influence the quality of healthcare play a role in the perception of parents regarding the quality of primary healthcare for their children?

To answer this question, the following three sub questions will be investigated: 1) which factors influence the perception of parents regarding the quality of primary healthcare for their children, 2) what importance do parents attach to these factors and 3) which method is best suited to properly map the importance parents attach to a certain factor.

3 METHOD

INTRODUCTION

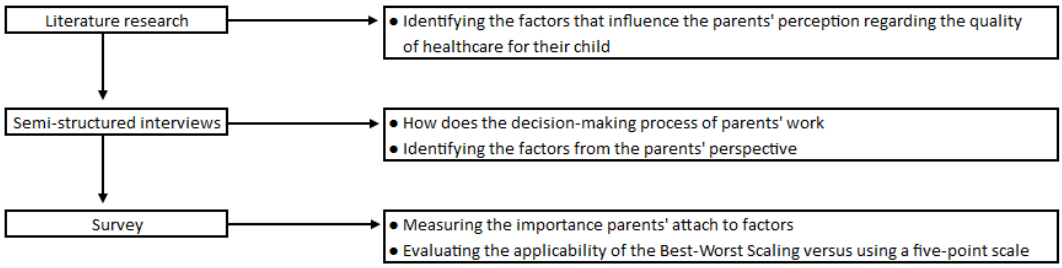
This section describes the method that was used in this research. The design of the study, research population, respondent selection, data collection and data analysis are discussed.

3.1 RESEARCH DESIGN

First of all, the literature was studied. This identified factors that have an influence on the perception parents have of the quality of primary healthcare for their children. Before the importance of the factors that have an influence on the parents' perception regarding the quality of healthcare for their child could be quantified, it first needed to be clear what these factors actually meant in the context of the parents. This mainly required qualitative research. That is why this study employs a so-called mixed method (see Figure 6). First, semi-structured interviews are conducted to identify the factors from the perspective of parents. Semi-structured interviews are a relevant way of collecting context rich information in a structured manner. This information was then used to develop a survey to quantitatively determine the importance parents attach to the factors (Saunders, Lewis, Thornhill, Booij, & Verckens, 2011; Verschuren & Doorewaard, 2005).

Figure 6

Research design



3.2 RESEARCH POPULATION AND SAMPLE POPULATION

3.2.1 QUALITATIVE RESEARCH

First, this research collected qualitative data by conducting semi-structured interviews. This investigated how the decision-making process of parents works and which factors play larger roles for parents when they look for quality primary healthcare for their child(ren). These semi-structured interviews were accessible to both male and female respondents with at least one child aged 18 or under. This respondent group was selected due to the fact that children aged 18 and under are covered by the insurance of their parents. This means that the parents are more likely to be aware of the healthcare given to their children, because they will be notified (with the medical bill, for example) whenever their children use the healthcare system. This study only focused on Dutch parents, which is why the interview was only available in Dutch.

The interviews were conducted in the period from October 17th 2016 until October 23rd 2016. In this period, nine parents were interviewed. The study also aimed to diversity the group of respondents as much as possible. This was accomplished by interviewing respondents with different levels of education, ages of the child(ren) and current state of health of the child(ren). The respondents were approached in person through personal networks (family, friends and acquaintances).

3.2.2 QUANTITATIVE RESEARCH

When the interviews were conducted and their results had been processed, two different surveys were developed, namely 1) a five-point scale and 2) the Best-Worst Scaling (BWS) case 1, to map the degree of importance parents attach to the factors. The same inclusion and exclusion criteria that were used for the semi-structured interviews are used again. A convenience sample was used to gather respondents. Respondents were approached in person at a convenient location to fill out the survey, such as a sports club, a theatre, day care or music school, elementary school, or through a personal network (Saunders et al., 2011). The response rate benefitted from this personal approach and it allowed the respondents to be informed of the importance of this research.

The data received through the survey was collected between December 17th 2016 and March 1st 2017. A total of 142 respondents filled out the survey on paper. Four of these surveys were excluded from the research, as these did not comply with the inclusion criteria to take part in this research. Three respondents either did not correctly answer the questions or did not fill out the survey completely. There was one respondent who systematically entered the same option (part 1 and 2) with the five-point scale, which raised the suspicion that this respondent did not take the survey seriously. There were eight respondents who systematically entered the same answer in either part 1 or part 2 of the survey, but since variations were found in the other answers, it was assumed that these respondents did take the survey seriously, which is why their data was included in this research.

3.3 DATA COLLECTION

3.3.1 QUALITATIVE DATA

3.3.1.1 INTERVIEWS

After the literature study was complete that identified the possible factors that influence the parents' perception regarding the quality of primary healthcare for their children, the interviews were conducted. These interviews were conducted to gain more insight into the way parents make decisions when they look for quality healthcare for their child(ren) and which factors play an important role in this (see Appendix 1). The ultimate purpose of these interviews was to compare the factors that were found from the interviews with the factors that were found in literature and testing them based on a survey. The interviews were, along with the results of the literature study, used in the development of the surveys.

3.3.1.2. INTERVIEW STRUCTURE

The interviews were conducted face-to-face, with the purpose of gathering as much information as possible and leading the respondents on as little as possible. The interview was aimed at certain topics that needed to be addressed, but they were not explicitly asked for, so this interview was described as a semi-structured interview. The interview consisted of four parts. First, background information was gathered, such as the amount of children and their age. Then questions were asked regarding previous experiences of parents with the use of primary healthcare for their child and how this care program played out. The third part determined how the parents defined the factors that were described in the theoretical framework (chapter 2, paragraph 2.3) and whether they influenced their choices. In the final part of the interview, more background information was gathered, such as gender, age, level of education and employment status to gain more information about the interviewee.

3.3.2 QUANTITATIVE DATA

3.3.2.1 SURVEY

Surveys were used to determine which factors were important to the parents' perception regarding the quality of primary healthcare for their children. Two separate surveys were used. This project serves as a pilot for further research within the MOCHA project, so it was decided to measure the importance of twenty factors (see Table 2) in two different manners. Both of these surveys consisted of three parts: previous experiences (part 1), importance of factors (part 2) and background questions (part 3). Part 1 and 3 were the same for both surveys, only part 2 was different. In one survey, the importance of factors was measured using a five-point scale (very important, important, neutral, unimportant, very unimportant) and the other survey measured the importance of factors with a Best-Worst Scaling method (BWS). By applying the two different surveys for measuring the importance, it was possible to look at the differences in the results of the BWS and five-point scale. The purpose of the surveys was to gather information regarding previous experiences of respondents and to measure the importance of the factors identified by both the literature study and the interviews. The survey was only available on paper, as the respondents were approached in person.

Table 2

Factors influencing the quality of care in the perception of parents

Nr.	Factor	Description
1	Affordable	Healthcare for my child is affordable [It is feasible for me to pay the insurance fees and the possible statutory personal contribution
2	Reachability by phone	My child's healthcare provider is easily reachable by phone
3	Short term appointment	When I call for an appointment, I can make an appointment for my child within the near future
4	Helped on time	When we have an appointment, my child and me will be helped at the agreed upon time
5	Opening hours	My child's healthcare provider has extended opening hours
6	Distance	My child's healthcare provider is easily accessible [The practice of my child's healthcare provider is reasonably close to my house and it is easy for me to travel the distance]
7	Professionalism	My child's healthcare provider is professional
8	Experience	My child's healthcare provider has lots of experience
9	Reputation	My child's healthcare provider has a good reputation
10	Relation	I have a good relationship with my child's healthcare provider
11	Listening	My child's healthcare provider listens to me
12	Being taken seriously	My child's healthcare provider takes my child's health seriously
13	Friendly	The healthcare providers involved with my child's care are friendly
14	Knows the child	My child's healthcare provider knows who my child is
15	Acceptable	My child's healthcare is acceptable [The healthcare for my child is tailored to the needs and wishes of my child]
16	Complete	The healthcare for my child is continuous [The healthcare for my child is complete: there are no areas where my child's call for health care will go unanswered]
17	Coordinated	The healthcare for my child is properly coordinated [My child's healthcare providers are aware of each other's involvement, they properly work together and align their plans of action]
18	Righteous	The healthcare for my child is righteous [My child will receive the healthcare he/she is entitled to, comparable to the healthcare received by other children]
19	Decision involvement	My child's healthcare provider involves me and my child in the medical decision-making process for my child
20	Open and honest	My child's healthcare providers are open and honest about the quality, costs and services

3.3.2.2 SURVEY STRUCTURE

As explained in paragraph 3.3.2.1, two different surveys were developed in this project to determine the factors' influence on the perception of parents regarding the quality of primary healthcare for their children. Survey 1 (with the five-point scale) consisted of 50 questions (see Appendix 2) and survey 2 (Best-Worst Scaling) consisted of 44 questions (see Appendix 3).

PREVIOUS EXPERIENCES (PART 1)

The first part of the surveys determined which healthcare provider (general practitioner, consultation bureau, school doctor, physiotherapist or dentist) was last visited by the respondents and their children. Then the respondents were provided with twenty statements (see Table 2), which could be answered on a five-point scale (strongly agree, agree, neutral, disagree, strongly disagree). These statements described possible experiences with regard to the previous experiences of respondents when visiting primary healthcare providers with their child. Measuring the previous experience of parents in this manner allowed for a complete overview of the previous experiences respondents had with the most recent visit to a primary healthcare provider with their child.

IMPORTANCE OF FACTORS FIVE-POINT SCALE (PART 2)

The second part of the survey included twenty more statements, again with a five-point scale (very important, important, neutral, unimportant, very unimportant). However, this section asked for the importance of factors.

IMPORTANCE OF FACTORS BEST-WORST SCALING (PART 2)

The importance of factors was also measured with a BWS case 1 method. The respondents were required to select the best (most important) and worst (least important) item from a collection of items. The importance of factors were once again measured with the twenty factors described in Table 2. When developing the BWS case 1 survey, twenty factors were selected from the interviews and literature. Not all twenty factors could be placed inside a "block" (question) in the survey. This is why, when creating scenarios for the survey, a Balanced Incomplete Block Design (BIBD) scheme was used, see Table 3. Every question needed to contain the same amount of items and every item had to make the same amount of appearances in the survey. This survey included twenty factors, fifteen scenarios (questions) and there were eight items (factors) per "block". Every factor made an appearance six times in these fifteen scenarios.

Table 3

Balanced Incomplete Block Design (BIBD) schema

Block	1ste item	2de item	3de item	4de item	5de item	6de item	7de item	8ste item
1	4	14	7	17	8	18	9	19
2	3	13	6	16	8	18	10	20
3	2	12	5	15	9	19	10	20
4	1	11	8	18	9	19	10	20
5	4	14	5	15	6	16	10	20
6	3	13	5	15	7	17	9	19
7	2	12	6	16	7	17	8	18
8	1	11	5	15	6	16	7	17
9	2	12	3	13	7	17	10	20
10	2	12	4	14	6	16	9	19
11	3	13	4	14	5	15	8	18
12	1	11	2	12	3	13	4	14
13	1	11	4	14	7	17	10	20
14	1	11	3	13	6	16	9	19
15	1	11	2	12	5	15	8	18

BACKGROUND CHARACTERISTICS (PART 3)

The third part of the survey asked eight questions regarding the personal characteristics of the respondents. Questions included: 1) the gender (male or female), 2) age (open question), 3) level of education (high school or lower, MBO, HBO, or WO), 4) employment status (unemployed, part time, full time), 5) age of the children (open question), 6) health of the children (good, average, bad), 7) the amount of times the child was in contact with a primary healthcare provider in the last year (0 times, 1 to 2 times, 3 to 4 times, 5 to 6 times, or more than 6 times) and 8) the province of residence of the respondent (all the twelve provinces in the Netherlands were provided as an option). The three questions regarding age, number and health of children, only children aged up to and including 18 were included in the study. The background data of the respondents was included to gain insight in the general research population.

3.3.3 PRE-TEST

Before the survey was filled out by the respondents, a pilot was held among a small group of five respondents. The respondents filled out both surveys. The purpose of the pre-test was to determine whether or not the questions asked were clear enough and easy enough to understand, which could prevent misunderstandings and mistakes. The use of a small pilot also allowed the assessment of the questions regarding importance, usability and relevancy.

3.3.4 RESULTS OF THE PRE-TEST

The surveys were generally well received by the participants. It took around circa seven minutes to fill out the five-point scale survey and it took around circa fifteen minutes to fill out the BWS survey. The respondents regarded the questions as easy to understand, well-formulated and clear, with a couple of exceptions. The areas of improvement mainly involved the choice of words and the explanation of certain concepts. A question also rose about what was considered a part time job and a full time job. Question 3d was pointed out as a bit unclear. These points were all adapted accordingly after the pre-research. The respondents thought the statements were good and easy to read through, especially thanks to the underlined concepts. Finally, the respondents stated that the survey that employed the BWS method was very time consuming.

3.4 DATA ANALYSIS

3.4.1 QUALITATIVE RESEARCH

3.4.1.1 INTERVIEWS

Interviews were recorded with a smartphone. The interviewees were asked for their consent before the recording started. The interviews were literally transcribed and processed in Word 2013. The transcribed interviews were then loaded into a software program that allows for qualitative analyses. When coding the interviews, the software program MAXQDA Analytics Pro 12. The interviews were then deductively and thematically coded, using the main found factors in the literature. After this the data was analysed using an inductive method to identify various sub-codes (Saunders et al., 2011).

3.4.2 QUANTITATIVE RESEARCH

3.4.2.1 SURVEYS

The data was collected based on two different surveys. The surveys were filled out on paper and their results were entered manually. The data was then analyzed with the software programs IBM SPSS Statistics 22.0 and Microsoft Excel 2013.

BACKGROUND CHARACTERISTICS

Descriptive statistics were used when describing the gathered background data of the respondents. Frequency distributions were used for the gender, level of education, employment status, number of visits to primary healthcare providers, most recent visit with a healthcare provider and the province of residence. Averages and standard deviations (SD) were used for the amount of children and the age of both respondents and children. By using frequencies, averages and SDs, a clear overview of the research population was given.

PREVIOUS EXPERIENCES

First of all, a frequency table was used to check for typing errors that may have occurred when processing the surveys. Frequencies, averages and SDs were used to provide a clear image of previous experiences of parents and their children with primary healthcare within the research population. Also, previous experiences and the importance of factors were plotted in a figure to allow for the assessment of distributions and possible outliers.

IMPORTANCE OF FACTORS

The importance of the factors was measured with two different surveys, namely a five-point scale and the Best-Worst Scaling method. The surveys were compared based on difference in the ranking of the factors and the difference in the time it took to fill out both surveys during the pre-test.

FIVE-POINT SCALE

Similar to the previous experiences, a frequency table was used to check for typing errors when processing the surveys. Frequencies, averages and SDs were used to create a clear picture of which factors were considered to be (un)important to parents. This allowed for the assessment of the factors that are most and least important to parents when they are looking for primary healthcare for their child(ren). Furthermore, the range of the scale is between 0 and 4, with a 0 assigned to the 'very unimportant' answering option and a 4 assigned to the 'very important' answering option.

BEST AND WORST SCORES

A sum analysis was conducted first, regarding the amount of times the respondents checked the most or least important options for factors. This was followed by summing up all the factors that were checked as "most important" and all the factors that were checked as "least important". Then the level of importance was determined. For this, the amount of times a factor was considered to be least important (worst) was subtracted from the amount of times that same factor was considered to as most important (best) in every choice set. The level of importance of every factor depended on the amount of respondents (n=72) and the frequency of appearance of a factor in the choice sets (6 times) (Adamsen, Rundle-Thiele, & Whitty, 2013). The higher the score, the more often a factor was selected as most important. Then the standard B-W scores were determined. This was accomplished by dividing the B-W score with the amount of respondents and the frequency of appearance of a profile in the design of a choice set (6 times) [48]. This standard B-W score could vary between +1 and -1. When the standard B-W score was positive, it meant that a factor was more often selected as "most important". A negative standard B-W score meant that a factor was more often selected as "least important".

The results were normalised as well. This was done by multiplying the frequency of appearance of a factor within a survey (6 times) with the amount of respondents (n=72) who filled out the survey. Every factor made a total of 432 appearances. For every factor, the amount of most important selections and least important selections were divided by 432, which allowed for the calculation of how often a factor was considered to be most or least important in regard to the amount of times the factor was asked about. The standardised best counts and standardised worst counts were plotted against each other in a figure, which allowed for an evaluation of the distribution of the factors.

4 RESULTS

INTRODUCTION

In this chapter, first the results of the qualitative research are described, such as demographic characteristics of the respondents and the factors that were found. After the qualitative part, the results of the quantitative part of this research are described.

4.1 QUALITATIVE RESEARCH

INTRODUCTION

This paragraph describes the results of the semi-structured interviews. The first aspects discussed in paragraph 4.1.1 are the demographic characteristics of the interviewed respondents. Paragraph 4.1.2 describes how the seven factors (see Figure 5) are viewed by the respondents. Based on these results, a survey was developed for the quantitative research.

4.1.1 DEMOGRAPHIC CHARACTERISTICS RESPONDENTS QUALITATIVE RESEARCH

The research group consisted of six females (respondents 1, 3, 4, 6, 7 and 8) and three males (respondents 2, 5 and 9). The majority of the research group had a vocational education. Five of the respondents had a secondary vocational education diploma (MBO) (respondents 2, 3, 4, 8 and 9) and one respondent had a preparatory vocational education diploma (VMBO) without further education (respondent 6). The three other respondents had a higher vocational education diploma (HBO) (respondents 1, 5 and 7). A majority of the respondents was older than 40 years (respondents 3, 4, 5, 6, 7, 8 and 9) and the other two respondents were relatively young parents aged 23 (respondent 2) and 25 (respondent 1). Of the nine respondents, three had a full time job (respondents 2, 4 and 9), five were working part time (respondents 3, 5, 6, 7, and 8) and one was unemployed (respondent 1). The number of children varied. The majority of the respondents had two (respondents 4, 8 and 9) or three (respondents 5, 6 and 7) children. Two respondents had one child (respondents 1 and 2) and one respondent had four children (respondent 3). The majority of the children was older than 11 years (respondents 3, 4, 5, 6, 7, 8 and 9) and the age of the child of the other two respondents was 1,5 years (respondent 1 and 2).

4.1.2 MOST IMPORTANT RESULTS

ACCESSIBILITY

The semi-structured interviews first of all indicated that the accessibility, which is also a factor in the MOCHA-model is an important factor for the perception of parents regarding the quality of primary healthcare for their child. This was indicated by the fact that all nine respondents said that they find the accessibility of healthcare very important. The possible importance of telephonic reachability was indicated by the fact that this was considered to be important by eight of the respondents (all respondents except for respondent 7). Respondent 4, for example, stated that she considered contact by phone important. A quote by respondent 2 is also illustrative of this finding: "*if hospital A picks up the phone faster than hospital B, I would call hospital A first".*

The geographic accessibility was also regarded as an important factor for the perception of the interviewed parents regarding the quality of healthcare, which is indicated by the fact that five of the respondents considered this to be important (respondents 3, 4, 5, 7 and 8). The following two quotes are illustrative: "*they have to be nearby, if I have to travel far for healthcare, I'd go somewhere else" (respondent 4)* and "*distance should be practical, there might be a great physical therapist in the city, but with two young kids, travelling to the city is not practical if you can also visit a therapist at school or nearby"* (respondent 7).

AVAILABILITY

Furthermore, the semi-structured interviews indicate that the availability could be an important factor for the perception of parents regarding the quality of healthcare for their child. This was indicated, among other things, by the fact that five respondents (respondent 2, 3, 4, 7 and 9) stated that they find availability of healthcare very important. Availability was also an important factor in the MOCHA-model. The statement that the availability of healthcare could be important to the perception of the interviewed parents regarding the quality of healthcare is supported by the fact that they stated that they want to be helped as quickly as possible when they have a need for healthcare. Respondent 2 said that he wants to be helped as soon as possible. An illustrative quote by respondent 3 is: "*it does not matter which hospital I need to go to, as long as I am helped as soon as possible".* Respondent 6 indicated that it is becoming increasingly difficult to find available healthcare providers, as, for example, the general practitioner is often fully booked.

AFFORDABILITY

The semi-structured interviews also indicated that the costs associated with healthcare are not considered to be very important to the interviewed parents regarding their perception of the quality of primary healthcare for their child. The reasons given for this were that they find healthcare affordable, because this is covered by their insurance and that when it comes to the health of their child, money should not play a role. The statement that money does not play a role is difficult to test when healthcare is affordable. However, affordability is a factor in the MOCHA-model.

The fact that the respondents find healthcare for their child affordable due to the insurance coverage is supported by the following quote: "*It is very convenient that my child is covered by my insurance and does not have a deductible of his own"* (respondent 1). Respondent 5 also indicated that healthcare costs are affordable thanks to the fact that his children are automatically insured under his insurance.

The fact that money should not play a role is derived from the majority of the interviews (eight of the nine respondents). The following illustrative quotes were given: "*we never really go to a general practitioner or something like that, so if there is a problem, we take it seriously and money does not matter to me"* (respondent 3) and "*I would not consider the money"* (respondent 5).

COORDINATION BETWEEN HEALTHCARE PROVIDERS

The semi-structured interviews also indicated that the coordination (which is also a factor in the MOCHA-model) between the healthcare providers is possibly an important factor that influences the perception of parents regarding the quality of primary healthcare for their child. This was evident from the fact that six respondents indicated that they find this important (respondents 1, 3, 5, 7, 8, and 9). The respondents value a good cooperation between healthcare providers and find it important when they are aware of each other's involvement. Respondent 3 underlined the fact that a proper coordination can speed up the healthcare process. Respondent 6 was of the opinion that healthcare providers should know about the prior history of a patient, otherwise they cannot provide targeted treatments. The following two quotes are illustrative: "*I often run into the fact that healthcare providers are unable to access each other's files, which is difficult"* (respondent 1) and: "*healthcare providers should be aware of the situation to prevent having to re-tell the story all over again"* (respondent 2).

RELATIONSHIP WITH THE HEALTHCARE PROVIDER

The semi-structured interviews also showed that the relationship with the healthcare provider (which is a factor within the MOCHA-model) could be an important factor that influences the perception of parents regarding the quality of primary healthcare for their child. This was evident from the fact that all nine respondents indicated that they find the relationship with the healthcare provider very important. Respondent 1 stated that the lack of a connection between her and the healthcare provider of her child would make her go somewhere else.

Respondent 4 stated that if she feels like she is not being taken seriously, she will switch healthcare providers. The following two quotes are illustrative: *"of course you need a certain connection with your general practitioner, because the general practitioner is the first person you visit when you are sick. If I do not have a connection or bond with the general practitioner, it is uncomfortable to me"* (respondent 6) and "*if you lack a good relationship with the general practitioner, you're more inclined to say never mind"* (respondent 2).

QUALITIES OF THE HEALTHCARE PROVIDER

Furthermore, the semi-structured interviews indicated that the qualities of a healthcare provider (which is a factor in the MOCHA- model) could influence the perception of parents regarding the quality of primary healthcare for their child. This was evident from the fact that all nine interviewed parents indicated that they find the qualities of a healthcare provider very important. This was also evident from the fact that all interviewed parents mentioned the importance of proper knowledge and skills of a healthcare provider. Multiple interviewed parents mentioned that healthcare providers should be experienced experts and that they should stay up-to-date with new developments in their field and to stay informed (all respondents except for respondent 8). Respondent 2, for example, stated that he assumes his child is examined by experts. Respondent 9 found it important that his children were properly treated and supervised during the healthcare process. The following two quotes are illustrative: "*sometimes, you hear about mistakes that I would find unacceptable, and I wouldn't go to that healthcare provider as a result" (respondent 2)* and: "*if you hear very negative stories, I would avoid that healthcare provider" (respondent 3).*

TRANSPARENCY

Finally, the semi-structured interviews showed that transparency, which was not a factor of the MOCHA-model, but found in the literature, could play an important role and influence the perception of parents regarding the quality of primary healthcare for their child. This was evident from the fact that eight of the nine respondents (all respondents except for respondent 9) stated that they find this important. Transparency mainly consists of the public availability of open and honest information regarding the quality, costs and service of a healthcare provider. Illustrative quotes that support the statement that transparency is important for the healthcare choice are: "*you should have a choice and transparency is very important"* (respondent 5) or: *"that allows you to choose where to go"* (respondent 8).

4.2 QUANTITATIVE RESEARCH

INTRODUCTION

This paragraph describes the results of the surveys. The first aspect discussed in paragraph 4.2.1 were the demographic characteristics of the respondents. Paragraph 4.2.2 describe the earlier experiences of respondents with primary healthcare of their child, 4.2.3 the importance of the five-point scale, 4.2.4 the importance of the Best-Worst Scaling, 4.2.5 the earlier experiences and the importance and paragraph 4.2.5 describe the ranking of the factors.

4.2.1 DEMOGRAPHIC CHARACTERISTICS RESPONDENTS QUANTITATIVE RESEARCH

Both surveys (five-point scale and BWS) demonstrated that a majority of the respondents (82.7%) lives in Friesland, followed by a group of 10.8% that lives in Groningen, 4.4% in Overijssel, 1.5% in Utrecht and one respondent (0.7%) in Noord-Holland. The respondents have an average of 1.9 (SD=0.83) children (aged 18 and under). Of all the children, 94.3% were in good health according to their parents and the health of 5.7% of the children was mediocre. Table 4 shows that a majority (72.5%) of the respondents were female. The average age of the respondents was 41.3 years (SD=8.4). Of the respondents, 52.2% had completed secondary vocational education (MBO) and 38.4% of the respondents had completed higher vocational education (HBO). The majority of the respondents (59.4%) worked part time. The average age of the children was 10.0 years (SD=5.3).

The majority of the respondents (68.8%) used the primary healthcare system for their children between 1 and 4 times in the last year, 28.9% had used it 5 or more times and 2.9% did not use the primary healthcare system for their child. Finally, 43.5% had the most recent contact with their general practitioner, followed by the dentist with 33.3%. More background information regarding the respondents per survey is displayed in Table 4.

Table 4

Characteristics of study population

	Five-point scale	**BWS**	**Total**	**Percent (%)**
Characteristic (n)	66	72	138	-
Gender				
Male	22	16	38	27.5
Female	44	56	100	72.5
Age respondent				
Mean age (SD)	42.0 (7.6)	40.7 (9.0)	-	41.3 (8.4)
Education				
Primary education or lower	3	2	5	3.6
MBO	32	40	72	52.2
HBO	27	26	53	38.4
WO or higher	4	4	8	5.8
Employment status				
No work	2	9	11	8.0
Part time	39	43	82	59.4
Full time	25	20	45	32.6
Age children*				
Mean age (SD)	9.2 (5.7)	10.6 (5.0)	-	10.0 (5.3)
The amount of times the child was in contact with a primary healthcare provider last year				
Not	0	4	4	2.9
1 to 2 times	27	26	53	38.4
3 to 4 times	21	20	42	30.4
5 to 6 times	4	10	14	10.1
More than 6 times	14	12	26	18.8
Last contact parent with				
General practitioner	28	32	60	43.5
Physiotherapist	5	8	13	9.4
Consultation bureau	7	3	10	7.3
School doctor	3	6	9	6.5
Dentist	23	23	46	33.3

* Children up to Eighteen years old

4.2.2 EARLIER EXPERIENCES WITH PRIMARY HEALTHCARE PROVIDERS

The results (see Table 5) firstly show that a majority of the respondents had a good experience with the expertise of the child's healthcare provider (PROFESSIONALISM, M=3.22, SD=0,58), followed by the primary healthcare provider takes the child's health seriously (BEING TAKEN SERIOUSLY, M=3.16, SD=0.56). It was also shown that the respondents had a less than optimal experience in their last visit to a primary healthcare provider when it comes to extended opening hours (OPENING HOURS, M=2.59, SD=0.70) and a good coordination between healthcare providers (COORDINATED, M=2.57, SD=0.81). Respondents had the least satisfied experiences with being helped at time they agreed on (HELPED ON TIME, M=2.27, SD=0.97). However, experiences of the respondents regarding this matter vary, as the SD of this factor is the largest. Furthermore, the majority of the respondents had good experiences with a primary healthcare provider, because they gave often the same answer option, namely strongly agree or agree. There are some interesting outliers in the data, with six different respondents indicating very negative experiences (strongly disagree, see Table 5) with regard to the factors: healthcare provider is easily reachable by phone (REACHABILITY BY PHONE , 0.7%), healthcare providers are open and honest about the quality, costs and services (OPEN AND HONEST, 1.4%), COORDINATED (1.4%) and HELPED ON TIME (1.4%).

Table 5

Assessments of the research population (n=138) regarding their earlier experiences with a primary healthcare provider measured using the five-point scale

Factor	Rank	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean (SD)*
Professionalism	1	41 (29.7%)	88 (63.8%)	8 (5.8%)	1 (0.7%)	0	3.22 (0.58)
Being taken seriously	2	32 (23.2%)	98 (71.0%)	6 (4.3%)	2 (1.4%)	0	3.16 (0.56)
Friendly	3	31 (22.5%)	96 (69.6%)	9 (6.5%)	2 (1.4%)	0	3.13 (0.58)
Distance	4	33 (23.9%)	91 (56.9%)	12 (8.7%)	2 (1.4%)	0	3.12 (0.61)
Experience	5	32 (23.2%)	89 (64.5%)	16 (11.6%)	1 (0.7%)	0	3.10 (0.61)
Reachability by phone	6	18 (13.0%)	107 (77.5%)	10 (7.2%)	2 (1.4%)	1 (0.7%)	3.01 (0.57)
Listening	7	24 (17.4%)	89 (64.5%)	22 (15.9%)	3 (2.2%)	0	2.97 (0.65)
Decision involvement	8	23 (16.7%)	90 (65.2%)	21 (15.2%)	4 (2.9%)	0	2.96 (0.66)
Righteous	8	16 (11.6%)	100 (72.5%)	20 (14.5%)	2 (1.4%)	0	2.94 (0.56)
Reputation	8	31 (22.5%)	68 (49.3%)	34 (24.6%)	5 (3.6%)	0	2.91 (0.76)
Affordable	9	21 (15.2%)	90 (65.2%)	19 (13.8%)	8 (5.8%)	0	2.90 (0.72)
Acceptable	9	17 (12.3%)	92 (66.7%)	25 (18.1%)	4 (2.9%)	0	2.88 (0.64)
Relationship	10	26 (18.8%)	76 (55.1%)	30 (21.7%)	6 (4.3%)	0	2.88 (0.78)
Short term appointment	11	17 (12.3%)	92 (66.7%)	20 (14.5%)	9 (6.5%)	0	2.85 (0.71)
Open and honest	12	20 (14.5%)	75 (54.3%)	37 (26.8%)	4 (2.9%)	2 (1.4%)	2.82 (0.68)
Complete	12	12 (9.4%)	88 (63.8%)	31 (22.5%)	6 (4.3%)	0	2.78 (0.67)
Knows the child	13	19 (13.8%)	69 (50.0%)	40 (29.0%)	10 (7.2%)	0	2.70 (0.80)
Opening hours	14	8 (5.8%)	75 (54.3%)	46 (33.3%)	9 (6.5%)	0	2.59 (0.70)
Coordinated	15	13 (9.4%)	66 (47.8%)	48 (34.8%)	9 (6.5%)	2 (1.4%)	2.57 (0.81)
Helped on time	16	9 (6.5%)	59 (42.8%)	32 (23.2%)	36 (26.1%)	2 (1.4%)	2.27 (0.97)

* Average of earlier experiences using a five-point scale from 0 to 4, where 4 represents strongly agree.

4.2.3 IMPORTANCE, ASSESSED WITH FIVE-POINT SCALE

The results of the questionnaire (see Table 6) first demonstrate that respondents find the factor PROFESSIONALISM (M=3.85, SD=0.40) to be the most important, followed by the factor BEING TAKEN SERIOUSLY (M=3.75, SD=0.44). Furthermore, the results show that child's healthcare provider involves the child and parent in the medical decision-making process (DECISION INVOLVEMENT, M=3.58, SD=0.53), my child's healthcare provider listens to me (LISTENING, M=3.56, SD=0.59), and the healthcare provider of my child is righteous (RIGHTEOUS, M=3.53, SD=0.56) are also considered to be very important in the perception of parents for a good quality of primary healthcare for their children. Table 6 shows that parents find the factor DECISION INVOLVEMENT more important than the factor LISTENING, however, upon closer examination of the average, the difference is minimal. This difference could be the result of a larger spread within the group of respondents with the factor LISTENING, causing this to have a lower average than the factor DECISION INVOLVEMENT with a minimal difference.

Furthermore, the results show that the respondents find my healthcare provider is easily and close to my house accessible (DISTANCE, M=2.95, SD=0.98) and HELPED ON TIME (M=2.92, SD=0.97) less important. The factor that appeared to be the least important in the perception of parents for a good quality of primary healthcare for their children was OPENING HOURS (M=2.77, SD=0.89). In addition, respondents are more divided in their opinions on lower scoring factors (i.e. AFFORDABLE, KNOWS THE CHILD, DISTANCE and HELPED ON TIME) than regarding higher scoring factors (i.e. PROFESSIONALISM and BEING TAKEN SERIOUSLY), as the SD of higher scoring factors are generally lower than of lower scoring factors.

Further there are some interesting outliers in the data. Three different respondents are indicating very negative experiences with regard to the factors: healthcare for my child is affordable (AFFORDABILITY, 3.0%) and the healthcare provider knows my child (KNOWS THE CHILD, 1.5%). Next to that, there was one respondent who indicated several factors as not important, namely the parent can make an appointment for my child within the near future (SHORT TERM APPOINTMENT), HELPED ON TIME, OPENING HOURS and DISTANCE.

Table 6

Assessments of the research population (n=66) regarding the importance of the factors measured using the five-point scale

Factor	Rank	Very important	Important	Neutral	Unimportant	Very unimportant	Mean (SD)*
Professionalism	1	57 (86.4%)	8 (12.1%)	1 (1.5%)	0	0	3.85 (0.40)
Being taken seriously	2	49 (74.2%)	17 (25.8%)	0	0	0	3.74 (0.44)
Decision involvement	3	39 (59.1%)	26 (39.4%)	1 (1.5%)	0	0	3.58 (0.53)
Listening	4	40 (60.6%)	23 (34.8%)	3 (4.5%)	0	0	3.56 (0.59)
Righteous	5	37 (56.1%)	27 (40.9%)	2 (3.0%)	0	0	3.53 (0.56)
Experience	6	37 (56.1%)	22 (33.3%)	5 (7.6%)	2 (3.0%)	0	3.42 (0.77)
Complete	7	32 (48.5%)	29 (43.9%)	5 (7.6%)	0	0	3.41 (0.63)
Acceptable	8	29 (43.9%)	33 (50.0%)	4 (6.1%)	0	0	3.38 (0.60)
Reachability by phone	8	31 (47.0%)	30 (45.5%)	4 (6.1%)	1 (1.5%)	0	3.38 (0.67)
Short term appointment	8	33 (50.0%)	28 (42.4%)	3 (4.5%)	1 (1.5%)	1 (1.5%)	3.38 (0.78)
Coordinated	9	32 (48.5%)	23 (34.8%)	11 (16.7%)	0	0	3.32 (0.75)
Open and honest	9	33 (50.0%)	25 (37.9%)	4 (6.1%)	4 (6.1%)	0	3.32 (0.84)
Friendly	10	29 (43.9%)	30 (45.5%)	5 (7.6%)	2 (3.0%)	0	3.30 (0.74)
Affordable	11	31 (47.0%)	23 (34.8%)	6 (9.1%)	4 (6.1%)	2 (3.0%)	3.17 (1.03)
Knows the child	12	31 (47.0%)	20 (30.3%)	10 (15.2%)	4 (6.1%)	1 (1.5%)	3.15 (1.00)
Reputation	12	25 (37.9%)	29 (43.9%)	9 (13.6%)	3 (4.5%)	0	3.15 (0.83)
Relationship	13	22 (33.3%)	31 (47.0%)	11 (16.7%)	2 (3.0%)	0	3.11 (0.79)
Distance	14	22 (33.3%)	26 (39.4%)	12 (18.2%)	5 (7.6%)	1 (1.5%)	2.95 (0.98)
Helped on time	15	20 (30.3%)	28 (42.4%)	12 (18.2%)	5 (7.6%)	1 (1.5%)	2.92 (0.97)
Opening hours	16	13 (19.7 %)	31 (47.0%)	17 (25.8%)	4 (6.1%)	1 (1.5%)	2.77 (0.89)

* Average importance using a five-point scale from 0 to 4, where 4 represents very important

4.2.4 IMPORTANCE, ASSESSED WITH BEST-WORST SCALING

Table 7 shows the total best minus worst (B-W) scores of all the respondents. The factors PROFESSIONALISM and BEING TAKEN SERIOUSLY were, similar to the five-point scale, considered to be the most important. Next to that, respondents find child's healthcare continuous (COMPLETE) and acceptable (ACCEPTABLE) very important as well. The factors HELPED ON TIME, DISTANCE and OPENING HOURS were, similar to the five-point scale, considered to be the least important factors in the perception of parents for a good quality of primary healthcare for their children.

Furthermore, all the factors were chosen as the most important or least important at least once by the respondents, except for the factors BEING TAKEN SERIOUSLY and OPENING HOURS. The factor BEING TAKEN SERIOUSLY was not chosen once as least important and the factor OPENING HOURS was not chosen once as most important by the respondents. The factor the healthcare provider knows my child (KNOWS THE CHILD) was equally frequently chosen by the respondents as least important (42 times) and most important factor (42 times), so the opinion of the respondents regarding this factor was highly divergent. In addition, the scatterplot in Figure

7 shows the division of the standardized best and worst counts of the factors chosen by the respondents, which was shown in Table 7. This scatterplot shows an inverse relationship between the factors chosen by the respondents as most important or least important. The factors PROFESSIONALISM and BEING TAKEN SERIOUSLY have the highest best counts and the lowest worst counts. Furthermore, the factors OPENING HOURS, DISTANCE and HELPED ON TIME have the most worst counts and the fewest best counts. There also appears to be a relatively large group of factors in the centre middle of the scatterplot, which indicates that the standardized best and worst scores are almost equally divided. The same is true for the factor KNOWS THE CHILD. When looking at the total best and worst scores (see Table 7), the factor KNOWS THE CHILD appears to be chosen relatively often by respondents as most important and least important. This shows that the opinion of the respondents did not align regarding this factor.

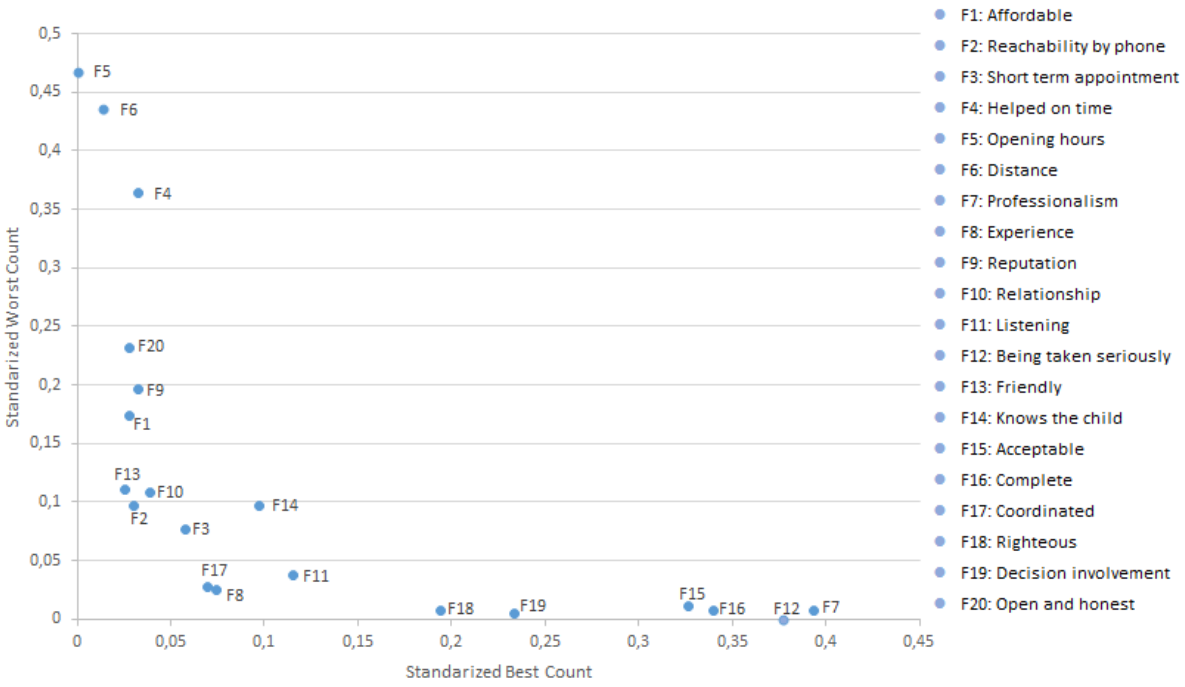
Table 7

Total most important and least important scores of the research population (n=72) measured using Best-Worst Scaling

Factor	Rank	Most important	Least important	B-W score	Standard B-W score
Professionalism	1	170	3	167	0.39
Being taken seriously	2	163	0	163	0.38
Complete	3	147	3	144	0.33
Acceptable	4	141	5	136	0.32
Decision involvement	5	101	2	99	0.23
Righteous	6	84	3	81	0.19
Listening	7	50	16	34	0.08
Experience	8	32	11	21	0.05
Coordinated	9	30	12	18	0.04
Knows the child	10	42	42	0	0
Short term appointment	11	25	33	-8	-0.02
Reachability by phone	12	13	42	-29	-0.07
Relation	13	17	47	-30	-0.07
Friendly	14	11	48	-37	-0.09
Affordable	15	12	75	-63	-0.15
Reputation	16	14	85	-71	-0.16
Open and honest	17	12	100	-88	-0.20
Helped on time	18	14	157	-143	-0.33
Distance	19	6	188	-182	-0.42
Openings hours	20	0	202	-202	-0.47

Figure 7

Distribution of standardized best and worst counts



4.2.5 PREVIOUS EXPERIENCES AND IMPORTANCE

Figure 8 shows a distribution of the results of the previous experiences of respondents with a primary healthcare provider together with their child and how important parents find the factors. A five-point scale was used to measure the importance and previous experience of the respondents. First of all, Figure 8 show that respondents had the best experience with the factors of PROFESSIONALISM (F7), BEING TAKEN SERIOUSLY (F12), and DISTANCE (F6). In addition, it was found that the factors of PROFESSIONALISM and BEING TAKEN SERIOUSLY were assessed as very important by the respondents. The experience with DISTANCE was good but in the perception of parents, it was less important for a good quality of primary healthcare for their child. Furthermore, Figure 8 shows that the respondents' experiences with the factors HELPED ON TIME (F4), OPENING HOURS (F5) and COORDINATED (F17) were not that good during their last visit to their child's healthcare provider. HELPED ON TIME and OPENING HOURS were perceived by the parent to be less important for a good quality of care. It is also interesting that COORDINATED appeared to be quite important in the perception of parents with respect to a good quality of primary healthcare for their child. Furthermore, Figure 8 shows that there was little variation between the factors in terms of importance (M=2.77 to M=3.85). This may be explained by the fact that the five-point scale had 'fixed' values of 0 (very unimportant) to 4 (very important). However, it was found (see Figure 8) that respondents only used a relatively small part of this scale.

In Figure 9, the importance was measured using the BWS method and the previous experience with five-point scale, the factors of PROFESSIONALISM (F7), BEING TAKEN SERIOUSLY (F12), and the healthcare provider of my child is friendly (FRIENDLY, F13) were assessed as important by respondents. Also, as in Figure 8, it was found that the factors of PROFESSIONALISM and BEING TAKEN SERIOUSLY were once again considered to be very important by the respondents. FRIENDLY, on the other hand, was perceived by parents to be less important with respect to good quality of care for their child. Furthermore, Figure 9 shows that respondents had a very good previous experience with the DISTANCE (F6), but it turned out that respondents did not find this factor very important. Respondents had less favorable experiences with the OPENING HOURS (F5), HELPED ON TIME (F4), and COORDINATED (F17). OPENING HOURS and HELPED ON TIME were not considered to be very important by respondents (see also Table 7). However, parents perceived COORDINATED as quite important with respect to a

good quality of primary care for their child. Figure 9 also shows that there is a large variation in the importance of the factors: from a B-W Score of 167 to a B-W Score of -202. This was possible as the BWS scale was more flexible, the greater the differences stated by respondents were, the wider this scale became.

Figure 8

Previous experience and importance of the research population (n=66) measured using the five-point scale

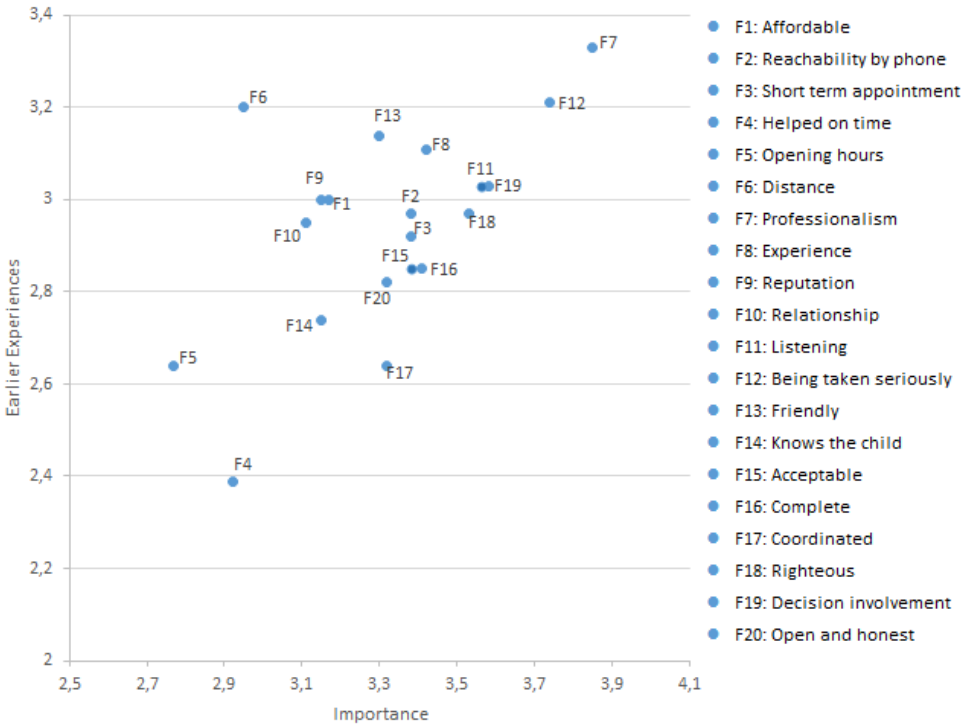
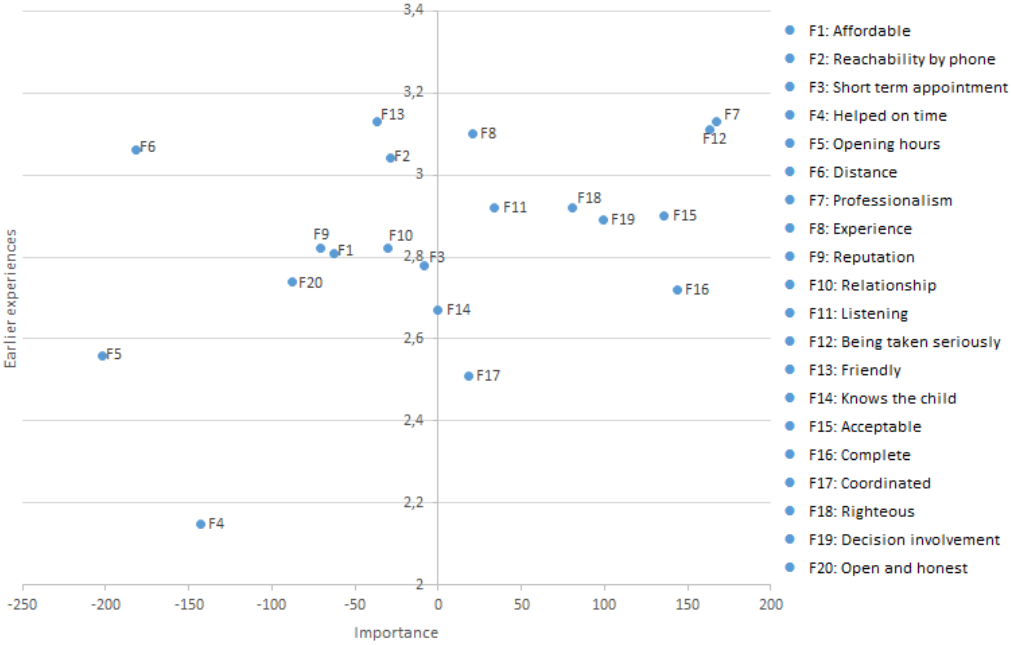


Figure 9

Previous experience and importance of the research population (n=72) measured using the Best-Worst Scale survey



4.2.6 SUITABLILITY OF THE FIVE-POINT SCALE AND BEST-WORST SCALING METHOD

The results of the surveys with the five point scale and BWS show that, in principle, the BWS method is more accurate, because it creates a stronger discrimination between the different rankings. When looking at the discrimination, the differences in importance are much smaller for the five-point scale, ranging from M=2.77 to M=3.85 (see Figure 8) as opposed to the BWS method that ranges from a B-W score of -202 to a B-W score of 167 (see Figure 9). Furthermore, the ranking of the five-point scale also features items with the same rankings, because they had the exact same averages (see Table 6 and 8). This is possible because there were only five answering options with corresponding discrete values. When comparing the five-point scale and BWS, it is noteworthy that there are no large differences in the results (see Table 7). Both surveys show that PROFESSIONALISM and BEING TAKEN SERIOUSLY are the most important and HELPED ON TIME, DISTANCE and OPENING HOURS are the least important. The other factors do vary in ranking, but the differences are small (see Table 8). Furthermore, the time respondents took during the pre-test to fill out the two surveys was fifteen minutes for the BWS survey and seven minutes for the scaling survey.

Table 8

Overview of rankings based on the importance of the twenty factors measured using the five-point scale and Best-Worst Scaling

Rank	Five-point scale	Rank	Best-Worst Scaling
1	Professionalism	1	Professionalism
2	Being taken seriously	2	Being taken seriously
3	Decision involvement	3	Complete
4	Listening	4	Acceptable
5	Acceptable	5	Decision involvement
6	Experience	6	Righteous
7	Complete	7	Listening
8	Righteous	8	Experience
8	Reachability by phone	9	Coordinated
8	Short term appointment	10	Knows the child
9	Coordinated	11	Short term appointment
10	Open and honest	12	Reachability by phone
11	Friendly	13	Relation
12	Affordable	14	Friendly
12	Knows the child	15	Affordable
13	Reputation	16	Reputation
14	Relation	17	Open and honest
15	Distance	18	Helped on time
16	Helped on time	19	Distance
17	Opening hours	20	Opening hours

5 DISCUSSION

INTRODUCTION

This chapter will first discuss the key results and other important findings of this research. Then the strengths and limitations of this research are described, followed by recommendations. The chapter is finalized with a conclusion.

5.1 FINDINGS AND COMPARISONS WITH THE LITERATURE

The purpose of this research was to find out to what degree factors that influence the quality of healthcare are of importance to the perception of parents regarding the quality of primary healthcare for their children.

The study was performed in the North-Eastern part of The Netherlands amongst 138 parents and showed first of all that out of the twenty factors (see Table 2) of which the importance was measured, the parents find PROFESSIONALISM and BEING TAKEN SERIOUSLY the most important factors for a good quality of healthcare for their children. These results coincide with research conducted by Sixma et al. (1998), which indicated that Dutch patients in general find it very important to be taken seriously by their general practitioner. Research by Grol et al. (1999) also showed that in general, patients find it important that their general practitioner regularly attends courses to keep his knowledge of medical developments up-to-date.

Contrary to the most important factors, there were also factors that Dutch parents considered to be the least important, which were: HELPED ON TIME, DISTANCE and OPENING HOURS. The fact that being HELPED ON TIME is not important for the research group is supported by the studies from Sixma et al. (1998); Grol et al. (1999) and Groenewegen et al. (2005), which also showed that waiting times do not have a high priority amongst patients, as long as they fall within a reasonable timeframe (according to Sixma and Groenewegen this is no longer than 15 minutes). This result contradicts the findings from the NZa study (2007), which showed that patients find it generally important to not have to wait in the waiting room when they have an appointment with a healthcare provider (NZa, 2007). Furthermore, the fact that DISTANCE is not considered to be an important factor is contradicted by literature, as numerous studies have shown that distance is in fact an important factor. A possible explanation for this could be the fact that the primary healthcare system in The Netherlands is geographically very approachable, with clinics situated in the surrounding neighbourhoods of parents (NZa, 2007; RIVM, 2010; Schäfer et al., 2010; van den Berg et al., 2011; Wiegers et al., 2011). The result of this study further shows that parents attach little importance to the OPENING HOURS of healthcare providers, which contradicts earlier findings from Klink (2008); RIVM (2010) and Levesque et al. (2013), which claimed that OPENING HOURS do influence the healthcare decisions of patients.

The results of the practical research also showed that opinions regarding the AFFORDABILITY of healthcare varied amongst Dutch parents (see Table 6) and that this factor is generally not regarded as important by parents. This result supports the findings from Grol et al. (1999) and Groenewegen et al. (2005), where patients indicated that they do not mind paying extra for medication, and that they generally do not care whether or not their general practitioner is aware of the costs associated with medical treatments. This result does not coincide with the research conducted by Levesque et al. (2013), as this study showed that healthcare costs do influence the use of healthcare by patients in general. An explanation for this is that healthcare costs of children aged 18 and younger are largely covered by the insurance companies in The Netherlands, so that parents have little to no costs when their child uses the primary healthcare system.

In addition, there were some other similarities with factors from the literature and the factors included in this study. For example, in the studies by Sixma et al. (1998) and Grol et al. (1999), Dutch patients found that a good collaboration between healthcare providers was not very important, which is the same in this study (ranking 8 and 9). The study of Sixma et al. (1998) also reveals that Dutch patients found the factor of LISTENING quite important. This is also apparent from this study (ranking 4 and 7). In addition, the studies of Sixma et al. (1998) and Groenewegen et al. (2005) demonstrated that factors aimed at the service were less important, which can also be seen in the results of this study.

Furthermore, the study by Sixma et al. (1998) and Groenewegen et al. (2005) showed that Dutch patients considered it to be very important for the general practitioner to be easily reachable by phone. This, however, is not entirely the same in this study as this factor had a ranking of 8 and 12 in this study. It was also noted that the study by Grol et al. (1999) indicated that Dutch patients, in general, consider it to be important that they can make an appointment in the short term. However, this does not appear from this study as it had a ranking of 8 and 11.

The results of the surveys with the five-point scale and the BWS show that the BWS method is more suitable than the five-point scale method, as this creates a more reliable ranking as opposed to using the data of a five-point scale. The study also shows that the BWS method has a 'better' discrimination than the scaling methods (see Figure 8 and 9), because of the variation between the factors. This occurred because parents continuously had to assess the relative importance of numerous different factors. It is more difficult to create a ranking based on the results of the five-point scale (see Table 6) when compared to the BWS method (see Table 7), as the rankings of the five-point scale were sometimes overlapping. The reason for this is that per item respondents can only make five distinctions in the ranking. Parents would often regard all factors as important, which led to the same ranking for multiple factors. This created a weak discrimination (see Figure 8), leading to a more complicated process of deriving reliable conclusions regarding the relative importance of factors. These findings coincide with research conducted by Flynn and Marley (2014), where it was found that the BWS method leads to a strong discrimination (see Figure 9). Furthermore, Hein, Jaeger, Carr, and Delahunty (2008) explained that a stronger discrimination will lead to more reliable conclusions. However, the differences when comparing the results of the five point scale method and the BWS method were small. For example, both surveys showed that PROFESSIONALISM and BEING TAKEN SERIOUSLY were most important and HELPED ON TIME, DISTANCE and OPENING HOURS were the least important.

The research further showed that the application of the BWS method is very time consuming, as the amount of items to test is very high. This finding agrees with the studies from Iyengar and Lepper (2000) and DeShazo and Fermo (2002), which also indicate that the BWS method can be time consuming, which could demotivate the respondents to fill in the survey correctly.

This study takes place within the MOCHA- project, which uses the MOCHA-model (see Figure 4) to map the quality of primary healthcare systems (see paragraph 2.2 of the literature study), so it is important to compare the MOCHA-model with the factors that were found in this research that possibly influence the perception of parents regarding the quality of primary healthcare. In the context of the MOCHA-model, this study only focusses on the outputs of the MOCHA-model. The outputs of the model are, in this case, affordable, accessible, acceptable, appropriate, continuous, coordinated, equable and empowering. The aspect transparency does not occur in this list of important aspects, although this factor did come up in both the literature study and the practical research.

The found output aspects affordable, accessible and coordinated of the MOCHA-model fully coincide with the conceptual model with factors of this research. All other five aspects of the MOCHA-model, equable, empowering, continuous, acceptable and appropriate all fall into the category 'relationship with healthcare provider' of the conceptual model, in the context of this research.

A clear overlap was found between the different factors that were found in the practical research and those of the MOCHA-model. Actually, only one new factor were found during the interviews, namely: KNOWS THE CHILD. The factor RIGHTEOUS from the practical research, for example, shows a lot of overlap with the concept 'equable' of the MOCHA model. The aspect empowering of the MOCHA-model coincides with the factors DECISION INVOLVEMENT and LISTENING. The aspect continuous of the MOCHA-model strongly resembles the COMPLETE factor that was found in the practical research. The aspect acceptable of the MOCHA-model also coincides with the factor ACCEPTABLE found in the practical research. Finally, the term appropriate of the MOCHA-model can be a collection of the following factors that were found in the practical research: BEING TAKEN SERIOUSLY, FRIENDLY, RELATIONSHIP and KNOWS THE CHILD. This aspect of the MOCHA-model was also discussed as the factor quality of the healthcare provider in the conceptual model, with the related factors that were found in the practical research: PROFESSIONALISM, EXPERIENCE, REPUTATION, OPEN AND HONEST and RELATION.

The above analysis of the similarities and differences of the outputs of the MOCHA-model, the factors of the conceptual model and those of the practical research show furthermore that the factors of this research are mainly aimed at the interaction between the patients and the healthcare provider, like the relationship with and the quality of the healthcare provider. The MOCHA-model, on the other hand, focusses more on the systemic aspects of healthcare. The systemic level of this research was limited to the affordability, accessibility and coordination and their importance according to parents regarding the primary healthcare for their children.

5.2 STRENGHTS AND LIMITATIONS

In the context of this research, a couple of strengths and limitations were found. First of all, one of the limitations was that the amount of participating respondents was relatively low. This was partly caused by the fact that two different surveys were conducted. This could have influenced the results of this research. The relatively small size of the research group also made it difficult to gauge the influence of certain characteristics of respondents on the results. Another limitation was that it was not possible to use a random sample to increase the reliability and validity of this research. The limited amount of available time and the underestimated difficulty of recruiting respondents resulted in the use of a convenience sample. A large part of the respondents therefore originated from Friesland. This could influence the decisions of the respondents, as they often have to travel further to primary healthcare providers. This limits their choices when compared to respondents located in the west or in large cities. Also, by using a research population that was recruited by means of personal networks, the diversity was lower than optimal.

Both surveys also contained many questions and especially the BWS survey was very time consuming. This could be a reason for the difficulty that was experienced when recruiting respondents. On the other hand, it turned out that personally approaching respondents for the practical research was very effective, as opposed to sending an email. This directly motivated the respondents to fill out the survey. This also allowed for further explanations of how to fill out the survey, which was especially true for the BWS survey, because most of the respondents were unfamiliar with this method. A disadvantage of the personal approach was that the number of respondents that were reached was lower than what would have been possible with an online survey.

The sensitivity of the answers to the five point scale turned out to be low. The results of this research show that a majority of the respondents have answered the five-point scale statements in a similar manner. This is a known phenomenon when using scaling methods. For instance in Table 5 and 6 a majority of respondents gave the same answer option, namely 4 (strongly agree or very important) or 3 (agree or important). Another aspect that could have negatively influenced the results was the fact that the order of appearance of the questions was the same for both the five point scale and the BWS method. A solution for this was to randomise the order of the questions, but this was unpractical, as most surveys were conducted in writing, so 138 different surveys should be drawn up with random question orders.

Finally, this study only focused on parents who are living in the Netherlands, which makes it difficult to generalise these results to, for example, other countries in Europe and parents with a migration background. The way healthcare is organised can differ strongly from country to country, as was shown by the literature study.

5.3 RECOMMENDATIONS

Based on the literature study and the practical research, numerous factors were found that possibly influence the perception of parents regarding the quality of primary healthcare for their child. These were analysed in a qualitative manner. A recommendation is therefore to replicate this study with a larger amount of respondents and to test whether these factors are also found amongst a larger population when it comes to the parents' perception of quality of healthcare for their child. The study could preferably be conducted in different European countries, so that possible differences between parents from different countries can be investigated as well.

This study also focussed on parents with children in the age category of 0 up to and including 18 years. It might be interesting to investigate how the importance of the factors from the parents' perspective changes with the age of the child. The MOCHA-model, for example, differentiates between pre-school children, school children and adolescents. Due to the small amount of respondents, no differences or associations were found between the characteristics of certain respondents and the importance of the factors for their perception of quality. Further research could be conducted to investigate the influence of respondent characteristics.

In addition, it might be interesting to investigate within the MOCHA project (optimizing primary healthcare systems) how factors can be improved, as these factors receive a poor scoring based on earlier experiences of parents, but at the same time were giving a high priority by parents (i.e. COORDINATION) in evaluating the quality of primary healthcare for their children.

5.4 CONCLUSION

This research was conducted amongst 138 parents in the North-Eastern part of The Netherlands and shows which factors are important for the perception of parents regarding the quality of primary healthcare for their child. The results show that the factors PROFESSIONALISM and BEING TAKEN SERIOUSLY are the most important. The factors HELPED ON TIME, DISTANCE and OPENING HOURS are least important for the perception of parents regarding the quality of primary healthcare for their children. Furthermore, this study concludes that the Best-Worst Scaling method is the most suitable in the context of this research.

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APPENDICES

APPENDIX 1 INTERVIEW

Voorstellen

Selma Mulder, 24 jaar, master student Health Sciences aan de Universiteit van Twente.

Informatie onderzoek

Doel onderzoek

Het doel van dit onderzoek is om inzicht te krijgen in welke factoren van invloed zijn op de keuzes welke ouders maken met betrekking tot de eerstelijnsgezondheidszorg voor hun kinderen.

Doel interview

Het doel van het houden van interviews is om meer inzicht te krijgen in hoe ouders beslissingen nemen wanneer zij zorg zoeken voor hun kind en welke factoren hierbij van belang zijn. Het uiteindelijke doel is om de factoren besproken in het interview te vergelijken met de gevonden factoren in de literatuur en deze te testen op basis van een enquête.

Opzet interview

Vragen of de geïnterviewde akkoord gaat met het opnemen van het interview. De vragen welke worden gesteld zijn gericht op de Nederlandse eerstelijnsgezondheidszorg (uitleg eerstelijnsgezondheidszorg, zoals huisarts, fysiotherapeut, consultatiebureau, jeugdgezondheidszorg, tandarts) en hoe u zorg vanuit de eerstelijnsgezondheidszorg ervaart wanneer u zorg zoekt voor u kind. Ten slotte zullen er nog een paar achtergrondvragen worden gesteld. De informatie welke wordt besproken in dit interview wordt vertrouwelijk behandeld en anonimiteit wordt gewaarborgd.

Heeft u vooraf vragen?

1) Hoeveel kinderen heeft u?
2) Wat is/zijn de leeftijd van u kind(eren)?
3) Wat was de laatste keer dat u zich zorgen maakte om de gezondheid van u kind?
4) Wat was er toen aan de hand?
5) Wat heeft u toen gedaan? Waarom?
6) Wat vind u belangrijk wanneer u zorg zoekt voor u kind? Waarom vind u dit belangrijk?
7) Wat vind u onbelangrijk wanneer u zorg zoekt voor u kind? Waarom vind u dit niet belangrijk?
8) Uit de theorie blijkt dat bereikbaarheid van zorg invloed heeft op zorgkeuzes. Wat verstaat u onder de bereikbaarheid? Heeft dit in u geval ook invloed op u zorgkeuze(s)? Waarom?
9) Uit de theorie blijkt dat beschikbaarheid van zorg invloed heeft op zorgkeuzes. Wat verstaat u onder de beschikbaarheid? Heeft dit in u geval ook invloed op u zorgkeuze(s)? Kunt u dit toelichten?
10) Uit de theorie blijkt dat betaalbaarheid van zorg invloed heeft op zorgkeuzes. Wat verstaat u onder de betaalbaarheid? Heeft dit in u geval ook invloed op u zorgkeuze(s)? Waarom?
    a. In hoeverre zijn kosten voor een behandeling van belang voor de keuze voor zorg wanneer u de kosten zelf/of niet zelf zou moeten dragen?
11) Uit de theorie blijkt dat de samenwerking tussen (verschillende) zorgverleners invloed heeft op zorgkeuzes. Wat verstaat u onder samenwerking tussen zorgverleners? Heeft dit in u geval ook invloed op u zorgkeuzes? Kunt u dit uitleggen?
12) Uit de theorie blijkt dat de band tussen een patiënt en de zorgverlener invloed heeft op zorgkeuzes. Wat verstaat u hieronder? Heeft dit in u geval ook invloed op u zorgkeuze(s)? Kunt u dit verder toelichten?
13) Uit de theorie blijkt dat de kwaliteit van zorg invloed heeft op zorgkeuzes. Wat verstaat u hieronder? Heeft dit in u geval ook invloed op u zorgkeuze(s)? Waarom?

14) Uit de theorie blijkt dat het leveren van patiëntgerichte zorg door de zorgverlener van invloed is op zorgkeuzes? Wat verstaat u onder patiëntgerichte zorg? Heeft dit in u geval ook invloed op u zorgkeuze(s)? Kunt u dit uitleggen?
15) Uit de theorie blijkt dat openheid van gegevens van zorgverleners/zorginstellingen (zoals werkwijze, diensten, kostenstructuur en kwaliteiten) invloed heeft op zorgkeuzes? Wanneer een zorgverlener openheid geeft, heeft dit invloed op u zorgkeuze? Kunt u dit verder toelichten?

Ten slotte nog een paar achtergrondvragen

16) Geslacht: m/v
17) Wat is uw leeftijd?
18) Wat is uw hoogst genoten opleiding?
19) Heeft u op dit moment een betaalde baan? Fulltime, parttime of werkloos?
20) Heeft u zelf nog vragen, toevoegingen en/of opmerkingen?

Bedankt voor u medewerking. Wilt u de resultaten van dit onderzoek ook ontvangen?

APPENDIX 2 FIVE-POINT SCALE SURVEY

Beste deelnemer,

Allereerst wil ik u hartelijk danken voor uw medewerking aan mijn afstudeeronderzoek. Het doel van deze enquête is om meer inzicht te krijgen in hoe ouders de zorg voor hun kind ervaren en welke factoren belangrijk zijn wanneer zij zorg zoeken voor hun kind(eren).
De enquête bestaat uit drie onderdelen. Per vraag is er **één antwoord** mogelijk. Deze enquête duurt maximaal 10 minuten. De enquête is geheel anoniem en de gegevens zullen vertrouwelijk worden behandeld.

Succes met het invullen van de enquête.

Met vriendelijke groet,
Selma Mulder

DEEL 1: EERDERE ERVARINGEN

1. **Met welke van de onderstaande eerstelijns gezondheidszorgverlener had uw met (een van uw) kind(eren) het laatste contact?**

   - O Huisarts
   - O Consultatiebureau
   - O Schoolarts
   - O Fysiotherapeut
   - O Tandarts

2. **Wat was het probleem?**

3. Wanneer u, uw antwoord baseert op de laatste keer dat u contact en/of een afspraak had met uw kind bij een eerstelijns gezondheidszorgverlener [huisarts, consultatiebureau, schoolarts, tandarts en fysiotherapeut], in hoeverre bent u het dan eens of oneens met de onderstaande stellingen?

		Zeer eens	Eens	Neutraal	Oneens	Zeer oneens
a.	De zorg voor mijn kind is betaalbaar [Het is voor mij haalbaar de verzekeringspremie en eventuele eigen bijdrage voor de zorg voor mijn kind te betalen]	O	O	O	O	O
b.	De zorgverlener van mijn kind is telefonisch goed bereikbaar	O	O	O	O	O
c.	Als ik bel voor een afspraak kan ik op een korte termijn een afspraak maken voor mijn kind	O	O	O	O	O
d.	Als wij een afspraak hebben, zijn ik en mijn kind aan de beurt op het afgesproken tijdstip	O	O	O	O	O
e.	De zorgverlener van mijn kind heeft ruime openingstijden	O	O	O	O	O
f.	De zorgverlener van mijn kind is goed bereikbaar [De praktijk van de zorgverlener van mijn kind is op een redelijke afstand van mijn huis, en het is voor mij eenvoudig deze afstand te overbruggen]	O	O	O	O	O
g.	De zorgverlener van mijn kind is deskundig	O	O	O	O	O
h.	De zorgverlener van mijn kind heeft veel ervaring	O	O	O	O	O
i.	De zorgverlener van mijn kind heeft een goede reputatie	O	O	O	O	O
j.	Ik heb een goede relatie met de zorgverlener(s) van mijn kind	O	O	O	O	O
k.	De zorgverlener van mijn kind luistert naar mij	O	O	O	O	O

		Zeer eens	Eens	Neutraal	Oneens	Zeer oneens
l.	De zorgverlener van mijn kind neemt de gezondheid van mijn kind serieus	O	O	O	O	O
m.	De zorgverlener(s) betrokken bij de zorg voor mijn kind zijn vriendelijk	O	O	O	O	O
n.	De zorgverlener weet wie mijn kind is	O	O	O	O	O
o.	De zorg voor mijn kind is aanvaardbaar [De zorg voor mijn kind is afgestemd op de behoeften en wensen van mij en mijn kind]	O	O	O	O	O
p.	De zorg voor mijn kind is continu [De zorg voor mijn kind is volledig, d.w.z. er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft]	O	O	O	O	O
q	De zorg voor mijn kind is goed gecoördineerd [De zorgverleners van mijn kind weten van elkaars betrokkenheid, werken goed samen en stemmen hun acties op elkaar af]	O	O	O	O	O
r.	De zorg voor mijn kind is rechtvaardig [Mijn kind krijgt de zorg waar hij/zij recht op heeft, te vergelijken met de zorg voor andere kinderen]	O	O	O	O	O
s.	De zorgverlener van mijn kind betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	O	O	O	O	O
t.	De zorgverleners van mijn kind zijn open en eerlijk over de kwaliteit, kosten, service en werkwijze.	O	O	O	O	O

DEEL 2: BELANG FACTOREN

4. Wanneer u denkt aan de kwaliteit van de eerstelijns gezondheidszorg [huisarts, consultatiebureau, schoolarts, tandarts en fysiotherapeut] in Nederland, hoe belangrijk zijn dan voor u de volgende factoren?

		Erg Belangrijk	Redelijk belangrijk	Neutraal	Redelijk onbelangrijk	Zeer onbelangrijk
a.	De zorg voor mijn kind is betaalbaar [Het is voor mij haalbaar de verzekeringspremie en eventuele eigen bijdrage voor de zorg voor mijn kind te betalen]	O	O	O	O	O
b.	De zorgverlener van mijn kind is telefonisch goed bereikbaar	O	O	O	O	O
c.	Als ik bel voor een afspraak kan ik op een korte termijn een afspraak maken voor mijn kind	O	O	O	O	O
d.	Als wij een afspraak hebben, zijn ik en mijn kind aan de beurt op het afgesproken tijdstip	O	O	O	O	O
e.	De zorgverlener van mijn kind heeft ruime openingstijden	O	O	O	O	O
f.	De zorgverlener van mijn kind is goed bereikbaar [De praktijk van de zorgverlener van mijn kind is op een redelijke afstand van mijn huis, en het is voor mij eenvoudig deze afstand te overbruggen]	O	O	O	O	O
g.	De zorgverlener van mijn kind is deskundig	O	O	O	O	O
h.	De zorgverlener van mijn kind heeft veel ervaring	O	O	O	O	O
i.	De zorgverlener van mijn kind heeft een goede reputatie	O	O	O	O	O
j.	Ik heb een goede relatie met de zorgverlener(s) van mijn kind	O	O	O	O	O

		Erg Belangrijk	Redelijk belangrijk	Neutraal	Redelijk onbelangrijk	Zeer onbelangrijk
k.	De zorgverlener van mijn kind luistert naar mij	O	O	O	O	O
l.	De zorgverlener van mijn kind neemt de gezondheid van mijn kind serieus	O	O	O	O	O
m.	De zorgverlener(s) betrokken bij de zorg voor mijn kind zijn vriendelijk	O	O	O	O	O
n.	De zorgverlener weet wie mijn kind is	O	O	O	O	O
o.	De zorg voor mijn kind is aanvaardbaar [De zorg voor mijn kind is afgestemd op de behoeften en wensen van mij en mijn kind]	O	O	O	O	O
p.	De zorg voor mijn kind is continu [De zorg voor mijn kind is volledig, d.w.z. er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft]	O	O	O	O	O
q	De zorg voor mijn kind is goed gecoördineerd [De zorgverleners van mijn kind weten van elkaars betrokkenheid, werken goed samen en stemmen hun acties op elkaar af]	O	O	O	O	O
r.	De zorg voor mijn kind is rechtvaardig [Mijn kind krijgt de zorg waar hij/zij recht op heeft, te vergelijken met de zorg voor andere kinderen]	O	O	O	O	O
s.	De zorgverlener van mijn kind betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	O	O	O	O	O
t.	De zorgverleners van mijn kind zijn open en eerlijk over de kwaliteit, kosten, service en werkwijze.	O	O	O	O	O

DEEL 3: ACHTERGROND FACTOREN

5. Wat is uw geslacht?

- O Man
- O Vrouw

6. Wat is uw leeftijd?

_____ Jaar

7. Wat is uw hoogst afgesloten opleiding?

- O Middelbare school of lager
- O MBO
- O HBO
- O WO of hoger

8. Wat is uw werkstatus?

- O Ik werk niet
- O Ik werk parttime (tussen de 12 en 34 uur per week)
- O Ik werk fulltime (meer dan 35 uur per week)

9. In welke provincie woont u?

- O Drenthe
- O Friesland
- O Flevoland
- O Gelderland
- O Groningen
- O Overijssel
- O Utrecht
- O Noord-Holland
- O Zuid-Holland
- O Noord-Brabant
- O Zeeland
- O Limburg

10. Wat is de leeftijd van uw kind(eren)?

Kind 1	Jaar
Kind 2	Jaar
Kind 3	Jaar
Kind 4	Jaar
Kind 5	Jaar

11. Hoe beoordeeld u de gezondheid van uw kind(eren)?

Kind 1	O goed	O matig	O slecht
Kind 2	O goed	O matig	O slecht
Kind 3	O goed	O matig	O slecht
Kind 4	O goed	O matig	O slecht
Kind 5	O goed	O matig	O slecht

12. Hoe vaak heeft uw met uw kind(eren) het afgelopen jaar contact gehad met een zorgverlener uit de eerstelijnsgezondheidszorg (huisarts, fysiotherapeut, tandarts, consultatiebureau of schoolarts)

O Niet
O 1 tot 2 keer
O 3 tot 4 keer
O 5 tot 6 keer
O Vaker dan 6 keer

Dit is het einde van de enquête, bedankt voor uw medewerking aan dit onderzoek.

APPENDIX 3 BEST-WORST SCALING SURVEY

Beste deelnemer,

Allereerst wil ik u hartelijk danken voor uw medewerking aan mijn afstudeeronderzoek. Het doel van deze enquête is om meer inzicht te krijgen in hoe ouders de zorg voor hun kind(eren) ervaren en welke factoren belangrijk zijn wanneer zij zorg zoeken voor hun kind(eren).
De enquête bestaat uit drie onderdelen. Per vraag is er één antwoord mogelijk. Het invullen van deze enquête duurt u ongeveer 10 minuten. De enquête is geheel anoniem en de gegevens zullen vertrouwelijk worden behandeld.

Succes met het invullen van de enquête.

Met vriendelijke groet,
Selma Mulder

DEEL 1: ERVARINGEN

13. Met welke van de onderstaande eerstelijns gezondheidszorgverlener had uw met (een van uw) kind(eren) het laatste contact?

- O Huisarts
- O Consultatiebureau
- O Schoolarts
- O Fysiotherapeut
- O Tandarts

14. Wat was het probleem?

_____

_____

_____

_____

15. Wanneer u, uw antwoord baseert op de laatste keer dat u contact en/of een afspraak had met uw kind bij een eerstelijns gezondheidszorgverlener [huisarts, consultatiebureau, schoolarts, tandarts en fysiotherapeut], in hoeverre bent u het dan eens of oneens met de onderstaande stellingen?

		Zeer eens	Eens	Neutraal	Oneens	Zeer oneens
a.	De zorg voor mijn kind is betaalbaar [Het is voor mij haalbaar de verzekeringspremie en eventuele eigen bijdrage voor de zorg voor mijn kind te betalen]	O	O	O	O	O
b.	De zorgverlener van mijn kind is telefonisch goed bereikbaar	O	O	O	O	O
c.	Als ik bel voor een afspraak kan ik op een korte termijn een afspraak maken voor mijn kind	O	O	O	O	O
d.	Als wij een afspraak hebben, zijn ik en mijn kind aan de beurt op het afgesproken tijdstip	O	O	O	O	O
e.	De zorgverlener van mijn kind heeft ruime openingstijden	O	O	O	O	O
f.	De zorgverlener van mijn kind is goed bereikbaar [De praktijk van de zorgverlener van mijn kind is op een redelijke afstand van mijn huis, en het is voor mij eenvoudig deze afstand te overbruggen]	O	O	O	O	O
g.	De zorgverlener van mijn kind is deskundig	O	O	O	O	O
h.	De zorgverlener van mijn kind heeft veel ervaring	O	O	O	O	O
i.	De zorgverlener van mijn kind heeft een goede reputatie	O	O	O	O	O
j.	Ik heb een goede relatie met de zorgverlener(s) van mijn kind	O	O	O	O	O
k.	De zorgverlener van mijn kind luistert naar mij	O	O	O	O	O

		Zeer eens	Eens	Neutraal	Oneens	Zeer oneens
l.	De zorgverlener van mijn kind neemt de gezondheid van mijn kind serieus	O	O	O	O	O
m.	De zorgverlener(s) betrokken bij de zorg voor mijn kind zijn vriendelijk	O	O	O	O	O
n.	De zorgverlener weet wie mijn kind is	O	O	O	O	O
o.	De zorg voor mijn kind is aanvaardbaar [De zorg voor mijn kind is afgestemd op de behoeften en wensen van mij en mijn kind]	O	O	O	O	O
p.	De zorg voor mijn kind is continu [De zorg voor mijn kind is volledig, d.w.z. er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft]	O	O	O	O	O
q	De zorg voor mijn kind is goed gecoördineerd [De zorgverleners van mijn kind weten van elkaars betrokkenheid, werken goed samen en stemmen hun acties op elkaar af]	O	O	O	O	O
r.	De zorg voor mijn kind is rechtvaardig [Mijn kind krijgt de zorg waar hij/zij recht op heeft, te vergelijken met de zorg voor andere kinderen]	O	O	O	O	O
s.	De zorgverlener van mijn kind betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	O	O	O	O	O
t.	De zorgverleners van mijn kind zijn open en eerlijk over de kwaliteit, kosten, service en werkwijze.	O	O	O	O	O

DEEL 2: BELANG FACTOREN

Voorbeeldvraag: wanneer u zorg zoekt voor u kind, welke factor vindt u het meest en welke factor vindt u het minst belangrijk?

In het onderstaande voorbeeld worden in de middelste kolom de factoren beschreven welke invloed kunnen hebben op uw zorgkeuze. In de linker kolom kan de factor welke het meeste invloed heeft op uw keuze worden aangekruist, in dit voorbeeld is dit: "de zorgverlener van mijn kind is deskundig". In de rechter kolom kan de factor welke voor u het minst belangrijk is wanneer u zorg zoek voor u kind worden aangekruist, in dit voorbeeld is dit: "ik heb een goede band met de zorgverlener van mijn kind".

Let op, u mag maar 1 kruis zetten in de linker kolom en 1 kruis in de rechter kolom.

Welke van de volgende factoren vindt u het meest belangrijk?	**Voorbeeldvraag** **De zorgverlener van mijn kind is…**	Welke van de volgende factoren vindt u het minst belangrijk?
	Is telefonisch goed bereikbaar	
	Weet wie mijn kind is	
X	Is deskundig	
	Heeft veel ervaring	
	Luistert naar mij	
	Heeft een goede reputatie	
	Heeft een goede relatie met mij en mijn kind	
	Is op redelijke afstand van mijn huis	**X**

16. Wanneer u denkt aan de kwaliteit van de eerstelijns gezondheidszorg [huisarts, consultatiebureau, schoolarts, tandarts en fysiotherapeut] in Nederland, welke factor(en) vindt u het meest belangrijk en welke factor vindt u het minst belangrijk?

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 1** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Als mijn kind en ik een afspraak hebben zijn wij aan de beurt op het afgesproken tijdstip	
	Weet wie mijn kind is	
	Is deskundig	
	Werken goed samen en stemmen acties op elkaar af	
	Heeft veel ervaring	
	Geeft mijn kind de zorg waar hij/zij recht op heeft	
	Heeft een goede reputatie	
	Betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 2** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Regelt op korte termijn een afspraak	
	Is vriendelijk	
	Is op redelijke afstand van mijn huis bereikbaar	
	Geeft mijn kind volledige zorg, er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft	
	Heeft veel ervaring	
	Geeft mijn kind de zorg waar hij/zij recht op heeft	
	Heeft een goede relatie met mij en mijn kind	
	Is open over de kwaliteit, kosten, service en werkwijze	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 3** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Is telefonisch goed bereikbaar	
	Neemt de gezondheid van mijn kind serieus	
	Heeft ruime openingstijden	
	Geeft mijn kind zorg welke is afgestemd op de behoeften en wensen van mij en mijn kind	
	Heeft een goede reputatie	
	Betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	
	Heeft een goede relatie met mij en mijn kind	
	Is open over de kwaliteit, kosten, service en werkwijze	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 4** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	De zorg voor mijn kind is betaalbaar	
	Luistert naar mij	
	Heeft veel ervaring	
	Geeft mijn kind de zorg waar hij/zij recht op heeft	
	Heeft een goede reputatie	
	Betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	
	Heeft een goede relatie met mij en mijn kind	
	Is open over de kwaliteit, kosten, service en werkwijze	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 5** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Als mijn kind en ik een afspraak hebben zijn wij aan de beurt op het afgesproken tijdstip	
	Weet wie mijn kind is	
	Heeft ruime openingstijden	
	Geeft mijn kind zorg welke is afgestemd op de behoeften en wensen van mij en mijn kind	
	Is op redelijke afstand van mijn huis bereikbaar	
	Geeft mijn kind volledige zorg, er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft	
	Heeft een goede relatie met mij en mijn kind	
	Is open over de kwaliteit, kosten, service en werkwijze	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 6** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Regelt op korte termijn een afspraak	
	Is vriendelijk	
	Heeft ruime openingstijden	
	Geeft mijn kind zorg welke is afgestemd op de behoeften en wensen van mij en mijn	
	Is deskundig	
	Werken goed samen en stemmen acties op elkaar af	
	Heeft een goede reputatie	
	Betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 7** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Is telefonisch goed bereikbaar	
	Neemt de gezondheid van mijn kind serieus	
	Is op redelijke afstand van mijn huis bereikbaar	
	Geeft mijn kind volledige zorg, er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft	
	Is deskundig	
	Werken goed samen en stemmen acties op elkaar af	
	Heeft veel ervaring	
	Geeft mijn kind de zorg waar hij/zij recht op heeft	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 8** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	De zorg voor mijn kind is betaalbaar	
	Luistert naar mij	
	Heeft ruime openingstijden	
	Geeft mijn kind zorg welke is afgestemd op de behoeften en wensen van mij en mijn kind	
	Is op redelijke afstand van mijn huis bereikbaar	
	Geeft mijn kind volledige zorg, er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft	
	Is deskundig	
	Werken goed samen en stemmen acties op elkaar af	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 9** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Is telefonisch goed bereikbaar	
	Neemt de gezondheid van mijn kind serieus	
	Regelt wanneer ik bel op korte termijn een afspraak	
	Is vriendelijk	
	Is deskundig	
	Werken goed samen en stemmen acties op elkaar af	
	Heeft een goede relatie met mij en mijn kind	
	Is open over de kwaliteit, kosten, service en werkwijze	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 10** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Is telefonisch goed bereikbaar	
	Neemt de gezondheid van mijn kind serieus	
	Als mijn kind en ik een afspraak hebben zijn wij aan de beurt op het afgesproken tijdstip	
	Weet wie mijn kind is	
	Is op redelijke afstand van mijn huis bereikbaar	
	Geeft mijn kind volledige zorg, er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft	
	Heeft een goede reputatie	
	Betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 11** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	Regelt wanneer ik bel op korte termijn een afspraak	
	Is vriendelijk	
	Als mijn kind en ik een afspraak hebben zijn wij aan de beurt op het afgesproken tijdstip	
	Weet wie mijn kind is	
	Heeft ruime openingstijden	
	Geeft mijn kind zorg welke is afgestemd op de behoeften en wensen van mij en mijn kind	
	Heeft veel ervaring	
	Geeft mijn kind de zorg waar hij/zij recht op heeft	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 12** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	De zorg voor mijn kind is betaalbaar	
	Luistert naar mij	
	Is telefonisch goed bereikbaar	
	Neemt de gezondheid van mijn kind serieus	
	Regelt wanneer ik bel op korte termijn een afspraak	
	Is vriendelijk	
	Als mijn kind en ik een afspraak hebben zijn wij aan de beurt op het afgesproken tijdstip	
	Weet wie mijn kind is	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 13** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	De zorg voor mijn kind is betaalbaar	
	Luistert naar mij	
	Als mijn kind en ik een afspraak hebben zijn wij aan de beurt op het afgesproken tijdstip	
	Weet wie mijn kind is	
	Is deskundig	
	Werken goed samen en stemmen acties op elkaar af	
	Heeft een goede relatie met mij en mijn kind	
	Is open over de kwaliteit, kosten, service en werkwijze	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 14** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	De zorg voor mijn kind is betaalbaar	
	Luistert naar mij	
	Regelt wanneer ik bel op korte termijn een afspraak	
	Is vriendelijk	
	Is op redelijke afstand van mijn huis bereikbaar	
	Geeft mijn kind volledige zorg, er zijn geen gebieden waar mijn zorgvraag voor mijn kind onbeantwoord blijft	
	Heeft een goede reputatie	
	Betrekt mij en mijn kind bij het nemen van beslissingen in de zorg voor mijn kind	

Welke van de volgende factoren vindt u het **meest** belangrijk?	**Vraag 15** **De zorgverlener van mijn kind…**	Welke van de volgende factoren vindt u het **minst** belangrijk?
	De zorg voor mijn kind is betaalbaar	
	Luistert naar mij	
	Is telefonisch goed bereikbaar	
	Neemt de gezondheid van mijn kind serieus	
	Heeft ruime openingstijden	
	Geeft mijn kind zorg welke is afgestemd op de behoeften en wensen van mij en mijn kind	
	Heeft veel ervaring	
	Geeft mijn kind de zorg waar hij/zij recht op heeft	

DEEL 3: ACHTERGRONDVRAGEN

17. Wat is uw geslacht?

- O Man
- O Vrouw

18. Wat is uw leeftijd?

_____ Jaar

19. Wat is uw hoogst afgesloten opleiding?

- O Middelbare school of lager
- O MBO
- O HBO
- O WO of hoger

20. Wat is uw werkstatus?

- O Ik werk niet
- O Ik werk parttime (tussen de 12 en 34 uur per week)
- O Ik werk fulltime (meer dan 35 uur per week)

21. In welke provincie woont u?

- O Drenthe
- O Friesland
- O Flevoland
- O Gelderland
- O Groningen
- O Overijssel
- O Utrecht
- O Noord-Holland
- O Zuid-Holland
- O Noord-Brabant
- O Zeeland
- O Limburg

22. Wat is de leeftijd van uw kind(eren)?

Kind 1	Jaar
Kind 2	Jaar
Kind 3	Jaar
Kind 4	Jaar
Kind 5	Jaar

23. Hoe beoordeeld u de gezondheid van uw kind(eren)?

Kind 1	O goed	O matig	O slecht
Kind 2	O goed	O matig	O slecht
Kind 3	O goed	O matig	O slecht
Kind 4	O goed	O matig	O slecht
Kind 5	O goed	O matig	O slecht

24. Hoe vaak heeft uw met uw kind(eren) het afgelopen jaar contact gehad met een zorgverlener uit de eerstelijnsgezondheidszorg (huisarts, fysiotherapeut, tandarts, logopedist, diëtist, kinderthuiszorg, consultatiebureau of schoolarts)

- O Niet
- O 1 tot 2 keer
- O 3 tot 4 keer
- O 5 tot 6 keer
- O Vaker dan 6 keer

Dit is het einde van de enquête, bedankt voor uw medewerking aan dit onderzoek.