OBJECTIVE: To compare patient satisfaction in women’s clinics (WCs) versus traditional primary care clinics (TCs).

DESIGN: Anonymous, cross-sectional mailed survey.

SETTING: Eight Department of Veterans Affairs (VA) medical centers in 3 states.

PATIENTS: A random sample of women stratified by site and enrollment in WC versus TC (total response rate = 61%).

MEASURES: Overall satisfaction and gender-specific satisfaction as measured by the Primary Care Satisfaction Survey for Women (PCSSW).

ANALYSIS: We dichotomized the satisfaction scores (excellent versus all other), and compared excellent satisfaction in WCs versus TCs using logistic regression, controlling for demographics, health status, health care use, and location.

RESULTS: Women enrolled in WCs were more likely than those in TCs to report excellent overall satisfaction (odds ratio, 1.42; 95% confidence interval, 1.00 to 2.02; P = .05). Multivariate models demonstrated that receipt of care in WCs was a significant positive predictor for all 5 satisfaction domains (i.e., getting care, privacy and comfort, communication, complete care, and follow-up care) with the gender-specific satisfaction instrument (PCSSW).

CONCLUSIONS: This study is the first to consistently show higher satisfaction in WCs versus TCs despite age and race differences and comparable health status. Since these WCs show better quality in terms of satisfaction, other quality indicators should be evaluated. If WCs reduce fragmentation and improve health care delivery, the model will be applicable in VA and non-VA outpatient settings.

KEY WORDS: patient satisfaction; primary health care; quality of health care; veterans; women.


Women’s concerns about outpatient care may differ from those of men in regard to content.² or communication within the patient–physician relationship.³⁻⁵ In fact, evidence suggests that a greater percentage of women compared to men change physicians due to dissatisfaction.⁶ In response to women’s concerns about their health care, hospital-associated women’s health centers have grown from 19% in 1990 to 42.5% in 2000.⁷ These programs vary in their organization, ranging from comprehensive gender-specific primary care delivered by women’s health specialists to strictly reproductive care for women.⁸

Despite the increasing numbers, few data demonstrate whether specialized women’s health centers improve the quality of primary care for women. Two recent studies compared satisfaction, 1 aspect of quality, in specialized women’s clinics (WCs) versus traditional primary care clinics (TCs)¹⁹ and found similar ratings of overall satisfaction between patients in the 2 settings. While 1 study did find differences along items specific to patient–physician communication,¹ the findings did not impact overall outcomes. However, these studies were limited to a small number of academic practices in a single city serving primarily higher-income women.

In contrast, medical centers within the Department of Veterans Affairs (VA) offer the opportunity to compare WCs and TCs in multiple locations with a less affluent population. Since 1992, when the VA began encouraging the development of specialized women’s health programs to address disparities for women veterans,¹⁰ a majority (62%) of VA sites report a women’s health program or center.¹¹ We initiated this study to evaluate patient satisfaction among women veterans in WCs versus TCs. On the basis of the concept that comprehensive centers or single systems with multispecialty services¹² provide higher satisfaction, we hypothesized that patient satisfaction would be higher in VA women’s clinics. Our study attempted to address some of the methodological concerns discussed in previous studies. First, we used tools that would assess general and gender-specific domains of satisfaction. Second, we sampled patients from multiple sites covering a large geographical region. Some sites had a university affiliation and others did not. Third, we choose the VA to minimize selection bias. Assignment to VA clinics is done administratively, not by self-selection. While the process is not random, it is usually independent of patient preferences.

METHODS

Setting

This study uses data from a 10-site survey of women veterans conducted in the VA integrated service network...
comprised of Pennsylvania, Delaware, and West Virginia. Clinics exist in the following locations: Altoona, Butler, Coatesville, Erie, Lebanon, Pittsburgh, Philadelphia, and Wilkes-Barre, all in Pennsylvania, as well as Clarksburg, West Virginia, and Wilmington, Delaware. Two sites (Butler and Clarksburg) were excluded from this analysis because they had no WC during the study period. The scope of services and staffing in each clinic varied. Of the sites included, 2 are located in urban areas and provide comprehensive, integrated internal medicine and gynecological facilities with allied health staff on site. The other sites are smaller and provide services ranging from primary care to focused gender-specific screening (e.g., pap smear, mammogram, or osteoporosis screening).

In general, women veterans are assigned to a clinic on the basis of the services available at their clinical site rather than patient preferences. At locations where a comprehensive WC is present, the VA administration assigns all women to the WC. At locations that may have a limited WC (i.e., screening clinic), patients are uniformly assigned to a TC and then referred to the WC for gender-specific screening.

**Study Population**

We used the National Patient Care Database (NPCD) maintained by the Austin Automation Center for the Veterans Health Administration. We drew our selected population from the Outpatient Care Files in the NPCD, with stratification by site and clinic stop code. We pulled all unique female veterans who attended 1 of the 10 VA medical centers in our regional area during the designated 12-month period from March 1, 1999, to March 1, 2000. We assigned women to priority groups by clinic visits.

Women who had at least 1 visit to a WC were assigned to the first group. Women who had at least 1 TC visit and no WC visits during the same period were in the comparison group. Some of the patients in the WC group may have also had a visit to another clinic during this period (e.g., traditional primary care, specialty clinic, or other). However, no women in the TC group had visits to a WC. From the sample of women who met inclusion criteria (i.e., veteran status, clinic enrollment, and outpatient visit during the designated time period), we selected a stratified random sample. In general, the target sample was 170 WC patients and 80 traditional primary care patients at each site. In sites that had less than 170 unique WC patients, we sampled all patients in the WC and oversampled in the primary care group to obtain a site total of 250. Institutional Review Board approval was obtained for each of the sites.

**Procedures**

We used a 3-step mailing process modified from the total design method.13 The initial mailing included: a cover letter from the regional network Director and principal investigator describing the study; the survey questionnaire; and a postage-paid return envelope. The initial packet was followed at 1 week intervals by a reminder/thank you postcard and then by a repeat mailing of the survey and return envelope. Since the survey was anonymous, return envelopes were coded as to whether the patient was randomized from a WC or a TC. Completed surveys were scanned into an Access database using Teleform software (Cardiff Software, Inc., Vista, Calif).

Our random sample consisted of 2,315 female patients from 10 VA medical centers identified previously. We excluded 80 persons who were either deceased or had incomplete mailing addresses. Of the 2,235 surveys mailed, 74 were not deliverable. The final number of surveys assumed delivered was 2,161. Of this group, 1,321 anonymous surveys were completed and returned for an overall response rate of 61% (1,321/2,161). Further exclusions included the removal of 222 women who used the 2 sites without a comparison WC and the removal of 128 women who did not specify their VA clinic location. The analytic sample for this report was 971 respondents.

We used the VA administrative database to compare the demographics of all respondents (N = 1,321) to the overall random sample because the survey was anonymous. In general, respondents were older (mean age 58.6 vs 52.1 years; P < .0001), more likely to be white (88.1% vs 83.6%; P = .0001), and more likely to report incomes above $20,000 (38.6% vs 30.2%; P < .0001). The proportion of married women was similar between the randomized and respondent samples (34% vs 33.7%; NS).

**MEASURES**

**Patient Satisfaction**

For the overall satisfaction rating, we used a modified single item from the VA National Survey of Ambulatory Care14: “Overall, how would you rate the quality of care you received at the VA in the past 12 months?” The 5 response categories ranged from “poor” to “excellent.” In addition, we included the draft version of the Primary Care Satisfaction Survey for Women (PCSSW) developed by researchers from the Federal Centers of Excellence in Women’s Health.15 The 34-item PCSSW was developed using focus groups of women from different demographic backgrounds, and the items constructed reflect the health care issues deemed important by women.15 Twenty-nine of the items are divided into 5 domains identified by the focus groups as important for the health care needs of women: getting care; privacy and comfort; communication; complete care; and follow-up care. Patients rated each item on a 5-point scale from “poor” to “excellent.” We created summary scores for each PCSSW domain by adding responses for all items. Persons rating all items of a domain as excellent were considered to have a perfect score. We calculated the summary scores for each domain and the related descriptive statistics. (Data not shown.) The internal consistency by Cronbach’s α for each domain was good and ranged from 0.77 to 0.96.16 For 4 domains (getting care, privacy