Understanding Client Satisfaction & Perceived Quality of Care within Reproductive Health (RH) Services

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Measuring client satisfaction is desirable for any service delivery organization, providing invaluable insight into clients’ intentions to revisit a service. Among health service organizations, client satisfaction assessments can also predict the likelihood of clients’ adherence to treatment regimes and provider advice.

This review was undertaken by Population Services International (PSI) to uncover the best practices currently used to assess client satisfaction. These findings helped develop a client exit interview tool that can be used to assess satisfaction with outpatient reproductive health services in developing regions.

The review scanned three categories of available literature: health sector literature, business services literature, and literature discussing the satisfaction construct across all sectors. Although the review did not employ systematic procedures for finding relevant literature, it was comprehensive and identified both peer-reviewed and grey literature. Additionally, while the majority of the available literature incorporates Western thought and has been tested primarily in developed regions, great effort was made to utilize studies within developing regions and low-income populations, particularly within outpatient reproductive health clinics.

The review revealed that despite a breadth of information and tools that have been developed to measure client satisfaction, there currently are no universally accepted measures. Some factors that have contributed to this gap are: 1) a variety of definitions of satisfaction, 2) differing intentions for the use of a satisfaction measure, 3) the conflation of satisfaction with perceived quality, especially within the health services literature, and 4) the reliability issues inherent to measuring satisfaction.

Despite these challenges, a deeper analysis of the literature reveals some prevailing best practices for measuring satisfaction. The determinants that emerge are both measureable and actionable for health service organizations seeking to improve their clients’ satisfaction with reproductive health services.

KEY TAKEAWAYS

- Satisfaction is a complex, multi-dimensional concept that is challenging to capture.
- Understanding satisfaction factors can provide invaluable insight into clients’ future health service choices.
- There are currently no universally accepted measurements of satisfaction.
- Although they do not necessarily correlate, satisfaction and perceived quality are frequently conflated in the health sector.
- The business services sector provides a more theoretically sound understanding of satisfaction: perceived quality is just one of several satisfaction determinants.
- In the absence of a standardized measurement approach, it is preferable to find determinants specific to the area of study. Several of these emerged from thorough exploration of RH-specific literature.
- The scales used to measure satisfaction determinants are more theoretically sound in the business services sector. These scales place value on a patient’s experiences as a consumer, instead of ensuring that those services occurred.
SATISFACTION: A BRIEF HISTORY

There are currently no universally accepted measurements of satisfaction

In the last few decades, there has been increased demand for users' assessment of their health services to both democratize health services and stress a patient-centered approach. (Aldana, Piechulek, & Al-Sabir, 2001) Health service organizations around the world use satisfaction surveys to try and meet these needs.

A 2006 review of patient satisfaction literature confirmed that of the thousands of patient satisfaction measures available, no current instruments could be considered satisfactory in their current form – even those used frequently. (Hawthorne, 2006) Hawthorne’s review found that most measures were developed on an ad hoc basis, with insufficient evidence of their psychometric properties. These findings were echoed in a review almost a decade earlier, which found that 81% of patient satisfaction studies used a new instrument and 60% failed to report any psychometric data, suggesting a lack of standardization and rigor in tools. (Sitzia, 1999) A comprehensive literature scan in 2009 by the Centre for Clinical Governance Research again found no universally accepted measures of satisfaction. (Travaglia, 2009)

In 2009, a systematic review that focused specifically on sexual health clinics found a gap in validated approaches to measuring client satisfaction. (Weston, Dabis, & Ross, 2009) The review’s particular attention to sexual health services satisfaction is important because of the unique services rendered at these facilities and the unique sample population – generally younger, lower-income, and more concerned with confidentiality. (Weston et al, 2009)

Complicating the issue, patient satisfaction is a complex, multi-dimensional concept that lacks an accepted definition in the health services sector. (Gill & White, 2009) Although one review identified 138 studies investigating satisfaction determinants, no prevailing, current construct has emerged. (Crowe, Gage, Hampson, Hart, Kimber, & Storey, 2002) In fact, much of the thinking regarding patient satisfaction is thought to simply be restatements of older theories from the 1980s. (Gill & White, 2009) A 2009 review of the satisfaction construct in health services found most literature regarding the construct to be negative - due to conflicting approaches, the lack of a standardized tool, low reliability, and uncertain validity. (Gill & White, 2009)

“Satisfaction” questionnaires in health services are not always used to measure satisfaction

This review revealed that a significant portion of “satisfaction” questionnaires are used to measure the quality of a health service. Few tools drill down to capture a client’s satisfaction with the services received. This distinction is important, because satisfaction has its own distinct impact on patients.

Several studies have found that patient satisfaction impacts behavioral intentions, such as adherence to treatment and care regimes and following provider advice. (Gotlieb, Grewal, & Brown, 1994) (Perreault, Renaud, Bourassa, Beauchesne, Mpiana, Bernier et al, 2010) Satisfaction has also been found to impact future interactions with the medical community – while satisfied clients are more likely to intend to use the same facility again in the future, dissatisfied clients will seek out other providers. (Alden, Do, & Bhawuk, 2004) (Schutt, Cruz, & Woodford, 2008) (Perreault et al, 2010) These findings are particularly important for outpatient practices, where clients are free to change providers at will.
Satisfaction and perceived quality are frequently conflated in health services, including reproductive health

In the health services sector, there is a history of measuring perceived quality and satisfaction a proxy for one another. (Gill & White, 2009) This conflation is troublesome, since patients’ perception of quality and satisfaction with services are two separate cognitive constructs that do not necessarily correlate with one another. (Williams, Coyle, & Healy, 1998) (Alden et al, 2004) (Gill & White, 2009) A 2001 study of family planning clinics in rural Bangladesh confirmed this lack of correlation, suggesting that the distinction remains important in the context of the developing world and reproductive health services. (Aldana et al, 2001)

Exploring the source of this measurement conflation, this review found possible clues in the popular Donabedian health quality framework of the 1980s and the reproductive health-specific Bruce-Jain framework of the 1990s: both identify satisfaction as one inevitable outcome of quality. (Bruce, 1990) (Donabedian, 1988) The increased focus on quality in reproductive health services since the 1990s encouraged increased use of the Bruce-Jain framework as a standard for measuring quality in the field. (Bessinger & Bertrand, 2001) However, a reliance on these frameworks and the lack of a prevailing satisfaction framework may have encouraged the assumption that the existence of one construct guarantees the other.

An underlying issue with this particular measurement conflation is that perceived quality measurements ask clients to confirm if a service occurred and rate how well it was administered. (This may involve asking clients to confirm a service via Yes/No and rate it on a scale of Poor → Good.) However, patients’ rating of a service does not necessarily correlate with their satisfaction. Many negative feelings may go unreported because patients feel that the clinic is doing its “duty”, or is operating as well as possible given the circumstances. (Williams et al, 1998) For example, if questionnaire asks clients to rate the quality of “interpersonal relations” with their provider, such as the quality of counseling, a client may report that a provider administered high-quality counseling. Yet, this does not guarantee that the client had positive feelings about the interaction: a client may feel like the necessary information was relayed, but there may have been unsettling or negative aspects to the encounter.

A second issue with this conflation is the assumption that capturing items associated with quality guarantees satisfaction measurement – as long as scales are emotive. In one example, a client satisfaction tool produced by a peer organization asks clients if they were satisfied with several quality components within the clinic. This approach serves as an improvement upon the approach mentioned above, probing deeper for client feelings by asking if they were “satisfied” with their experience. However, the approach still assumes that the elements of perceived quality (such as the Bruce-Jain construct) and satisfaction are one and the same. As demonstrated by the lack of correlation between the two constructs, using quality components to proxy for satisfaction components remains of theoretical concern.
SATISFACTION MEASUREMENT BEST PRACTICES

Measure satisfaction in a theoretically sound relationship to perceived quality

As a measurement, perceived quality has been appealing to measure because of the greater accessibility of validated instruments and the tangible, actionable information it provides to facility staff. Additionally, perceived quality has well-documented benefits: in reproductive health literature, high perceived quality is associated with the continued use of a contraceptive method and a reduced cost in total care. (Koenig, Hossain, & Whittaker, 1997) (Kenagy, Berwick, & Shore, 1999) However, while it is appealing to try to apply the rigor of quality measurements to the more amorphous construct of satisfaction, the literature demonstrates that measuring quality does not also guarantee measuring satisfaction. (Gill & White, 2009)

Some studies suggest that a more sound representation of the relationship between perceived quality and satisfaction is found in the business services sector. In business literature, there is more general acceptance that perceived quality is just one of several cognitive precursors to satisfaction. (Alden et al, 2004) Business approaches remove perceived quality from its problematic place as a proxy, and instead places it as one of several satisfaction determinants.

Look to the health sector literature to find determinants of reproductive-health-specific satisfaction

If perceived quality is just one of several determinants of client satisfaction, what are the others? The literature advises that in the absence of a standardized satisfaction approach, it is preferable to identify satisfaction determinants specific to the area of study.

Although there has been difficulty capturing its complexity, several studies have explored the specific determinants of satisfaction with reproductive health services. Two popular approaches to achieve this have been to engage patients in in-depth conversations on the topic of satisfaction, and to study the relationships between general reports of “satisfaction” and other indicators. Research has consistently found that feelings regarding the following attributes are associated with satisfaction with reproductive health services (Aldana et al, 2001) (Alden et al, 2004) (Weston et al, 2009):

1. Appointment conveniences such as clinic location, availability of appointments, and waiting time
2. Privacy and confidentiality
3. Staff attitude and friendliness toward patients
4. Attention given to treatment

Medical staff’s technical competence has been found to be a relatively less important determinant of satisfaction in developing countries. (Aldana et al, 2001) However, studies have found that this can change: when women require surgical services such as abortions, they are more likely to prioritize the technical aspects of care. (Elul, 2011)

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It is important to keep in mind that perceived quality does not necessarily correlate with actual quality. (Glick, 2009)
Look to the business sector literature to find other determinants of satisfaction

In general, this review found that the business services sector provides more useful theoretical guidance regarding satisfaction, more standardized understanding of the subject, and less frequent practice of conflating satisfaction and quality.

These findings prompted the exploration of business literature for other, relevant satisfaction determinants that may provide a comprehensive and holistic understanding of satisfaction in health services. This exploration revealed several additional determinants that appear relevant to reproductive health services (Newsome & Wright, 1999) (Alden et al, 2004) (Gilbert & Veloutsou, 2006) (Chakraborty & Majumdar, 2011):

1. **In-facility emotions:** in the business literature, this is a general concept addressing the feelings that occur during a service. Each of the four RH-specific determinants mentioned previously (appointment conveniences, privacy, staff attitude, attention) fit neatly under this category.
2. **Accessibility (or “equity theory”):** a concept that satisfaction occurs when what individuals put into their experience equals that they received from it. This determinant may be quite relevant to populations in developing regions, since it is likely that patients have overcome several physical or cultural barriers to reach clinics.
3. **Clients’ confirmation or disconfirmation of their expectations:** an act that occurs post-visit, when a client determines if their overall expectations were met.
4. **Willingness to return and willingness to recommend:** this emerged from both the health and business services literature as a measurement to test for the presence of satisfaction in its entirety.

All satisfaction determinants – both from the business services sector and the reproductive health-specific literature – are visualized in **Figure 1**.

**Structure scales to capture the most accurate responses**

This scan uncovered a breadth of scales currently used to measure satisfaction determinants in questionnaires. As mentioned previously, the majority of health sector satisfaction scales ask clients to confirm if a service occurred (with scales such as Yes/No) and rate how well it was administered (with scales such as Poor → Good). Using these scales to measure satisfaction can reinforce the conflation of perceived quality and satisfaction.

Studies have suggested that satisfaction scales need to investigate patients’ **actual experiences of services and the meaning they attach to them** far more than most instruments currently do. (Williams et al, 1998) Capturing these experiences also fulfills a need to value the dignity of patients who may have traditionally associated medical spaces with powerlessness. (Sitzea & Wood, 1997) The business services sector has also demonstrated a greater understanding that client feelings need to be taken into account with more emotive scales. (Williams et al, 1998) (Wirtz & Lee, 2003)

In response to this finding, this review examined several satisfaction questionnaires in the business sector to see how appropriate they would be for use. The most popular satisfaction questionnaire used in the business sector is SERVQUAL, which measures clients’ expectations and how services met expectations, in five domains. (Alden et al, 2004) However, there have been mixed reviews of the application of this
FIGURE 1: A CONCEPTUAL MODEL OF RH SERVICES SATISFACTION, DERIVED FROM RECENT LITERATURE

**PERCEIVED QUALITY**
- A) Choice of methods
- B) Information provided
- C) Interpersonal relations
- D) Follow-up
- E) Technical competence
- F) Appropriate constellation of services (such as HIV/AIDS and MCH integration)

**ACCESSIBILITY**
- K) Feeling that what was "put in" to acquire services was worth what was received, referred to as "equity theory" in the business literature

**IN-CLINIC EMOTIONS**
- G) Feelings regarding appointment conveniences
- H) Feelings regarding privacy and confidentiality
- I) Feelings regarding attitude of staff
- J) Feelings regarding attention given to treatment

**CONFIRMATION OR DISCONFIRMATION OF EXPECTATIONS**
- L) Feeling that the overall expectations of the experience were confirmed or disconfirmed

**WILLINGNESS TO RETURN**
- M) Willingness/intention to return to the clinic

**WILLINGNESS TO RECOMMEND**
- N) Willingness to recommend to another

*This maps to the RH literature.
†This maps to the business literature.
questionnaire in health services: several researchers have argued that expectations (a key component of the SERVQUAL scales) play a much smaller role in patient satisfaction than in consumer services. (Vandamme & Leunis, 1993) (Newsome & Wright, 1999) (Ramsaran-Fowder, 2005)

Other business sector satisfaction scales were assessed for their applicability. From this search, several semantic differential scales emerged with high reliability and discriminant validity – indicating that they capture the construct well repeatedly, and across different situations. (Wirtz & Lee, 2003) Semantic differential scales capture clients’ attitudes along a numerical scale between two bipolar adjectives, such as “Pleased → Displeased”, or “Contented → Discontented”. These permit for more emotive expressions than the scales such as “Poor → Good” or “Agree → Disagree”, which are often used as evaluative measures of the quality of a service in the health sector.

Last, it was found that a mixed methods approach can be beneficial when conducting reproductive health-specific satisfaction surveys. (Chow, Quine, & Li, 2010) Qualitative questions can probe deeper into the why and how of each client’s level of satisfaction.

**Consider patient characteristics that may predict satisfaction**

Several studies have found that satisfaction levels may be predicted by a few patient characteristics. While these variables are out of a clinic’s control, knowing they play a role in predicting satisfaction can inform a broader understanding of the construct. In particular, patient age, education, culture, and individual health history (such as sexual health needs, self-reported health, perceived urgency of the current problem, and previous dissatisfaction) have all been found to play a role in a patient’s level of satisfaction. (Alden et al, 2004) (Senarath, Fernando, & Rodrigo, 2006) (Schutt et al, 2008) (Weston et al, 2009)

It is also important to consider that two patient characteristics may alter the satisfaction determinants put forward in Figure 1: A) a patient’s previous level of service experience and B) the services a patient is admitted for. (Alden et al, 2004) (Murakami, Imanaka, Kobuse, Lee, & Goto, 2010) (Bjertnaes, 2012) When patients with less previous experience with reproductive health clinics are surveyed, appointment conveniences matter less and expectations matter more. (Alden et al, 2004) And, as mentioned previously, when women require more technical procedures like abortions, the technical aspects of care play a larger role in determining satisfaction. (Elul, 2011)

**Consider the reliability challenges posed by client exit interviews regarding satisfaction**

As evidenced by the almost universal satisfaction reported within clinics in the developing world, there are several reliability issues in satisfaction measurements. (Glick, 2009) One of the most potent is courtesy bias, a tendency for interviewees to give answers that they think the interviewer wants to hear, rather than what they really feel. It is a well-established in the literature that satisfaction questionnaires elicit more favorable responses when they are administered via exit interview than household survey, particularly regarding staff treatment and provider consultation. (Glick, 2009) (Bjertnaes, 2012)

However, using the methods uncovered in this review – which assess the various aspects of satisfaction individually, rather than directly asking if the client was satisfied – may improve variability in responses.
CONCLUSION

There are considerable challenges to measuring client satisfaction. Although no single best practice tool emerged from our review, the literature does provide theoretical guidance for a conceptual model of reproductive health services satisfaction. Exploration of the business services and reproductive health-specific literature reveals this conceptual model's building blocks, and theoretically suitable scales.

Integrating an intentional, comprehensive satisfaction measurement into health services frameworks can help ensure that client voices are being heard, and that programs are alerted to the barriers that may prevent clients from returning for important services in the future.
REFERENCES


