HEALTH CARE UTILISATION AND GENERAL PRACTITIONER SATISFACTION IN YOUNG WOMEN

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ABSTRACT

That existing health care services do not fully cater to women's needs is well documented. In the present study the distinct health needs of young women, as a group, pertaining to general practice care was addressed. The study aimed to examine the impact of general practitioner care on the respondent in terms of her own assessment of the satisfaction derived from this interaction, using quantitative and qualitative data. Other objectives of the study were to identify determining factors associated with young women's heavy use of general practitioner services (using Anderson's Behavioural Model of Health Service Utilisation) and to explore the relationship of selected access factors to health care utilisation and general practitioner satisfaction. A non-random convenience sample of ninety six young women from Wellington city, aged from 18 - 26 years, participated in the questionnaire survey.

Regarding patient satisfaction, the qualitative data showed that the highest priority was accorded to the excellence of the interpersonal rapport established during the consultation, a factor which has been found to be a significant predictor of patient satisfaction in previous studies. The quantitative data showed that the respondents were least satisfied with the quality of information provided by their general practitioner concerning their complaint. Regarding health service utilisation, the chief reason for general practitioner use was the presence of physical symptoms. Accessibility, measured by mode of transport to the general practitioner, emerged as the only significant access factor, whereby young women without private transport were found to utilise general practice services more.

Overall, the results underscore the importance of interpersonal skills in general practice care and the primacy of need factors (rather than predisposing and enabling factors as described in Anderson's model) in determining general practitioner use.

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INTRODUCTION

Overview

In the last few decades both internationally and in New Zealand (NZ), there has been a growing interest in the area of women's health, as illustrated more recently by the 4th World Conference on Women in Beijing (1995), and in NZ, Department of Health inquiries such as the Women's Health Committee Report (Women's Health Committee, 1988).

The major catalyst of this surge in interest in women's health issues, is the women's movement and the development in the 1960's and 1970's of it's offshoot, the women's health movement. The needs and rights of women in society are fundamental issues. Specifically, the women's health movement aims to alter and improve the health system making it more responsive to their needs (Broadsheet, 1980).

Women, as a group, have specific needs aside from those of the community as a whole (Women's Health Committee, 1988). In the health care arena women's needs have clearly not been met. This is evident through NZ research conducted by the Department of Health, and by numerous independent studies. Findings suggest that women are dissatisfied with the way health services are provided, both in terms of the type of service and in terms of their relationships with the medical profession. This theme of women's dissatisfaction appears to run through the overseas literature as well as through the NZ data. Since patients who are dissatisfied with their health care are more likely not to comply with medical advice and treatment (Korsch, Gozzi, & Francis, 1968) and return to their GPer (Ben-Sira, 1976), attention to the causes of their dissatisfaction is of paramount importance.

Women's needs must be known before they can be met. Reliance solely on available statistics, expert opinion, and the views of lobby groups, distorts understanding of

women's health needs, providing an incomplete and possibly bias picture (Redman, Hennrikus, Bowman, & Sanson-Fisher, 1988) - "...results may be biased as they are based on the idiosyncratic views of people who see community needs from their own perspective" (Perkins, Sanson-Fisher, Girgis, Blunden, & Lunnay, 1995, p. 268). Redman et al. (1988) emphasise the unique perspective of consumers of health care. These authors surveyed a random sample of women from the community and found that women's personal priorities differed from the priorities identified by lobby groups. Thus, evidence suggests that women provide a different and valuable perspective on their own health requirements.

The rest of the introduction is organised as follows. Firstly, a rationale for studying young women is proposed. Secondly, patient satisfaction research is reviewed. Implications of patient satisfaction are highlighted and research to date is critically evaluated. Thirdly, Anderson's Behavioural Model of Health Service Utilisation, applied to the study sample, is reviewed and critically assessed. Finally, the research objectives of this thesis are specified.

Why Study Young Women ?

"An[other] emerging and important area concerns the study of 'special' populations who may have unique expectations and cognitive 'sets', as well as different ways of evaluating health providers" (Zastowny, Roghmann, & Cafferata, 1989, p. 705).

The Women's Health Committee Report (Women's Health Committee, 1988) made a number of recommendations. One such recommendation encouraged research into the health needs of specific groups of women. Inder (1996) states, "Young women are often overlooked as a specific group, with distinct characteristics, issues and needs" (p. 20). Supporting this observation, young women are often studied within wider gender or age boundaries. As a result, important findings may be diluted and therefore rarely concentrate on the specific health issues of this group.

In recognition that young women are a distinct group with unique perspective's of health care and the information currently available does not adequately reflect their perspectives, the present study addresses their health needs. Specifically, the study concerns their perceptions and evaluations, as expressed through their satisfaction or dissatisfaction with health care as it is currently provided. The primary value of such information, for the purposes of the present study, would be to identify deficiencies (if any) in health services as perceived by young women that might be manipulated in order to improve the provision of health care and the level of patient satisfaction. To the authors knowledge this is the first investigation in NZ targeted at the health experiences of young women as a specific group.

The present analysis is service specific, in respect of the care young women receive from their general practitioners (GPers). Analysis limited to general practice (GP) care is reasonable since research indicates that GPers are the most widely consulted health professionals in NZ (Household Health Survey, 1992 - 93: cited in Statistics New Zealand, 1993) and young women (aged from 15 - 24 years) visit their GPer more frequently than all other age groups up to the age of 60 years (Ministry of Health and Statistics New Zealand, 1993: cited in Howell, 1996). Thus, in the aggregate young women are disproportionately heavy users of GPer services, a finding similarly reported in overseas data (McPherson, 1993). Following on from the above finding, a secondary focus of the present study concerns the identification of factors which may underlie this comparatively heavy use. Factors have been identified in previous research, however determinants of GP consultations by this specific group, have not been directly addressed.

Hershey, Luft, and Gianaris (1975) advise against analysing utilisation data with a restricted set of independent variables. In light of this the present study includes a full complement of relevant measures (quantitative in nature) derived from Anderson's Behavioural Model of Health Service Utilisation (1968) (see chapter two).

CHAPTER ONE

SATISFACTION IN GENERAL PRACTICE - WHAT DO WOMEN REALLY WANT ?

Health research in the past 20 years has been concerned with a broad range of health behaviours and it's determinants, social and mental as well as physical. The present study adopts this wider view of ***health***, namely "...a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organisation, 1978, p. 2).

Considering the volume of ***patient satisfaction*** research, it would be reasonable to expect some uniformity in the definition of the concept. This however is not the case. Currently there appears to be much confusion, with a variety of definitions being adopted. Hunt (1977: cited in Pascoe, 1983) regards satisfaction as an evaluative reaction resulting from the interaction of the product/situation with the individuals expectations. Implicit in this definition is emphasis on satisfaction as a 'quasi-cognitive construct' rather than an emotion. In contrast with Hunt's definition Linder-Pelz (1982b) views satisfaction as an affective response, determined by the individuals perceptions, attitudes, and comparison processes which exist prior to experiences of health care.

In the authors view patient satisfaction encompasses both of the above domains - cognitive and affective. Thus, the present study adopts a definition offered by Pascoe (1983). In this regard patient satisfaction is seen as involving a cognitively based evaluation of health care and an affectively based response, or emotional reaction to health care.

1.1 Dimensions of Patient Satisfaction

The bulk of research suggests that patient satisfaction is a multi-faceted concept (Lewis, 1994; Linder-Pelz, 1982a; Zastowny, Roghmann, & Hengst, 1983) - "Patient satisfaction

is multidimensional insofar as the individual evaluates distinct aspects of the care in addition to making an overall evaluation of the health care event as a whole" (Linder-Pelz, 1982a, p. 583). The number of dimensions patients distinguish in their evaluations of care, and the nature of such dimensions, is not however universally agreed, although encouragingly there is considerable overlap between the dimensions isolated. In their comprehensive review on patient satisfaction, Ware, Davies, and Stewart (1978) proposed a taxonomy of eight different patient satisfaction dimensions: art of care, technical quality of care, accessibility/convenience, finances, physical environment, availability, continuity and efficacy, and outcomes of care. Subsequent higher-order factor analysis confirmed four distinct satisfaction dimensions: physician conduct, availability of care, continuity/convenience of care, and access mechanisms. Regarding the first dimension of the doctors conduct, Hulka, Zyzanski, Cassel, and Thompson (1970) and Hulka, Zyzanski, Cassel, and Thompson (1971) found that patients clearly tend to distinguish between doctors technical skills and interpersonal skills. Williams and Calnan (1991) reviewed previous patient satisfaction research from America and Britain. Based on their examination they proposed four underlying dimensions of patient satisfaction: the doctor-patient relationship, professional skills and the quality of care, accessibility and availability of health care services, and organisational aspects of care. The authors report confidence in the content validity and exhaustiveness of their schema.

The multidimensional nature of patient satisfaction indicated by previous research has two implications for the present study. Firstly, young women as a group may express varying levels of satisfaction with different aspects of GP care and secondly, differences in an individual woman's experiences across the multiple aspects of care provided by her GPer may also vary. Both of the above implications will be addressed in this study.

1.2 Determinants of Patient Satisfaction

While the specific determinants of patient satisfaction discussed have varied between health care studies, four major categories are identified consistently. These are: (1) Patient characteristics, (2) Provider characteristics, (3) General practitioner-patient interaction, and (4) Organisational and access factors. The following discussion details research related to the determinants of patient satisfaction outlined above[1]. Note, this is not an exhaustive review, instead it presents a number of illustrative studies which conveys a reasonable cross-section of the research to date.

1.2.1 Patient characteristics

Patient characteristics may be divided into two categories, attitudes and sociodemographic characteristics. The following brief discussion shall examine these categories.

Several studies have demonstrated that patient ***attitudes*** towards health care services influence satisfaction (Greenley & Schoenherr, 1981; Tessler & Mechanic, 1975). An American study examining satisfaction with different practice plans found degree of satisfaction to be related to several factors, including low skepticism toward medical care (Tessler & Mechanic, 1975). Greenley and Schoenherr (1981) found that patients with negative attitudes regarding health care services (i.e., that such facilities generally provide low-quality service) were less satisfied.

Regarding ***sociodemographic correlates of patient satisfaction***, conflicting results have been obtained. Patient's age has demonstrated the most consistent relationship with health care satisfaction. Most reviewers agree that older patients are more satisfied (Hall & Dornan, 1990; Locker & Dunt, 1978; Pascoe, 1983; Ware et al., 1978). A number of possibilities are suggested to account for this finding: it may reflect differences in the experience of health care between generations, for example, older patients may have closer relationships with their GPers (Cartwright, 1967; Cartwright & Anderson, 1981; Locker & Dunt, 1978) or may reflect a greater

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1 Organisational factors are not addressed in the present study, thus will not be discussed.

deference and respect by older persons towards health professionals (Williams & Calnan, 1991). Older patients may be less critical and have lower expectations as far as the care they receive is concerned (Hall & Dornan, 1990). Supporting this possibility Cartwright and Anderson (1981) found that person's over 65 years of age expected less information from their GPers. GPers may be more responsive in providing treatment for older patients (Hall & Dornan, 1990). A videotape study cited by these authors provides some support for this hypothesis. The study found physicians to be "...less communicatively dominant, more nonverbally responsive as listeners, and more egalitarian in their interactions with middle-aged and older patients relative to their encounters with younger clients" (Street & Buller, 1988, p. 81: cited in Hall & Dornan, 1990, p. 817). The nature of the patients presenting illness may be important. Dr. K. S. De Silva believes that GPers in general are more receptive and tend to pay more attention to illnesses which may have an organic basis, as is commonly the case in the older population, whereas GPers, perhaps partly by virtue of the training they have received, tend to be more uneasy and uncertain in their management of symptoms which may have a functional basis, which is more common in the younger age group (personal communication, June 18, 1996).

Pertaining to sex of patients and health service satisfaction, findings are mixed. Several reviews have identified women as being slightly more satisfied than men (Pascoe, 1983; Ware et al., 1978; Weiss, 1988). A meta-analysis by Hall and Dornan (1990) however failed to sustain such findings. Upon examination of cited studies previously reviewed, these authors found only four showing women to be more satisfied. They thus state, "...it seems that our meta-analysis reached the appropriate conclusion regarding patient sex" (p. 816), namely absence of a male - female difference in satisfaction.

Inconsistent findings have also been obtained with regard to the relationship between patient satisfaction and sociodemographic variables such as income, education, occupation, social class, marital status, family size, religion, and race (Fox & Storms, 1981). In general, when a relation is found it is reported to be weak (Hall & Dornan, 1990; Ware et al., 1978). Hall and Dornan (1990) argue that "Finding weak relations

between satisfaction and background variables lends support to the validity of the satisfaction instruments, since they were designed to measure events (or perceptions of events) in the process of medical care and not simply be a reflection of response biases of the patient" (p. 816).

Several possibilities are suggested to account for conflicting results. Like and Zyzanski (1987) suggest that individual responses may differ depending on (a) whether the patient responds to items regarding a specific clinical encounter, their own GPer, or GPers in general; (b) whether the patient is surveyed when she[2] is actively seeking care, as opposed to when she is healthy and not seeking care; (c) where the study is being conducted (for example, in a hospital, private clinic, or in the patients home). Other explanations include: true population differences in the relationships (Ware & Snyder, 1975), measurement problems and differences (for example, nonstandardisation and varying operational definitions of variables), and methodological pitfalls (including sampling bias and reliability of scores) (Health Services Research Group, 1992; Ware & Snyder, 1975).

In summary, older patients consistently report greater satisfaction with health care implying that younger patients report the opposite. The present study, regarding GP care, investigates the sources of young women's dissatisfaction (if any). Regarding sociodemographic variables apart from age, inconsistent results have been obtained "...leading to the necessity for further clarification of the variables most important in patient satisfaction outcome" (Murphy-Cullen & Larsen, 1984, p. 163). In adopting this view the present research includes a full complement of relevant sociodemographic variables.

1.2.2 Provider characteristics

Provider characteristics may be divided into two categories, sociodemographic characteristics and personal attributes i.e., the providers technical and interpersonal skill. In the following, these categories shall be briefly discussed.

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[2] Given that the focus of the present research is on women - henceforth 'she' and 'her' will be used to refer to both 'she' and 'he' and 'her' and 'his'.

Examination of GPers ***sociodemographic characteristics*** as potential determinants of patient satisfaction is scant in the literature to date. Although there are findings to the contrary (Anderson & Zimmerman, 1993), findings reported in several studies indicate that these characteristics influence satisfaction levels (Comstock, Hooper, Goodwin, & Goodwin, 1982; Hall & Dornan, 1988a; Murphy-Cullen & Larsen, 1984; Ross, Mirowsky, & Duff, 1982). Murphy-Cullen and Larsen (1984) found that patients in their sample preferred the younger, less experienced physicians. Corroborating this finding, Hall and Dornan's (1988a) meta-analysis of satisfaction with medical care found that younger GPers received higher satisfaction ratings than more experienced GPers. Ross et al. (1982) show that younger GPers display more competence, technically and interpersonally. These authors assert "...that clients have expectations not just of what a physician does, but of who a physician is, and that these expectations affect satisfaction" (p. 327).

Pertaining to the providers ***personal attributes***, it appears, rather surprisingly, that the GPers technical skills are not always accorded high priority. Interpersonal skills correlate better with satisfaction ratings in a number of studies (see section 1.2.3).

In summary, research suggests that provider characteristics impact patient satisfaction. For the purposes of the present study, the GPers personal attributes are examined as potential determinants of young women's satisfaction in both the quantitative and qualitative data.

1.2.3 General practitioner-patient interaction

"Care of the Dr-patient relationship has far too long been left to chance; because of it's importance to GP it must now be examined, defined, and taught, for only then can it be practiced efficiently" (Editorial, 1967, p. 483). Numerous studies since the 1970's have investigated the impact of factors within the GPer-patient relationship on the patient's levels of satisfaction. Elements of the relationship that have been shown to influence patient satisfaction include: communication between GPer and patient, negotiative quality, and the affective tone of the relationship.

Within each of the above domains, selected studies are illustrated in the following which identify the main issues and themes related to patient satisfaction. In addition two further issues shall be briefly discussed, GPer-patient divergence and gender in GPer-patient relationships.

COMMUNICATION BETWEEN GENERAL PRACTITIONER AND PATIENT

"Communication is a process by which senders and receivers of messages interact in given social contexts" (Bennett, 1976, p. 3). Previous studies indicate that patients are highly reactive to GPer communication behaviour's. In general, patients value clear information about health issues (Gerace & Sangster, 1987; Kincey, Bradshaw, & Ley, 1975; Woolley, Kane, Hughes, & Wright, 1978), and sometimes even prefer it to medical treatment (Van de Kar, Knottnerus, Meertens, Dubois, & Kok, 1992). Listening skills are favoured by a majority of patients (Auckland, 1989: cited in Buchanan, 1991; Smith & Armstrong, 1989), indeed a NZ study found that 69% of patients were dissatisfied by their GPers failure to listen (Burt & Cooper, 1983) although 96% of NZ patients in Richards and McPherson's (1982) study were satisfied with their GPers listening skills. Amount of information conveyed to patients has been positively related to satisfaction (Hall & Dornan, 1988b), GPers being critised for failing to volunteer enough (Cartwright & Anderson, 1981). Seligmann, McGrath, and Pratt (1957: cited in Korsch et al., 1968) found that GPers tend to underestimate the patients understanding of their illness and medical knowledge, which leads them to provide less information. Some patients however avoid information, especially if it might have negative connotations (Armstrong, 1991).

Patient dissatisfaction has been associated with the lack of a clear explanation by the GPer concerning the diagnosis and causation of their complaints (Korsch et al., 1968). Tuckett (1981) demonstrated that adequate explanations are rare in GP consultations. Patient dissatisfaction has also been linked to GPers use of technical language (Korsch et al., 1968) - "...health terms have both a clinical and lay meaning, constituting a basis for misunderstanding which could lead to patient dissatisfaction" (Hadlow & Pitts, 1991, p. 195). Studies have demonstrated differences of understanding of common medical terms between GPers and patients (Boyle, 1970).

The potential benefits of improved communication between GPer and patient include: greater patient satisfaction (Bartlett et al., 1984; Korsch et al., 1968), greater GPer satisfaction (Caughey, 1987; Winefield & Murrell, 1992), increased compliance with treatment regimes, (Bartlett et al., 1984) and reduced anxiety and distress (Ley, 1988: cited in Buchanan, 1991), whereas a major effect of poor communication is patient dissatisfaction. As stated by Davis and Fallowfield (1991), "Such feelings detract from the value of the consultation by interfering with its real concerns" (p. 9).

NEGOTIATIVE QUALITY refers to participation by the patient in decision-making. "Physician-patient interaction is rooted in a power relationship" (Haug & Lavin, 1981, p. 212), in this regard the GPer traditionally is authoritative and powerful whilst the patient is dependent and passive. A strong consumer movement toward increased participation in decision-making has occurred in recent decades - "...consumerism is incompatible with the sick-role model of the dependent patient and the doctor authority figure" (Haug & Lavin, 1981, p. 213).

Patient participation in decision-making implies understanding and respect for the views held by both protagonists involved in the GPer-patient relationship. This has been associated with: patient satisfaction (Anderson & Zimmerman, 1993; Bertakis, Roter, & Putnam, 1991; Buller & Buller, 1987), sense of personal control, which has been associated with improved treatment outcomes (England & Evans, 1992), increased compliance (Eisenthal, Emery, Lazare, & Udin, 1979; Eisenthal & Lazare, 1977; Stewart, 1984), and a higher level of perceived GPer competency (Pendleton, 1981: cited in Editorial, 1983). Although some GPers interpret patient's participatory behaviour as challenging their authority (Stimson, 1976: cited in McCormick, 1979), others believe that the autonomy of the patient should be respected and indeed encouraged (Fabb, 1995).

Some patients do put themselves entirely and unquestioningly in the GPers hands, for example, patients presenting physical problems and patients receiving prescriptions have been found to prefer generally a directed, rather than a shared style of consultation (Savage & Armstrong, 1990). As with any relationship between two

individuals, personality factors dictate preference. It is of importance therefore that GPers be sensitive to individual differences and preferences and be flexible in dispensing care.

AFFECTIVE TONE OF THE RELATIONSHIP refers to the interpersonal relationship between the GPer and patient. It has been argued that patients do not distinguish between technical and interpersonal aspects of health care[3] (Like & Zyzanski, 1987; Ware et al., 1978), however, the bulk of research refutes this finding (Baker, 1990; DiMatteo, Taranta, Friedman, & Prince, 1980; Hulka, Kupper, Daly, Cassel, & Schoen, 1975.; Segall & Burnett, 1980; Ware & Snyder, 1975; Williams & Calnan, 1991). A GPers technical skills have been related to patient satisfaction (Ben-Sira, 1982; Haigh & Armstrong, 1989; Ross, Wheaten, & Duff, 1981; Williams & Calnan, 1991; Willson & McNamara, 1982). Professional competence however, as noted previously, is not always accorded high priority by patients (Segall & Burnett, 1980). In an Australian study, only 6% of the patients identified 'knowledge and skill' as qualities that GPers require, 46% of respondents mentioned understanding and compassion (Cymbalist & Wolff, 1988). In questions asking subjects the qualities of a good GPer, Lloyd, Lupton, and Donaldson (1991) found that 65% gave responses relating to interpersonal features and 56% to technical features of care. A GPers interpersonal skills (ability to communicate, empathise, show concern) have also been related directly to patient satisfaction (Ben-Sira, 1976; Brody, Miller, Lerman, Smith, Lazaro, & Blum, 1989; Buller & Buller, 1987; DiMatteo & Hays, 1980; Korsch et al., 1968; Larson & Rootman, 1976; Ross et al., 1981; Willson & McNamara, 1982). There is evidence that female GPers are more strongly oriented towards interpersonal aspects of care (Heins, Hendricks, Martindale, Smock, Stein, & Jacobs, 1979; Weisman & Teitelbaum, 1985) and personality tests conducted on female GPers have confirmed this finding (Waller, 1988).

Thus, it appears that interpersonal aspects of care are as relevant to satisfaction in GP as are technical aspects. As stated by Donabedian (1988), "...the interpersonal process

[3] Interpersonal care is variously labeled 'affective quality', 'personal interest' and 'expressive' and is contrasted with dimensions related to the GPers technical ability or professional competence.

is the vehicle by which technical care is implemented and on which its success depends" (p. 1744).

GENERAL PRACTITIONER/PATIENT DIVERGENCE refers to the extent to which GPers and patients expectations and perceptions differ. Wilson (1963: cited in McKinlay, 1972) conceives of the GPers role as being partially defined by the patient's expectations (and vice versa). It follows therefore that when the expectations of the parties involved conflict, the overall consultation as well as the outcome will be less than desirable.

The concept of patient expectations is problematic as some patients do not have specific expectations (Lipton & Svarstad, 1974), or are uncertain what to expect from health care (Fitzpatrick, 1983: cited in Calnan, 1988), however, previous studies have shown that many patients do have expectations of GPer care and when unfulfilled satisfaction tends to be low (Korsch et al., 1968; Larson & Rootman, 1976; Ross et al., 1981). Patients are also less likely to comply with treatment regimes and return for appointments (Francis, Korsch, & Morris, 1969; Hayes-Bautista, 1976; Kincey et al., 1975; Stimson, 1974). These expectations include adequate technical expertise as well as GPer sensitivity in terms of interpersonal care (Cartwright & Anderson, 1981; Korsch et al., 1968; Laing, 1995).

It is important to note, some patients hold unrealistic or 'inappropriate' expectations of their illness as well as its outcome (Williamson, 1989). It behoves the GPer to clear these misapprehensions to the best of his or her ability to provide for a more satisfactory outcome.

Previous research indicates a lack of congruency in GPers and patients perceptions (Anderson & Zimmerman, 1993; Kurata, Nogawa, Phillips, Hoffman, & Werblun, 1992; Martin, Russell, Goodwin, Chapman, North, & Sheridan, 1991; Rasid, Forman, Jagger, & Mann, 1989). Martin et al. (1991) found significant divergence between GPers and patients perceptions concerning severity of illness, cause and nature of the complaint, and content of the consultation. Anderson and Zimmerman (1993) found

that GPer-patient agreement, although not related to subsequent patient satisfaction, was no better than chance. It is important that GPers realise how these differing expectations and perceptions, both on their part as well as their patients, can crucially affect outcomes.

GENDER IN GENERAL PRACTITIONER-PATIENT RELATIONSHIPS

Few studies of patient satisfaction consider the sex of the GPer as an explanatory variable. An American study (Ross et al., 1982) found that when patients were assigned to GPers (i.e., in large prepaid group practices) they were less satisfied with GPers whose characteristics were 'non-normative'. Although not explicitly stated by these authors this may have implied that because male GPers are generally in the majority, female GPers received poorer satisfaction ratings. Thus, patients were less satisfied with female GPers than with male GPers, whereas numerous other studies indicate that female patients prefer to consult female GPers (Callacombe, 1983; Cartwright, 1967; Gray, 1982) and Comstock et al. (1982) found significantly higher female patient satisfaction with female GPers.

In summary, research pertaining to GPer-patient interaction shows that patients place emphasis on the relationship established in the GP consultation, and the way the relationship is perceived by the patient can affect subsequent satisfaction. Specifically, patients value adequate explanation regarding their complaint, conveyed in understandable terms. Patients desire a GPer who listens to them, promotes an interactive relationship, and displays an 'interpersonal rapport' in addition to technical expertise, both these aspects being relevant predictors of patient satisfaction. Research also shows that differing GPer-patient expectations can adversely affect outcomes, in terms of patient dissatisfaction, failure to keep appointments, and noncompliance with treatment regimes. Unfulfilled patient expectations can lead to lower satisfaction ratings. Pertaining to GPer gender, the bulk of research suggests that female patients prefer to consult female GPers and some women report greater satisfaction following same-sex interactions.

The present study seeks to either confirm or refute the above findings by obtaining the views of young women on their interactions with their GPers. Attention was specifically directed at the nature of the interaction, expectations brought to the consultation, and expectations unfulfilled (if any). Also their perceptions of desirable and undesirable attributes of GPers in general were sought. The study also addressed young women's perceptions of (including preferences for) male and female GPers. Certain open-ended questions addressed these issues affording the opportunity for young women to formulate their own response. Additionally, a 7-item instrument accessing GPer performance was adapted from a previous study (Gray, 1980). A rating scale methodology was utilised to gauge young women's views.

1.2.4 Access factors

Thus far we have examined patient and provider characteristics and GPer-patient interaction as determinants of patient satisfaction. The fourth major category identified by previous research reflects access factors.

Although 'access' has been discussed frequently, definition of the concept has been broad and nonspecific. Penchansky and Thomas (1981) define it in multidimensional terms. According to these authors the concept of access summarises a set of specific dimensions representing the degree of fit between the patient and the delivery system. The specific dimensions identified are: availability, acceptability, affordability, accommodation, and accessibility. Empirical evidence provides strong support for the existence and validity of the dimensions proposed.

Several previous studies have utilised access factors to predict GPer utilisation (Gribben, 1992,1993). As the present study concerns patient satisfaction and GPer utilisation, the following brief discussion examines access factors (affordability, accommodation, accessibility)[4] and their relationship with both.

[4] These are the foci of the present study.

AFFORDABILITY refers to the relationship of cost of health services to the patients income and ability to pay. In 1993 major changes in the NZ health subsidy situation occurred. Under the present system, government subsidies are provided for the visits of children and holders of community service or high-user cards. Those who do not fit the above criteria are not subsidised for doctors fees.

Little research has addressed the effect of the change on use of GPer services and patient satisfaction. Significant dissatisfaction with GPer charges has been documented in NZ research prior to 1993 (Doctor, doctor, 1992; Fergussion, Horwood, & Shane, 1989; Gribben, 1993; Thomson, 1987; Walton, Romans-Clarkson, & Muller, 1988). Thomson (1987) surveyed 100 patients in a solo rural practice and found a 23% level of dissatisfaction with GPer fees. Walton et al. (1988) surveyed 2000 women from the community. Comments about the cost of a visit to a GPer were unanimously unfavourable. Fergussion et al. (1989) found widespread dissatisfaction regarding GPer charges, over two-thirds of respondents thought that charges for adult consultations were too high.

NZ GPers charges have been clearly shown to have significant variability (Doctors' fees, 1996; Thomson, 1989). Thomson (1989) surveyed GPers in the Auckland urban area and found that variability of GPer fees was not significantly related to quality of the service, workload, practice structure, or location. Results did not provide the reasons for variability. The Consumer (Doctors' fees, 1996) asserts that GPers can charge whatever they like. Higher fees levied by certain GPers in various geographical areas could be a contributing factor for further patient dissatisfaction.

A recent survey included 102 GPers in face-to-face interviews. Forty two percent reported increasing patient fees since the introduction of the health reforms. Seventy one percent said they believed cost concerns were a barrier to health care ('Patients delaying GP visits', 1995). These beliefs are reflected in the data provided by several NZ studies (Clarkson & Lafferty, 1984; Dixon, Watt, Thompson, Lewis, Crane, & Burgess, 1994; Doctor, doctor, 1992). Dixon et al. (1994) found that 40% of patients attending nineteen GPers delayed visiting their doctor. The most common reasons for

delay were hope that their illness would improve spontaneously and the cost of the consultation. The Consumer (Doctor, doctor, 1992) reported similar findings relating to delays in doctor visits because of perceived high charges. For some whose illnesses initially were minor but subsequently worsened, hospitalisation became necessary. A study conducted in Northland (Flight, 1986: cited in Gribben, 1992) demonstrated an association of lower fees with higher utilisation. Stone (1988) states, "...consultation fees inhibit use by many Maori people" (p. 34). Other studies have failed to find an association between patient fees and utilisation of GPer services (Burt & Cooper, 1983; Gribben, 1992). Burt and Cooper (1983) in a study of self-medication, reported that only 4% of patients were often discouraged from consulting the GPer because of medical costs. McKinlay (1972) argues that the association between health service costs and utilisation is indirect. The author states, "...differences in the presence of financial resources alone cannot adequately account for patterns of utilisation" (p. 120).

A priority health issue for many individuals is free health care. The Women's Health Committee Report (Women's Health Committee, 1988) recommends that "...the current financial barriers to access should be removed" (p. 29). An Australian study (Wyn & Stewart, 1992) interviewed 100 young women and found that the majority advocated free medical care. A very recent development in NZ saw 'The Next Step Democracy Movement' collect 130,000 petitions seeking free health care. Alliance leader Jim Anderton said, "...it behoves politicians to listen seriously to what's being said" ('Health, education petitions', 1996, p. 2), however the medical fraternity in NZ believes that the traditional fee-for-service principle should be maintained.

In summary, NZ research prior to the government subsidy reforms indicates significant patient dissatisfaction with GPer fees. Variability in consultation charges (geographical and amongst GPers) has been documented by several authors. GPer utilisation levels were inversely associated with GPer fees and currently free health care is advocated by many NZers. Current research is necessary to monitor patient satisfaction and GPer utilisation patterns as consultation charges change, among different categories of patients and in the various geographical regions of NZ. The

present study reflects this need in investigating young women's levels of satisfaction with GPer fees and subsequent use of GPer services.

ACCOMMODATION relates to 'customer service' features of the providers service and the patients ability to accommodate to these features and perception of their appropriateness. Principal among these features are appointment systems, waiting times, and length of consultations. The former two features are addressed in this study and will be briefly discussed in the following.

Appointments for GP consultations are now the norm in New Zealand (Gribben, 1992; Richards & McPherson., 1981). Richards and McPherson (1981) found that 94% of all doctors in NZ used an appointment system. In a recent study Gribben's (1992) reported similar findings, where 95% of doctors consulted by patients operated an appointment system. Although such systems are the norm many doctors find it difficult to adhere to their appointment schedules (Walton, Romans-Clarkson & Herbison, 1990). Reasons include: the desire of patients to discuss problems and complaints additional to those they initially presented with, the requirement for time-consuming counselling, multiple consultations involving other family members (Walton et al., 1988), and the need to consult urgent cases (Dr. K. S. de Silva, personal communication, July 10, 1996). Such delays adversely affect provider satisfaction (Kurata et al., 1992; Walton et al., 1990) and patient satisfaction (Kurata et al., 1992). Walton et al. (1990) suggest that appointment schedules may be better maintained if patients are made aware of normal consultation duration and that specific requests for longer consultations may well be accommodated if prior notice is provided.

Gribben (1992) found that 80% of individuals surveyed in Auckland were able to get an appointment on the same day and 13% had to wait until the following day. In areas where GP services are less easily obtained, securing appointments on the same day is more difficult. Burt and Cooper (1983) found that only 36% of Invercargill patients sampled were able to obtain an appointment on the same day, whilst 8% reported usual delays of four or more days. Pascoe (1983) cites several British and American

studies which show increased satisfaction for lessened appointment difficulties and briefer delays in obtaining services.

Their is no NZ data regarding patient satisfaction with the structured appointment system currently in use. An Australian study (Wyn & Stewart, 1992) targeted at young women found appreciable dissatisfaction with the above system. Many young women felt the drop-in system allowed for a high degree of flexibility which did not involve planning ahead. Findings by Allen, Leavey, and Marks (1988) however, suggest that patients using open access systems are more than twice as likely to delay consulting their GPer due to anticipated waiting time in the doctor's surgery than are users of appointment systems concerned about securing appointments. Thus, a mixed system where patients present on certain days or within specified times may be a reasonable compromise for those patients who prefer a degree of flexibility. This system applies to many Australian practices (Allen et al., 1988).

A number of NZ studies suggest that patients are dissatisfied with the ***waiting time*** in the GPers surgery prior to consultation (Doctor, doctor, 1992; Gribben, 1993). The Consumer (Doctor, doctor, 1992) surveyed 1600 members and found an average waiting time of 20 minutes for users of GPer services. Similarly, Gribben (1992) found a median waiting time of 20 minutes for a population of South Auckland residents. Individuals in both studies expressed dissatisfaction with this service feature. Reti (1994) assessed the relative arrival and waiting time's for 407 Whangarei booked patients and found that the majority of patients arrive early for their appointments. An Australian study confirms these findings, with the majority of patients arriving 5.5 minutes before their allotted appointment (Jackson, 1991). Consequently, these patients have a longer actual waiting time than on time or late patients. Reti suggests modification of patients arrival time may reduce overall waiting time.

Allen et al. (1988) surveyed 793 patients and found, for patients with an appointment, 41% usually waited less than 15 minutes, 33% waited 15-30 minutes, and 19% waited more than 30 minutes. The corresponding figures for patients without an appointment

were 18%, 30%, and 47%. While these findings suggest shorter waiting time's when appointment systems are in use, paradoxically both groups appeared equally satisfied with the waiting time required. This could be because patients without an appointment anticipated longer waiting time and were prepared to accept this inconvenience to secure a consultation.

The importance of reducing waiting time's is highlighted by the following: shorter waiting time's have been found to increase patient satisfaction (Aday & Anderson, 1975: cited in Steven & Douglas, 1988), long waiting time's are associated with decreased utilisation of GPer services (Gribben, 1992; Walton et al., 1988), and have been shown to increase patient dissatisfaction with unrelated aspects of surgery routine such as courtesy shown by nurses (Aday & Anderson, 1975: cited in Steven & Douglas, 1988), and decrease patient willingness to discuss issues related to the presenting illness, or on health advice (Doctor, doctor, 1992).

In summary, although most NZ GPers use an appointment system, appointment schedules are not always maintained. Reasons were suggested as to why this is so. Results also imply that GP numbers per population served partly determines whether appointments are easily obtained. A mixed system, as previously described (which allows patients to consult GPers without an appointment), may provide the mechanism for those patients who desire a degree of flexibility. Patient dissatisfaction with the waiting time prior to their consultation is indicated by previous research. Shorter waiting times are associated with increased satisfaction, whereas long waiting times are associated with decreased GPer use.

The present study examines young women's waiting time to obtain an appointment and waiting time in the GPers surgery before their consultation and the effect of these factors (if any) on patient satisfaction and GPer utilisation.

ACCESSIBILITY refers to geographic accessibility, taking account of mode of transport to the GPer, distance to cover, travel time, and cost. Urban based population studies have found that distance to cover and travel time/cost to the GPer have little

effect on utilisation of medical services (Bice, Eichhorn, & Fox, 1972; McKinlay, 1972; Morrell, Gage, & Robinson, 1970) although this effect is well established for rural populations (Morrell et al., 1970; Wyn & Stewart, 1992; Walton et al., 1988). Bice et al. (1972) argue that greater availability of public transport and the concentration of medical services in urban areas, means that patients living in these areas are less affected by these accessibility features. Based on these findings the present study shall focus on ***mode of transport*** to the GPer.

The NZ 1991 Census showed that 12.5% of private homes were without a private vehicle (Department of Statistics, 1992: cited in Barwick, 1992). Richards and McPherson (1982) interviewed 1373 heads of households, 78% of which were women, and found that 62% had access to a private vehicle, 27% walked, and 8% used various other means to get to their doctor. Corresponding figures for women reported by the Social Indicators Survey (Department of Statistics, 1984) were 67%, 23%, and 9%. The respective figures for men were 87%, 9%, and 3%. These figures suggest that NZ women are comparatively disadvantaged in access to transport. "The lack of access to transport impacts upon health directly in reducing access to health care services" (Barwick, 1992, p. 50). The above studies did not investigate any association with health utilisation directly. Gribben (1992) in a survey of South Auckland residents reported no association between mode of transport and use of GPer services.

An Australian study (Wyn & Stewart, 1992) surveyed 100 young women and found the majority to be concerned about accessibility to health care. Many respondents advocated locally based health centres within easy reach of transport. Three quarters of young women sampled utilised medical services in their local area.

In summary, results suggest that the majority of patients use private transport to get to their GPer, however, women appear slightly disadvantaged in access to a private vehicle. The present study explores young women's means of transport to their GPer and whether this influences subsequent levels of satisfaction and utilisation of services.

1.3 Implications of Patient Satisfaction

A number of studies have related patient satisfaction with commitment to a GPer and have documented that satisfied patients are more likely to remain committed (Hulka et al., 1970; Pascoe, 1983; Ware & Davies, 1983). Conversely, studies indicate that dissatisfied patients are more likely to 'doctor-shop' (Kasteler, Kane, Olsen & Thetford, 1976; Vuori, Aaku, Aine, Erkko, & Johansson, 1972). Kasteler et al. (1976) studied 1,897 patients from upper-and lower-income households. Forty eight percent of upper and 37% of lower income families in the sample had changed doctors because of dissatisfaction with a variety of aspects of medical care received.

Considerable research has demonstrated that patient satisfaction is an important predictor of certain health related behaviours i.e., satisfied patients are more likely to keep appointments (Francis et al., 1969; Hertz & Stamps, 1977) and comply with treatments (Kincey et al., 1975; Linder-Pelz & Struening, 1985; Pascoe, 1983; Starfield, Wray, Hess, Gross, Birk, & D'Lugoff, 1981; Vuori et al., 1972; Willson & McNamara, 1982) although Francis et al. (1969) found that a substantial number of highly satisfied patients failed to follow the GPers advice. "Such behavioural consequences of patient satisfaction should result in better medical care and improved outcomes, but only if satisfaction correlates primarily with health care of high technical quality" (Health Service Research Group, 1992, p. 1728).

Regarding the relationship between patient satisfaction and utilisation of health services, findings are mixed. Roghmann, Hengst, and Zastowny (1979) found that satisfaction increased the predictability of utilisation. The direction of the relationship varied from setting to setting. Mirowsky and Ross (1983) found that satisfaction with the doctor increased the frequency of visiting the doctor which, in turn, decreased satisfaction. Zastowny et al. (1983) cite several studies which reveal conflicting findings with regard to mutual dependency between satisfaction and utilisation. It appears, therefore, based on research to date, that "...the relation of satisfaction with utilisation still requires theoretic and empiric clarification" (Zastowny et al., 1983, p. 294).

The past 30 years has seen an increase in the use of alternative care systems, such as naturapathy, acupuncture, and herbalism. Several authors have suggested that the increasing recourse to these non-conventional medical services indicates a degree of dissatisfaction with orthodox medicine (Hull, 1984; Tonkin, 1982) however, there is no empirical research which demonstrates this effect and as indicated by Donnelly, Spykerboer, and Thong (1985), usually alternative medicine is used as an adjunct to orthodox medicine and patients express satisfaction with both, as such it is unlikely "...that patients who use alternative medicine are those who are disgruntled with orthodox medicine" (p. 539).

1.4 Methodological Issues

This section shall briefly discuss several methodological issues relating to research in patient satisfaction. Firstly, previous studies have found that patients tend to rate medical care highly (Gray, 1980; Kincey et al., 1975). While such positive ratings may reflect the true nature of patient satisfaction (Pascoe, 1983) other factors may contribute to this finding. Scores may be high as a result of the 'courtesy factor' - "...a tendency for respondents to provide answers which are non-controversial, agreeable, and socially desirable" (Donnelly et al., 1985, p. 540). Merely asking individuals to rate something can produce favourable evaluations (Fisher, 1983: cited in Sheppard, 1991). The patient may want to present her health provider in a favourable light thus denying her true feelings (Lebow, 1974) or may fear adverse consequences if she does not express satisfaction, such as withdrawal of treatment (i.e., in the case of specific intervention) (Justice & McBee, 1978). Favourable response may also be an artifact of questionnaire design (Lebow, 1974) i.e., how one frames a question and selects response categories can subsequently affect the answers received. All of the above can potentially contribute to inflated satisfaction ratings. Pertaining to the present study, on the one hand since the study concerns the patients usual provider as opposed to general GP services, respondents might be hesitant to appear critical of their GPer. On the other hand a situation in which the pressures to give a socially desirable response can be assumed to be somewhat less since anonymity was guaranteed.

A second methodological issue to be considered is the use of patient reports, particularly in regards to the validity of patient responses. The ability of patients to judge technical features of medical care has been questioned. Empirical evidence is mixed. Several studies indicate that satisfaction ratings correlate positively with expert-developed indices of technical competence (Willson & McNamara, 1982). For common medical consultations, Davies and Ware (1988: cited in Health Services Research Group, 1992) show that patients and GPers tend to agree in their assessment of technical quality. Conversely, other study findings suggest that patients are unable to judge the technical quality of care (Ben-Sira, 1976,1980; Ross et al., 1981; Ross et al., 1982). Based on such mixed findings, Lebow (1974) advises caution in the use of patient assessments. It is important to recognise however, that although patient perceptions may not be accurate these perceptions are nonetheless important "...since they may ultimately affect patients behaviours and outcomes" (Brody et al., 1989, p. 1034).

The following shall briefly discuss the value of qualitative methods in patient satisfaction research. Although quantitative research remains the mainstream of published patient satisfaction studies, selected studies have complemented such research with qualitative data, namely detailed accounts usually in the form of written text. Denzin (1970: cited in Stimson & Webb, 1975) argues that no single method can ever completely reveal the totality of the subject, and so multiple methods must be used. Similarly, Mechanic (1989) believes that an integrated approach is required - "...researchers should be prepared to use a variety of methods that contribute to a deeper understanding" (p. 154). The quantitative method allows statistical analysis of relations perceived but has the disadvantage of stripping away subjective and potentially meaningful perceptions of respondents which by their very nature are not conducive to strict statistical analysis. Also the quantitative method uses terms (i.e., forced choice format) which most certainly define and limit responses. In contrast, qualitative methods provide research techniques to probe for information outside the confines of a rigid questionnaire type format. It denies the possibility of narrow researcher set definitions being imposed, although subsequent analysis of information obtained is potentially subject to a degree of researcher bias. Based on the above, the

patient satisfaction component of the present study gathers qualitative as well as quantitative data. The former approach allows young women to articulate their own views as they see fit. Although the nature of their replies are necessarily subjective, this approach provides an added dimension and a more complete picture of respondents views of GP care than would otherwise be obtainable.

CHAPTER TWO
HEALTH SERVICE UTILISATION

Considerable research has been undertaken to establish why individuals use health services. Data on factors influencing use can be applied in several ways: in explaining and predicting behaviour (Anderson, 1995), in identifying the barriers and stimulants to health service use (Hulka & Cassel, 1973), in preventing unnecessary consultations, in preventing delay in treatment (Van de Kar et al., 1992), in identifying those factors which might be manipulated as a means of improving the health system (Snider, 1980), in providing baseline information on health behaviour, and in decision-making concerning resource allocation.

Different models have been developed to determine the factors associated with health service use. A review of models formulated is beyond the scope of the present discussion, therefore the following is limited to the model of health service utilisation subject to the present analysis.

RESEARCH FRAMEWORK

The behavioural model of health service utilisation developed by Anderson (1968) (depicted in Figure 1) and refined with his colleagues (Aday & Anderson, 1974,1978) is the most widely used conceptual framework in the field (Hulka & Wheat, 1985). The model presents use of health services as a function of the 'predisposing', 'enabling', and 'need' characteristics of the individual.

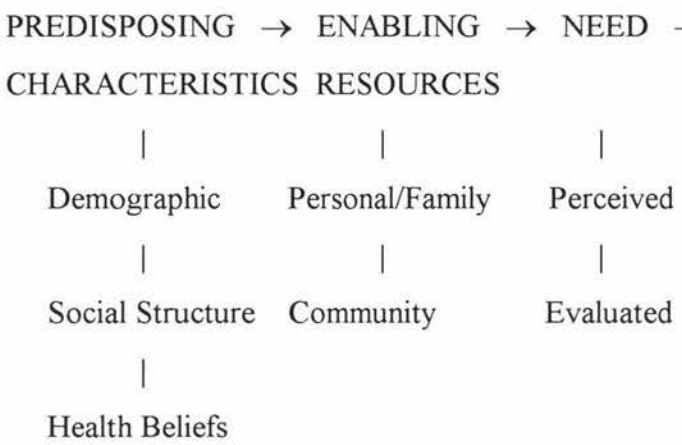

Figure 1: The Initial Behavioural Model (1960's)

Source: Anderson (1995) p. 2

Predisposing characteristics are those that exist prior to an illness episode, that describe the propensity of individuals to seek care. These characteristics include:

- Demographic factors (age, sex, marital status) including access to a telephone and household composition.
- Social structural characteristics (employment, education, ethnicity) and
- Health beliefs (health worries, sense of health control).

* Variations in demographic characteristics lead to variations in patterns of illness, resulting in differences in the utilisation of the various health services.
* Variations in social structure reflect different lifestyles, which, as a result, lead to differential use of health care services.
* An individuals beliefs regarding health matters would impact on her decision to use health services.

Enabling characteristics provide the means for individuals predisposed to seek care, to actually use health care services. Two dimensions are considered:

- 'Family resources' (income, the presence of health insurance, having a regular doctor, social supports) and
- 'Community resources' (availability of health facilities and personnel).

When sufficient family and community resources exist, then individuals are more likely to use health services.

"Although the predisposing and enabling components are necessary conditions for use of health services, they are not sufficient ones. To use health services the individual must have or perceive some illness (or it's possibility)" (Wolinsky & Johnson, 1991, p. 346). Thus, the third class of characteristics specified in the behavioural model represent the individuals need to use health services.

Two types of need variables are identified:

- 'Perceived need', (routinely measured by self-rated health and self-reports of symptoms) and
- 'Professionally evaluated need' (i.e., assessment by a doctor).

Anderson's schema encompasses most of the explanatory variables found in the utilisation literature. Consequently, it will be used to organise the following discussion on the influence of various predisposing, enabling, and need characteristics on GPer use. Note, in a brief discussion it is possible to do no more than call attention to the most salient and consistent findings.

2.1 Predisposing Characteristics

2.1.1 Demographic factors

Age and ***Sex*** are the most frequently studied and consistent demographic factors which have been shown to influence health service use. A number of NZ studies reveal that

women are higher users of GPer services than men. The 1992 - 93 Household Health Survey found that 81% of women and 74% of men had consulted their GPer (Statistics New Zealand, 1993). Two surveys conducted by the Royal NZ College of GPers in 1979 (Hamilton) and 1980 (Christchurch) found that women were predominant users of GPer services. In the Hamilton study, 57.3% of females consulted their GPer, although females constituted only 49.4% of the study population. The corresponding figures for women in the Christchurch survey were 59% and 51.2%[5] (Bunnell, 1987).

Pertaining to age, the Hamilton and Christchurch studies found that women's higher rates of utilisation varied according to age. Particularly high rates of consultation were found in the 15 to 40 year age group. A study conducted in Dunedin in 1991 (Ministry of Health and Statistics New Zealand, 1993: cited in Howell, 1996) found that young women (aged from 15 - 24 years) visit their GPer most frequently of any group under the age of 60 years. Davis (1987) found that young Maori women (aged from 15 - 24 years) attend more GP consultations than non-Maori women.

Thus, the weight of NZ evidence shows that women are greater users of GPer services than men and in overseas research (pertaining to medical services in general) similar results have been obtained (McKinlay, 1972). Women's greater use persists even after excluding conditions related to reproduction (Hulka & Wheat, 1985). GPer use also varies in respect of age, with young women demonstrating particularly high use.

McKinlay (1972) states, "Unfortunately, perhaps with the exception of age and sex differences, sociodemographic findings do not reveal in any depth why variations [in health services utilisation] exist, and further research into the context in which services are utilised becomes necessary" (p. 121).

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[5] In neither study was this difference significant by chi - square test.

The ***telephone*** can provide the patient with quick and convenient contact. Little NZ research has addressed telephone use among patients and it's effects on GPer consultation rates. West and Harris (1980) surveyed 1283 NZ households and found that most households (approximately 90%) had access to a telephone. West states, "...it may be that the very families deprived of this device are among those who need the doctor most" (p. 265). A British study (Allen et al., 1988) surveyed 793 patients and found that 80% had a telephone in their home. Although 83% of patients advocated telephone access to the GPer, only 27% had actually telephoned and spoken to their GPers personally. Similarly, Hallam (1991) reported the finding that few British and Welsh patients telephone their GPer compared with American and Canadian patients. A significant minority of British patients in Arber and Sawyer's (1985) study thought that telephone contacts were not permitted. It appears that British GPers are both willing and available to accept patient calls, however, some patients do not realise this (Hallam, 1991).

In summary, British findings suggest that "...practices need to provide a telephone consultation service or, if there is already one, make its existence clearer to users" (Allen et al., 1988, p. 165).

2.1.2 Social structural characteristics

There is little NZ research into the impact of ***unemployment*** on GPer use. Overseas studies investigating the health effects of unemployment tend to focus on men. Yuen and Balarajan (1989) analysed data from two consecutive British general household surveys (1983,1984) to investigate the relation between unemployment and use of GPer services among 13,275 men. Results showed that GPer visits were significantly greater for the unemployed than employed. These findings correspond with previous studies (Beale & Nethercott, 1985; D'Arcy, 1986; Linn, Sandifer, & Stein, 1985). Financial barriers in NZ may influence patterns of health service use among the unemployed, as in this country, in contrast with Britain, the fee-for-service still exists.

Linn et al. (1985) found that symptoms of anxiety, depression, and somatisation were more pronounced following job loss. Corroborating this finding, Brenner and Levi (1987: cited in Barwick, 1992) found that job loss has an adverse impact on both mental and physical health. These findings suggest that unemployment may trigger ill health which may partly account for greater health care use among this group.

Thus, several studies suggest that unemployment is a factor affecting GPer use. In NZ, young people constitute the single largest group represented in the unemployment figures (Mason, Morris & Cairncross, 1992), and Howell (1996) identifies young women as more likely to experience unemployment than young men. Therefore, it is of paramount importance to investigate the effects of unemployment on the utilisation of health services by this group.

Ethnicity

Pertaining to the NZ Maori, the health status of Maori people in general is poorer than that of European NZers (Stone, 1988), and is more marked for Maori and nonMaori women than for their male counterparts (Davis, 1987). Furthermore, Davis (1987) reported higher usage of GPer services among Maori women compared to nonMaori women. The difference in usage however, was not as great as would be expected considering the high mortality rate reported for Maori women. This difference may well be explained by socio-economic factors, as indicated by subsequent analysis.

Stone (1988) states, "The health statistics suggest that existing services and structures have not been appropriate to the needs of the Maori" (p. 33). As 22% of young Maori women are aged from 15 - 24 years compared to 16.1% of nonMaori women (Howell, 1996), health initiatives targeted at young women will provide more comparative benefit for Maori women as a group. Although the health issues canvassed throughout this study are inclusive of Maori women, the author appreciates the special health needs of this group and thus recognises a need for specific research embracing a Maori concept of health (see Kilgour, 1991 and Stone, 1988).

There is little NZ research which specifically addresses the utilisation behaviour of other minority groups, such as Pacific Island populations. As highlighted by Kilgour (1991), ethnic groups comprise a small proportion of the population and even when included in analysis, representative samples may not include enough individuals to detect racial differences.

2.1.3 Health beliefs

"Health beliefs are attitudes, values, and knowledge that people have about health and health services that might influence their subsequent perceptions of need and use of health services" (Anderson, 1995, p. 2). Several studies have revealed a positive association between health beliefs and use of GPer services. Research by Mechanic (1979) and Wolinsky and Johnson (1991) shows that individuals who worry about their health are more likely to consult their GPer. Berkanovic, Telesky, and Reeder (1981) found that the most powerful predictors of GPer use were variables measuring symptom-specific health beliefs, namely whether going to a doctor would aid the problem, perceived likelihood of symptom recurrence, and perceived seriousness of symptoms. The latter predictor was confirmed by Van de Kar et al. (1992).

Anderson (1995) and Tanner, Cockerham, and Spaeth (1983) together agree that specificity in measuring health beliefs will increase predictive strength - "If we examine beliefs about a particular disease, measuring need associated with that disease, and observe the services received to deal specifically with the disease, the relationships will probably be much stronger" (Anderson, 1995, p. 2).

2.2 Enabling Characteristics

2.2.1 'Family resources' [6]

A factor that enables an individual to use needed health is the ability to pay. For those with

[6] These are the foci of the present study.

health insurance, cost is less of a restraining factor. Health insurance can reimburse some or all of the cost of day to day medical treatment, for example, GPer fees, hospital treatment, and prescription charges. Most countries, including NZ, operate national insurance schemes. McGrath (1988) highlights the rapid growth of private medical insurance in NZ.

Health insurance coverage has been positively associated with health service use (Aday & Anderson, 1978; Bice et al., 1972; Galvin & Fan, 1975; Rabin, Bice, & Starfield, 1974; Wolinsky & Johnson, 1991) - "Insurance assumes financial security, and people with such security are also more likely than the uninsured to seek medical care" (McKinlay, 1972, p. 119). Bice et al. (1972) found that with Medicare coverage, poor persons were more likely to visit the doctor. Wolinsky and Johnson (1991) found that older adults with private health insurance coverage were more likely to have had contact with a doctor than their uninsured counterparts. A NZ study (McGrath, 1988) surveyed 389 households in the Wellington area. For those with health insurance (47%) the greatest use made of the policy was to cover GPer costs.

Regular doctor

The 'usual source effect' predicts increased utilisation for individuals consulting a given GPer for prolonged periods (Kuder & Levitz, 1985). Several studies have demonstrated this effect (Aday & Anderson, 1978; Scitovsky, Benham, & McCall, 1979). Hulka and Wheat (1985) state, "Having a regular source of care indicates that medical care has become available to the patient, that a relationship has been established, and that access has been facilitated" (p. 449).

Gribben (1992) surveyed 290 NZ households, 98% of which reported consulting a regular doctor. Findings failed to confirm the 'usual source effect' predicting greater GPer use among this sample. Gribben suggests two possibilities: (1) desire, on the patients part, to consult a different GPer, and (2) desire not to trouble their regular GPer. Richards and

McPherson (1981) received information from 898 NZ GPers concerning GP issues. Eighty four percent of doctors surveyed considered that patients should be encouraged to stay with one doctor.

Social Supports

The provision of advice, support, and encouragement by family and friends are typically identified as enabling factors which promote consultations with health professionals (Bass & Noelker, 1987; Counte & Gerald, 1991; Freedman, 1993; Miller & McFall, 1991; Wolinsky & Johnson, 1991). Authors have remarked on the absence of measures of social support in Anderson's health service utilisation framework (Bass & Noelker, 1987; Dunlop & Burton, 1980; Ward, 1977), and in general research assessing utilisation behaviour (McKinlay, 1972; Wolinsky & Johnson, 1991). Anderson (1995) in a recent paper encourages inclusion of these measures in research regarding this subject.

The positive influence of social supports on GPer use has been demonstrated by several studies (Van de Kar et al., 1992; Wolinsky & Johnson, 1991). Wolinsky and Johnson's (1991) investigation of health service use by older adults included social support measures, tapping kin and nonkin (i.e., friends and neighbours) supports. Both kin and nonkin supports had a positive effect on GPer consultation rates. These authors state, "This suggests that in the course of routine interaction with family and friends, the older adult's health is discussed and encouragement provided for going to see the doctor" (p. 355).

2.3 Need

To recap, this need component has two dimensions, perceived need and professionally evaluated need.

2.3.1 Perceived need captures the individuals subjective evaluation of their health status. There are a plethora of morbidity measures reflecting aspects of disease and illness. Two broad types of measures however, are frequently used:

-Indices of health status, for example, regarding general physical symptoms.
-Self-report measures, for example, regarding current state of general health (routinely included as a single-item, global rating). "Whereas physicians have been trained to identify discrete, disease problems they can manage in specific ways, patients tend to have a more global view" (Mechanic, 1979, p. 390).

2.3.2 Pertaining to the second dimension of need - professionally evaluated need - when unavailable measures of mobility limitation and restricted activity (i.e., restricted activity days due to ill health) are used as proxy variables. Several authors argue that a professional assessment would ensure a more accurate diagnosis of the patients health (Mechanic, 1979; Van de Kar et al., 1992). Asher, Fordham, and Pitcher (1979) counterargue that "...people do not seek medical help because they have a condition which could be clinically diagnosed. Rather, they utilise services if they perceive themselves as having a complaint, and then only if they regard it as problematic" (p. 5).

PRIMACY

The bulk of health utilisation research applying Anderson's framework, has found that need characteristics are the primary factors in determining health service use (Coulton & Frost, 1982; Eve, 1988; Gribben, 1992; Hershey et al., 1975; McAuley & Arling, 1984; Wolinsky, 1978; Wolinsky & Johnson, 1991). Several authors argue however, that the model places too much emphasis on need at the expense of other predisposing and enabling factors (Coulton & Frost, 1982; Mechanic, 1979; Wolinsky & Johnson, 1991). Anderson (1995) counterargues that "Any comprehensive effort to model health service use must consider how people view their own general health and functional state" (p. 3).

2.4 Assessment of Anderson's Behavioural Model

Empirical results from the behavioural model's widespread application have been inconsistent or conflicting. Some studies suggest the primacy of the need variables (Coulton & Frost, 1982; Eve, 1988; McAuley & Arling, 1984; Wolinsky & Johnson, 1991). Other studies find that predisposing and enabling variables also explain significant

variance (Chappel, 1985; Krout, 1983; Snider, 1980). Anderson and Newman (1973: cited in Bass & Noelker, 1987) contend that results vary across studies in relation to how utilisation is represented i.e., 'volume' measures vs 'contact' measures vs visits occurring within an 'illness episode'. Additionally, conflicting results may be a function of, the predictive variables selected for inclusion in the study and the analysis applied (Wolinsky & Coe, 1984). Pertaining to the present study, choosing amongst utilisation and predictor variables required a value judgment on the part of the author. Anderson's framework served as a guide to selecting the most appropriate ones.

Using a large number of predictors the model has shown only modest success in accounting for variance in health service use (ranging from 9% to 27%). Explanations for the low predictive utility of the model include measurement deficiencies in the independent variables (i.e., lack of specificity) (Wolinsky, Coe, Miller, Prendergast, Creel, & Chavez, 1983).

Rundall (1981) contends that predisposing, enabling, and need characteristics are not independent of one another i.e., that all three components must be present before utilisation will occur, however, Wolinsky (1981: cited in Tanner et al., 1983) found predisposing and enabling components to be unstable predictors of utilisation over time.

Wolinsky and Johnson (1991) argue that "...substantial improvements in R^2 will not likely result from further refinement or proliferation of the traditional measures of the predisposing, enabling and need characteristics" (p. 354). Tanner et al. (1983) however, constructed a new variable, namely the 'respondents subjective evaluation of symptoms' (whether or not the individual perceives those symptoms experienced as being serious enough to consult a GPer) and found it to be a relatively strong predictor of GPer utilisation. Additionally, Anderson (1995) recently refined the model including feedback loops, emphasising the dynamic nature of health service use. Anderson argues that further refinement better illustrates an understanding of health behaviour.

The present study applies Anderson's model to the special case of young women. Although the model has been frequently employed in health utilisation research, previous applications have focused mainly on elderly populations. Consequently, Anderson's model has not been thoroughly tested on women. This also delimits the comparability of findings that are obtained. Additionally, most previous studies are examples of large scale nationally based studies, whereas the present research uses a regional sample. As such, there may be a limitation regarding the generalisability of the results.

CHAPTER THREE
OBJECTIVES

Attention devoted to women's issues has increased considerably over the last few decades, and the health care context is no exception to this trend. As stated by Bunnell (1987), "Women's health [in NZ] is now seen as a priority area for research, for policy and for action" (p. 1).

The decision to study women in the present study was influenced by previous research. Studies show that women have specific needs aside from the community as a whole, and in the health care arena women's needs have clearly not been met.

The decision to focus on young women as a specific group was influenced by two factors. Firstly, because of the paucity of health research on young women, knowledge regarding their perceptions and evaluations concerning health care services is modest at best. As stated earlier, when this type of research has been performed young women have comprised only a segment of the total population studied, potentially diluting important findings pertaining to this group. Secondly, it has been shown that this group of women make high demands for GPer services. To date, reasons for this disproportionate use are unknown.

It was also recognised that traditional methods of gaining insights into community views and behaviour such as expert opinion and the views of lobby groups, may not provide an accurate representation of women's perspectives and have the potential to reflect biased opinions. This has therefore provided the impetus to study this specific group utilising a personalised questionnaire.

The ***aims*** of the present study (pertaining to GP care) are to:

* provide baseline health information, specific to young women.
* obtain an overview of the contemporary state of young women's health.
* bridge gaps in our understanding of young women's health.

The ***specific objectives*** of this study are exploratory in nature. The following three objectives are addressed:

1. While many women report satisfactory relationships with their GPers and satisfaction in general with services received, others are critical. Instances of dissatisfaction are sufficiently prevalent to be of legitimate concern. Thus, the present study concerns the impact of GPer care on the individual in terms of her own assessment of the satisfaction derived from this interaction. In identifying elements of the interaction related to patient satisfaction, GPers may be encouraged to reflect upon their own style of consultation, and to instigate changes if necessary to improve patient response.

The research focuses on the perceptual dimension of the interaction which differs somewhat from the objective aspects of care and can be considered separately - "Consumer assessments of health care reflect the perceived effectiveness of a service in reaching and satisfying its customers" (Walton et al., 1988, p. 80). Both quantitative and qualitative approaches are utilised in obtaining this information allowing for a broader and deeper understanding of both the context and factors which influence patient satisfaction.

2. As previously mentioned, young women in the aggregate are disproportionately heavy users of GPer services. Since the reasons for this have not been elucidated in previous work, this study pays particular attention in attempting to determine reasons for their frequent attendance by applying Anderson's behavioural model of health services utilisation to the study sample. Previous research suggests that need factors are likely to dominate variance in GPer use, however, conflicting evidence in the earlier work highlights the importance of also assessing predisposing and enabling factors. Therefore,

this study also considers the relevance of the latter factors in conjunction with the need variables.

3. The concept of access has been defined in multidimensional terms (Penchansky & Thomas, 1981), the specific dimensions being availability, acceptability, affordability, accommodation, and accessibility. For the purposes of the present research the latter three access dimensions are addressed. As previous research indicates these component dimensions influence utilisation of GPer services and patient satisfaction, the present study explores the relationship of these dimensions to GPer utilisation and satisfaction in the study sample.

CHAPTER FOUR

METHOD

4.1 Subjects And Sampling Procedures

In March 1996 200 young women from Wellington city agreed to participate in this study. The only inclusion criterion used was that participants be aged from 18 - 26 years[7]. The non-random convenience sample for this study were recruited from the following three sources:

(1) Notices displayed in public locations (libraries, cafes, community notice boards).

(2) A notice placed in a local weekly paper (the 'City Voice') for two consecutive weeks.

Note, there is the suggestion that the women who responded to the public notices and the local paper are a highly motivated, benevolent group of women by way of their willingness to contact the researcher and participate in the study. It was hoped however that these methods employed would allow for a relatively broad and general sample.

(3) Young women within the Wellington region were approached by the researcher and asked to participate in the study.

Note, demographic representativeness was attempted by drawing on individuals from varying locations (the employment office, academic institutions, community and leisure facilities). Most women (89%) were recruited by this last method.

Ninety six of the 200 questionnaires initially distributed were returned to the author, yielding a response rate for the study of 48%. This is an acceptable response rate for this type of study with much of the drop out rate possibly being accounted for by the length of the questionnaire and the amount of time required to fill it out.

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[7] It is noted that alternative definitions of young women may have been used in the published literature.

4.2 Measures

Individuals who consented to participate in the study were given a questionnaire to complete to be returned using the prepaid envelope supplied (see Appendix 2). A 1-page introductory letter ('Information Sheet') was attached to the front of the questionnaire giving a brief outline of what the study involved (see Appendix 1). The outline also emphasised the purpose and anonymous/confidential nature of the study. It was hoped that the guaranteed anonymity would promote more accurate and honest responses.

4.2.1 Dependent measures

Two dependent measures were included in the analysis, namely GPer utilisation and patient satisfaction. The former was measured by the respondents answer to the question, 'How many times in the last 12 months have you seen any GP or been visited by one?' representing the 'volume' (or extent) of GPer utilisation in the last year. Pertaining to patient satisfaction, patients responded to 7 statements regarding GPer performance (adapted from items included in the work of Gray (1980)). Patient satisfaction was defined as the unweighted sum of the respondent's satisfaction derived from the seven items.

4.2.2 Independent measures

For ease of analysis, the independent measures will be considered under the three headings of: Patient Satisfaction, General Practitioner Utilisation, and Factors Relating To Patient Satisfaction And General Practitioner Utilisation, namely access factors and sociodemographic factors.

In regards to patient satisfaction, Locker and Dunt (1978) highlight two limitations in the use of global measures. First, the masking of different levels of satisfaction with various health care aspects and second, failure to indicate how a health care situation would have to be changed in order to increase patient satisfaction. In regards to health care utilisation, Anderson (1978) highlights the importance of using multiple indicators when possible rather than relying on a single measure. In light of the above, the components of the questionnaire include a full complement of relevant measures.

A. PATIENT SATISFACTION

As previously noted, Denzin (1970: cited in Stimson & Webb, 1975) argues that no single method can ever completely reveal the totality of the subject, and so multiple methods must be used. In accordance with this view, two approaches (quantitative and qualitative) were utilised in the satisfaction component of the questionnaire to add richness to the data and gain a wider perspective.

Index of patient satisfaction: Quantitative

Gray (1980) used an unspecified factor analytic method to develop a 7-item index of patient satisfaction measuring physician performance. The 7 statements covered: (1) the overall quality of the medical care, (2) the adequacy of consulting time, (3) the amount of doctor's information, (4) the doctor's courtesy, (5) the doctor's explanation of home care, (6) the doctor's follow-up care, and (7) the doctor's personal interest.

In the present study Grays' index was used to gauge young women's opinions of the medical care they had received from their GPer. The index was adapted in two ways for inclusion in the study. Firstly, 'the amount of doctor's information' considered vague by the author was redefined to 'the quality of information your doctor provides for you regarding your complaint' and 'the quality of information your doctor provides for you regarding treatment'. Secondly, 'the doctor's explanation of home care' considered by the author to be redundant in GP today, was omitted from investigation. The internal consistency reliability (Cronbach's alpha) for the satisfaction index was .92.

Responses to the statements were scored on a 7-point Likert-type scale, with 1 being delighted, 2 pleased, 3 mostly satisfied, 4 mixed, 5 mostly dissatisfied, 6 unhappy, and 7 terrible (considered sensitive enough to register the range of patient feelings) such that a low score indicated high satisfaction (scores could range from 7 - 49). Note, previous studies have found that patients tend to rate medical care highly (Francis et al., 1969; Gray, 1980; Linder-Pelz & Struening, 1985). In view of this finding the upper three items

of the scale are positive descriptions to better stratify people who tend to rate on the high end.

Exploratory: Qualitative

Young women were given the opportunity to comment freely on their GPer services in response to open-ended inquiry. In developing an appropriate methodology, published satisfaction studies and meta-analysis were reviewed prior to question construction. The author focused on: (1) response format, (2) response bias, and (3) item wording. Note, response bias was largely preempted by the mixing of positive and negative worded items.

Based on prior research identifying dimensions of patient satisfaction, and for the purposes of the present study, the following dimensions of GP were examined: (1) GPer-patient interaction, (2) professional skills and the quality of care, and (3) accessibility of care. Thus, questions were asked which operationalised the specific dimensions outlined above. These questions were pretested on eleven young women (Maori and European) for feasibility, acceptability, and the time taken for completion. To maximise variation in the ratings and reduce positive skewness several questions were subsequently revised.

The final version of the exploratory section comprised of 12 questions presented under the following three headings:

- ***General practitioner-patient relationships***, including the nature of the relationship (friendly or businesslike and when given a choice, which was preferred), characteristics of a 'good' and 'bad' GPer, power dynamics (namely GPer intimidation), expectations of the consultation (and expectations unfulfilled), and negative experiences experienced during the consultation.
- ***Gender of general practitioner***, including general preference (and preference when presenting women's health problems) for a male or female GPer, and traits attributed to both.
- ***General aspects of health care***, including support for clinics especially for women and for regular check-ups.

Data analysis: Standard statistical procedures were not used in analysing the qualitative items. Instead, patient responses to open-ended questions were classified and assessed by the author with emphasis on the content and frequency of different replies (see Appendix 3). Given the exploratory nature of this section, no attempts were made to assess inter-coder reliability.

B. GENERAL PRACTITIONER UTILISATION

The following independent measures reflect the predisposing, enabling, and need characteristics of the individual and were derived from previous studies applying Anderson's health care services utilisation framework. Necessarily certain value judgements have been made in selecting the measures used in the analysis.

***Predisposing measures*:** The following demographic variables were utilised in the study: age in years, marital status (categorised in five levels from 1(never married) to 5 (widowed)), living arrangement (from 1(own home) to 4 (other)), and yearly income (from 1 (below $10,000) to 7 ($60,000 plus)). Also included were access to a telephone and household composition (i.e., whether the household is multigenerational) indicating whether living in an extended family situation has any bearing on GPer utilisation.

Social structural measures included education level (from 1(no school qualification) to 8 (other)), occupational status (from 1 (employed full-time) to 7 (other)), and race (New Zealander of Maori, European or Pacific Island decent or 'other').

Since earlier research has shown that health beliefs influence use of GPer services (Berkanovic et al., 1981), two markers of an individual's health beliefs were incorporated in the study. The first, reflecting health worries, asked respondents whether their overall health for the past 12 months had caused them a great deal of worry, some worry, hardly any worry, or no worry at all. The second, reflecting sense of control over future health, asked respondents how much control they think they had over their future health: would they say a great deal, some, very little, or none. Prior findings predict that individuals more

worried about their health who feel less in control of their future health are more likely to utilise health services (Newman, 1975 & Rodin, 1986: cited in Wolinsky & Johnson, 1991).

***Enabling measures*:** The family resources dimension of the enabling characteristics was measured by the following: having a community services card, high use health card, or chronically ill card, having health insurance coverage for GPer visits which has been shown to increase the likelihood of contact with a GPer, and having a regular GPer (a positive association of time with current GPer and utilisation is what one would expect from previous findings in the literature). The positive influence of social supports on GPer use demonstrated by previous studies provides the rationale for including social contacts as an enabling measure. Six measures of social contacts were included in the analysis derived from Wolinsky and Johnson (1991). These were: the presence of living brothers or sisters (or children), phone contact (or physical contact) with relatives or friends in the past two weeks, and participation at any group events (or religious services) in the past two weeks. Social contact measures were summated to form a composite score.

Two financial measures were included in the study derived from Eve (1988), namely the respondents reported satisfaction with her standard of living (very satisfied to very dissatisfied) and her ability to get along on her income (always have money left over to can't make ends meet). These measures, used as proxy indicators of socioeconomic status, were analysed in relation to GPer utilisation and patient satisfaction dependent variables.

***Need measures*:** On the grounds that individuals with the greatest need for health services might be more likely to utilise health services, four measures were employed in the analysis of the need for GPer services. Two tapped the respondents perceived need. The first measure was a single item global rating of health status, shown to be a fairly reliable and valid measure of health status (Friedsam & Martin, 1963). The question asked respondents to rate their overall health. Response categories were: excellent, good, not so good, and poor. The second measure assessed respondent's general physical health.

Respondents were asked, with the aid of a checklist, what symptoms, if any, had bothered or disturbed them during the previous month. Response categories were: not at all, a little, moderately, quite a bit, and extremely.

Two other measures tapped the evaluated need dimension. The first measure presented a checklist of long-term health problems. Respondents were asked to indicate problems identified by a health professional in the previous six months or more. An open-ended question followed which prompted respondents to indicate 'other' medical conditions they perceived in the previous three months or longer. Their answers were scored 1 if they listed conditions and 2 if no conditions were listed. Study design did not allow assessment by a GPer, thus a measure of 'restricted activity' was used as a proxy indicator of professionally evaluated need. Respondents indicated the number of days (if any) ill health had interfered with their ability to perform normal daily activities in the previous three months.

C. FACTORS RELATING TO PATIENT SATISFACTION AND GENERAL PRACTITIONER UTILISATION

Access factors

The three access features examined were affordability, accommodation, and accessibility. Questions reflecting these features were derived from Gribben (1992). Reflecting affordability, respondents were asked if the cost of the visit had ever stopped them from consulting the GPer. Response categories were: not at all, occasionally, some of the time, and often. Two questions reflecting accommodation aspects of access were asked: the first, regarding waiting time for appointments, asked respondents when they usually secured an appointment to see the GPer: on the same day (coded 1) or day after (coded 2). The second question asked respondents how long they had to wait in the GPers waiting room before being seen by the GPer. The accessibility feature was measured by mode of transport to the GPer: private transport (coded 1) or walk, bus, taxi, bicycle, train, other (coded 2).

Sociodemographic factors

Demographic measures (marital status, living arrangement, yearly income) and social structural measures (education level, occupational status, race) considered predisposing factors in the health services utilisation model, were analysed in relation to GPer utilisation and patient satisfaction dependent variables.

Data analysis: The data analysis techniques included: standard descriptive statistics on demographic factors and dependent measures (patient satisfaction and GPer utilisation), dependent measures by sociodemographic and access factors (based largely on t-tests and Pearson correlation coefficients), correlations between health utilisation independent (predictor) variables and GPer utilisation, and finally, standard multiple regression analysis assessing the unique contribution of selected predictor variables to GPer utilisation rates. The data were analysed using the PC version of the Statistical Package for the Social Sciences (SPSS-PC version 4.0) with the significance level for all analyses set at a minimum of $p < 0.05$.

CHAPTER FIVE
RESULTS

The results are presented in two sections. The first section deals with qualitative data reflecting patient satisfaction. Three issues were addressed: general practitioner-patient relationships, gender of general practitioner, and general aspects of health care. Young women responded to open-ended questions which addressed these issues. Content analysis of patient responses is presently discussed. The second section deals with quantitative data. The analysis of the data focuses on the following issues: first, the characteristics of the subjects are discussed and the demographic characteristics presented in Table 4, second, a descriptive breakdown of dependent measures (patient satisfaction and GPer utilisation) is summarised in Table 5, third, the associations between the dependent measures and the sociodemographic and access factors are examined using correlations, the t-test or one-way analysis of variance (ANOVA) depending on the level of measurement of the variables, fourth, the correlations between the health service utilisation predictor variables and GPer utilisation are discussed and shown in Table 9. Finally, standard multiple regression analysis conducted to assess the unique contribution of selected predictor variables to GPer utilisation rates is shown in Table 10.

5.1 Qualitative

5.1.1 General practitioner-patient relationships

DEGREE OF FORMALITY

Equal numbers of women (47%) maintained formal and informal relationships with their GPers. Respondents were asked whether they preferred a more friendly or businesslike relationship. A breakdown of this 47% showed that 20% in a formal relationship wanted it to remain the same (the commonest reason advanced related to maintaining a level of professionalism), 15% preferred a more friendly consultation (mainly to feel more relaxed), 2% preferred it more businesslike (no reasons were given for this preference), for 2% degree of formality preferred was dependent on the severity of the presenting illness (one woman preferred a businesslike approach concerning minor problems, whereas

another woman preferred this approach when presenting with what she considered were complaints of a serious nature). A further 3% were uncertain and 5% did not indicate.

Respective figures concerning women maintaining an informal relationship were: 36% (common reasons included: 'comfortable in relationship', 'is relaxed', 'allows for free communication'), 5% (reasons were not given), no women preferred it more businesslike, 3% (dependent on the sex of the GPer, i.e., prefer their GPer to be more friendly if female (and vice versa)), there were no women in the 'uncertain' category, and 3%.

5% of women maintained a balanced relationship and wanted it to remain the same. One respondent did not reply to either of the two questions asked.

EVALUATION OF A GENERAL PRACTITIONER

Two open-ended questions gauged respondents attitudes on what characterises a 'good' and 'bad' GPer. Lloyd et al. (1991) presented a similar question to a population of Australian residents. Responses were coded into six categories: 'Instrumental', 'Affective', 'Accessibility', 'Continuity of Care', 'Recommendation', and 'General/Other'. After surveying the range of responses in the present study, four of Lloyd's categories were deemed relevant, being Instrumental, Affective[8], Accessibility, and General/Other. An additional category (Holistic) was developed by the author. These categories are defined as follows:

***Technical features*:** professional competence of the GPer, his or her clinical skills/medical knowledge, and willingness to obtain a second opinion if indicated.

***Interpersonal features*:** characteristics of the interpersonal relationship between GPer and patient, encompassing a caring and empathic attitude toward the patient.

***Accessibility features*:** proximity (distance to travel), convenience (appointments required, waiting times), and consultation charges.

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[8] For the purposes of the present study, the 'Instrumental' and 'Affective' categories were labelled 'Technical' and 'Interpersonal' respectively.

***Holistic medicine*:** attention to the patients individual needs and total health status (including a comprehensive medical history) rather than adopting a more 'compartmentalised', clinical approach to her problems, and providing advice regarding the various treatment options available.

***General and other features*:** responses that were too general or did not fit other categories.

Table 1 illustrates the qualities considered important by the respondents in determining whether a GPer is good or bad, emphasising the importance attached to interpersonal factors. Eighty six percent of women mentioned such factors in a good GPer and 73% noted their absence in bad GPers. Thus, respondents considered a GPer more favourably if he or she related to them personally ('listens', 'is friendly and understanding', 'explains fully', 'shows concern') and less favourably if he or she lacked interpersonal skills ('doesn't explain or listen well', 'has a cold, distant manner', 'is dismissive and disrespectful'). Technical features (particularly professional competence, diagnosing skills and current knowledge) were viewed as being less important in determining a good or bad GPer (corresponding percentages for these attributes were 47% and 32%).

A minority of women (14%) valued holistic features in a good GPer (including, whole-patient care, comprehensive history-taking and explanations of alternative options available to them). Only 2% mentioned their absence in bad GPers. Three percent of women valued accessibility features in a good GPer and 4% noted their absence in bad GPers. The corresponding figures for responses that were too general or did not fit other categories were 5% and 8%.

Table 1

Respondents Views On What Characterises A Good Or Bad General Practitioner.

Question	Response Category	Frequency (n = 96)	Percentage
What characterises a good GPer?	Technical	45	47
	Interpersonal	83	86
	Accessibility	3	3
	Holistic	13	14
	General/other	5	5
What characterises a bad GPer?	Technical	31	32
	Interpersonal	70	73
	Accessibility	4	4
	Holistic	2	2
	General/other	8	8

GENERAL PRACTITIONER INTIMIDATION

The majority of women (66%) did not feel intimidated by their GPer. Typical comments expressed by those who felt intimidated (28%) were: 'when patronised or judged', 'when my GPer doesn't listen or fully explain', 'regarding sex-related problems', 'by male GPers especially'. Three percent of women were intimidated 'sometimes', dependent on whether the consultation caused embarrassment, or the problem was not treated seriously. Three percent did not reply to this question.

EXPECTATIONS OF THE CONSULTATION

Eighty three percent of women held expectations regarding their consultations. Sixty four percent of these expectations related to technical factors, particularly the provision of an accurate diagnosis, medication if deemed appropriate, and relief of their ailments. Forty four percent held expectations of an interpersonal interaction with their GPer, including a

friendly and sympathetic attitude, to be listened to, and treated with respect. Five percent related to accessibility factors, namely affordable fees and to be seen on time. Four percent centered on holistic factors, namely consideration of her overall health status, ongoing problems and information be given regarding the various treatment options available. Only one woman said she had no expectations concerning her consultations and 16% did not respond to this question.

Sixteen percent of women reported that their expectations of the GP consultation were fulfilled. Unfulfilled expectations centered on: technical factors (13%) involving provision of an accurate diagnosis and relief of symptoms, accessibility factors (6%) relating to a short waiting time in the GPers surgery and affordable fees, and interpersonal factors (3%) involving open communication. A further 2% were uncertain and more than half (62%) were unable, or unwilling to respond to this question.

NEGATIVE EXPERIENCES

Fifty six percent of respondents described negative GPer experiences, including sexual tension and misconduct (asked to undress unnecessarily) suffered in the hands of male GPers (5%) (these women failed to elaborate further), misdiagnosis of illness (5%), dismissive and patronising GPer behaviour (5% and 4% respectively), and feelings of discomfort and embarrassment (both 3%). Various other experiences were described by 30% of respondents. One woman noted that all her GPer experiences were negative however specific experiences were not described. Five percent said they had no negative experiences and 38% did not reply to this question.

5.1.2 Gender of general practitioner

PATIENT PREFERENCES

Given a choice of whom to consult, 59% of women prefer to consult female GPers. The main reasons for this choice, indicated by respondents, are highlighted in Table 2. Only 2% of women prefer to consult a male GPer (reasons were not given). Fifteen percent of respondents prefer a female GPer according to circumstances. One circumstance which

clearly emerged in their choice of a female GPer, was consultations concerning women's health problems. Twenty one percent of women did not express a gender preference. Of this 21%, 7% gave specific reasons emphasising that GPer sex was irrelevant as long as standards were professional and ethical, treatment was appropriate, they were treated with respect, and their needs were met. Three percent failed to reply. Responses suggest that preferences for female GPers, among women in this sample, are not limited to sex-related problems.

Table 2

Respondents Reasons For Choosing A Female General Practitioner.

Reason	Percentage of Respondents
More comfortable	10
Female GPer more understanding	6
Relate better	6
Easier to talk to	4
Safety	4
Don't know, no reply	3

When specifically asked whether treatment by a female GPer was preferred for women's health problems, the majority of women (77%) replied affirmatively. The main determinants of this choice are highlighted in Table 3. Only one respondent expressed a preference to see a male GPer rather than women (no reason was given). Fifteen percent denied a preference and 7% did not reply to this question.

Table 3

Respondents Reasons For Choosing A Female General Practitioner For Women's Health Problems.

Reason	Percentage of Respondents
More comfortable	19
Shared experiences	15
Female GPer more understanding	10
Don't know, no reply	6

SEX-TRAITS

Twenty one percent of women felt that neither male nor female GPers exhibit distinct traits. Sixteen percent identified stereotypical male traits, including: 'clinical', 'directive', 'distant', and 'unemotional'. One percent was uncertain and the remainder (62%) did not indicate. Twenty six percent identified stereotypical female traits, including: 'listens', 'sympathetic', 'concerned', 'empathic', and 'caring'. One percent was uncertain and 52% did not reply to this question.

5.1.3 General aspects of health care

CLINICS ESPECIALLY FOR WOMEN

Strong support emerged for the establishment of medical clinics especially for women (72%), perhaps stimulated in part by specific reference to it in the questionnaire. The commonest reasons advanced for support were: the opportunity to provide specialised care, more comfortable for women to consult, and to encourage regular visits. Nine percent of respondents were unsupportive of women's clinics, the reasons being: the belief that existing health care services cater adequately for the needs of women, and the need to improve existing health services rather than developing new ones. Six percent were uncertain and 13% did not indicate.

CHECK-UPS

Forty four percent of women noted that they attend regular check-ups. Of women who said they do not attend (49%) only 5% gave reasons. These were: high fees, GPer intimidation, and fear of the detection of serious illness. Seven percent did not reply to this question.

These results reflect the widespread belief in the utility of regular check-ups, whereby most women in the sample (82%) support such health behaviour (a considerable percentage (43%) of women who previously stated they did not attend regular check-ups nevertheless advocated check-ups for women on a regular basis). Typical reasons were: early detection of ill health, as a preventative measure, particularly for older individuals or individuals with a relevant family history. Of those supportive, 5% made the proviso that such attendances could potentially lead to obsessive health-centered behaviour (2%) and ultimately such attendances are a personal choice (3%). A small percentage (3%) denied support (only one woman gave a reason being the belief that "check-ups alienate people from their bodies and autonomy over them"). The remainder (15%) did not answer this question.

5.2 Quantitative

5.2.1 Sample characteristics

The ethnic composition of young women in the sample was 81.3% NZ European, 2.1% NZ Maori, 6.2% NZ Pacific Islander, and 10.4% 'other', which was slightly atypical when compared with 'Wellington City' census data (Department of Statistics, 1991). The corresponding figures were (for women aged from 15 - 24 years) 77%, 9%, 6%, and 8%, indicating that NZ European women and women belonging to other ethnic groups are marginally overrepresented in the study sample whereas NZ Maori are underrepresented (reducing the power to detect ethnic differences if they did exist).

5.2.2 Demographic characteristics

Means (or percentages) and standard deviations for the following demographic variables

were computed: age, ethnicity, marital status, education, occupational status, income, and living arrangements (presented in Table 4, to 2 decimal places).

Table 4

Means, Percentages, And Standard Deviations For The Demographic Variables.

Variables	M	Percentages	SD
Age	22.65		2.20
European		81.3	
Never married		81.3	
Education	4.58		1.58
Employed full-time		42.7	
Income	2.12		1.22
Rented accommodation		69.8	

Notes :

1. Education was rated on a 8 point scale with 1 being no school qualification, 2 school certificate, 3 sixth form certificate or university entrance, 4 university bursary or scholarship, 5 trade or professional certificate or diploma, 6 university undergraduate degree or diploma, 7 university postgraduate qualification, and 8 other.

2. Income was rated on a 7 point scale ranging from 1 (below $ 10,000) to 7 ($ 60,000 plus).

The sample consisted of 96 women. The mean age was 22.65 years (SD = 2.20) with an age range from 18 - 26 years. Most of the respondents (81.3%) were born in NZ of European decent and had never married. The majority of respondents (69.8%) rented accommodation. With respect to level of education, 52.1% of the respondents had some form of tertiary education. Of the respondents, 42.7% were working full-time and had an annual gross income of below $10,000.

5.2.3 Dependent measures

Means and standard deviations for the dependent measures, patient satisfaction and GPer utilisation, are shown in Table 5.

Table 5

Means And Standard Deviations For The Dependent Measures, Patient Satisfaction And General Practitioner Utilisation.

Dependent Measure	M	SD
Patient satisfaction	19.87	7.42
GPer utilisation	4.24	3.75

PATIENT SATISFACTION

The patient satisfaction dependent measure pertaining to GPer performance was adapted from the 7-item index of statements developed by Gray (1980). Each item was measured on a 7-point Likert-type scale and summed to form a total satisfaction score (range from 7 - 49, where 7 reflects high satisfaction). The distribution of scores on the satisfaction items, as in related studies, was positively skewed (indicating respondents in the study were more satisfied than dissatisfied with GPer provided services) with mean scores for the individual satisfaction items ranging from 2.36 to 3.02 where 1 reflects high satisfaction and 7 reflects dissatisfaction (see Table 6). 'The courtesy your doctor shows towards you' received the highest mean overall satisfaction score (M = 2.36), while 'The quality of information your doctor provides you regarding your complaint' had the lowest relative satisfaction (M = 3.02).

Table 6

Means And Standard Deviations For The Satisfaction Statements Pertaining To General Practitioner Performance.

Satisfaction Statements	M	SD
Adequacy of consulting time	2.96	1.20
Quality of information regarding complaint	3.02	1.39
Quality of information regarding treatment	2.95	1.36
GPers personal interest	2.86	1.36
GPers courtesy	2.36	1.12
Arrangements for follow-up care	2.96	1.30
Overall quality of medical care	2.70	1.23

GENERAL PRACTITIONER UTILISATION

Respondents reported a mean of 4.24 visits (SD = 3.75) to a GPer during the past 12 months. Indeed the majority of respondents had seen a GPer more than once over that period and up to 6 consultations was reported with considerable frequency.

5.2.4 Dependent measures by sociodemographic and access factors

This section describes the nature of relations between the sociodemographic and access factors and the dependent measures. The sociodemographic factors considered in relation to these measures include: respondents race, marital status, education, occupation, income, and living arrangements. The three access factors examined were: affordability, accommodation, and accessibility. Respondents were asked the direct question 'Do you feel that the cost of the visit ever stops you from going to see the doctor when you really need to be seen by the doctor?'. Sixty seven point seven percent answered yes to this question. An appointment to see the doctor could be arranged on the same day for 56.8% of respondents and on the next day for 32.6% of respondents. The median average waiting time in the waiting room was 15 minutes, with the range of 0 minutes to 120 minutes. Forty four point eight percent of respondents walked to their doctor, and 42.7% used a

private vehicle. Ten point four percent took the bus, and the remainder (2%) used a bicycle or the train.

SOCIODEMOGRAPHIC AND ACCESS FACTORS ASSOCIATED WITH LEVEL OF PATIENT SATISFACTION

Sociodemographic factors

These factors did not show strong relationships to patient satisfaction suggesting only a minor role. The association between education and patient satisfaction was examined using correlational analysis. A higher education was significantly associated with lower levels of satisfaction $r = 0.23$, $p < .05$.

Access factors

There were no significant relationships between affordability, accommodation, and accessibility factors and levels of patient satisfaction (correlations and t-tests are presented in Tables 7 and 8, respectively).

Table 7

Correlations Between Affordability And Accommodation Factors And Patient Satisfaction.

Factor	r With Patient Satisfaction
Affordability	
Cost	.05
Accommodation	
Waiting time	-.02

Table 8

T-tests Comparing Mean Satisfaction Levels By Accommodation And Accessibility Of General Practice Service.

Factor	Satisfaction	Ratings			
Accommodation	*same day*		*day after*		*t*
	X	(SD)	X	(SD)	
Appointments	19.64	8.06	19.96	6.62	-.18
Accessibility	*private vehicle*		*other*		*t*
	X	(SD)	X	(SD)	
Mode of transport	19.50	6.03	20.14	8.18	-.42

SOCIODEMOGRAPHIC AND ACCESS FACTORS ASSOCIATED WITH GENERAL PRACTITIONER UTILISATION

Sociodemographic factors

All sociodemographic factors were weakly related to GPer utilisation. Only one finding is worthy of note. A one-way ANOVA was conducted on occupational status to compare the mean scores of respondents working full-time, part-time, and looking for work on GPer utilisation rates. People who were looking for work utilised GPer services at a higher rate but this difference was not significant, $F(2,75) = 2.55$, $p = 0.08$.

Access factors

The accessibility factor was measured by mode of transport to the GPer. A t-test was used to determine if GPer rates differed according to mode of transport used. The different categories employed were recoded to produce 2 binary groups: respondents who used a private vehicle (coded 1) and those who used other means, namely walk, bus, taxi, bicycle, train, other (coded 2). Results show that respondents who use means other than a private vehicle to get to their GPer utilise services more, t (94) = -2.12, $p < .05$. Neither

affordability nor accommodation were significantly associated with utilisation.

5.2.5 General practitioner utilisation

CORRELATIONAL ANALYSES

The associations between GPer utilisation and the predictor variables (the predisposing, enabling, and need characteristics of the individual) were examined using correlations. The correlation coefficient used was the Pearson Product Moment Correlation Coefficient. Findings are presented in Table 9.

Inspection of the correlations reveals that the variables most strongly associated with GPer utilisation were the need measures, perceived symptoms, self-rated health (indicators of perceived need), and restricted activity (the proxy indicator of professionally evaluated need) ($r = 0.44$, $p < .001$, $r = 0.36$, $p < .001$ and $r = 0.31$, $p < .01$, respectively). Analysis of data related to self-rated health revealed that 91.7% reported their health as excellent or good. Regarding restricted activity, analysis revealed a mean of 3.48 ($SD = 6.03$) restricted days because of ill health in the past 3 months.

One predisposing variable was strongly correlated with use of GPer services, being health worries $r = 0.28$, $p < .01$. Consistent with the findings of previous research, health worries were positively associated with visits to the GPer.

One enabling variable correlated with GPer utilisation, greater satisfaction with standard of living was significantly associated with lower utilisation rates $r = - 0.25$, $p < .05$.

Table 9

Correlations, T-tests, And Anova Showing The Effects Of The Predisposing, Enabling, And Need Characteristics On General Practitioner Utilisation.

Variables	T-test / Anova	Correlations
Predisposing characteristics		
Demographic		
Marital status	-.12	
Living arrangements	1.05	
Income		.02
Telephone	.02	
Social Structure		
Education		-.20*
Occupational status	2.55	
Health Beliefs		
Health worries		-.28**
Health control		.10
Enabling characteristics		
Family Level		
Community services card	.75	
Health insurance	-.80	
Regular GPer	.33	
Social contacts		.17
Satisfied with way of living		-.25*
Able to get along on income		-.17

Need characteristics	Correlations
Perceived	
Self-rated health	.36***
Perceived symptoms	.44***
Evaluated	
Long-term health problems	.24
Restricted activity	.31**

*p<.05, **p<.01, ***p<.001.

MULTIPLE REGRESSION ANALYSIS

In order to identify those predisposing, enabling, and need factors that are associated with GPer visits, a standard multiple regression analysis was conducted with GPer visits as the dependent variable and the predisposing, enabling, and need factors as independent variables.

The following focuses on two issues: first, the procedure adopted by the author regarding selection and measurement of predictor variables is briefly discussed, and second, results of the multiple regression analysis are summarised.

Selection and measurement of predictor variables Regarding the predictor variables chosen for analysis, the author relied on insight and understanding of the present inquiry, the strength of the correlations, and previous work related to the study (i.e., the most consistent predictors of GPer utilisation, as indicated by research to date). In selecting the best combination of predictor variables, variables that were initially expected to be important but later proved to have nonsignificant coefficients or a low contribution to R^2, were omitted. As such the regression model was modified several times. For the purposes of the present study, all variables were entered into the regression model in one step.

Multiple regression analysis The results of this analysis are presented in Table 10 which displays the standardised regression coefficients ($\mathcal{B}$), R, R^2, adjusted R^2, and R^2 change. The R for regression was significantly different from zero, $F(9,75) = 3.665$, $p < .001$. Total perceived symptoms contributed significantly to GPer visits ($\mathcal{B} = 2.86$). Thus, consistent with previous studies, utilisation of GPer services was for the most part related to need. The main symptoms reported were: (in order of the magnitude of their means) headaches, stomach upset or pain, and insomnia/sleep problems. Altogether 31% (22% adjusted) of the variability in GPer utilisation was explained by the predisposing, enabling, and need factors.

Table 10

Standard Multiple Regression Of Predisposing, Enabling And Need Characteristics On General Practitioner Visits Showing Standardised Regression Coefficients, R, R^2, Adjusted R^2, And R^2 Change (N=85).

Variables	Beta
Predisposing characteristics	
Health control	.204
Health worries	- 1.261
Income	1.524
Enabling characteristics	
Health insurance	1.037
Social contacts	1.570
Regular GPer	.248
Community service card	1.349
Need	
Perceived symptoms	2.862**
Self-rated health	.653
R	0.55***
Total R^2	0.31
Adjusted R^2	0.22
R^2 change	0.31

*p<.05, **p<.01, ***p<.001.

CHAPTER SIX
DISCUSSION

The paucity of health research on young women provided the impetus for an exploratory investigation of health issues relevant to this specific group. Three objectives were addressed. As evident through earlier research, women as a group are dissatisfied with various aspects of their health care. Based on this finding the first objective of the present study was to examine the impact of GPer care on the respondent in terms of her own assessment of the satisfaction derived from this interaction. A more comprehensive picture of consumer opinion was obtained by the concurrent use of quantitative and qualitative methods. A second objective sought to identify determining factors associated with young women's heavy use of GPer services, a finding demonstrated in previous research. A third objective was to explore the relationship of access factors, affordability, accommodation, and accessibility (adopted from Penchansky and Thomas's schema) to GPer utilisation and satisfaction in the study sample.

Important features of the study results are discussed in the following five sections. Note, the first three sections report findings relating to the three study objectives respectively outlined above. Specifically, the first section, reflecting patient satisfaction, reports quantitative results on the 7-item index of statements adapted from Gray and on sociodemographic factors associated with patient satisfaction. In addition, qualitative results are discussed, highlighting factors of particular relevance to young women regarding GP care and more general aspects of health care. Following this, implications of the findings are discussed. The second section, reflecting health service utilisation, highlights determinants of GPer utilisation among the sample group. Other findings are discussed. The third section discusses the impact of access factors on GPer utilisation and patient satisfaction. In the fourth section limitations of the study and methodological issues are examined. Finally, directions for further research are proposed in the fifth section.

6.1 Patient Satisfaction

6.1.1 Quantitative

INDEX OF PATIENT SATISFACTION This 7-item index directly assessed patient satisfaction with GPer performance (adapted from an index devised by Gray (1980)). Consistent with the findings of Gray and other studies (Kincey et al., 1975), expressed levels of satisfaction were typically high indicating respondents in the study were more satisfied than dissatisfied with GPer provided services.

Respondents were least satisfied with the quality of information provided by their GPer regarding their complaint. This result concurs with previous studies which emphasise the importance of good communication between the GPer and patient. In this regard, Cartwright and Anderson (1981) demonstrated that patients are more critical of the information they receive from doctors than of any other aspect of medical care. Korsch et al. (1968) found that patient dissatisfaction was associated with the lack of a clear explanation by the GPer concerning the diagnosis and causation of her complaint whereas Comstock et al. (1982) found that patient satisfaction correlated strongly with the physicians verbal skills of information-giving and courtesy skills (in the present study the most satisfactory component regarded the degree of courtesy shown by the GPer towards the patient). According to Lewis (1994), "People are driven by uncertainty to see their doctor and a requirement for information is high on their agenda" (p. 667). In considering what information doctors should convey to patients, Ley (1988) highlights the need to inquire about what the patient wants to know and the nature of his or her health beliefs - "This enables the doctor to provide information to correct perceptions when they are wrong" (Buchanan, 1991, p. 63). The Women's Health Committee Report (Women's Health Committee, 1988) recommends that adequate information be provided by health professionals to enable women to make informed decisions.

SOCIODEMOGRAPHIC FACTORS The only sociodemographic factor that relates to patient satisfaction is respondents levels of education. Women with higher levels of education indicate lower levels of satisfaction with GPer care. Hall and Dornan (1990)

speculate that this may be because "...they have heightened expectations or apply stiffer standards in their evaluations of care (regardless of the nature of that care), and are consequently disappointed compared to less educated patients" (p. 817). Some support for this assertion can be found in the data provided by Walton et al. (1988) which shows that women with higher education generally make more critical comments. This negative relation for education has been documented in previous studies (Anderson & Zimmerman, 1993), however, other studies have failed to find a relationship or have reported contradictory findings (cited in Ware et al., 1978). Such conflicting results warrant further investigation of the variables most important in patient satisfaction outcome.

6.1.2 Qualitative

To recap, three issues were addressed in this section, being GPer-patient relationships, gender of GPer, and general aspects of health care. Although no attempt was made to explicitly assess satisfaction in terms of these issues, earlier work has already confirmed that these same parameters have directly influenced patient satisfaction. This body of research will also be discussed in what follows.

GENERAL PRACTITIONER-PATIENT RELATIONSHIPS

In considering ***the respondents perception of a 'good' and 'bad' GPer***, interpersonal skills were most highly regarded. Several major themes emerged in response to the inquiry. Firstly, respondents commented on poor communication. A core set of communication deficiencies emerged within the GPer-patient interaction, namely the GPers failure to listen to the patients statements and the lack of a clear explanation by the GPer regarding the cause and significance of their complaints. Criticisms of this nature have been emphasised in previous studies (Cartwright & Anderson, 1981; Korsch et al., 1968).

Previous studies have also demonstrated similar communicative deficiencies suggesting that patients are adequately perceptive in this regard. Stewart et al. (1979) showed that 54% of patient complaints and 45% of patient worries were not detected by GPers.

Beckman and Frankel (1984) found that in only 23% of consultation visits did patients' (of both sexes) have the opportunity to complete an opening statement of their concerns. Tuckett (1981: cited in Editorial, 1983) demonstrated that explanations are rare in GP consultations. Interestingly, Martin et al. (1991) found that male GPers give explanations more to male patients than to female patients. Moreover, "Patients' reports of providers' information-giving...have repeatedly been found to correlate positively with objective data on information giving gathered from taped medical encounters" (Hall & Dornan, 1988a, p. 642).

Interestingly, a NZ survey (Richards & McPherson, 1981) in which 898 GPers were questioned about their work attitudes, found that most GPers believe their patients should be given a full explanation about the cause of their illness and the rationale of treatment. Additionally, consultations rated by GPers as most satisfactory are characterised by verbal interaction with the patient (Winefield & Murrell, 1992). The pertinent question then is why, when both patient and GPer advocate clear communication in the manner described, are problems in communication still apparent? As stated by Grace (1995), "There are, of course, many constraints on doctors in this area of doctor-patient interaction which are sociological and political in nature and relate to the organisation of medical care and the health system as a whole in NZ at the present time" (p. 105). Buchanan (1991) points to cultural factors - "Many doctors exhibit a lack of cultural understanding in their communication with Maori patients" (p. 63). This, of course, applies to other ethnic groups. These various factors may act as barriers to effective GPer-patient communication. Apart from good communication respondents attached importance to an empathic attitude and the GPers show of warmth and concern ('emotional support'), a finding supported by previous research (Korsch et al., 1968).

In placing more store on interpersonal factors it is possible to suggest that young women's levels of satisfaction would be increased if the GPer displayed these features. Indeed, as previously noted, earlier work has demonstrated this effect (although young women as a specific group have not been studied). Several studies indicate that clear communication in

the form of adequate and comprehensive explanations is directly related to increased patient satisfaction (Kincey et al., 1975; Korsch et al., 1968; Woolley, Kane, Hughes & Wright, 1978). Korsch et al. (1968) reviewed patient satisfaction in a paediatric clinic and found that patients were most satisfied if they were listened to. Regarding the interpersonal quality of the providers manner in terms of emotional support, if perceived by the patient, satisfaction ratings are increased (Ben-Sira, 1976; Buller & Buller, 1987; DeMatteo et al., 1980; Korsch et al., 1968).

Three possibilities are suggested by Brody et al. (1989) to explain the consistent finding that patient satisfaction relates more strongly to the interpersonal than technical aspects of patient care. Firstly, patients may feel less able to form opinions about the GPers technical skills. As previously mentioned, empirical evidence is mixed regarding the ability of patients to judge technical features of medical care. Secondly, technical care may be so uniformly good that it cannot contribute to the variation in patient satisfaction ratings. The nature of the present study made it impossible to test this hypothesis. Lastly, interpersonal aspects of care maybe regarded as more personally meaningful to patients than technical features.

Confirming previous studies, most respondents in the present study held ***expectations*** regarding their consultations with their GPer. These related more to technical features of care (an accurate diagnosis, appropriate medication, symptom relief for themselves) than to interpersonal, accessibility, and holistic features. Nevertheless, a substantial number of women held expectations of an interpersonal nature, that their GPer be friendly, sympathetic, and listen to them, possibly suggesting that for this segment of the sample technical expertise was not their predominant concern.

For a minority of women (21%) their expectations regarding technical, accessibility, and interpersonal aspects of their care (in order of relevance) were seldom fulfilled. Since previous research indicates less satisfaction when patient expectations are not met (Francis et al., 1969; Kincey et al., 1975; Korsch et al., 1968; Larson & Rootman, 1976; Ross et

al., 1981) it is possible to suggest less satisfaction among these women as a result. As stated by Korsch et al. (1968), "The failure to have expectations handled does increase the probability of dissatisfaction in the patient" (p. 861). Of course, some dissatisfaction may result from unrealistic or 'inappropriate' expectations (Williamson, 1989), particularly since trends indicate expectations are rising ('Joint Working Party', 1994). Nevertheless, "...if her expectations cannot be met, they should at least be acknowledged" (Korsch et al., 1968, p. 17), as such potential misunderstandings are avoided. From the authors viewpoint, most of the expectations expressed by respondents in the present study appear quite reasonable and well within the scope of the accepted practice of good medicine.

GENDER OF GENERAL PRACTITIONER

According to Gray (1982) several factors predispose women to prefer female doctors, one of which are gynecological complaints. Indeed, most women in the present study prefer to consult a GPer of their own sex when complaining of problems pertaining to their sex. Women's preferences for female GPers however are not limited to sex-linked health problems, a finding corroborated by previous studies (Cartwright & Anderson, 1981; Graffy, 1990; Preston-Whyte, 1983). The majority of women, if given a choice, prefer to visit a female GPer. These women believe that female GPers are more understanding and easier to talk to. These perceptions are supported by earlier work which has found that female GPers hold more sensitive attitudes than do men (Heins et al., 1979), and are more strongly oriented towards the interpersonal aspects of health care, (Weisman & Teitelbaum, 1985) although it is not clear whether the behaviour of female GPers corresponds with these attitudes.

The pertinent question is whether this preference is important?. Challacombe (1983) contends, "It would matter if the treatment given were different or if patients were more (or less) satisfied seeing female or male doctors" (p. 850). Regarding treatment, Hausfeld (1976) found that men and women with identical symptoms are often treated significantly differently (according to sex) by the same GPer, a finding corroborated by Armitage, Schneiderman, and Bass (1979). Gray (1982) cites several studies which show that male

GPers are more likely than women GPers to propose more orthodox and technical solutions. Thus, there is limited evidence that GPers treatment of male and female patients do differ but no compelling evidence exists to date. Unfortunately regarding patient satisfaction, few studies have addressed GPer gender as impacting on the above. Comstock et al. (1982) found significantly higher female patient satisfaction with female GPers, a finding corroborated by Delgado, Lopez-Fermandez, and Luna (1993). Challacombe (1983) suggests that the observed preference of female patients for female GPers is likely to be based on the perceived feeling of greater interpersonal rapport. Some support for this suggestion can be found in the comments expressed by women in the present study.

Many young women in the present study attributed different ***traits*** to male and female GPers. The female traits ('empathic', 'sympathetic', 'concerned') appear to reflect more motherly/nurturant qualities attributed to females in general. The male traits ('directive', 'distant', 'unemotional') appear to correspond more with masculine/authoritative qualities attributed to males in general. These differences seem to stem from the divergent socialisation processes affecting males and females from early childhood onwards, where males are socialised to be detached and unemotional and females are socialised to be caring, involved, and emotional (Gray, 1982).

GENERAL ASPECTS OF HEALTH CARE

Check-ups: The health check places emphasis on preventive care (i.e., screening for cancer and disease) and health education, namely encouraging people to lead healthier lives. Although most respondents in the present study were positive and supportive of regular check-ups for women, over half of these women did not attend regular check-ups themselves. It is difficult to gauge why as few reasons were given by these women.

The value of routine health checks remains a matter of debate (the benefits and otherwise derived from these initiatives are complex and beyond the scope of this discussion). Richards and McPherson (1982) report that NZ GPers are more assiduous in

recommending check-ups than the British, which may be a reflection of the incentive provided by the fee-for-service principle applying to medical practice in NZ as opposed to the capitation system within the NHS. However, more recently British GPers are contractually obliged to offer preventive care services, as specified in the 1990 GP contract (Ellis, 1991).

Clinics especially for women: "Some existing services to women generally, are too uncoordinated to cater satisfactorily for the health needs of this group" (Maskill, 1991, p. 104). This has led to the establishment of specific or separate health services for women. Lloyd (1983) emphasises the distinction between clinics especially for women and 'well-woman clinics', where the latter tend to offer a broader, more comprehensive service which may include all the components of the former (such as cervical screening, breast screening and contraception) in addition to more positive support towards mental and social good health.

Strong support emerged in the present study for the establishment of clinics especially for women (well-woman clinics were not specifically addressed). Respondents highlighted the benefits of a specialised service and comfortable surrounds. Some women felt that the establishment of such services would encourage regular check-ups. Maskill (1991) contends that to be most effective the establishment of women's clinics needs strong community support. It appears, based on the response of young women in this study, that some support does exist for this type of health care initiative.

In summary, an integrated approach utilising quantitative and qualitative methods was adopted in the present study to gauge young women's health requirements regarding GP care. The qualitative data serve to confirm the desire, on the part of the patient, to engage in an interpersonal exchange with her GPer. Specifically, respondents desire to consult with a GPer whose manner communicates warmth, who listens to them, and fully explains their illness and treatment. Previous studies indicate that failure to accommodate patients' needs regarding interpersonal treatment results in less satisfaction. Results from the

quantitative analysis show less patient satisfaction with the quality of information provided by her GPer than other aspects of GPer performance.

More stress was laid by young women as a group on expectations of a technical nature than on other aspects of their care. Some women held expectations (regarding technical, accessibility, and interpersonal features of care) which were seldom fulfilled. Previous research reporting similar findings reveals less satisfaction among these women highlighting the importance of initially determining the patient's expectations of the forthcoming consultation. Respondents prefer to consult a GPer of the same sex not only for sex-linked health problems but also for conditions which are not sex-related. Preference appears to be based on the patients' perception of more effective communication and greater rapport. Supporting this finding, the traits attributed to female GPers appear to correspond with the qualities young women desire in a good GPer, which are interpersonal in nature. Most respondents were supportive of both regular check-ups and clinics especially for women.

6.1.3 Implications

Some implications for the selection of medical students, medical education, the distribution of women in the workforce, and health care initiatives can be drawn from the study findings. These will be discussed in the following. In addition, the issue of patient's responsibilities will be briefly discussed.

STUDENT SELECTION

The study findings highlight the importance of interpersonal relationships between young women and GPers, encompassing effective communication and a sensitive and empathic exchange. These results suggest that affective attributes and non-academic abilities such as communication skills are qualities necessary in GPers in addition to technical prowess. Corroborating this finding there is increasing evidence that selection of medical students

based solely on prior academic achievement will not produce the 'best' doctors (Glick, 1994). Personality factors may be equally significant predictors of students becoming effective doctors.

Two universities in NZ conduct selection procedures, being the Auckland School of Medicine and the Otago Medical School. At present, selection for medical school entry at Otago is dependent on grades entirely. As far as the University of Auckland School of Medicine is concerned, personality factors as well as academic achievement are included among the criteria for the selection of medical students, a development espoused by the World Federation for Medical Education (WFME) in 1988 (cited in Parsell & Bligh, 1995) and since echoed by several recent reports (Boland, 1995; Kamien & Rotem, 1995) and adopted by many medical schools internationally (Glick, 1994). A complex interview procedure is in place in Auckland "...designed to give priority to those showing the potential to learn communication skills" (Grant, 1995). "In general there is a developing trend to use psychometric data (for example, cognitive abilities, moral reasoning, capacity for empathy) in admission procedures" (T. Egan, personal communication, December 6, 1996).

MEDICAL EDUCATION

Most of the comments made by young women regarding their GP care seem to reflect a deficiency in the ability of their GPer to employ a more humanistic attitude, poor communication, lack of sensitivity and concern, and, in short, all the facets of good interpersonal relationships between GPer and patient. Various proposals to reform medical education have been implemented in several countries, including NZ, to correct the perceived deficiencies in GPer-patient relationships. The "...organisation of curricula have been scrutinised in order to reconcile population needs with appropriate health-care" (Parsell & Bligh, 1995, p. 397).

Between the two medical schools in NZ (Auckland and Dunedin)[9] the educational curricula may of course differ. However, on a national basis there is increasing awareness of the importance of communication skills in medical education, particularly in general practice undergraduate and vocational training programmes. The Auckland School of Medicine has placed particular emphasis on this aspect of a doctors undergraduate training, adopting insights from the psychology of learning (Grant, 1995).

Frequently it has been argued, by GPers especially, that time constraints in GP consultations prevent time-consuming listening and explanation. Korsch et al. (1968) contends that much time in consultation is lost in 'ineffective verbalisation' - "By allowing the patient's concerns prompt expression serious communication barriers are removed and frequently it actually takes less time to arrive at the point of joint problem-solving" (Korsch & Aley, 1973, p. 14). This also applies to patient expectations which Korsch et al. (1968) indicates are readily obtainable with simple interview questions. The undergraduate training course in Auckland addresses this time constraint issue by teaching students how to structure the consultation and apply this style of communication in a brief interview.

Regarding postgraduate education, the teaching of communication skills is a central feature of year 3 of the General Practice Vocational Training Programme (GPVTP) provided by The Royal College of General Practitioners (RNZCGP). At the end of the year registrars are examined in Primex[10] (the Primary Membership Examination of the RNZCGP) through simulated patient interviews (J. H. Hindmarsh, personal communication, November 12, 1996). Currently the GPVTP obtains Government funding to train only 50 doctors per annum, which means a significant number of doctors are entering GP in this country without adequate training (Coster, 1995). A greater commitment by the Government to GP training is required to ensure that practicing GPers have the necessary skills.

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[9] Both Christchurch and Wellington medical schools are affiliated to Dunedin medical school.
[10] Primex is a pre-requisite to the final phase of the programme.

Current evidence suggests that communication skills can be taught. Can empathy be taught, or is this quality inherent in the person, modulated by life experience?. Davis (1990) contends that the behaviour itself cannot be taught as a skill, although the process can be facilitated to occur. P. J. Farry echo's this viewpoint, "We can only encourage it in a number of ways, for example, teaching students how to actively listen and use patient centred methods, encouraging self awareness and the ability to bracket personal bias so that the patient's experience can be fully comprehended" (personal communication, December 6, 1996). This also highlights the importance of assessing these qualities in prospective medical students.

The nature of the ***negative experiences*** described by young women have implications for the education of medical students. These experiences included dismissive and patronising GPer behaviour. A British study investigated medical students attitudes towards women and found that male students were more likely to agree with statements which stereotyped women in a negative way (Savage & Tate, 1983). Clearly, such attitudes are inappropriate and undoubtedly interfere with communication between the patient and GPer. Phillips (1995) contends that knowledge and skills are emphasised in medical education above the importance of attitudes. The Women's Health Interschool Curriculum Committee of Ontario has developed goals and objectives for medical education as they relate to women's health (cited in Phillips, 1995). Desired attitudes are defined which serve to present women and their problems in a positive manner. This might also serve to diminish the possibility of sexual misconduct occurring during the GPer-patient interaction, as was reported by a minority of women in the study.

Several initiatives have been proposed to address the inadequacy of conventional medical education to meet women's health needs, including establishing a women's health specialty and incorporating a women's health curriculum into medical training (Allen, Gilchrist, Levinson & Roter, 1993). Although controversial, this would serve to focus attention on the present shortcomings perceived by female patients in their interactions with GPers.

DISTRIBUTION OF WOMEN IN THE WORKFORCE

Results indicate that young women's preferences for female GPers are not limited to problems pertaining to their sex, confirming the findings of previous studies which have dealt with women as a group (Graffy, 1990; Preston-Whyte, 1983). Based on current research it cannot be concluded that GPer gender has any discernible effects on medical treatment received. The present findings do suggest however that interactions between female patients and female GPers may be characterised by more effective communication and greater rapport than opposite-sex interactions. As a result it may be expected that young women are generally more satisfied with their visits to female GPers. Clearly, based on these findings female GPers have a special role in providing health care for young women.

The number of women entering medical school in New Zealand has climbed steadily in the past 15 years. Currently, approximately 28% of active GPers are women (Laing, 1995). Consequently there are increased opportunities for young women to consult GPers of their own sex. The study findings support this development. However, a considerable number of these women work part-time due to family commitments. Resolving the conflict of multiple roles is extremely problematic.

HEALTH CARE INITIATIVES

Check-ups: It is difficult to gauge why many young women in this study chose not to attend regular check-ups as few reasons were given. Pill, French, Harding, and Stott (1988) described the major differences between men and women who did and did not attend for a general health check-up within an inner-city Cardiff practice. Non-attenders were more likely to be less educated and of lower social status, a finding corroborated by other studies (Makuc, Fried, & Kleinman, 1989; Schwoon & Schmoll, 1979). Unfortunately in the present study the demographic characteristics of attenders and non-attenders was not compared.

Literature addressing medical check-ups is scant in this country. In Britain two main invitation methods have been employed to encourage patients to attend health checks. The first involves the use of invitation letters. By including an appointment in the invitation (as opposed to an open invitation) greater attendance rates have been obtained (Norman & Conner, 1992). However, those accepting an invitation to a health check are likely to be people in affluent social classes, who are healthier, better educated, highly motivated, and not necessarily the patients at highest risk (McPherson, 1993; Pill et al., 1988). The second method involves opportunistic health checks during routine consultations. This strategy is convenient for the patient and more effective in reaching high risk patients although Sacks and Marsden (1989) found that only 25% of their target population had attended a health check after a period of 2.5 years. A third strategy would seek to encourage patients (particularly the 'at risk' groups) to take more responsibility for their health by emphasising the benefits derived from regular check-ups. As stated by Pill and Stott (1988), "...consumer attitudes and beliefs are the most important determinants of whether a patient decides to attend or not" (p. 59). Foremost however, the utility of regular check-ups should be prospectively evaluated so that age and sex-specific guidelines may be formulated.

Clinics especially for women: The strong support given by respondents in this study for the establishment of clinics especially for women is promising to ensure acceptability, however, to receive government funding (surely needed if progress is to be made) this health initiative would have to prove itself as necessary. Clearly, precise evidence assessing the effectiveness of this health service in meeting women's needs is warranted. To date, much of the pioneering work of setting up such clinics in this country has remained undocumented. If proved effective and successfully operated, this health initiative would not only provide a service sensitised to women's needs but would also increase the pool of health professionals, giving women more choice in health care.

PATIENT'S RESPONSIBILITIES

As stated by the World Health Organisation (1978), "...people have the right and duty to

participate in the process for the improvement and maintenance of their health" (p. 23). Similarly, Donabedian (1988) contends that the patient, as well as the GPer, must carry some of the responsibility for the success or failure of medical care. Too often however, patients are willing to abrogate all responsibility.

Korsch et al. (1968) evaluated tapes of patients' visits in a pediatric clinic. Considering the importance of the patient's expectations it is surprising that only 35% of expectations were mentioned to the GPer during the consultation. Bain (1979) found that GPers initiate more of the verbal interaction than do patients. Clearly, patients should be encouraged to initiate discussions with their GPers, fully disclose all relevant information, and voice all expectations and concerns which may increase the likelihood of them being responded to.

Interestingly, Sawyer (1979: cited in Gray, 1982) found that females are more 'mute' with male GPers. Training patients to communicate with their GPers would be a progressive step forward. Lorig (1991) presents a practical guide to planning a patient education programme, whereby GPers play an active educational role in the community. Patients are advised not to cast health professionals in an adversarial role. Such initiatives may encourage patients to assume more responsibility for their health.

6.2 General Practitioner Utilisation

To recap, young women in the aggregate are disproportionately heavy users of GPer services. Since the determinants of GP consultations by this specific group had not been elucidated in previous research, the present study addressed this issue.

6.2.1 Determinants of general practioner utilisation

Quantitative information derived from applying Anderson's Behavioural Model of Health Service Utilisation (relates an individual's decision to use health services to predisposing, enabling, and need components) to the study sample, brought forth some consistent findings. Corroborating earlier work, the need characteristics appear to be the most important determinants of GPer utilisation. Specifically, the total number of perceived symptoms emerged as the only predictor of GPer utilisation contributing the greatest increment to the total explained variance in the regression equation. The fact that respondents suffered from few long-term health problems is not surprising considering their age. Thus, demands on GPer services by young women in this study appear to reflect behaviour in response to physical illness perceived. Similarly, a British study (Morrell & Wale, 1976) of 198 women aged from 20-44 years drawn from the register of a GP in Lambeth, found that patients recording more symptoms were more likely to consult the GPer (although methods employed by the two studies differed, whereby the above study used health diaries to record the patients' symptoms and the present study depended on patient's identifying symptoms from a medical checklist).

Concerning physical illness, the data from general population studies consistently show that women, as a group, have higher rates of morbidity than men (Mechanic, 1976; Verbrugge 1976,1985), especially for minor conditions and inventories of symptoms (Ritchey, Gory, & Mullis, 1991). To date, the precise reason(s) for the reportedly greater incidence of illness in women has not been determined however five categories of explanation have been proposed. These will be briefly outlined in the following. In addition, evidence (based on empirical research) will be presented concerning the relative

merit of the alternative explanations. Note, some comprehensive reviews of sex differences in morbidity already exist. The present discussion highlights the most salient findings.

The first explanation concerns ***'biological risks'*** - "Women report higher morbidity rates because they experience greater disease pathology and more reproductive conditions" (Ritchey et al., 1991, p. 33). Within this framework women's more complex reproductive system increases risks of female-specific disorders. For example, cyclical symptoms are complained of by a large proportion of pre-menstrual females resulting from hormonal changes associated with their monthly menstrual cycle. Many of these symptoms, collectively grouped under the term 'pre-menstrual syndrome', are a common and recurring reason for consultation (Dr. K. S. De Silva, personal communication, November 12, 1996). Also within this framework the reproductive events of pregnancy and childbirth pose unique morbidity risks not experienced by males.

Evidence: Regarding women's reproductive system, some support for this explanation can be found in the data provided by a recent study of morbidity in Thailand. Menstrual problems experienced by Thai women appear to account for most of the sex differences in morbidity (Fuller, Edwards, Sermsri, & Vorakitphokatorn, 1993). Regarding reproductive events, even after reproductive conditions have been excluded women experience an excess in illness (Nathanson, 1975).

The second explanation centers on ***'acquired risks'*** - primarily a function of lifestyle, social roles, and psychological distress which determine the occurrence of illness. Differences between men and women, in respect of these factors, have typically been used to explain the observed higher rates of morbidity among women. Key lifestyle behaviours include, smoking, alcohol consumption, and physical activity. Social roles reflect role attachments (employment, marriage, parenthood) and social involvement. Psychological distress refers to incidence of and vulnerability to stress related illnesses. Regarding social roles, on the one hand it is suggested that women can more easily adopt the 'sick role' because of less demanding and more flexible role obligations (for example, housekeeping

and part-time employment). On the other hand it is posited that women as compared with men typically have multiple roles (for example, their obligations as spouses, mothers, and paid employees) which are likely to interfere with self care, leading to greater morbidity (Gove & Hughes, 1979). Thus, because of minimal social involvement (feeling bored and unchallenged) or too much, women's social roles are presumed to trigger psychological stressors.

Evidence: Verbrugge (1989) analysed sex differences in morbidity and found that women's low levels of employment were associated with poorer health. When role differences were controlled, morbidity data suggested a disadvantage for men. Bird and Fremont (1991) also found that women, in general, spend less time in paid work, earn lower wages, and have more social and emotional responsibilities. When gender differences in social roles were controlled, being male was associated with poorer health than being female. These authors concluded that "...if gender roles were more equal, women would experience better health than men, more consistent with their greater longevity" (p. 126).

Women feel more psychological distress than men, including anxiety, depression, and worry (Gove & Tudor, 1973: cited in Bird & Fremont, 1991). Furthermore, it has been shown that psychological distress makes an individual more susceptible to physical illness (Jemmott & Locke, 1984). Having reviewed the literature, Gove (1984) concludes that "...because of such distress they [women] are more likely to receive treatment, and that the distress is largely a product of their roles" (p. 77).

The third explanation concerns ***'psychosocial aspects of symptoms and care'***, also called 'illness behaviour', which reflects "...how people perceive symptoms, assess their severity, and decide what to do to relieve or cure health problems, as well as their ability to take desired actions" (Verbrugge, 1989, p. 283). The principal point espoused in this approach to sex differences in morbidity is that men and women perceive symptoms differently and accordingly behave differently, a suggestion for which there is some support.

Evidence: The evidence pertaining to women's attitudes indicates more attentiveness to health matters. Also, women feel much more vulnerable to illness, take more extensive care for illness episodes (for example, drugs), take more time off for the problem, and stay home from work (Verbrugge 1985,1989).

The fourth explanation concerns ***'health-reporting behaviour'***, whereby gender roles may lead men and women to report symptoms differently. It is generally thought that women are more candid about health matters, being more willing to report their symptoms to others and having greater recall ability than men. Also, women may give more detail when reporting their symptoms.

Evidence: To date there is no convincing evidence that sex differences in health-reporting behaviour exist. Verbrugge (1985) states, "Reporting factors nudge morbidity statistics in small ways. Their principal effect is to colour interviews and medical histories" (p. 173).

The fifth explanation concerns ***'prior health care and caretakers'*** - "...how therapeutic actions chosen by oneself or by a health professional influence the course of current diseases and the future onset of new diseases" (Verbrugge, 1989, p. 283). Women's more active response to illness may result in quicker recovery from current problems, slowing the onset of chronic conditions. Also, women's greater use of medical services may increase their chances of early diagnoses and effective treatment. Additionally, differential care given to men and women if based on biased attitudes can lead to inappropriate diagnoses and treatment (Verbrugge, 1985).

Evidence: There is as yet no evidence to support the above hypotheses. Regarding differential care, there is limited evidence that sex bias in medical care occurs, however, there is no compelling evidence to suggest that this leads to inappropriate care (Verbrugge, 1985).

In summary, it appears based on evidence to date that women's higher morbidity stems largely from acquired risks (roles and stress) and to a lesser extent from psychosocial factors (Verbrugge, 1989).

6.2.2 Other findings

Two other need factors that were positively associated with GPer utilisation were self-rated health and restricted activity. Regarding self-rated health, authors have commented that complementary information from the GPer should be obtained to ensure an accurate diagnosis of the patient's health (Mechanic, 1979; Van de Kar et al., 1992). However, several early studies demonstrate the validity of self-reports (although these studies deal with elderly populations) whereby self-rated health status can adequately be compared with physician ratings (Friedsam & Martin, 1963), although it is recognised that subjects with a higher neurotism score are prone to distort or misinterpret their symptoms and would therefore be expected to score more heavily on subjective indices of ill health. By contrast, the phenomena of symptom denial could also lead to inaccuracies in the assessment of health status (Dr. K. S. De Silva, personal communication, January 15, 1997). With the above two provisos in mind, a reasonable estimate of general health may be possible in response to patient's self-reporting of their health status. Furthermore, Ware et al. (1981) after reviewing 39 general health perception studies concluded that single-item health status ratings appear reliable.

Regarding the indicator of evaluated need, restricted activity, several reviews document that women restrict their activities for health problems more than men (Nathanson, 1975; Verbrugge, 1985). Two authors note limitations of this measure. Mechanic (1979) indicates that such restricted activity is learned in part and relates to health attitudes more generally. Anderson (1978) notes that restricted activity days can be influenced by other factors than ill health, such as the comprehensiveness of employees sickness benefits and financial incentives or disincentives to attend to their work.

Consistent with the existing literature (Mechanic, 1979; Wolinsky & Johnson, 1991),

worrying about one's health resulted in greater levels of GPer utilisation, confirming the importance of health beliefs and more broadly, the relevance of predisposing factors. However, this association does not necessarily imply a 'cause and effect' relationship. As stated by Wolinsky and Johnson (1991), "What is not clear from these data, [however], is whether the health worries caused the use of health services, or vice versa. This question is not easily resolved" (p. 353).

Only one enabling measure emerged as significantly related to GPer utilisation rates. The greater the respondents satisfaction with her standard of living, the lower the rate of GPer utilisation. It is possible to speculate that those respondents satisfied with their standard of living are most likely to have a fairly high standard of living, decreasing their susceptibility to disease. One would expect these persons to be healthier and as a result seek health care less frequently. Also, the satisfaction that results would presumably lead to a lower level of anxiety in this group which would also translate to a lower incidence of anxiety-related symptoms. Since anxious people are more likely to consult the GPer (Morrell & Wale, 1976) one would expect the opposite for people with low levels of anxiety.

6.2.3 Variance explained

As stated previously, the amount of explained variance in health service use reported by researchers utilising Anderson's framework has ranged from 9 to 27%. In this study the Anderson model, when applied to a regional sample of young women, explained 31% of the variance in GPer utilisation which, for the most part, exceeds the levels of explained variance reported in previous studies (Coulton & Frost, 1982; Wolinsky & Coe, 1984). One must be cautious however in comparing results between this and previous studies as most previous studies are examples of large scale nationally based studies dealing with representative samples, whereas the present sample is a non-random, non representative sample.

Consistent with the existing literature, almost all of the variance in GP attendance is accounted for by the need factors. Aday and Anderson (1974) contend that this indicates

an equitable health care system, responding primarily to patient need. Care must be taken however in reaching such a conclusion as only a modest amount of the variance in utilisation behaviour has been explained. As stated by Wolinsky and Johnson (1991), "...we do not really know what accounts for most health services use, and we should not placidly take refuge in the assumption that the error variance results from a truly random process" (p. 355).

6.3 Access Factors

To recap, Penchansky and Thomas (1981) characterise access as comprising of 5 specific dimensions: affordability, accommodation, accessibility, availability, and acceptability. The present study aimed to assess the effect of the former three dimensions on GPer utilisation rates and patient satisfaction. Questions reflecting these factors were derived from Gribben (1992).

None of the three access factors outlined above were associated with patient satisfaction. The only factor associated with GPer utilisation was accessibility, measured by mode of transport to the GPer. Contrary to prior expectations, results show that young women without private transport utilise services more. It is possible to speculate that persons disadvantaged in access to a private vehicle are most likely to be of lower socio-economic status, suffer more ill health, and consequently seek health care more frequently.

6.4 Limitations of the Present Study and Methodological Issues

The limitations of the present study must be acknowledged. First, the non-random nature of the sample means that the replicability of these findings in different contexts and with other groups of young women is unclear. Also, the small sample size raises issues of statistical power (Rosnow & Rosenthal, 1989: cited in Flett, Biggs, & Alpass, 1995). In addition, the sample is not representative of the heterogeneous character of the population of young women in the Wellington area. Specifically, young Maori women are underrepresented which reduces the power to detect racial differences if they did exist. Therefore, due to the small number of women in the sample and the lack of minority

representation no claim is made as to the generalisability of the results to the wider population.

Secondly, the nature of the research design utilised in the present study focuses on the behaviour of individuals who have already experienced health problems or initiated medical care. This results in potential recall problems for the respondent, for example, respondents were asked to report the number of visits to/by the GPer in the last year and physical symptoms experienced during the last month (although a checklist was provided which would have aided recall). Also, respondents were asked to describe aspects of the GPer-patient interaction. Degree of accuracy is unclear since previous research has demonstrated that patient recall about the content of a consultation is far from perfect (cited in Brody et al., 1989).

Thirdly, although comparisons between this and previous studies have been made, because of methodologic and measurement variations between studies caution is required. As yet no method has been developed for measuring patient satisfaction or GPer utilisation which could be adopted as a standard to allow comparisons across studies.

A cross-sectional research design was employed in the present study so that a range of parameters could be assessed in a relatively short timeframe. However, one of the drawbacks of this approach is that whilst it identifies associations it does not permit tests of causation, a problem that is particularly troublesome in the area of health care utilisation where the directions of the associations is not usually self-evident. Take the example of health worries, it is not interpretable from the cross-sectional data whether the health worries caused the use of health services or vice versa. Consequently, interpretation of the present findings is limited by the inability to establish cause and effect relationships. Ideally this study should be longitudinal in nature (due to resource constraints this was not possible) so that the sequence of events and time relationships (i.e., the dynamic processes involved) would be more clearly distinguished. For example, pertaining to time relationships, previous health use and prior satisfaction measures, both of which have

emerged as significant predictors of health care utilisation and GPer satisfaction, respectively, (Eve, 1988; Gray, 1980) could be incorporated in the study as explanatory variables.

6.5 Directions For Future Research

As mentioned earlier, to the authors knowledge this is the first investigation in NZ targeted at the health experiences of young women as a specific group. The author suggests that a larger survey (based on a national sample), using random selection of participants and a longitudinal research design, but otherwise based on the same approach (in terms of integrating quantitative and qualitative methods in the patient satisfaction section and utilising Anderson's health care utilisation framework), be conducted. This could potentially provide a useful means of developing a more sophisticated appreciation of the issues at hand, and would establish a base-rate against which other researchers could compare their findings (in the case of small-scale research, results could be viewed in context).

Although the amount of variance in GPer utilisation accounted for by the variables included in this study exceeds the levels of explained variances reported in previous studies, it is modest nevertheless. Clearly, other factors that were not examined may be operative. Future research should aim to identify these factors. Possibilities might include: genetic factors, psychological characteristics (mental dysfunction, cognitive impairment, autonomy), and organisational factors (i.e., how medical care is organised) (Anderson, 1995). In a similar vein, several authors suggest that patient satisfaction research could benefit from an examination of additional factors. These include, psychological differences between patients (Pascoe, 1983) including psychological distress (cited in Like & Zyzanski, 1987). It is important to note, society is not a static system therefore changes in lifestyle and environmental factors may warrant inclusion in future studies. The potential payoff of incorporating new variables into future research regarding health care utilisation and patient satisfaction is there in terms of greater understanding of health behaviour and the key factors that influence patient satisfaction.

Several authors contend that increased specificity of predictor variables will result in stronger, more meaningful relationships with health service use (Mechanic, 1979; Tanner et al., 1983). This possibility requires further investigation. In the present study, 6 indicators of social contact were derived from Wolinsky and Johnson (1991). Although diverse, these measures fail to identify which specific aspects of social contact result in health service use. It is suggested therefore that future research clarify the specific types of social contact that affect individual health behaviour and the conditions under which this occurs, that is, under what circumstances does contact with others trigger health seeking behaviour?, which particular members of the family/community play a more influential role in utilisation behaviour?, are there occasions inwhich social contact deters individuals from contacting a GPer?. Also, in the present study the perceived symptoms measure only addressed the presence of symptoms and did not consider the respondents subjective evaluation of the symptoms experienced in terms of requiring medical attention. This is especially important since research shows that individuals perceive symptoms differently and accordingly behave in different ways (Jones, Wiese, Moore, & Haley, 1981). In this regard, certain persons act on symptoms (i.e., seek medical aid) whilst others do not. Also, only a minority of such symptoms are taken to the GPer, suggesting that patients are highly selective in deciding which symptoms necessitate medical care (Morrell & Wale, 1976). This factor (indicative of respondents subjective disability rating), developed by Tanner et al. (1983), proved to be a strong predictor of physician utilisation. It would seem plausible that inclusion of more detailed measures in the future may increase the salience of these factors in relation to health service use.

A premise of the present study is that young women be recognised as a specific group, with unique perspectives and experiences of health care. The author appreciates however that within this population exist subgroups of women who may have health care needs distinct from young women as a group. In this respect, the particular needs of ethnic minorities are noted. Pertaining to Maori women, as mentioned earlier, health care which is appropriate to this groups needs would encompass concepts of health that are firmly based in Maori culture. As such, surveys are needed in the future that explicitly address

the health concerns of identifiable female groups. This should include young women living in rural communities, remoteness from medical services and isolation from others may impact their use of health services and their levels of satisfaction. When these issues are adequately researched and the findings reported it would then be possible to gain a better appreciation of their health needs and thereby provide a more directed delivery of health services to such groups.

In the present study, young women's preference for female GPers appears to be based on the perceived feeling of greater interpersonal rapport. Clearly, not all female GPers offer this degree of interpersonal care nor do all male GPers deny this. Further advances could be made in this area through assessing the impact of interpersonal interactions on subsequent health outcomes. One might intuitively hypothesise that treatments based on higher levels of interpersonal rapport would lead to improved health outcomes.

Although numerous population surveys have investigated health service utilisation rates, 'appropriate utilisation' remains an undefined parameter. It would appear timely for future research to establish age/sex specific norms for appropriate utilisation in order to gauge under- or over utilisation. In the absence of norms, our understanding of the adequacy of utilisation has been based on needs (Hulka & Wheat, 1985). In the present study the need factor, perceived symptoms, emerged as the main determinant of GP consultations by young women. Future research should be directed towards determining the immediate and long-term effects of young women's excess morbidity, in terms of health outcomes (particularly in relation to health benefits achieved) and social consequences such as their social productivity and the financial repercussions.

On a general level, ill health in women clearly generates large costs as far as themselves, their families, and society is concerned (Verbrugge, 1976). In the interests of reducing this burden, it would certainly be advantageous for future research to pay particular attention to elucidating the causative factors involved and thereby lead to improvements in their overall health status.

On a positive note, it is apparent that women's roles in society are rapidly changing. One would hope that these changes in role would serve to eventually narrow the health differential that exists at present between the two sexes.

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APPENDIX 1: Information Sheet

INFORMATION SHEET

Who are the researchers and where can they be contacted?

This survey is being carried out by Sonali de Silva (under supervision of Dr Ross Flett), as part of her Masters thesis in Psychology at Massey University. Sonali can be contacted on ph (04) [redacted]

What is the survey about?

The present survey concerns women's perceptions and evaluations of the medical care and health services available to them. In particular we are interested in your views of the medical care provided by your general practitioner.

What will I be asked to do?

You will be asked to respond to a single questionnaire. Your name will not be required on your questionnaire so no one will be able to link your name to your questionnaire answers.

How much time will be involved?

The questionnaire will take around 30-45 minutes to complete.

What can I expect from the researchers?

If you choose to take part in this survey you have the right to:

* contact the researchers at any time to discuss any aspects of the study
* refuse to answer any question, or withdraw from the study at any time
* provide information on the understanding that it is completely in confidence to the researchers, to be used only for the purposes of the research
* receive information about the results of the study on its completion

If you would like to take part in this survey, please answer the questions provided in the questionnaire. Please keep this information sheet for your own reference. Thank you for your cooperation. When you have completed the questionnaire please return it to us in the prepaid envelope supplied.

APPENDIX 2: Questionnaire

In this first section, we are interested in gathering some general background information about you. Circle the answer which is best for you or give details in the spaces provided.

In what year were you born? 19___

What is your present marital or relationship status?

Never married 1
Married 2
Living in a de facto relationship 3
Separated / divorced 4
Widowed . . . . . .

Which one of the following groups best describes who you usually live with? (Do not include people who are visiting or temporarily residing with you such as family or friends of family).

Live alone 1
Live with spouse / partner 2
Live with children (single-parent household) 3
Live with spouse / partner and children 4
Live with mother and / or father 5
Live with extended family (spouse / partner, children ***and*** other relatives . . . 6
Live with other adults (e.g, flatting) 7
Other (please specify):_____ 8

Which one of the following groups best describes the ethnic group you belong to?

New Zealander of Maori descent 1
New Zealander of European descent 2
New Zealander of Pacific Island descent 3
Other (please specify):_____ 4

If you were ***not*** born in New Zealand, how long have you resided here?

_____ years and _____ months

How long have you lived at your present location? (ie, area of town, city or country)

_____ years and _____ months

What is the highest level of education you have reached?

No school qualification 1

School Certificate passes in one or more subjects 2

Sixth Form Certificate or University Entrance in one or more subjects 3

University Bursary or Scholarship 4

Trade or Professional Certificate or Diploma 5

University Undergraduate Degree or Diploma 6

University Postgraduate qualification 7

Other (eg, overseas) :_____ 4

What is your personal yearly income before tax?
Please include income from ***all*** sources:

Below $10,000 1
$10,000 - $19,999 2
$20,000 - $29,999 3
$30,000 - $39,999 4
$40,000 - $49,999 5
$50,000 - $59,999 6
$60,000 plus 7

Are you engaged in any community volunteer work (ie, unpaid work)?

Yes ☐ No ☐

If yes, how many hours of community volunteer work do you do each week on average?

_____ hours

Would you classify yourself as ***mainly***:

Employed fulltime 1
Employed part-time 2
Taking care of a home 3
Looking for work 4
Too unwell to work 5
Retired 6
Other (please specify):_____ 7

What is your main paid job? _____

Which one of the following groups best describes your current living arrangements?

I own my own home (with or without mortgage) 1
I live in a house owned by a family member 2
I live in rented accomodation 3
Other (please specify):_____ 4

Do you have a community services card?

Yes 1
I have applied for one, but haven't received it yet 2
No 3

Do you have a high use health card or a 'chronically ill' certificate?

Yes 1
I have applied for one, but haven't received it yet 2
No 3

Which statement best describes how satisfied you are with your overall standard of living?

Very dissatisfied 1
Dissatisfied 2
Satisfied 3
Very satisfied 4

Which of the following statements best describes how you feel about your ability to get along on your income?

Can't make ends meet 1
Have just enough money 2
Have enough money with a little left over 3
Always have money left over 4

Do you have a telephone in your home from which calls can presently be made? . . . . . Yes No

Do you have access to a motor vehicle for your private use? . . . . . Yes No

Do you belong to a health insurance scheme which refunds some or all of the money that you've paid for health care(eg, doctor's fees, prescription fees)? . . . . . Yes No

Do you have any living brothers or sisters? . . . . . Yes No

Do you have any living children? . . . . . Yes No

Have you spoken on the phone with your relatives or friends over the past two weeks? . . . . . Yes No

Have you got together with your relatives or friends over the past two weeks? . . . Yes No

Have you gone out to any group events (eg, meals with others, sports functions, classes etc) over the past two weeks? . . . . . Yes No

Have you attended a religious service (eg, church) in the past two weeks? . . . . . Yes No

The next group of questions are about your general physical health. Please indicate how much each one of the following problems has bothered or disturbed you during the *last month*. If you haven't been bothered by the problem, circle 1. If the problem has been an extreme bother, then circle 5, and so on, as shown in the scale below:

1	2	3	4	5
not at all	a little	moderately	quite a bit	extremely

Eye problems	1	2	3	4	5
Ear Problems	1	2	3	4	5
Nose Problems	1	2	3	4	5
Asthma or wheezing	1	2	3	4	5
Breathing difficulties	1	2	3	4	5
Chest pains	1	2	3	4	5
Racing heart	1	2	3	4	5
Cold hands or feet even in hot weather	1	2	3	4	5
Leg cramps	1	2	3	4	5
Insomnia or sleep problems	1	2	3	4	5
Toothaches	1	2	3	4	5
Stomach upset or pain	1	2	3	4	5
Problems passing urine or motions	1	2	3	4	5
Muscles or joint pain	1	2	3	4	5
Sensitive, itching or tender skin	1	2	3	4	5
Acne or pimples	1	2	3	4	5
Boils	1	2	3	4	5
Sweat, even in cold weather	1	2	3	4	5
Headaches	1	2	3	4	5
Hot flushes, face flushes	1	2	3	4	5
Dizziness, feel faint	1	2	3	4	5
Chills	1	2	3	4	5
Numbness or tingling in any part of body	1	2	3	4	5
Twitching of eyelid	1	2	3	4	5
Twitching other than eyelid	1	2	3	4	5
Hands tremble or shake	1	2	3	4	5
Sore throat	1	2	3	4	5
Nausea or vomiting	1	2	3	4	5

The next set of questions are about long-term health problems you may have. Long-term health problems are more serious health problems that you have had for *six months or more*, or health problems that are likely to last for at least six months or more. Please circle 'Yes' or 'No' to indicate if a doctor, nurse or other health care worker has told you that you have any of the following long-term health problems.

Cancer	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
High blood presure or hypertension	Yes	No
Heart trouble (for example, angina or myocardial infarction)	Yes	No
Asthma	Yes	No
Other respiratory conditions (for example, bronchitis)	Yes	No
Stomach ulcer or duodenal ulcer	Yes	No
Chronic liver trouble (for example, cirrhosis)	Yes	No
Bowel disorders (for example, colitis or polyps)	Yes	No
Hernia or rupture	Yes	No
Chronic kidney or urinary tract conditions	Yes	No
Chronic skin conditions (for example dermatitis or psoriasis)	Yes	No
Arthritis or rheumatism	Yes	No
Hepatitis	Yes	No
Hearing impairment or loss	Yes	No
Sight impairment or loss	Yes	No

Please name or describe any ***other*** medical conditions, impairments or ailments not mentioned so far that you have had for three months or longer:

_____

_____

_____

_____

How many days over the last three months has ill health interfered with your ability to perform normal daily activities (for example, going to work, playingsport, doing housework, and so on)?

_____ days

Overall, how would you say your health is? (Circle a number).

1 excellent --- 2 good --- 3 not so good --- 4 poor

Do you have a regular doctor (eg, family GP)?

Yes ☐ No ☐

If yes, how long have you been seeing this doctor?

0 - 3 months 1
4 - 12 months 2
1 - 2 years 3
3 - 5 years 4
Over 5 years 5

Is your regular doctor male or female?

Male ☐ Female ☐

How many times in the last 12 months have you seen ***any*** GP or been visited by one (eg, family doctor, but **not** a specialist)?

_____ visits

When do you usually get an appointment to see the doctor?

On the ***same day*** you contact the doctor or receptionist 1
On the ***day after*** you contact the doctor or receptionist 2
Other (please specify):_____ 3

Which of the following statements best describes how you normally get to the doctor's office?

Private vehicle 1
Walk 2
Bus 3
Taxi 4
Bicycle 5
Train 6
Other (please specify):_____ 3

Do you feel that the cost of the visit ever stops you from going to see the doctor when you really need to be seen by a doctor?

Not at all 1
Occasionally 2
Some of the time 3
Often 4

How long do you usually have to wait in the doctor's waiting room before being seen by the doctor?

_____ minutes

When was the last time you saw the doctor?

- In the last two weeks 1
- More than two weeks ago but less than three months 2
- More than three months ago but less than six months 3
- More than six months ago but less than one year 4
- One year ago 5
- More than one year ago 6

How many prescription items have you had for ***yourself*** from the chemist in the past 12 months?

- No prescription items 1
- 1 to 4 items 2
- 5 to 9 items 3
- 10 to 14 items 4
- 15 or more items 5

Over the past 12 months, which statement best describes the degree of worry your overall health has caused you?

- A great deal of worry 1
- Some worry 2
- Hardly any worry 3
- No worry at all 4

Which statement best describes how much control you think you have over your future health?

- A great deal of control 1
- Some control 2
- Very little control 3
- No control 4

In this section, the questions concern your view of the overall medical care you recieve from your family doctor or GP. If you do not have a regular doctor, please answer the questions according to the overall treatment you may have received from one or more doctors (e.g. from a medical centre). We are interested in your honest opinion so please circle the number that comes closest to describing your feelings in response to the statements that follow.

1 = Delighted
2 = Pleased
3 = Mostly Satisfied
4 = Mixed
5 = Mostly dissatisfied
6 = Unhappy
7 = Terrible

How do you feel about:

1. The adequacy of consulting time in the doctors surgery 1 2 3 4 5 6 7

2. The quality of information your doctor provides you regarding your complaint 1 2 3 4 5 6 7

3. The quality of information your doctor provides regarding treatment 1 2 3 4 5 6 7

4. The level of interest shown by your doctor in relation to your general wellbeing 1 2 3 4 5 6 7

5. The courtesy your doctor shows towards you 1 2 3 4 5 6 7

6. The arrangements for follow-up care 1 2 3 4 5 6 7

7. The overall quality of medical care your doctor provides for you 1 2 3 4 5 6 7

General practitioner-patient relationships

1. Do you tend to maintain a formal or informal relationship with your general practitioner (GPer)? (tick one)

___ tends to be formal

___ tends to be informal

2. Do you like it that way? - or would you prefer the relationship to be more friendly or more businesslike? Please comment below.....

3. In your opinion, what characterises:

- a 'good' doctor?

- a 'bad' doctor?

4. Do you ever feel intimidated by your GPer? Please comment.....

5. When visiting your GPer, what expectations do you bring to the consultation?

- which, if any, of your expectations are seldom fulfilled?

6. Please describe your most negative experience with a GPer

Gender of general practitioner

1. In general would you prefer to see a male GPer, or a female GPer, or does it make no difference to you?

___prefer male ___prefer female ___no difference

Please comment.....

2. When consulting your GPer over medical matters particular to women (e.g. cervical smears, breast disorders, gynaecological difficulties), do you prefer to be treated by a female GPer? If so, why?..... please comment

3. Are there other matters, unrelated to the above, where you prefer treatment by a female GPer?

4. Do you tend to attribute different traits to male and female doctors? Please describe below

General aspects of health care

1. Do you support establishment of medical clinics especially for women? Please comment.....

2. Do you have regular check-ups? Do you think women should do this?

APPENDIX 3: Content Analysis of Qualitative Data

Subjects	FORMAL	INFORMAL	> FRIEND/BUS.	COMMENT	"GOOD"DR	"BAD"DR	INTIMIDATED?	COMMENT	EXPECTAT'S	UNFULFILLED?
1		Y	F	> relaxed/personal	I/H	I	Y	Dr doesn't listen	T	T
2	Y		F	****	I/T	I/T	N	****	T	T
3		Y	F	****	I	I	N	****	I/T	ful.
4	Y		F	****	I	****	N	****	I/T	ful.
5	Y		depends	str.forward probs.>B	T/I	T/I	Y	****	T/O	ful.
6		Y	F	****	I	I	N	****	A	ful.
7		Y	as is	****	I/T/H	I	N	****	I/T	ful.
8	Y		as is	****	T	****	N	****	****	****
9	Y		?	****	I	I/T/H	Y	Dr:doesn't expl/s annoy/	I/T	I
10	Y		as is	****	I/H	I	Y	****	I/H	H/A
11		Y	F	****	I/T	I	N	****	T	ful.
12		Y	as is	****	I	I	N	****	I	****
13		Y	as is	****	I/T	I	Y	patronised/judged/	T/I	T
14		Y	depends	****	I	I	N	****	****	****
15	Y		B	****	I	I	N	****	T	****
16		Y	as is	****	I	I	N	****	T	****
17	Y		****	****	I/T	I	N	****	T	****
18		Y	as is	****	I/T	I	Y	sexist/disbelieves	I	ful.
19		Y	F	> relaxed	I/T	I	Y	med.cert.	****	****
20	Y		as is	****	I/T	T	N	****	T	****
21	Y		F	****	I/T	I/T	Y	ignorance	T	T
22	Y		as is	****	T	T	N	****	T	****
23	Y		as is	****	I	I/T	Y	blaise/elim.to diag.	T	T
24	Y		as is	****	I/T	I	Y	****	I/T/A	A
25	Y		as is	****	I/T	****	N	****	I	****
26	Y		F	****	I/T	I/T	N	****	I/T	ful.
27		Y	as is	****	I	I	N	****	I/T	****
28		Y	as is	****	I/T/A	****	N	****	****	****
29		Y	as is	****	I	I/T	N	****	I	ful.
30	Y		F	****	I	I/T	Y	by MDr's	****	****
31		Y	as is	****	I/T	I/T	Y	by MDr's	I/T	every one
32	Y		****	****	I/T	I/T	N	****	T	****
33		Y	as is	****	O/I	I	sometimes	embarr/dismissed	T	****
34		Y	as is	****	I/H	I	sometimes	embarrassed	I/T	ful.
35	Y	Y	as is	****	I	I	N	****	I/T	****
36		Y	as is	relaxed	I/T	I/A	N	****	T	****
37		Y	as is	****	I	I	Y	personal probs	T	ful.
38	Y		F	****	I/T	T	N	****	I/T	I/T
39	Y		as is	****	I	I	N	****	T	****
40	Y	Y	as is	****	I/T/O	I	N	****	I/T	****
41	Y		as is	****	I/T	I/T	N	****	I	****
42	Y		F	> whole ind.	I/A/H	I/A/O	N	****	I	****
43	Y		F	talk easier	I	****	N	****	A	****
44		Y	****	****	A	T	N	****	****	****
45	Y		F	****	O	I	N	annoyed	I/T	A/T
46	Y		F	****	I/T	I	Y	Dr is uninterested	T	****
47		Y	depends	>F if F Dr (v v)	I/T/H	I/H	Y	uncertain/upset/ill-inf.	I/T/H	****
48		Y	****	****	I	I	N	****	I	ful.
49	Y		as is	****	I/T	I	N	****	I/T	****
50		Y	as is	****	I	I	Y	MDr's esp.	I/T	****
51	Y		as is	B + relaxed	I	I	N	****	I/T	****
52		Y	as is	****	I	****	N	****	****	****
53	****	****	****	****	****	****	****	****	T	I/T
54	Y		as is	prof. but F	I/T	T	N	****	****	****
55	Y		as is	sustain prof.	I/T	I/T	Y	<listen/disregards conc's	T	****
56		Y	as is	comfortable	I	I/T	N	****	T	****
57	Y	Y	as is		I/T	I/O	N	****	I	****
58	Y		****	****	I/T	O	N	****	T	****
59	Y		depends:	v.concerned >B	I	I/T	Y	by conserv. Drs	****	****
60		Y	as is		T	T/A	N	****	O	****
61	Y		as is		I/H	O	N	****	I/T	****
62		Y	as is	F but prof.	I/T	I	N	****	****	****
63	Y		B	****	I/T	I	N	****	I	****
64		Y	as is	relaxed	I	I	N	****	I	****
65		Y	as is		I	I	N	****	T	****
66	Y		as is	but empathetic	I	I	N	****	T	****
67	Y		F	>relaxed/<opin.	I	****	N	****	T	****
68		Y	as is	free com.	I/T	I	Y	intimacy/<articulate	T/H	****
69		Y	as is	comfortable	I/T	I/T/O	N	****	I/T	T
70	Y		as is	****	I/H	I	N	Dr=friend	****	****
71		Y	****	****	****	****	****	****	****	****
72	Y	Y	as is		T	I/T	Y	older MDr's/new Dr's	T	****
73		Y	as is	free com.	I/H	I/T	N	****	I/T	ful.
74	Y		as is		T	T	N	****	T	****
75		Y	depends:	F Dr >F	I/T	I/T	Y	MDr+sex-rel.	I	****
76		Y	as is	****	I/T	I/O	N	****	I/T/A	A
77	Y		****	don't care	I/T	T	N	****	T	every one
78		Y	as is	****	I	I	N	****	I/T	****
79	Y		as is:	with M Drs	****	****	Y:	MDr's	****	****
80	Y		F	****	****	****	N	****	none	****
81		Y	as is	>equal rel-ship	I	I/O	Y	****	I/T	T
82	Y		****	****	I/T	****	Y	coerce ans.	I/T	****
83		Y	as is	2-way com.	I/H	I/T	N	****	I/A/H	A
84	Y		F	if consult. reg Dr	I/T	I/T	Y	****	T	****
85		Y	as is	****	I/H	T/A	N	****	T	ful.
86		Y	as is	equal com.	I/O	I/O	N	****	T	****
87	Y		as is	****	****	****	N	****	****	****
88		Y	as is	****	I	I	N	****	I	****
89	Y	Y	as is	****	I/H	I	sometimes	****	I	ful.
90		Y	as is	ask questions	I	I	N	****	T	T
91	Y		F	****	I/T	****	****	****	****	****
92	Y		?	****	I/T	I	N	****	T	****
93	Y		?	<exp. with Drs	I	I	Y	previous Dr	I	****
94		Y	as is	****	I/H/T	I	Y	rushed/prob.insig.	I/T/O	T/H
95		Y	as is	>comf/"Q's not avoided"	I/O	I/T	N	Dr explains/s comf.	T/O	A
96		Y	as is	friendly/supp.	T	T	N	****	T	?
		Formal=45	Friendly=19	**I= Interpersonal**	I=83	I=70	Y=27		I=42	I=3
		Informal=45	BusinessL=2	**O= Other**	O=5	O=8	N=63		A=5	A=6
		Formal/Informal=	as is=58	**H= Holistic**	H=13	H=2	sometimes=3		T=61	T=12
		No reply=1	?=3	**T= Technical**	T=45	T=31	No reply=3		O=5	0=0
			depends=5	**A= Accessibility**	A=3	A=4			H=4	H=0
			No reply=9							

Subjects	NEG.EXP'S.	PREFER M/F DR	COMMENT	SEX-R.PROBS:F DR?	COMMENT	OTHER:F DR?
1	MDr-top off unnec.	depends:	sex-rel.-prefer F	F	understand/ans.Q's/MDrs-vague	****
2	****	depends:	sex-rel.-prefer F	F	>comfortable/unnerved by MDrs	****
3	>neg.ca.myself/belittled	depends:	sex-rel.-prefer F	F	sim.exp's-understand	counselling
4	****	F	****	F	>comfortable	****
5	<age:no cure/>time	F	relate/sim.exp's	F	sim.exp's	****
6	****	NDiff	****	NDiff	****	****
7	misdiag.of prob.	F	****	F	relate/sim.exp's(intimately)	****
8	****	F:	sex-rel.	F	natural	no
9	abortion:formal Dr/<supp.	F	<embarr/discomfort	F	****	depression
10	****	F	relate	F	MDrs-<serious ca.probs	****
11	****	NDiff	prof/ethics	NDiff	****	****
12	<age:MDr-blunt/dismissive	F	****	F	>symp/MDr-abuse,humiliating	all
13	patronised	NDiff	needs/expect's met	F	sim.exp's/MDr-awkward	****
14	MDr-unnerving	F	suspicious-MDr's	F	<comfortable-MDr's	all
15	Dr-manipulates	F	relate	F	sim.exp's	****
16	Dr-blunt/joking	F	listens/talk easier/<formal	F	exp.vul/embarr.	all
17	****	F	>comfortable	F	****	all
18	intimidation	F	****	F	sim.exp's/helpful	****
19	Dr-dismissed pain	F	****	NDiff	****	****
20	****	NDiff	****	NDiff	****	****
21	prob.not treated as serious	F	>comfortable	F	****	no
22	anti-dep's for headache	M	****	NDiff	****	****
23	smear-discomf/blunt Dr	F	understand	F	understand/empathise	****
24	****	depends:	sex-rel.prefer F	F	symp.	all
25	****	F	understand/>ease	F	<intimidated	****
26	<age:patronised/judged	depends:	sex-rel.prefer F	F	****	****
27	****	F	relate/understand	F	>comfortable	****
28	****	F	****	NDiff	specialist	****
29	patronised	F	esp-sex-rel.probs	F	>comfortable	****
30	****	F	uncomf.exposing-MDr's	F	>comfortable	****
31	misdiag.	F	MDr's <undestand W	F	relaxed/express emotion	all
32	MDr:sex.perversion	F	****	F	>safe	all
33	prob.not treated as serious	depends:	sex-rel.prefer F	F	<shy/sim.exp's	****
34	MDr:exam.without permission	F	safer/<vul	F	>comfortable	all
35	MDr:cold hands	F	equal/supp.W	F	****	all
36	Dr:interrupted/rushed	depends:	sex-rel.prefer F	F	>comf.exposing myself	****
37	Med.C:>WT/misdiag.	F	relate	F	****	****
38	MDr:sex-rel:embarr.	depends:	sex-rel.prefer F	F	sim.exp's/empathise	weight probs
39	****	F	****	F	>comfortable/relate	****
40	MDr:rude/power trip	F	understanding	F	sim.exp's	****
41	Dr:joking	****	****	NDiff	happy with reg.MDr	****
42	****	NDiff	Dr is a Dr	****	****	****
43	none	NDiff	****	NDiff	****	****
44	****	NDiff	****	F	<embarr.	no
45	all bad	F	understanding/>com.	F	sim.exp's	all
46	embarr.	NDiff	MDr-<sex.tension/compet.	****	****	no
47	not inf.of 'pill' side-effects	depends:	sex-rel.prefer F	F	****	no
48	accussed of over-reacting	NDiff	M+FDr's-respect/app.treat.	****	****	no
49	Student H:>demanding	F	>comf-phys.contact	F	****	no
50	****	F	****	F	MDr's-intim/<exp+trust	****
51	emerg.Dr didn't expl/supp.	depends:	sex-rel.prefer F	F	****	no
52	Dr:>formal/<gentle,conc.	NDiff	****	F	<awkward+stressful	no
53	****	F	relate	F	sim.exp's	all
54	****	M	****	M	****	****
55	smug Dr	NDiff	as long as prof.	F	understand	no
56	Dr:condescending/arrog.	depends:	illness+vulerability	F	Family Planning-thorough	no
57	****	depends:	sex-rel.prefer F	F	gentle/relaxed/under.	****
58	****	NDiff	****	NDiff	****	no
59	****	NDiff	****	F	sim.exp's	no
60	****	F	****	F	shy>comfortable	****
61	****	F	****	F	understanding	no
62	****	NDiff	****	NDiff	****	no
63	****	NDiff	as long as prof.	NDiff	****	****
64	none	F	easier-talk to	F	>comfortable	****
65	****	F	>symp.-W's probs	F	symp/understanding	no
66	none	F	****	F	****	****
67	misdiag.	NDiff	****	NDiff	****	no
68	Dr:incompetence	F	****	F	empathise/>comf.disc.prob.	no
69	misdiag>hosp.	F	>comfortable	F	****	****
70	smear:uncomf/<expl.	F	****	F	>comf/sim.exp's	****
71	****	NDiff	****	****	****	****
72	MDr:top off unnec.	F	****	F	understand/symp.	depression
73	****	NDiff	****	NDiff	****	no
74	medicat.>prob.worse	F	>comfortable	F	understanding	****
75	MDr:pervert	F	safety	F	empathise/under.	no
76	>WT	F	>comfortable	F	>comfortable	all
77	exam:skin caught	NDiff	****	NDiff	****	no
78	****	F	>comfortable	F	>insight	no
79	MDr:sex-tension	F	uncomf-MDr's	F	<embarr.	all
80	none	F	easier-talk to	F	empathise/>comf.	****
81	FDr:embarr/felt naive	F	sim.exp's	F	understanding	contraception
82	****	NDiff	****	****	****	no
83	Dr:uninterested	F	****	F	empathetic	all
84	delayed tests-infection	F	>comfortable	F	****	contraception
85	smear-uncomf.	F	****	F	>comf.exposing body	no
86	Dr:to busy to consult	depends:	sex-rel.prefer F	F	****	no
87	****	****	****	****	****	****
88	reg.Dr:referred prob.to partner	F	****	F	>comfortable	all
89	none	F	****	F	****	****
90	patronised	F	easier-talk to/empathy	F	****	****
91	****	****	****	****	****	****
92	****	depends:	sex-rel.prefer F	F	>comf	no
93	****	F	****	F	identify better	****
94	other Dr present:no permission	F	>comf/sensitivity/id.	F	****	****
95	****	F	understand	F	<threat/easier to discuss	no
96	told hypercon.ca.serious prob.	F	reg.Dr h/w gen.'ind',not sex	F	****	no
		M=2		M=1		counselling=1
		F=57		F=74		depression=2
		NDiff=20		NDiff=14		contraception=2
		depends=14		No reply=7		weight probs=1
		No reply=3				all=15
						no=28
						No reply=47

Subjects	TRAITS:M DR'S/	F DR'S	SUPP. W'S CLINICS	COMMENT	REG.C-UPS	SUPP. REG C-UPS	COMMENT
1	****	trust/concern	Y:	if W's needs are unfull.	Y	Y	No1 priority
2	****	****	Y	>spec/thorough	N	Y	every 1-2 yrs
3	****	symp.	Y	esp. for solo mums	Y	Y	early detection
4	****	****	Y	W need>supp	****	Y	****
5	bus-like/fact oriented	sensitive/calm	Y	****	N	Y	****
6	****	****	Y	****	****	Y	****
7	jump to concl's	****	Y:	h/w not vital	N	Y	esp-smears/breast
8	****	****	Y	****	N	Y	****
9	<serious ca.probs	compass/understanding	?	****	Y	****	****
10	overriding/patronising	****	Y	****	N	Y	****
11	****	****	Y:	for sex-rel.probs	N	Y	unhealthy food/lifest/e.
12	****	****	N	Y-sexual H centres	Y	Y	preventitive/recurr.probs
13	****	****	Y	advice/referral	Y	Y	pre-existing/L-T probs
14	****	trust/<dismissive	Y	>comfortable	N	Y	N-scared ca.untreat.cond's
15	****	****	Y	****	N	Y	****
16	****	listen/respect	N	existing care-adeq.	Y	Y	early detection
17	****	****	N	****	N	****	****
18	****	****	Y	****	****	Y	care of over-concern
19	****	intimate	****	****	Y	Y	****
20	****	****	N	****	Y	****	****
21	****	****	Y	>comfortable	Y	Y	****
22	****	****	N	****	N	Y	****
23	clinical	****	Y	>ease	Y	Y	****
24	****	listen/symp/caring	****	****	N	Y	****
25	****	****	Y	****	N	Y	****
26	scientific/unemot.	listen/concern	N	reverse sexism	Y	Y	****
27	****	****	Y	****	N	Y	if med.history
28	no	no	****	****	N	Y	****
29	no	no	Y	****	N	****	N-cost
30	****	****	****	****	Y	Y	health safety
31	>formal/<symp.	relaxed/reassur/thorough	Y	<intimidating	Y	Y	****
32	****	****	Y	>comfortable	Y	****	****
33	no	no	Y	supp.W	N	Y	****
34	****	gentle/holistic/easier-talk to	Y	for W and child.	N	Y	****
35	****	compassion/nonjudg.	Y	>cultural/spec.	N	Y	****
36	no	no	Y	encourage visits	Y	Y	****
37	no	no	Y	****	Y	Y	****
38	****	unconventional	Y	spec/empower W	N	Y	care of over-concern
39	****	****	Y	specialised	Y	Y	****
40	no	no	Y	>comf/safe	N	Y	****
41	****	****	Y	spec/familarity	Y	Y	****
42	****	****	****	****	N	N	****
43	****	****	****	****	N	N	****
44	no	no	?	****	Y	Y	****
45	****	empathetic	?	****	Y	Y	h/w personal choice
46	clinical/label	motherly/understanding	N	****	N	Y	N-intimidated by Dr's
47	****	empathetic	Y	****	N	Y	if med.history
48	directive/calculating	listening/nurturing	Y	benefit W's health	Y	Y	****
49	no	no	Y	for M+W	N	Y	detect/prevent/treat.
50	****	****	Y	for M+W	N	Y	N-cost
51	****	understanding	Y	****	N	Y	****
52	no	no	Y	****	Y	Y	****
53	no	no	Y	encourage visits/>comf.	Y	Y	****
54	****	****	****	****	Y	Y	****
55	****	****	Y	encourage visits	Y	****	****
56	no	no	Y	positive impact	Y	Y	****
57	****	****	Y	****	Y	Y	>ease
58	no	no	Y	****	****	Y	****
59	no	no	Y	****	N	N	C-ups<autonomy/instinct
60	****	****	?	****	Y	****	****
61	unsymp/clinical	symp/listen/caring	Y	****	N	Y	"care of over-med"
62	****	****	****	****	N	Y	****
63	****	****	Y	****	Y	Y	for M+W
64	****	>serious ca.probs+respect	Y	****	Y	****	****
65	****	friendly/caring	Y	****	Y	Y	****
66	****	empathetic/efficient	Y	esp.for sex-rel.probs	N	Y	****
67	****	****	Y	encourage reg.visits	N	Y	for M+W
68	clinical/prof.	empathetic/personable	Y	opp.to spec.	N	Y	early detection
69	****	****	Y	****	N	Y	on-going probs/>age
70	****	****	****	****	Y	Y	peace of mind
71	****	****	****	****	****	****	****
72	****	****	Y	****	Y	Y	****
73	no	no	Y	<threat.+overpowered	N	Y	early detection
74	****	****	Y	****	N	Y	****
75	****	****	Y	****	Y	Y	>age
76	no	no	N	existing care-adeq.	N	Y	esp. >25yrs
77	no	no	Y	****	N	Y	>age
78	****	****	Y	spec-benefit to W	Y	Y	personal choice
79	****	****	Y	****	N	Y	****
80	****	****	Y	sim.exp's	Y	****	****
81	formal/condescending	concern/humour	Y	for M+W	N	Y	****
82	no	no	?	****	Y	Y	personal choice
83	****	****	Y	****	N	****	personal choice
84	****	****	Y	****	N	Y	N-cost
85	no	no	Y	****	Y	****	****
86	distant/efficient	****	?	****	Y	Y	esp-med.history
87	****	****	****	****	****	****	****
88	<friendly	****	Y	****	N	Y	****
89	no	no	Y	encourage visits	N	Y	****
90	****	****	Y	if improves treat.	N	Y	****
91	****	****	****	****	****	****	****
92	no	no	Y	****	Y	Y	****
93	****	symp.	N	improve existing access	N	Y	****
94	****	****	Y	****	Y	Y	****
95	<time+expl.	****	Y	>ease	Y	Y	prevent >illness+add.cost
96	?	?	Y	if W feel>comf.	N	Y	****
	no=20	no=20	Y=69		Y=42	Y=79	
	?=1	?=1	N=9		N=47	N=3	
	No reply=60	No reply=50	?=6		No reply=7	No reply=14	
			No reply=12				