

An evaluation of patient satisfaction amongst family practice patients with diverse ethnic backgrounds

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Summary

Objective: The aim of this study was to examine the impact of patients' ethnic diversity on the patient satisfaction rates.

Design: We used the methodology developed in an international EUROPE study. The patients were asked to fill in self-administered questionnaires on their evaluations of the care received in the year prior to the survey. The instrument consists of 23 questions regarding specific family physicians' tasks evaluated on a 5 point Likert scale.

Setting: Primary care practices of the National Railway Primary Health Care Services in Slovenia.

Study participants: A questionnaire was handed out to 600 patients cared for by 10 physicians.

Main outcome measures: Percentages of highly satisfied patients in groups of patients with different ethnic backgrounds.

Results: We achieved 65.7% response rate. The overall satisfaction was lower in non-Slovenian patients, however was not significant (83.6 vs. 85.8

points, $p = \text{NS}$). Non-Slovenian patients were less satisfied with regard to: "quick relief of their symptoms", "helping them to feel well so as to be able to perform their normal daily activities", physicians' "thoroughness" and their explanations concerning what the patients wanted to know about their symptoms and/or illness. In a multivariate analysis Slovenian nationality predicted higher patient satisfaction with the clinical "performance" of physicians.

Conclusions: As family practice remains an important source of primary health care for all patients, the providers should address the needs of all members of society regardless their social or cultural background. Undergraduate and postgraduate curricula have to address communication skills emphasising cultural differences.

Key words: primary care; family practice; patient satisfaction; ethnic groups; Eastern Europe

Introduction

Patient satisfaction is regarded as an important outcome of care [1] and it has been demonstrated to influence certain aspects of health related behaviour [2]. Health care systems should guarantee equity in the quality of health care for all patients. Several studies have shown that at least part of observed differences in satisfaction rates can be assigned to patients' demographic characteristics and among them, the diversity of their cultural backgrounds, and the expectations of populations in different countries as important factors contributing to patient (dis)satisfaction [3]. The differences in the quality of health care as measured by patient satisfaction due to cultural diversity also emerge within the same health care system [4-9]. It has been recognised that ethnicity of the patient independently influences physician behaviour [10], so that patients' evaluations of quality of care

can detect differences in physicians' practice style, and are usually lower amongst minority groups [4-6].

Slovenia is a newly independent country in Eastern Europe having reformed its health care system in the nineties, adopting the following features of primary health care: family physicians keep patients lists, they have a gate-keeping role and are paid by mixed capitation – a fee for service scheme. Great emphasis on quality of care has been proclaimed by the health policy makers. Although the country is relatively homogenous regarding language and culture, about 10% of the population are non-native speakers living in the country due to economic migration from other countries of former Yugoslavia during past decades of the common state. As the majority of them moved to Slovenia before independence, they were not obliged to

learn the Slovenian language or adopt local culture. Many of them kept their language and traditional culture and thereby potentially face problems in obtaining health care from native speaking health care providers. Separation movements in Eastern Europe have brought strong xenophobic feelings which potentially influence doctor-patient communication reflected in lower patient satisfaction amongst minority groups. Also socio-political changes which occurred in the last decade might

have hampered equity in receiving quality care. To the best of our knowledge we are not aware of any published study in Eastern Europe examining the relationship between patient satisfaction and cultural background.

In this study we wanted to examine the impact of patients' ethnic diversity on patient satisfaction rates. From previous studies in different countries we predicted that patient satisfaction would be lower amongst non-native patients.

Patients and methods

We used an instrument and methodology developed in an international EUROPE study. The methods and the instrument are described in detail elsewhere [11, 12]. Here we give only a short overview. The instrument consists of 23 questions regarding specific family physicians' tasks evaluated on a 5 point Likert scale.

We recruited 600 consecutive patients visiting 10 family physicians employed by the National Railway Primary Health Care Services in five locations (rural and urban) in Slovenia providing services to the workers, their relatives and retired workers of the National Railways Company. The health care centre was chosen due to the large proportion of workers of non-Slovenian nationality, thus ensuring sufficiently large numbers of respondents in both groups to draw reliable conclusions. The following non-Slovenian nationalities were represented in our sample: Serbs, Moslems, Croats and Albanians. The Moslems from Bosnia declare themselves as an ethnic group and are regarded as a "Moslem" nationality in the countries of former Yugoslavia. We obtained permission from the National Ethics Committee. Persons of non-Slovenian origin living in Slovenia for at least 7 years and capable,

according to doctors' opinion, of understanding the wording of the questionnaire. The patients in the study period from November 1 to November 20 1999 after the consultation with a family physician were approached by the practice nurse who explained the aims of the survey and the possibility to refuse the participation. The patients received a questionnaire in a prepaid and addressed envelope. After 14 days all patients received a mailed reminder. The participation was anonymous.

Intraclass correlation for patient satisfaction scale was 0.96. Factor analysis revealed two factors: factor 1 was associated with physician's clinical behaviour (item 1-17), and factor 2 with the organisation of the health care service (items 18-23). The overall satisfaction scores were calculated using the method described by Baker and Hearnshaw [13], with 0 scores indicating the lowest possible satisfaction and 100 the highest possible satisfaction. Multivariate regression analysis was performed using composite scores of patient satisfaction as the dependent variable and patient and physician characteristics as independent variables.

Results

394 (65.7%) questionnaires out of 600 handed-out returned in the study period. 229 (58.1%) of the respondents were male and 165 (41.9%) were female. There were more male respondents in the non-Slovenian group (78.4 vs. 52.3%, $p < 0.001$). The age of the respondents was 18 to 84 years, mean 49.8 years (SD 13.9 years). The respondents in the non-Slovenian group were on average two years younger (48.3 vs. 50.3, $p < 0.001$). 87 (22.1%) respondents completed primary education, 105 (26.6%) professional training programmes, 156 (39.6%) secondary school and 38 (9.6%) had finished university education. In the non-Slovenian group the education level was lower than in the Slovenian group ($p = 0.04$): 32 (32.3%) respondents completed primary education, 34 (35.1%) professional training programmes, 26 (26.8%) secondary school and 4 (4.1%) had finished university education. The majority of patients were of Slovenian origin (292; 75.1%), 46 (11.8%) Serbs, 26 (6.7%) Moslems, 17 (4.4%) Croats, 2 (0.5%) Albanians and 6 (1.5%) other nationalities. The patients made 0 to 50

primary care visits in the preceding year, mean 7.3 (median = 5.0). 168 (42.6%) patients suffered from a chronic condition. The groups did not differ in the number of office visits or in the percentage of patients with chronic conditions.

Table 1 shows percentages of the responses to the 23 items of the questionnaire by the native and non-native patients.

Non-Slovenian patients evaluated physician clinical behaviour lower than native patients (82.4 vs. 86.4 points, $p = \text{NS}$) with a marginally better factor 2 (also insignificant, 83.9 vs. 82.4 points, $p = \text{NS}$). The overall satisfaction was insignificantly lower in non-native patients (83.6 vs. 85.8 points, $p = \text{NS}$). Non-native patients evaluated the following variables significantly lower: "quick relief of their symptoms", "helping them to feel well so as to be able to perform normal daily activities", physicians' "thoroughness" and explanations concerning what the patients wanted to know about their symptoms and/or illness" (table 1).

In the multivariate regression analysis three patient characteristics predicted higher patient

Table 1

Percentages of responders to the items of the questionnaire, who marked the answer with 5 points on 5 point Likert scale.

Items	nationality		p	national figures ¹
	native	non-native		
1 making you feel you had time during consultations	56.3	44.7	.7	51.2
2 interest in your personal situation	45.7	46.1	.4	46.8
3 making it easy for you to tell him or her about your problems	48.9	38.6	.6	52.0
4 involving you in decisions about your medical care	52.7	45.6	.9	54.8
5 listening to you	68.1	57.1	.1	69.1
6 keeping your records and data confidential	70.3	66.7	.9	74.2
7 quick relief of your symptoms	61.1	51.1	.01	62.9
8 helping you to feel well so as to be able to perform your normal daily activities	56.8	47.3	.03	60.4
9 thoroughness	62.0	53.9	.05	58.0
10 physical examination	55.7	6.7	.4	55.3
11 offering you services for preventing diseases	63.1	58.9	.09	57.2
12 explaining the purpose of tests and treatments	57.2	51.1	.4	56.1
13 telling you what you wanted to know about your symptoms and/or illness	61.7	49.5	.05	61.7
14 help in dealing with emotional problems related to your health status	53.5	46.0	.4	54.6
15 helping you understand the importance of following his or her advice	56.6	53.3	.9	57.8
16 knowing what she/he had done or told you during previous contacts	54.9	51.1	.3	56.1
17 preparing you for what to expect from specialist or hospital care	55.0	48.2	.3	52.3
18 the helpfulness of staff (other than the doctor)	55.3	56.7	.8	56.9
19 getting an appointment to suit you	58.8	52.8	.7	56.9
20 getting through to the practice on the phone	66.1	65.9	.3	70.9
21 being able to speak to the general practitioner on the telephone	68.5	58.8	.6	71.6
22 waiting time in the waiting room	25.5	31.0	.1	23.8
23 providing quick services for urgent health problems	51.5	53.2	.6	61.9

¹ The percentage of the patients evaluating care as very good from a national survey on patient satisfaction [12].

satisfaction with physician clinical behaviour: intention not to change a family physician in the near future, a higher satisfaction with the current health care system and Slovenian nationality (R-square =

0.226, $df = 3$, $F = 15.685$, $p < 0.001$). Only a small part of the variance could be explained by the model.

Discussion

Multi-nationality, multi-ethnicity and diverse cultural backgrounds are more or less normal features of modern societies all around the world [14]. The results of this study show that quality of care as assessed by the patients in terms of overall patient satisfaction does not differ significantly regarding their ethnic backgrounds. The findings are supported by the results of previous evaluations of the patient satisfaction in Slovenia that showed a similar level and pattern of patient satisfaction [12, 15]. Contrary to the results some authors found for other ethnic minorities in other countries, we were not able to demonstrate such drastically lower satisfaction in the non-Slovenian patients [9]. The ethnic differences in our study could explain only a small part of the variance in the patient satisfaction scores. This can be partly explained by the closer relationship of the minority groups with the majority of the population and a long tradition of politically proclaimed equity of all the people. Another explanation for such tiny

differences can be high volumes of non-native patients in the practices under the survey that can bias our findings. The findings of a few items of the questionnaire showing only small significant differences should be interpreted with caution and tested in further surveys. On the other hand, lower evaluation of some aspects of care may reflect difficulties doctors have in communicating with patients according to different expectations of those with diverse ethnic backgrounds, and points to an area of improvement in better care for non-native patients (table 1).

Conclusions

We could not demonstrate any significant differences in the overall satisfaction between Slovenian and non-Slovenian patients, but in some fields there were some small differences regarding lower satisfaction in non-Slovenians, eg, on quick relief of the patients' symptoms, on helping patients feel well enough to be able to perform their normal

daily activities, on thoroughness of the doctor and on the explanation of the patient's symptoms and/or illness. These differences show the necessity that physicians should be more attentive to patients of non-Slovenian origin, showing empathy and understanding to the patients' problems and expectations. As family practice remains an important source of health care for all the patients regardless their ethnic, social or cultural background, the providers should address the needs of the all members of our society [14]. The results of this study support the recently adopted curriculum for undergraduate and postgraduate education which underpins communication skills as a core of each primary care consultation [16]. In spite of the fact that we studied the impact of cultural differences on physician / patient communication amongst non-Slovenians who were able to speak

Slovenian, we can not completely rule out the possibility that some differences might also have been attributable to language problems. A possible effect of different expectations of non-native speaking patients should be examined in the future research.

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