Patient Satisfaction and African American Women: A Missing Link in Health Services Research

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Introduction

With the rapid changes taking place in today's health care system, concerns are frequently voiced about the ability of physicians and other health care professionals to respond to the needs of diverse populations. The growth of dissimilar managed care organizations (MCO's) has increased our awareness of the value of consumers' assessments to health care quality. Consumer satisfaction is viewed as an important sentinel of potential problems in health care delivery, and has been linked to health care seeking, treatment compliance, and changes in one's doctor or health plan (Carr-Hill, 1992; Hall & Dornan, 1988; Marshall, Hays, Sherbourne, & Wells, 1993; Strasser, Aharony, & Greenberger, 1993).

Existing measures of patient satisfaction address a variety of domains. These include (1) perceived quality of care provided; (2) perceptions of the care experience; (3) outcomes of care; and (4) interpersonal factors with regards to the way care is provided. The definitions of patient satisfaction reflect assumptions about a patient's perception of health care and the way in which that care is provided.

The determinants of satisfaction are complex and may include such factors as life style, past experiences, future expectations, and the values of both individual and society (Carr-Hill, 1992). From a theoretical perspective, patient satisfaction has been conceptualized using either an expectancy-value model (Strasser, Aharony, & Greenberger, 1993) or a congruency model (Fox & Storms, 1981). Within the expectancy-value framework, satisfaction levels are determined from a comparison of perceived characteristics of health care with expectations for, or an anticipated standard of performance (Pascoe, 1983). Expectations may be shaped and influenced by past experiences with the health care system (one's own or that of a family member) or by an idealized conception of what care should be.

The congruency model assumes that people vary in their orientations to care due to both social and cultural factors and that satisfaction results when individuals' orientation match the conditions of care (Fox & Storms, 1981). This dynamic process be-

tween patient and practitioner influences the nature of health care encounters and contributes to satisfaction levels at any point in time (Strasser et al., 1993).

In both of these models, socio-demographic variables play potentially important roles. For example, financial barriers to access are well documented (Cornelius, 1993; Copeland, 1996; Lillie-Blanton, 1996), but less is known about the ways in which other demographic characteristics, independent of financial resources, influences the use of health services. In particular, there has been relatively little investigation of the impact of gender and race on satisfaction.

Satisfaction and Gender

Understanding how women evaluate health care is important because of the key role women play in health care seeking for themselves and their family members. Women constitute 60% of the outpatient visits made and are the key decision makers for their own health care as well as their family's (Lipkind, 1996; Schappert, 1996; Braus, 1997). They are more experienced and knowledgeable health care consumers than men (Issacs, 1997) and their assessments of the quality of care they receive is critical to utilization decisions. An improved understanding of what women value in health care would be useful in improving primary care services for all consumers.

A plethora of studies have examined the relationship between gender, patient satisfaction, and health care (Hall & Dornan, 1988a; Hall & Dornan, 1988b; Wensing, Jung, Mainz, Olesen, & Grol, 1998; Roter & Hall, 1989; Irish & Hall, 1995; Borges & Waitzkin, 1995; Bertakis, Helms, Callahan, Azari, & Robbins, 1995; Hall, Irish, Roter, Ehrlich, & Miller, 1994; Hall, Irish, Roter, Ehrlich, & Miller, 1994; Elstad, 1994). The results of these studies are conflicting: some authors suggest women are more satisfied than men with medical care received (Weiss, 1988), others find women to be more dissatisfied, and many suggest that there are no gender differences in satisfaction (Hall & Dornan, 1988). Yet, the lack of consistent gender differences in patient satisfaction measures may be due to the insensitivity of current instruments to women's unique concerns. In fact, some instruments have been specifically developed to minimize differences in experiences or expectations by socio-demographic variables, such as gender and race, in order to produce clearer health policy implications (Fox & Storms, 1981).

Some recent studies suggest that there may be important differences in how women and men evaluate health care. For example, a recent study of gender differences in the predictors of patients' overall satisfaction with their primary care physicians found that some structural aspects of health plans—such as the perceived ease of changing physicians or scheduling appointments—had stronger effects on women's overall satisfaction than on men's (Kolodinsky, 1997). Women may also be more likely to

change physicians due to dissatisfaction. In the 1998 Commonwealth Fund Survey of Women's Health, 18% of women ages 18 and over, compared with 9% of men, reported that they had changed physicians due to dissatisfaction in the past 5 years. (The remaining persons had either never changed physicians or changed physicians for other reasons.) Communication problems were the most frequently named reason for changing physicians (i.e., perceiving that their physicians did not listen to them or talked down to them) (Weisman, personal communication). Taken together, these results suggest that some aspects of the health care process that are particularly important to women—such as the quantity, content, or style of communication—may not be measured adequately in standard patient satisfaction instruments.

Satisfaction and Race

Given the well-documented racial differences in services use, the relative lack of attention to potential racial differences in satisfaction is surprising. African Americans are less likely than European Americans to have a regular source of care, to receive preventive care, and to obtain appropriate treatment for common conditions (Cornelius, 1993; Hahn, 1995; Newacheck, Hughes & Stoddard, 1996; Eggleston, Malveaux, Butz, et al., 1998). African Americans are also more likely to enter the health care system later, be sicker on entry, and stay longer than their white counterparts (Edmunds, 1993). Several rationales are given for racial differences in health care use, i.e., inadequate access, problems with child care, fear of hospitals, the possibility of being a guinea pig, the fear of death, lack of insurance coverage connected to unemployment, underemployment, or employment without health care benefits (Copeland, 1996; Lillie-Blanton, et al., 1996; Edmunds, 1993).

Schulman, Rubenstein, Chesley, and Eisenberg (1995) have argued that race as a factor in health services research is ill defined and is used as a proxy for social and economic characteristics associated with lower health care use. Studies utilizing this approach have consistently established the link between poverty and health for low income African American populations. However the body of research examining the link between race, gender, and education is quite small.

Relatively few studies have addressed potential racial differences in satisfaction. A 1986 Robert Wood Johnson Survey on access (Blendon et al., 1989 cited in Lillie-Blanton et al., 1996) found that African American adults were less satisfied than whites with both ambulatory and hospital care received. Although a 1993 Kaiser/Commonwealth Fund Survey did not find racial differences in satisfaction with care, African American respondents were more likely than whites to report that the problems in the health system were serious enough to warrant a restructuring of the system (Lillie-Blanton et al., 1996).

Using the National Survey of Black Americans in his work on race and mental health, Neighbors (1991) found that both problem severity and problem type were more predictive of seeking professional help than income, gender, education, or age. This finding suggesting need as a factor for health utilization is further supported by Burks (1992) in her work on utilization and prenatal services.

African American Women and Satisfaction

African American women make up an important subgroup that has received little research attention. Moreover, for selective preventive health practices, i.e., prenatal care, infant mortality, and pre-term birth, African American women in lower socio-economic groups at high risk for poor pregnancy outcomes are the most frequently studied (Burks, 1992; Walcott-McQuigg, Logan, & Smith, 1994; Murrell, Smith, Gill, & Oxley, 1996; Kelly, Perloff, Morris, & Liu, 1992; Handler, Rosenberg, Raube, & Kelley, 1998).

Recent studies utilizing national data to study health promotion and health education among African American women show that the proportion of African Americans receiving annual examinations is equal to whites, especially among those with high educational levels. In a study of 308 black and white women, with nearly identical age and education levels, who were followed for six years to determine health status and preventive health behavior, health care utilization and health status perceptions were nearly identical (Duelberg, 1992; Nesser, Husaini, Linn, Whitten-Stovall, & Zaharias, 1989).

In their study on social factors and the use of preventive health services among African American women, Lillie-Blanton et al. (1996) found that education, as both a social factor and a proxy for social status, measured a complex process in health services utilization. According to Lillie-Blanton, Bowie, and Ro (1996), “the character of the social encounter between a provider and client is a determining factor in the receipt of health services” (p.100). Lillie-Blanton et al.’s study validated some of the findings reported by Chatters (1991) and Schulman et al. (1995). Their work suggests that the social inequities—which are manifest in the racial differences in income, employment, education, use of emergency room care, and preventive health services use—influence care seeking more than satisfaction with care, although dissatisfaction has some influence. For African American women, education can shape the provider-client interaction in a number of ways. African American women with higher educational levels may possess more confidence in negotiating a specialized system of care, influence with provider, ability to understand information, patience in providers' thoroughness in taking client’s history, candor in sharing information with providers , and consideration for courtesies or explanations afforded either party.

However, in contrast to the documentation that exists on racial differences in health status and services utilization, the number of studies focusing on African American women and health care satisfaction is quite small. Of the research available, existing results vary regarding African American women and satisfaction with health care providers. For example, Lillie-Blanton et al. (1996) found the influence of education and satisfaction with care and social factors on the use of preventive health services. Weiss and Ramsey (1989) found patient satisfaction related to continuity in the physician-patient relationship. Kelley, Perloff, Morris, and Liu (1992) found no relationship between satisfaction and health care utilization. Handler et al. (1998) found a strong relationship between patient satisfaction and practitioner communication about procedures.

The work of Lillie-Blanton et al. (1996) suggests that the process by which care is received, versus how patients think it should be received, is sometimes more important to African Americans than the actual services provided. As a group that has experienced some alienation from the health care system, African American women may be sensitive to social encounters which are not genuinely user-friendly—whether intended or not. Therefore their ability to build trust in their patient-provider relationships and subsequently gain satisfaction in the health care system may be related to both their educational level and racial identity. For example, the research finding in the work by Rainey, Poling, Rheaume, and Kirby (1999) and Murell et al. (1996), regarding low income African American women and health care suggest that these women feel the health care system has pervasive negative stereotypes about them, which are validated via the sometimes differential treatment they receive due to their race and class.

Conclusions

African American women are an important subgroup that has received little attention in research on patient satisfaction. They are diverse with regards to class, income, education, and service use. Race and gender does not make this group monolithic. Lower income, poorly educated women have fewer options and feel less able to manage the health care system than highly educated and higher income women. During the social encounter surrounding the care poor women receive, they feel treated like a stereotype of the "welfare mother living off the system." Their response to this treatment is to withdraw from the system or change providers. Whereas, highly educated and high income African American women are better equipped to manage the system even when they feel stereotypes are present. Their response is to request better service. Thus, being African American may not be as important as the social inequalities of the social encounter during service use. Therefore, the social inequalities of the social encounter may be more predictive of service use than race.

Satisfaction methods need to address the stereotypes perceived by women of color during treatment. Methods to include the perspective of low income African American women in future studies should be developed. Given that the literature on gender and satisfaction primarily focus on European American women, studies on African American women may require satisfaction instruments specifically designed to capture African American women's concerns. Only with such information will we be able to level the health care "playing field" to ensure access to and use of health care resources based on need.

References

Bertakis, K. D., Helms, L. J. , Callhan, E. J., Azari, R. and Robbins, J. A. (April 1995). The influence of gender on physician practice style. Medical Care, 33(4), pp. 407-416.

Borges, S. and Waitzkin, H. (1995). Women's narratives in primary care medical encounters. Women & Health, 23(1), pp. 29-56.

Braus, P. (1997). Marketing health care to women: Meeting new demands for products and services. Ithaca, NY: American Demographics Books.

Burks, J. A. (April 1992). Factors in the utilization of prenatal services by low-income black women. Nurse Practitioner, 17(4), pp. 34, 46, 49.

Carr-Hill, R. A. (1992). The measurement of patient satisfaction. Journal of Public Health Medicine, 14, pp. 236-249.

Chatters, L. M. (1991). Physical Health. In Jackson, James S. (Ed.), Life In Black America. Newbury Park: Sage.

Copeland, V. C. (1996). Immunization among African American children: Implications for social work. Health and Social Work, 21(2), pp. 105-114.

Cornelius, L. J. (1993). Barriers to medical care for white, black, and Hispanic American children. Journal of the National Medical Association, Vol. 85, No. 4, pp. 281-288.

Duelberg, S. I. (1992). Preventive health behavior among black and white women in urban and rural areas. Social Science and Medicine, Vol. 34, No. 2, pp. 191-198.

Edmunds, M. M. (1993). Physical Health. Jackson, James S., Chatters, Linda M. and Taylor, Robert Joseph (Eds.). Aging in Black America (pp. 151-166). Newbury

Park: Sage.

Eggleston, P. A., Malveaux, F. J., Butz, A. M., Huss, K., Thompson, L., Kolodner, K. and Rand, C. S. (March 1998). Medications used by children with asthma living in the inner city. Pediatrics, 101(3), pp. 349-354.

Elstad, J. I. (1994). Women's priorities regarding physician behavior and their preference for a female physician. Women and Health, 21(4), pp, 1-19.

Fox, J. G., Storms, D. M. (1981). A different approach to sociodemographic predictors of satisfaction with health care. Social Science and Medicine, 15(A), pp. 557-564.

Hahn, B. A. (May 1995). Children's health: Racial and ethnic differences in the use of prescription medications. Pediatrics, 95(5), pp. 727-732.

Hall, J. A. and Dornan, M. C. (1988a). Meta-Analysis of satisfaction with medical care: Description of reserch domain and analysis of overall satisfaction levels. Social Science and Medicine, Vol. 27, No 6, pp. 637-644.

Hall, J. A. and Dornan, M. C. (1988b). What patients like about their medical care and how often they are asked: A meta-analysis of the satisfaction literature." Social Science and Medicine, Vol. 27, No. 9, pp. 935-939.

Hall, J. A., Irish, J. T., Roter, D. L., Ehrlich, C. M. and Miller, L. H. (September, 1994). Gender in medical encounters: An analysis of physician and patient communication in a primary care setting. Health Psychology, 13(5), pp. 384-392.

Hall, J. A., Irish, J. T., Roter, D. L., Ehrlich, C. M. and Miller, L. H. (December, 1994). Satisfaction, gender, and communication in medical visits. Medical Care, 32(12), pp. 1216-1231.

Handler, A., Rosenberg, D., Raube, K. and Kelley, M. A. (1998). Health care characteristics associated with women's satisfaction with prenatal care. Medical Care, Vol. 36, No. 5, pp. 679-694.

Irish, J. T. and Hall, J. A. (September, 1995). Interruptive patterns in medical visits: The effects of role, status and gender. Social Science & Medicine, Vol. 41(6), pp. 873-881.

Isaacs, S. L. (1997). Men's and women's information needs when selecting a health plan: Results of a national survey. Journal of the American Medical Women's Asso-

ciation, 52, pp. 57-59.

Kelley, M. A., Perloff, J. D., Morris, N. M. and Liu, W. (1992). Primary care arrangements and access to care among African-American women in three Chicago communities. Women & Health, Vol. 18(4), pp. 91-107.

Kolodinsky, J. (1997). Gender differences in satisfaction with primary care physicians in a managed care health plan. Women and Health, 26, pp. 67-86.

Lillie-Blanton, M., Bowie, J., Ro, M. (1996). African American women social forces and the use of preventive health services. In Falik, Marilyn M., Collins, Karen Scott (Eds.), Women's health: The commonwealth fund survey. (pp. 99-122). Baltimore: John Hopkins University Press.

Lipkind, K. L. (1996). National hospital ambulatory medical care survey: 1993 outpatient department summary. Advance Data from Vital and Health Statistics, No. 276. Hyattsville, MD: National Center for Health Statistics.

Marshall, G. N., Hays, Ron D., Sherbourne, C. D., and Wells, K. B. (1993). The structure of patient satisfaction with outpatient medical care. The American Psychological Association, Inc., Vol. 3, No. 4, pp. 477-483.

Murrell, N. L., Smith, R., Gill, G. and Oxley, G. (1996). Racism and health are access: A dialogue with childbearing women. Health Care for Women International, 17(2), pp. 149-159.

Neighbors, H. (1991). Mental health. In Jackson, James S. (Ed.), Life In Black America. Newbury Park: Sage.

Neser, W. B., Husaini, B. A., Linn, J. G., Whitten-Stovall, R. and Zaharias, J. B. (1989). Health care behavior among urban black and white women. Journal of Health and Social Policy, 1(2), pp. 75-89.

Newacheck, P. W., Hughes, D. C. and Stoddard, J. J. (1996). Children's access to primary care: Differences by race, income, and insurance status. Pediatrics, 97, pp. 26-32.

Pascoe, G. C. (1983). Patient satisfaction in primary health care: A literature review and analysis. Evaluation and Program Planning, 6, pp. 185-210.

Rainy, C., Poling, R., Rheaume, C., Kirby, S. (1999). Views of low-income, African American mothers about child health. Family Community Health, 22(1), pp. 1-15.

Roter, D. L., and Hall, J. A. (1989). Studies of doctor-patient interaction. Annual Review of Public Health, 10, pp. 163-80.

Schappert, S. M. (1996). National ambulatory medical care survey: 1994 summary. Advance Data from Vital and Health Statistics, No. 273. Hyattsville, MD: National Center for Health Statistics.

Schulman, K. A., Rubenstein, L. E., Chesley, F. D., and Eisenberg, J. M. (April 1995, Part II). The roles of race and socioeconomic factors in health services research. HSR: Health Services Research, 30, pp. 179-195.

Strasser, S., Aharony, L. and Greenberger, D. (1993 Summer). The patient satisfaction process: Moving toward a comprehensive model. Medical Care Review, 50, pp. 219-248.

Walcott-McQuigg, J. A., Logan, B. and Smith, E. (1994). Prevention health practices of African American women. Journal of National Black Nurses' Association, 7(1), pp. 25-35.

Weiss, G. L. (1988). Patient satisfaction with primary medical care. Medical Care, 26, pp. 383-392.

Weiss, G. and Ramsey, C. A. (June 1989). Regular source of primary medical care and patient satisfaction, QRB, pp. 180-184.

Wensing, M. J., Hans, P., Mainz, J., Olesen, F. and Grol, R. A. (1998). A systematic review of the literature on patient priorities for general practice care. Part 1: Description of the research domain. Social Science and Medicine, 47(10), pp. 1573-1588.