

Health Status and Satisfaction with Pharmacy Services

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Abstract

Objective: To evaluate the relationship between self-reported health status and satisfaction with pharmacy services.

Study Design: Secondary analysis of data previously collected via a computer-assisted telephone interview system.

Patients and Methods: Survey respondents were enrollees in a large managed care organization who were recent patrons of either traditional or mail pharmacy services. Satisfaction data were gathered using an existing satisfaction with pharmacy services survey. Health status was measured using the Medical Outcome Study's Short-Form 12-Item Health Survey. The relationships between satisfaction with pharmacy services and health status were analyzed using structural equation modeling.

Results: A significant positive relationship between mental health status and satisfaction with

pharmacy services was hypothesized and confirmed. The correlations between mental health status and satisfaction, however, were not strong ($r = .10$ to $.18$). No relationship between physical health status and satisfaction with pharmacy services was observed. Similar results were observed in patrons of both traditional and mail pharmacy services.

Conclusion: This investigation offers evidence that satisfaction with healthcare services is more closely related to mental health status than to physical health status. This has important implications for case-mix adjustments in the measurement of satisfaction with care.

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Health status—or health-related quality of life (HRQOL)—and patient satisfaction are patient-reported outcomes increasingly considered important indicators of the outcomes and quality of health services provided. To the extent that both concepts reflect quality of care, it is reasonable to expect a positive association between them. This relationship has been demonstrated in terms of satisfaction with medical care. It was postulated that because pharmacy services also involve the provision of care that can impact on patient health and HRQOL, a similar relationship would exist for satisfaction with pharmacy services. The purpose of this investigation, therefore, was to evaluate the relationship between HRQOL and satisfaction with pharmacy services, using data previously collected as part of a study comparing satisfaction with different pharmacy services.

Background

Interest in patient reports about healthcare has burgeoned along with the increasingly competitive nature of the US healthcare marketplace.¹ The level of satisfaction with medical care has been associated with a variety of health-related behaviors, including initiation of malpractice litigation,^{2,3} disenrollment from prepaid health plans,⁴ and adherence to medical regimens.⁵

Health-related quality of life is the patient's perception of his or her level of functioning and well-being. A positive association between HRQOL and patient satisfaction with medical care has been consistently observed in previous studies.^{6,7} In general, patients who are in good health tend to report greater levels of satisfaction with care. Further investigations have been conducted to determine if any "causal" relationship exists between HRQOL and patient satisfaction, or if the observed association could be explained by unmeasured confounding factors.^{8,9} In these investigations, structural equation modeling (SEM) procedures have been used to analyze longitudinal assessments of health status and patient satisfaction with care received. SEM procedures combine factor analysis and multivariate regression techniques to evaluate hypothesized models involving multiple latent variables and multiple relationships.^{10,11} Latent variables are constructs that are not directly measurable but can be represented by observed measures.¹⁰ For example, intelligence is a construct or latent variable that can be represented by the score on an intelligence quotient test. The fit of hypothesized models can be evaluated using empirical data.¹¹

Hall et al⁸ assessed health status using 4 of the 12 scales of the Sickness Impact Profile, and 6 general health perception items developed for the RAND Health Insurance Study.¹² Satisfaction with provider services was assessed using a 12-item scale covering overall satisfaction, amount of contact with providers, informativeness of providers, humaneness of providers, technical competence of providers, and relief from worry. The analysis revealed that earlier self-perceived health and functional ability predicted subsequent levels of satisfaction. There was no evidence for the reciprocal relationship; early levels of satisfaction did not predict later health.

Marshall et al⁹ subsequently distinguished between physical and mental health and among different dimensions of satisfaction with healthcare in the Medical Outcomes Study. In a 1-year longitudinal SEM analysis, these investigators found that mental health status was linked to satisfaction with

care, but that physical health had no relationship with patient satisfaction. However, in contrast to Hall et al,⁸ Marshall and colleagues found significant cross-lagged effects linking baseline general satisfaction with care to subsequent mental health and baseline mental health to subsequent general satisfaction with care.

No published research has been reported to date regarding similar relationships between multidimensional health status and satisfaction with pharmacy services. Fincham and Wertheimer¹³ indicated a positive relationship between satisfaction with pharmacy service and self-assessed health, although both concepts were measured with a single item. More recently, instruments that measure multidimensional aspects of satisfaction with pharmacy service have been used to assess the quality of those services.¹⁴⁻¹⁷

The analysis presented in this article involved data previously gathered in a cross-sectional survey of enrollees of a large managed care organization with recent pharmacy claims.¹⁶ The primary objective of the main study was to compare satisfaction among patrons of traditional pharmacy outlets with patrons of mail pharmacy services. For the purposes of the study, traditional pharmacy outlets were defined as retail settings other than mail services, where patients may purchase prescription medications and receive drug information and counseling. Included in this category were independent and chain pharmacies, as well as food store and mass merchandiser pharmacies. Full details on the sampling and measures can be found in earlier publications.^{16,17}

... METHODS ...

Sampling Design

Patrons of traditional and mail pharmacy services eligible for random selection were those who were 21 years of age and older, English-speaking, and with a computerized prescription claim in the previous 3 months. Subject selection was stratified by zip code, and enrollees who had patronized the mail service pharmacy were oversampled to provide a 3:1 (mail order:traditional) ratio in the initial sample frame list. Within the state or county, a maximum of 500 subjects per individual zip code were randomly selected to prevent overrepresentation of the urban areas.

Based on the results of the primary study, where significant differences in general satisfaction were observed between the two pharmacy

patron groups,¹⁶ it was decided *a priori* to consider the two patron groups separately. This decision also provided two subgroups for evaluating the hypothesized relationships.

Measures

The satisfaction survey instrument was based on the previously developed Satisfaction with Pharmacy Services Questionnaire.¹⁴⁻¹⁷ Although the instruments used in the full study were multidimensional,¹⁶ only the data from the General Satisfaction items (Appendix) were used. Based on previous analysis of the multidimensional data, it was determined that general satisfaction could be simultaneously represented by both an overall 4-item scale or as a set of distinct dimensions tapping unique aspects of satisfaction with pharmacy services.¹⁷ The 4-item measure of general satisfaction with pharmacy services was used for the analyses reported here. The scale included both positively and negatively worded items in an effort to control for acquiescent response set.¹⁸ Respondents were asked to indicate their level of agreement with items on a scale from 1 to 10, with 1 being definitely false and 10 being definitely true.¹⁷

HRQOL was measured using the 12-Item Short-Form Health Survey (SF-12).¹⁹ The Physical Component Summary score (PCS-12) and the Mental Component Summary score (MCS-12) of the SF-12 survey were constructed using the scoring program described by Ware et al.¹⁹ Possible PCS-12 and MCS-12 scores range from 0 to 100, with higher scores representing better health. Ware et al reported test-retest reliability coefficients of 0.89 and 0.77 for the PCS-12 and MCS-12, respectively, in a general US population study.

Survey instruments were administered using a computer-assisted telephone interview system. Only data from those subjects who completed the items for the General Satisfaction scale and the SF-12 could be included in the analysis. One item missing from the SF-12 results in the inability to calculate a summary score for that instrument, and thus subsequent exclusion from this analysis.

Data Analysis

The relationships between scales of satisfaction with pharmacy services and the SF-12 summary scores were analyzed through SEM using EQS for Windows 5.2.^{20,21} Separate SEM models were evaluated for both patron groups. Specification of the models was based on previous empirical findings regarding satisfaction with pharmacy services^{14,15}

and the structural relationship between HRQOL and satisfaction with healthcare.^{8,9} A positive relationship between mental health and satisfaction with pharmacy services was hypothesized. In contrast, it was hypothesized that the association between satisfaction with pharmacy services and physical health would not be significant.

In the initial models, all correlations between latent factors were freely estimated. Wald tests were performed to indicate if any parameter estimates could be dropped without reducing the statistical fit of the model to the data.²⁰ Lagrange multiplier (LM) tests for correlated uniqueness terms were performed to determine if adding an estimate would improve the fit of the model to the data.²⁰ The "fit" of the hypothesized model is then tested against empirical data and is indicated by select variables, such as the comparative fit index (CFI), normed fit index (NFI), and non-normed fit index (NNFI).^{20,21} These fit indices are ratios of the incremental fit of the hypothesized model versus the null model, either adjusted for the degrees of freedom (NNFI and CFI) or not adjusted (NFI).^{11,20,21} Fit indices greater than 0.90 are considered desirable.^{11,20,21}

... RESULTS ...

Subjects

Telephone interviews were conducted with 962 patrons of traditional pharmacy services. Complete data on all of the satisfaction with pharmacy services items and dimensions were available for 509 of the 962 respondents. Subjects averaged 55.9 years of age (SD, ± 16.9 years), and 62.3% were female; 50.9% lived in California, and the remainder were Arizona residents. Seventy-nine percent were white, 3.8% were black, 12.8% were Hispanic, 1.2% were Asian, and 3.0% were from other ethnic groups. Respondents reported having 1.6 chronic medical conditions (SD, ± 1.3) and taking 2.8 (SD, ± 3.3) medications.

Telephone interviews were conducted with 400 recipients of mail pharmacy services; complete data on all satisfaction with pharmacy services items were available for 143 of these respondents. Respondents averaged 64 years of age (SD, ± 14.2), and 63.6% were female. Eighty-five percent were white, 3.6% were Hispanic, 1.4% were black, 1.4% were Asian, and 8.0% were from other ethnic backgrounds. Respondents reported having 1.7 (SD, ± 1.3) chronic medical conditions and taking 3.1 (SD, ± 1.9) medications.

Structural Equation Models

Mail Pharmacy Services. For mail pharmacy patrons, the initial SEM specifications (Model M1) fit the data well ($\chi^2_{(9, N = 143)} = 9.62, P = 0.382, CFI = 0.99, NFI = 0.94, NNFI = 0.99$). The correlation between physical health and mental health was estimated and found to be nonsignificant and was set to zero. This result is expected, as the scoring for the SF-12 in fact forces the two summary scores to be orthogonal, thus having a correlation of zero.¹⁹ The results of the Wald test indicated that the correlation between physical health and General Satisfaction

could also be set to zero without a statistically significant loss of fit. LM tests for correlated uniqueness terms indicated that no additional specifications would result in a better fit of the data.

The model was then respecified by setting the covariances between physical health and mental health, and between physical health and General Satisfaction to zero. This model (M2, Figure 1) fit the data quite well ($\chi^2_{(10, N = 143)} = 11.67, P = 0.308, CFI = 0.99, NFI = 0.92, NNFI = 0.98$). The factor loadings for the individual items of the General Satisfaction scale were all statistically significant.

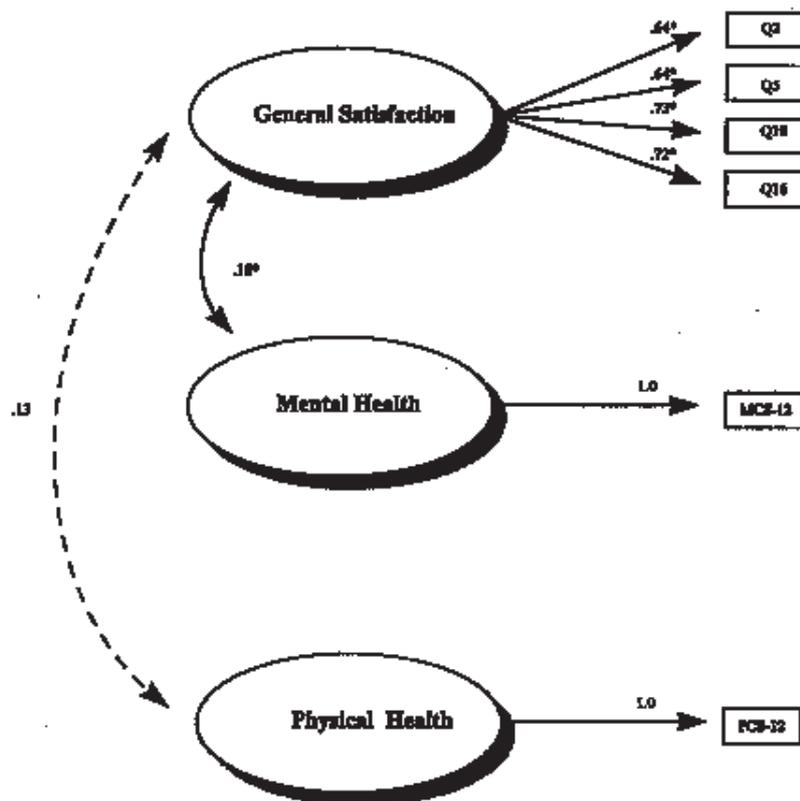
The correlation between mental health and General Satisfaction was also significant ($r = .18, P = 0.043$).

Traditional Pharmacy Services.

Similar to the model for mail pharmacy patrons, the initial SEM specifications for the relationship between satisfaction with traditional pharmacy services and health status (Model T1) fit the data well ($\chi^2_{(8, N = 509)} = 21.28, P = 0.006, CFI = 0.97, NFI = 0.95, NNFI = 0.94$). The results of the multivariate Wald test, nonetheless, suggested that all three correlations between the latent factors could be set to zero without a loss of statistical fit. However, based on the univariate test, the z value for the correlation between mental health and General Satisfaction with pharmacy services ($r = .10$) in the model was 1.96 ($P = 0.05$).

The model was then respecified to set the correlations between physical and mental health, and between physical health and General Satisfaction to zero; the correlation between mental health and General Satisfaction remained freely estimated. This model (T2, Figure 2) also fit the data well ($\chi^2_{(10, N = 509)} = 21.59, P = 0.017; CFI = 0.97, NFI = 0.95, NNFI = 0.96$). The correlation between General Satisfaction and mental health was .10, which was significant at the level of <0.05 . Moreover, the Wald

Figure 1. Structural Model M2: Health Status and General Satisfaction with Mail Pharmacy Services



Dashed line indicates nonsignificant correlations; *significant at $P < 0.05$. MCS-12 = Mental Component Summary score; PCS-12 = Physical Component Summary score; Qs represent item order in original survey.

test indicated that no parameter estimates needed to be dropped, suggesting that if the correlation between mental health and General Satisfaction with pharmacy services was fixed at zero, the fit of the data would be significantly reduced.

... DISCUSSION ...

Early empirical evidence on the relationship between HRQOL and patient satisfaction with medical care indicated that a positive relationship existed, that is, healthier patients tended to be more satisfied with the care they received.^{6,7} When longitudinal investigations to assess causal relationships between the two constructs were conducted, preliminary evidence suggested that initial health status was linked to subsequent satisfaction with care, whereas initial satisfaction with care had no relationship with later health status.⁸

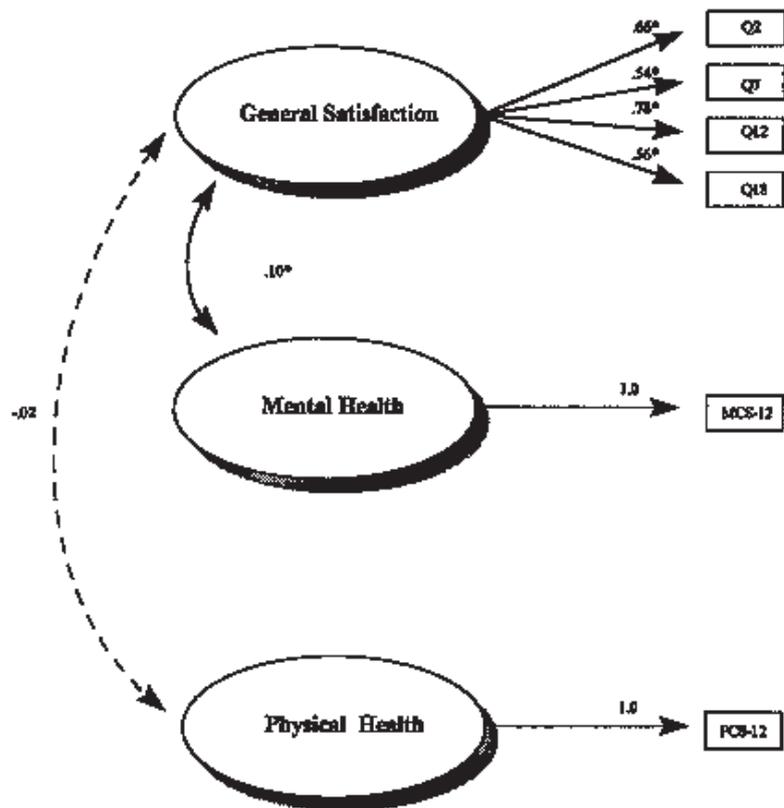
Furthermore, when health status was measured as the distinct, but related, domains of physical and mental health, it appeared that satisfaction with medical care was linked to mental health, but not physical health, in cross-sectional data.⁹ However, in contrast to Hall et al,⁸ it was observed that, in addition to baseline mental health being linked to subsequent satisfaction, baseline satisfaction was also linked to subsequent mental health (and vice versa) longitudinally.

The correlations between satisfaction and mental health observed in the present analysis were weaker than those reported by Marshall et al,⁹ but they appeared to support the conclusion that satisfaction with care is more strongly related to mental health status than to physical health status. The correlations between general satisfaction with pharmacy services and mental health in the present study were .18 and .10 for mail and traditional pharmacy patrons, respectively. Marshall et al observed correlations of .31 and .36 for subgroups with

depression and with chronic medical conditions, respectively. This may suggest a stronger relationship between satisfaction with medical care and mental health than between satisfaction with pharmacy services and mental health. However, the differences in the instruments, samples, and measurement models constructed in each investigation must also be considered.

Marshall et al⁹ used the 36-Item Short-Form Health Survey (SF-36) as the measure of health status and the Patient Satisfaction Questionnaire-III (PSQ-III) as the measure of patient satisfaction with

Figure 2. Structural Model T2: Health Status and General Satisfaction with Traditional Pharmacy Services



Dashed line indicates nonsignificant correlations; *significant at $P < 0.05$. MCS-12 = Mental Component Summary score; PCS-12 = Physical Component Summary score; Qs represent item order in original survey.

medical care. In that investigation, the mental and physical health composite scores from the full SF-36 were positively correlated. This was a result of the way the scales were scored, which did not force the correlation to be zero. The measurement model presented by Marshall et al shows that the dimensions of General Health Perceptions, Energy/Fatigue, and Social Functioning correlate with both summary scores of the SF-36. Thus, the common variance of these scales attributable to each factor distinctly is estimated. The New England Medical Center scoring of the SF-12 actually lets every item load on both the physical and mental health components, but it forces the components to be uncorrelated,¹⁹ as was observed in the data from the present study. This lack of correlation is somewhat counter-theoretical, especially to clinicians, because it is commonly accepted that the two concepts are related.²²

A further explanation for the weaker correlations observed in the present analysis may be that respondents do not perceive that the pharmacy services impact on their health as much as medical care services. With the trend of pharmacy services toward patient-focused care,^{23,24} satisfaction with the activities of pharmaceutical care may have a more positive impact on direct patient health. Current versions of instruments measuring satisfaction with pharmacy services are perhaps overly focused on the technical activities of dispensing prescription products. Development of items and measures to address patient-focused aspects of pharmacy services will be necessary to evaluate the impact of such services on patient outcomes.

Because participation in the mail pharmacy service was an option offered by the managed care organization, and there existed financial incentives for using the mail order service, subjects using either the mail or traditional outlets were likely self-selected into the service with which they were most satisfied. Differences in the observed strength of the relationship between general satisfaction and mental health status between mail and traditional pharmacy patrons in this analysis may reflect this self-selection bias. Furthermore, it is possible that mail order patrons are more likely to have more chronic medical conditions that limit their mobility and increase the need and cost of chronic medical therapies, factors which could predispose the use of mail order pharmacies. In fact, in these samples, the per-prescription copayment for mail order prescriptions was approximately equal to traditional patrons, although the mail order prescription volumes were larger.¹⁶ However, the number of self-reported

chronic medical conditions and total number of prescriptions did not differ between mail or traditional pharmacy patron groups.¹⁶ Longitudinal studies would be required to better evaluate the impact of this self-selection on satisfaction levels, and interaction with physical and mental health status.

The results of this secondary analysis should, of course, be considered in light of several limitations with the study design and data collected. First, the number of respondents with missing data on the measures used in this analysis was large and may result in some unknown systematic bias, thus limiting the generalizability of the results. It could be speculated that perhaps less healthy respondents were more likely to have missing data, and this bias results in the weaker observed correlations between mental health and satisfaction with pharmacy services.

Second, the distinction among various models of pharmacy practice may result in different levels of satisfaction with pharmacy services; however, we did not make any distinction between chains, clinical, or mass merchandiser pharmacies. However, this lack of distinction would have greater impact in studies comparing satisfaction with pharmacy services,¹⁶ which was not an objective of this secondary analysis. Additional research would be required to determine how and to what degree different practice settings affect satisfaction with pharmacy services. In addition, the distinction between patrons of mail order and traditional pharmacy services may be blurred. The content of the items used to measure general satisfaction in this investigation should be considered in this light. The mail pharmacy items have a clear referent to mail services, but traditional pharmacy services items are more general and could include both traditional and mail pharmacy services. Among respondents in the full study, only 11.6% of traditional pharmacy patrons reported using mail pharmacy services in the previous 3 months, while 64.1% of mail pharmacy patrons also reported using traditional pharmacy services in the same time frame. Thus, the possibility exists that respondents considered patrons of traditional pharmacy were not considering just those services in their responses. Again, this is an important confounding variable when comparing satisfaction between service types,¹⁶ but it may be less important in this secondary analysis where no such comparison was made.

The link between general satisfaction and mental health may have an element of causality, as suggested by research regarding satisfaction with medical

care.⁹ On a cross-sectional level, a positive relationship between mental health and satisfaction with pharmacy services appears to exist. If quality improvement efforts or disease management programs could increase satisfaction with medical care or pharmacy services, it is possible that a positive impact may also be achieved on the mental health of these patients. To illustrate the practical implications of this relationship, traditional pharmacy patrons who reported some level of depressive symptoms also reported lower satisfaction with the dimensions of technical quality and explanation about prescriptions.¹⁶

Managed care organizations or providers of pharmacy services might consider the benefits of a targeted pharmacy counseling service within its provider network for this specific patient population. Such a relationship must be further evaluated and these outcomes should continue to be measured in the population served by managed care organizations. Furthermore, the results of this study and other investigations suggest that there may be a response bias in satisfaction surveys that requires case-mix adjusting. This means that persons with greater levels of depression report greater dissatisfaction with care regardless of the actual quality of care.

... CONCLUSION ...

The results of the present investigation provided evidence to support the conclusion that satisfaction is more closely related to mental health than physical health status. This relationship appears to hold true for general satisfaction with pharmacy services as well as for general satisfaction with medical care. The relationship also holds when different forms of pharmacy services are considered. When organizations are using measures of patient satisfaction to assess the quality of healthcare services, it may be important to also assess HRQOL.

Baseline HRQOL measures can then be used for case-mix adjustments to satisfaction data, either cross-sectionally or longitudinally. Given the availability of relatively brief, valid measures of both health status and satisfaction, the advantages of measuring both concepts may outweigh the increased respondent burden in routine satisfaction surveys. Failure to address this important case-mix adjustment factor may result in misinterpretation of satisfaction results when those with lower mental health also express dissatisfaction with care.

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Appendix. Items of General Satisfaction with Pharmacy Services Scale

Traditional Pharmacy Services	Mail Pharmacy Services
The pharmacy services that I've received are just about perfect. I have some complaints about the pharmacy services.* I am very satisfied with the pharmacy services that I receive. There are things about my pharmacy services that I receive that could be better.*	The pharmacy mail services that I've received are just about perfect. I have some complaints about the mail pharmacy services.* There are things about the mail pharmacy service that could be better.* I am very satisfied with the mail pharmacy service that I receive.

*Indicates negatively worded items that were reverse scored before calculating item and scale scores.¹⁶