THE EFFECTS OF CULTURAL AND STRUCTURAL FACTORS ON MIGRANTS' SATISFACTION WITH HEALTH CARE SERVICES

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Health care educators are increasingly familiar with the need to identify characteristics of care that influence patients' satisfaction with health care services and consequently affect utilization of services. In an effort to increase satisfaction with services, emphasis has been placed on the need to integrate an understanding of patients' cultures and their environments into education for health professions and practice. The culture and environment may foster or inhibit use of health care services. Health care practitioners need to identify the interventions that affect satisfaction with health care services. These interventions vary with different cultures.

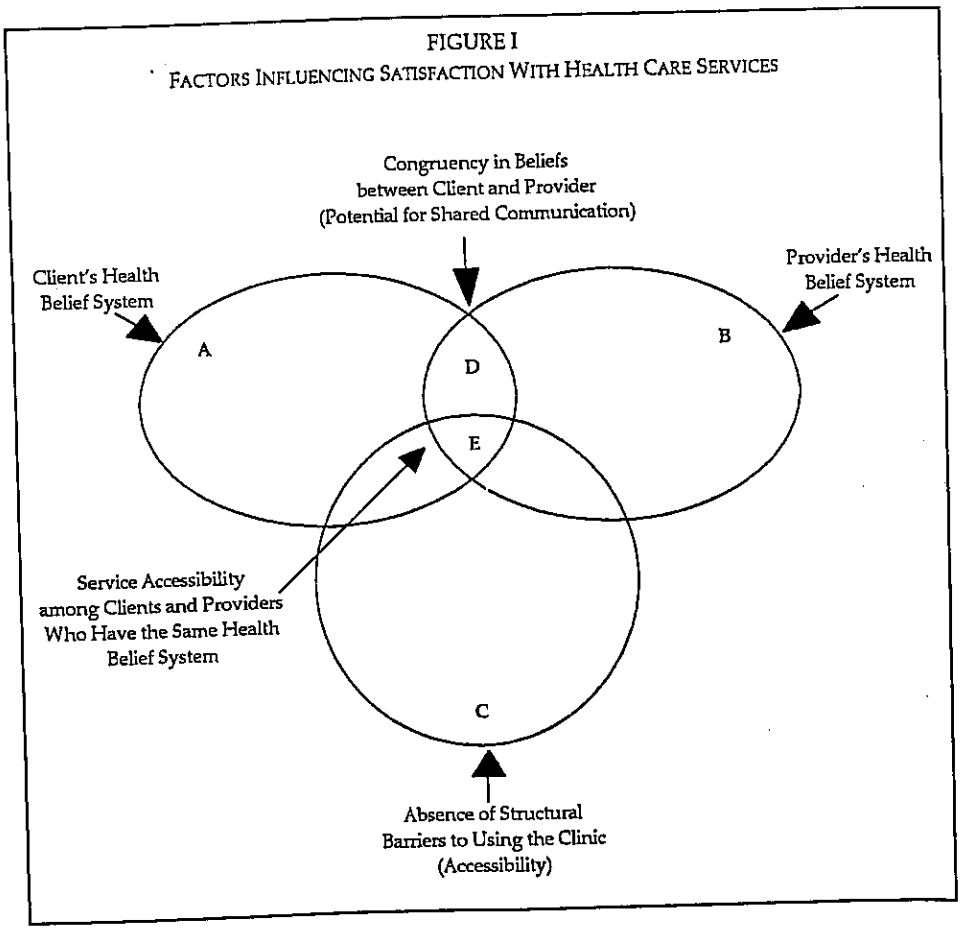
To identify the nursing interventions that influence satisfaction for migrant farmworkers in Niagara County, New York, a study was undertaken to measure the relationship of satisfaction with health care services to the congruency of the nurses' health beliefs with the farmworkers' health beliefs and to the structural factors affecting the farmworkers' use of health care services.

THE STUDY

Because researchers vary in their conclusions about the importance of both cultural concerns and structural factors affecting health care, this research investigated the relative effect of both. Migrant farmworkers' health beliefs and the structural barriers to health care were studied to determine the extent to which these two factors influence farmworkers' satisfaction with services. Data came from a 1986 survey of 91 migrant farmworkers living and working in Niagara County, who had used the clinic during the 1986 and/or 1985 harvest season and from eight nurses providing health care at the clinic. The research focused on two determinants of satisfaction with health care services for migrant farmworkers: 1) congruency/incongruency in cultural health care beliefs between the migrant farmworkers and the health care providers, and 2) structural factors that may be perceived by the migrants as barriers to using the migrant health clinic.

Figure I shows the conceptual model illustrating these determinants of satisfaction and their relationship to each other. The figure illustrates three factors present in the health care system. Circle A is the client's health belief

FIGURE I
FACTORS INFLUENCING SATISFACTION WITH HEALTH CARE SERVICES



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system, circle B is the provider's health belief system, and circle C is clinic accessibility, as measured by the client's perception of structural barriers to using the clinic. Section D represents the degree of congruency in health beliefs between the migrant and the provider, while Section E indicates clients who had the same cultural health belief system as the providers and had maximum accessibility to using the clinic. These clients would have the greatest level of satisfaction with health care services.

The sampling procedure for the clients in this study (N=91) consisted of nonrandom sampling and snowball interviewing. That is, each respondent referred the interviewer to subsequent respondents. The health care providers in this study (N=8) were all of the nurses working at the migrant health clinic.

Although the sampling procedure was developed to control many sources of bias and error, other uncontrollable sources of error may have influenced the study. Because the interviews were conducted only with workers whose employers permitted the investigator to be on their premises, sampling bias may have occurred. The inaccessible population may have responded differently than the sample population. The sample may also have been biased by selecting only workers who were clinic users. They may have been more acculturated and less concerned about cultural compatibility with clinic staff than nonusers of the clinic who were not included in the sample.

Three instruments of measurement were verbally administered to the clients: 1) a Health Beliefs Questionnaire to determine congruency in beliefs between clients and providers; 2) a Structural Factors Questionnaire to assess barriers to utilization; and 3) a Satisfaction Questionnaire to measure client satisfaction with health care services. The same health beliefs questionnaires which were given to the clients were administered to the nurses.

This single, cross-section survey combines a descriptive design and an ex post facto correlational design. The descriptive design examines each variable (congruency in health beliefs, perceived barriers to use, and client satisfaction) independently. The ex post facto correlational design describes the relationship of the first two variables with the third.

This research is also a retrospective investigation in which the level of satisfaction was determined by the survey and then the investigator determined whether the independent variables were major antecedents.

The data for the quantitative analysis were gathered in verbal responses to predetermined questions, whereas the data for the qualitative analysis were gathered in unstructured questioning which was frequently determined by the farmworker's answer to previous questions.

The tested model includes three independent variables: 1) individual structural barriers to use of the clinic, 2) the accumulative structural barriers to use, and 3) congruency in the cultural health care beliefs of clients and nurses. Analysis of variance and multiple regression analyses were performed to gain an understanding of clients' satisfaction with health care services.

RESULTS

Clients were asked to respond yes or no to whether they agreed with each of the following statements:

1. I don't know where the health center is.
2. I can't afford it.
3. I would lose pay or income from work.
4. Transportation is too difficult.
5. I am unable to get there at the time the service is offered .
6. The health center is too far away.
7. It takes too long to get an appointment.
8. I have to wait too long to get an appointment.

9. The health worker and I don't speak the same language.

10. There is no one to look after my children.

The analyses showed that the time the service is offered, a long waiting time at the clinic, and loss of pay when using the clinic appeared to account for the most significant differences in client satisfaction scores. The analyses also indicated that the number of factors perceived as barriers had an effect on satisfaction with service scores. Clients perceiving three factors, rather than only one or two factors, as barriers had satisfaction scores that were significantly lower than those of clients perceiving no barriers.

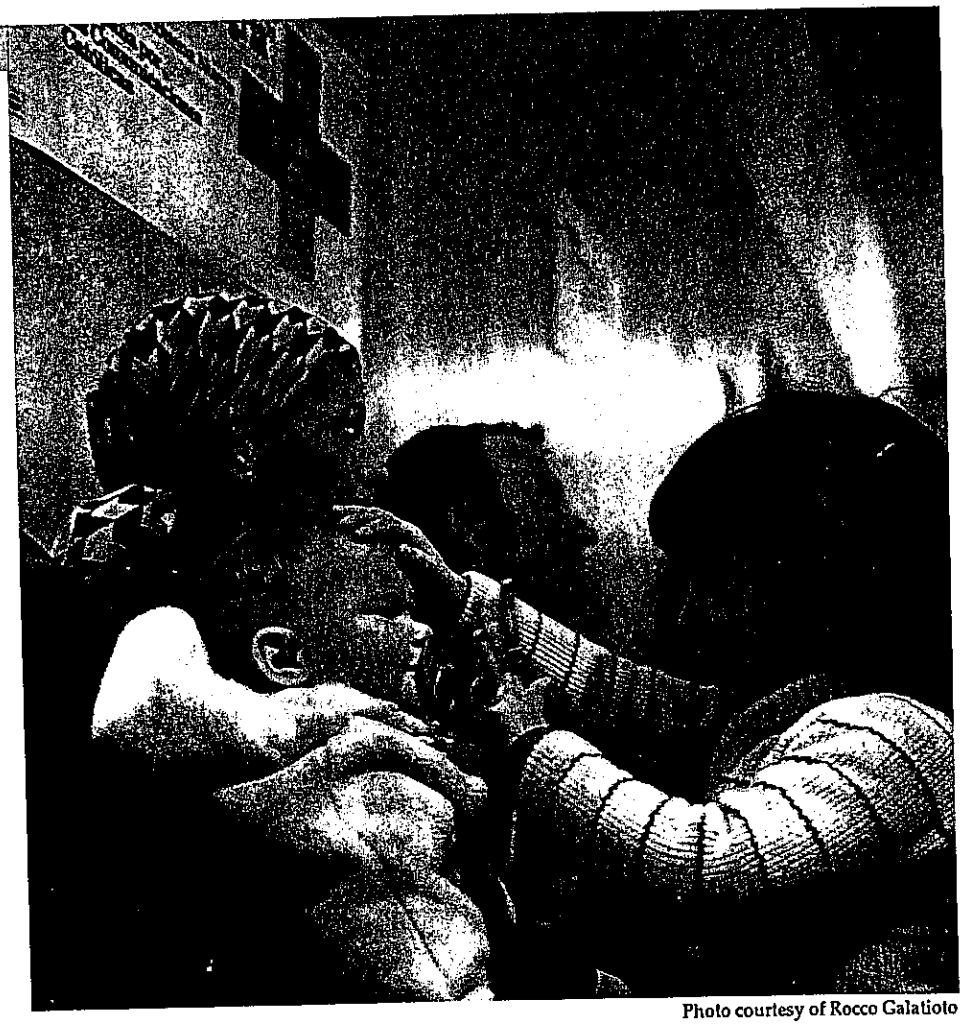
Congruency in health beliefs between the client and the provider did not significantly affect clients' satisfaction with health care services.

In addition to the findings based on clients' and providers' responses to the questionnaires, the informal interviews provided qualitative data relevant to identifying factors affecting satisfaction with migrant health care services.

A factor that was identified as decreasing the dissatisfaction with waiting at the clinic was a secondhand clothes store located in the basement of the building. Many clients said that as soon as they put their names on the waiting list, found out how many people were ahead of them, and estimated the length of time before they would be called to see the doctor, they would go to the clothes store to browse or shop. Another factor that was identified as affecting the clients' attitude toward waiting was the free punch, coffee and cookies provided by volunteers.

The time at which clinic services were offered was also identified as a significant factor affecting satisfaction with service. The clinic hours were Wednesday evening from seven o'clock until the last client was seen. Few people had complaints about these hours.

Farmworkers who had used both the Niagara County Migrant Health Clinic and other migrant clinics compared the costs of care. Most reported paying a $9.00 fee at other clinics compared to $2.00 donation at the Niagara County Clinic. Though most clients acknowledged that $9.00 per clinic visit was not an exorbitant cost, they complained about paying more yet being treated less courteously at other clinics.



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Many clients identified the providers' expression of caring for the client as the major factor contributing to their being satisfied with the clinic's services. Interviews with the nurses supported the clients' reports that feeling cared for was an important variable affecting client satisfaction. The few clients who reported dissatisfaction with the clinic had generally felt rushed, overlooked, and/or not taken seriously by the health care providers. Consequently, the qualitative analysis revealed the emergence of an independent variable affecting the farmworkers' satisfaction with health care services which was not taken into account in the quantitative analysis. Since this variable is qualitative, its relative significance was undeterminable. However, the data do reflect that farmworkers' perception of being cared for has a significant effect on satisfaction with health care services at the Niagara County Migrant Health Clinic.

IMPLICATIONS FOR NURSING EDUCATION

The combination of the quantitative and qualitative analyses seems to suggest that congruency in health care beliefs between nurses and clients is not a prerequisite to the nurse conveying a sense of caring and respect to the client. Respecting the clients' belief system is one component of respecting the entire individual and therefore must be recognized as a valuable component of providing satisfactory health care, even though congruency in belief systems does not appear to be a component of providing satisfactory health care. Nursing curricula must reflect consideration of individual value systems, health beliefs, and lifestyles,

even when a merging of beliefs does not occur.

This research has identified some of the health beliefs of the sample population. Two major beliefs about health issues were common among the migrant farmworkers. The first common belief was that elevation of normal body temperature is directly related to the seriousness of the health condition. Given such a belief, one might anticipate that an ill adult or a parent of an ill child could overlook the necessity of seeking medical attention for a serious or potentially serious health condition. For example, diabetes, anemia, hypertension, cancer and other illnesses are not generally accompanied by an elevated temperature, but each is a health condition that needs to be taken seriously. Consequently, nurses and other health care providers need to be aware of this belief among farmworkers and to focus on educating clients about signs and symptoms of health problems other than an elevated body temperature. They also need to encourage farmworkers, even when asymptomatic, to have routine physical examinations to support early diagnosis and treatment of many illnesses.

The second major belief common among the farmworkers in this study is that health problems which occur simultaneously are interrelated. The identification of this belief is similar to Fradel's (1985) finding that some clients may have no concept of discrete organ systems. A practitioner who did not understand this might have difficulty understanding the client's complaint and consequently miss an essential point that could lead to an accurate diagnosis.

For example, at one staff conference at the clinic a discussion arose about a farmworker seeking treatment for a sebaceous cyst on his scrotum and another cyst on his eyelid. The patient had suggested that the two cysts were related. When this information was shared with the nursing staff, their general reaction was to question why the client would think the two cysts were related. The client had arrived at a belief that seemed logical to him, but the nursing staff did not follow the same logic. This may have prevented the nursing staff from asking appropriate questions that would have given greater insights into this client's health condition. Perhaps having this man explain a step-by-step process would have provided the nursing staff with valuable information upon which to base their clinical assessment and subsequent treatment.

The results of the unstructured interviews also indicated that the clients tended to perceive health conditions as more serious than did the providers. A provider's failure to perceive a client's complaint as serious, when the client perceives it as such, could result in several outcomes. Clients might perceive the provider as not empathetic to them, thus creating a client-provider communication gap and strained relationship. Or the provider's failure to perceive the illness as serious might result in his or her failure to take a complete medical history that could disclose a related and potentially serious health problem. Consequently, provider's need to be encouraged to take clients' complaints seriously, while at the same time educating them about the medical consequences of their health conditions.

Finally, health care providers must remember to ask clients what they believe about the cause, symptoms and preferred treatment of their illness. Providers need to accept responsibility for communicating with clients and for identifying a basis upon which to structure their clients' education.

IMPLICATIONS FOR CLIENT EDUCATION

Another finding was that clients' beliefs were not medically accurate. Misinformation about manifestations and etiologies of illnesses can hinder clients' search for appropriate health care and foster health practices that may be detrimental.

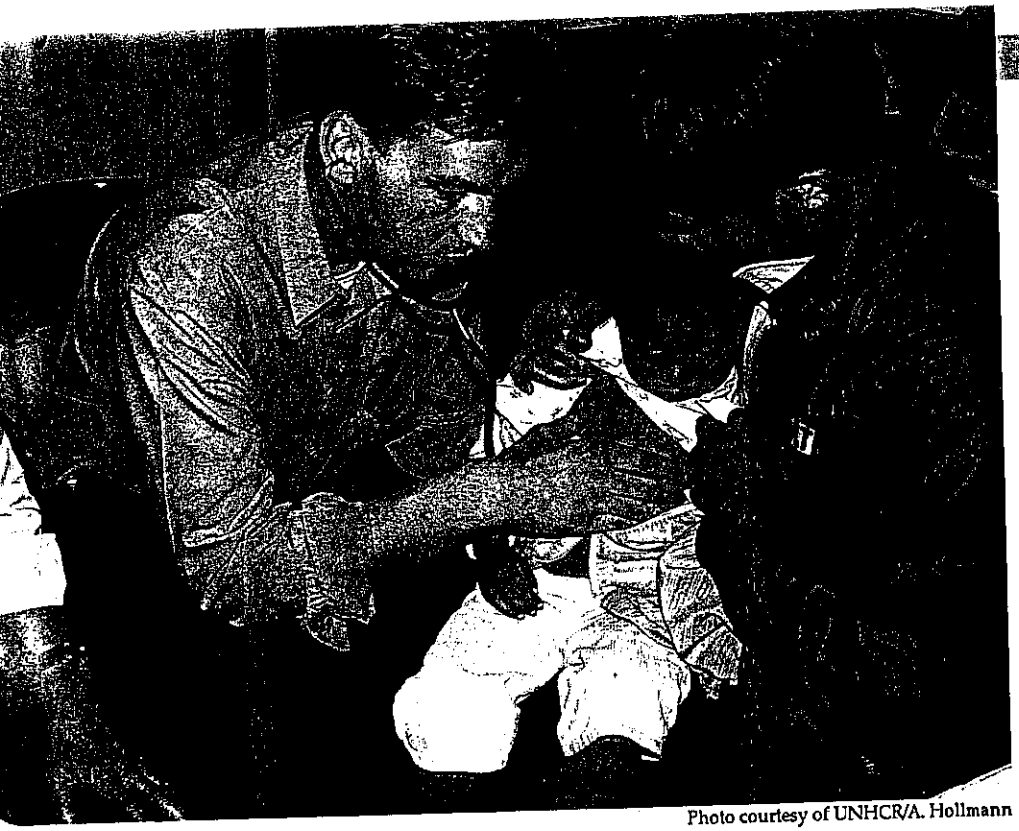
For example, lack of knowledge that tuberculosis is treatable could prevent a person from seeking medical treatment, from complying with the total year-long medication regiment of isoniazid (INH), or both.

Similarly, a belief that diabetes comes from not eating at the right

times might encourage a person to eat at the "right" times, yet do nothing to encourage him or her to eat the "right" foods and get the "right" medical treatment.

Eighty four percent of the clients in this study believed that hypertension is accompanied by weakness. These clients may neglect having their blood pressure checked if they are not feeling weak. Consequently, hypertension has the potential to go untreated and to justify its designation as "the silent killer." One client indicated that he had been advised how to avoid hypertension. He said that since he had heard that eating pork was not good for his blood pressure, he had begun eating beef every day. This farmworker clearly needed additional health education.

Clients need to be educated about the etiology, signs and symptoms of their presenting complaint. They need information about specific health practices related to their presenting complaint. Education of clients must be individualized to meet the client's specific concerns. Nurses and other health care providers need to be educated about the cultural beliefs of the clients they are serving and how to plan their client education programs accordingly.



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IMPLICATIONS FOR HEALTH POLICY AND PLANNING

This study suggests that health policy planners must ensure that health care is both available and accessible to migrants. They must recognize the complex nature of providing health care to such a diverse, multicultural group as migrant farmworkers.

The characteristics that seem to contribute to increased satisfaction with services are: 1) evening clinic hours; 2) free van services; 3) low-cost care; 4) the nearby secondhand clothes store managed by volunteers; and 5) the hospitality of and refreshments served by volunteers. The first three of these characteristics are time-cost factors. Rogers and Honkomp (1984) emphasize that time away from work is the farmworkers' major barrier to health care. The findings of this study reflected that, because of the characteristics identified, time-cost is not a barrier to use at the Niagara County Migrant Health Clinic. Even though 26.4 percent of the clients said having to wait too long was a barrier to use, a number of others accepted a long waiting period because certain positive characteristics of the clinic (the clothes store and refreshments) decreased the unpleasantness of a long wait.

Nurses have a vital role in reminding health policymakers and the community that health services that are not available and accessible do not promote a higher level of wellness. Nurses are accountable to migrant farmworkers who are victims of unjust distribution of health care; they are also responsible to the nursing philosophy that health care is a basic human right. One farmworker stated that "someone" needed to talk to the growers about the health hazards affecting the farmworkers. Undoubtedly the nursing profession has the numbers, the skills, and the responsibility to be that "someone."

Schools of nursing must encourage their students to explore and understand the socioeconomic context of migrant health care. They must structure their curricula so that students identify their own values and make a commitment to making health care available and accessible. Nursing professionals need to be aware of the political factors that affect migrants' health. For example, there are no pesticide controls set by the Department of Labor, Occupational Safety and Health Administration, no workmen's compensation and, in many states, no policies to ensure sanitary facilities and clean drinking water in the fields.

Within the educational system, students should be taught skills to influence the policies that ensure adequate and justly distributed health care for migrant farmworkers as well as for other consumers. Nurses in practice must be willing to go beyond their clinical roles to take political action in supporting national policies that advocate accessibility and availability of health care services. Implementing new policies will enable the health care system to expand to meet the needs of migrant farmworkers. Nurses must continue to support national health insurance, expanded roles for nurses, and the end of constraint of trade for nurse practitioners. If nurses choose to do so, they have the numbers and the influence to propose and support policy alternatives to promote accessibility and availability of health care services to underserved populations.

This study also suggests that client satisfaction with health care services can be increased by making minor changes. The staff of other clinics might find that their clients are more satisfied with services if they are offered refreshments while they wait. Clinic staffs need to be aware of minor changes which reflect a sense of caring.

The most important structural variables for predicting satisfaction with services were the time the services are offered and the length of waiting time. Also, perceiving any three factors as a barrier to use as opposed to not perceiving any barriers significantly lowered satisfaction with services. Congruency (shared cultural health care beliefs between the farmworker and the nurse) did not significantly affect clients' satisfaction with health care services.

The analyses also indicated the importance of the farmworker's perception of being cared for with consideration, as an individual with unique concerns and needs. Such changes may make a major impact on clients' satisfaction with migrant health care services.

Note:

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References available upon request.