NOTES FROM THE FIELD

Patient Satisfaction and the Role of Choice

An examination into the role that choice of provider plays in customer satisfaction

By Dennis O. Kaldenberg

Every form of health care financing manages the care of the patient. In particular, health maintenance organizations (HMOs) sometimes are portrayed as "managing" that care so rigidly, that the patients have little opportunity to choose who will treat them or where they will be treated. Forms of this management, however, vary considerably. Some plans provide discounts to the patient who selects a physician from a "preferred provider" list. Yet these lists can be so expansive that the patient may see little restriction in choice of provider.

In other plans, the patient's choice of provider may be more restricted—limited, for example, to those in a specific health system. Regardless of the plan's actual practice, the patients' perceptions of restriction are important. This perception likely will influence the belief that they have been given the opportunity to receive the best care possible.

Our study set out to examine the role that choice of provider plays in a patient's satisfaction with the hospital experience. The hypothesis guiding this research predicts that satisfaction with the hospital experience will be lower among patients who perceive reduced choice in their selection of physician or hospital. Specifically, this research examines the relationships between a patient's perceptions of provider limitation, the form of health care financing used, and the patient's evaluation of the health care experience.

THE QUESTIONNAIRE

Data for this study came from a subset (N=364) of the 476 hospitals that used the Press, Ganey patient-satisfaction questionnaire (from the South Bend, Ind.-based satisfaction measurement firm Press, Ganey Associates Inc.) from 1998. This standard questionnaire was mailed to the patient's home immediately after discharge. A mail survey was used to reduce costs and acquiescence bias. A total of 170,965 patient questionnaires returned during the last three months of 1998 were used in this analysis. The size of this sample, the number of hospitals represented, and the geographic spread of the patients make these data important estimates of patient perceptions.

The items on the questionnaire were compiled based on data from focus groups of hospital patients, input from health care managers, and literature on inpatient hospitals. The questions, similar to those developed to measure service quality in other settings (e.g., Parasurman, Zlotowski, and Berry’s SERVQUAL), covered 49 service issues related to the hospital experience. The questionnaire also contained a question to assess positive word of mouth stated in terms of the “likelihood of your recommending this hospital to others.” Patients rated each service issue using a 5-point Likert-type scale with the following anchors: very poor, poor, fair, good, very good. This response framework was selected because it met requirements of balance and uniformity of rating scale. Completed questionnaires returned by the

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patients were sent to a research firm for processing. The research firm transformed the responses to a 100-point scale on which 0 is low (very poor) and 100 is high (very good). These 49 questions were rolled up into 10 care domains (e.g., physician, admission, tests, and nursing) based on factor analysis results.

In addition to standard demographic variables (e.g., age, sex), the questionnaires captured the patients' insurance and financing information. The source of health care financing was determined by asking the patient to report the “main source of payment for hospital stay” using the following categories: “private insurance,” “Medicare,” “Medicaid,” “worker’s compensation,” or “self-pay.” The perception of limitation of provider was determined by asking: “Do you have insurance that limits your choice of physician or provider (e.g., HMO, PPO)?”

The Findings

Perception of Limits: Overall, 41% of patients reported that their insurance limited their choice of physician or provider. More females reported limitations (43%) than males (36%). (The size of the sample will make most differences statistically significant.) Further, patients admitted from the emergency department were less likely to report limitations (36%) than nonemergency admissions (44%). Patients who reported they were typically in “very good” health reported limitations to a greater extent (49%) than did patients in “very poor” health (30%). Patients 65 years of age and older were much less likely to report restrictions (23%) than patients younger than age 65 (52%), suggesting that financing source (e.g., Medicare) may be related to influence perception of limitation. Indeed, patients with private insurance reported limitations more frequently (51%) than did patients funded primarily from Medicare (19%), Medicaid (35%), worker’s compensation (33%), or self-pay (16%). These differences may reflect differences in limits, but it is also possible that they differ because patients don’t perceive Medicare, Medicaid, or worker’s compensation to be types of insurance. The perception of the restrictions appears to be related to the type of treatment. (See Exhibit 1.) Patients treated in obstetric or pediatric nursing units report significantly more restrictions in choice of provider than patients in rehabilitation, intensive care, or cardiology units of the hospital. The perception of limits varied by region of the country. (See Exhibit 2.) Patients in the western part of the United States are more likely to see limits than do patients in the Midwest. These differences most likely reflect the managed care penetration in different parts of the country.

Limits and Satisfaction: Patients who reported that their insurance limited choices of physician or provider were less satisfied with the overall hospital experience (Overall satisfaction score = 83.3) than patients who reported no limitations (Score=84.1) (t=8.4, p < .001). This pattern was consistent for each multi-item dimension of hospital care. The greatest differences were found in the dimensions dealing with “physician” and “visitors and family” and the smallest differences for “admission” and “meals” dimensions. The individual items, “time physician spent with you” and “help in arranging home care services” had the largest differences in satisfaction. Again, the patients reporting limiting insurance were less satisfied than patients reporting no limits. Not only did choice make a difference in scores, there also were significant differences in satisfaction by type of insurance. For patients reporting no restrictions, those with private insurance rated their health care experience significantly higher than patients whose health care was financed primarily by Medicare, Medicaid, or self-pay. (See Exhibit 3.) Among patients who report restrictions, those with private insurance rate their health care experience significantly higher than patients financed by Medicaid and worker’s compensation.

Managerial Implications: Patients’ perceptions regarding their access to
providers varies by type of patient, procedure, and source of funding. It is interesting to note that the sex with the highest use of health services perceives the greatest limitations in choice of provider. This is especially apparent in the level of restrictions reported in the treatment and service areas used by females (obstetrics, gynecology, and pediatrics). Although we don’t have data to determine the source of these differences in perceptions, we can speculate that it may be related to the relative unavailability of obstetricians or gynecologists in specific plans. The choice of these professionals likely is influenced strongly by word-of-mouth recommendations from previous users of these services. The patient may find that the provider who is recommended by a friend cannot be selected without “going out of plan” owing to contractual provisions of the plan.

Also interesting is the fact that perception of restriction is higher among patients who report they generally are in good or very good health. Consistent with the gender issue just described, healthy females report significantly more restrictions than healthy males. Among patients in fair or poor health, there were no differences in restriction by gender.

Patients who perceive that access is limited tend to be less satisfied with their care than patients who see no restrictions. Based on these findings, a health plan that appears to limit choices of health care provider will include plan members who are more dissatisfied with their hospital care than patients who perceive no restriction. The dissatisfaction among patients with private insurance is most visible in areas related to physician care and to visitor and family issues. This research suggests that the practices of insurers will influence the plan member’s satisfaction with the care they receive. Knowledge that satisfaction is influenced by perception of restriction may be useful to planners in health care institutions as they recognize that extra efforts may be required for these groups of patients to be as satisfied with care as patients who see fewer restrictions.

This study illustrates the extent and variability in perception of limits to choice in health care. It is important to note, however, that these are perceptions that may or may not reflect actual practices or quality of care. Even if restrictions exist, it does not necessarily imply that the quality of care was lower. Previous research has found that HMO financing does not restrict patients’ access to the best hospitals. Yet, the mere perceptions of restriction of choice may lead the
A better picture of trends in health care marketing has emerged, thanks to a recent survey sponsored by the Society for Healthcare Strategy and Market Development, a division of the Chicago-based American Hospital Association, and administered by the Princeton, N.J.-based Opinion Research Corporation International (ORC) market research firm. For the survey of health care marketers, which involved respondents from 124 freestanding hospitals and integrated delivery systems, data collected by ORC in previous years also was available for the identification of trends in health care marketing activity and expenditures. While the survey uncovered a number of changes occurring in the health care marketing arena, it also found that many aspects of health care marketing demonstrate persistent characteristics over several years.

**How Marketers are Employed**

Despite all of the consolidation that has occurred in health care, the "typical" (according to the sample surveyed) marketing professional still works for an independent hospital. More than half (about 53%) surveyed reported they are employed by an independent hospital, compared with 26% who reported working for a not-for-profit integrated system. Interestingly, only about 8% reported that they work for a for-profit integrated system. Further, the typical health care marketer toils in solitude both within his or her organization and within his or her market area. Many are the lone marketing employee in their organization, and more than one-third (35.5%) are employed in hospitals that have no competition nearby. Further, one out of six marketers work in market areas with less than 25,000 residents.

For those marketers employed by a system, the typical number of participating hospitals is three. However, 10% are employed by systems involving 30 or more hospitals. The most significant shift in this regard, however, is that two out of three marketers employed by systems were employed by independent hospitals as recently as two years ago. They did not change jobs, of course, but their hospitals joined systems.

The typical health care marketer holds the title of "director" within the organization, although nearly one-third hold a title comparable to vice president. Most respondents (65.5%) report to the chief executive officer. For those who report marketing managers above them, nearly 76% of these senior marketing executives report to the CEO. Gratifyingly, the
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