

FACTORS INFLUENCING THE TYPE OF HEALTH PROBLEMS PRESENTED BY WOMEN IN GENERAL PRACTICE: DIFFERENCES BETWEEN WOMEN'S HEALTH CARE AND REGULAR HEALTH CARE

ATIE VAN DEN BRINK-MUINEN, PH.D.

NIVEL (Netherlands Institute of Primary Health Care)

JOZIEN M. BENSING, PH.D.

Utrecht University, The Netherlands

ABSTRACT

Objective: Differences between health problems presented by women (aged 20-45) to female "women's health care" doctors and both female and male regular health care doctors were investigated. This article explores the relationship of patients' roles (worker, partner, or parent) and the type of health care, controlling for education, to the presentation of psychological, social, and purely somatic problems in general practice. *Method:* Data was derived from a "women's health care" practice and twenty-one group practices providing regular care. The doctors registered detailed information about all patient contacts during a three-month period. Logistic regression analysis was used in order to calculate the likelihood of women attending their doctor to present with psychological, social, or somatic health problems. *Results:* We found that the effect of education was much stronger than the effect of roles. Women attending women's health care presented more psychological and social problems and less somatic problems than women visiting regular health care doctors. Patients of female and male doctors providing regular care did not differ in this respect between each other. *Conclusions:* This study showed that patient characteristics, like roles and education, are related to the type of health problems presented to general practitioners. The type of health care was also important in explaining differences in the problems presented to them. Future research in primary care should include doctor

characteristics to better understand how these characteristics might relate to patient outcomes.

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Key Words: general practice, women's health care, psychological problems, social problems, roles, education

INTRODUCTION

Considerable research has been done on the presentation of health problems in general practice. An increasingly important topic in this area is the relationship between the multiple roles of women and their physical and mental health. The literature on how these health problems are presented to doctors reveals inconsistent findings. Possibly, the inconsistency has to do with the way in which the relationship has been investigated. Almost exclusively the demand-side of health care, i.e., the patients, has been included in studies on this subject. The influence of the suppliers of health care, i.e., the doctors, on the presentation of health problems has scarcely been investigated. Nevertheless, there are indications that general practitioner's characteristics, such as gender, are related to the presentation of health problems. Previous studies showed that patients presented different health problems depending on whether they saw a male or female doctor [1, 2]. It might be expected that even stronger effects might be found when the type of health care is taken into account. Nearly all general practitioners in the Netherlands as well as in other Western countries provide regular health care. Another type of health care provided is "women's health care." Women's health care is defined as "consciously providing care from the perspective that patients' problems may be related to their socialization and their situation in society, and encouraging patients to map out strategies aimed at the realization of self-determination and self-responsibility with regard to both body and lifestyle [3]. The presentation of health problems in women's health care may differ from that in regular health care because of the specific principles on which this type of health care is based, especially with respect to psychological and social problems. Moreover, it might be a case of a "double selection mechanism": women may prefer to present their problems to a female doctor, and even more so to a female doctor providing women's health care.

Accordingly, the aim of this study was to investigate differences in the type of health problems presented to doctors by female patients. The patients visited women's health care doctors or regular health care doctors. The relation between the type of problems and women's multiple roles was investigated. Also, the relation of these problems with the type of care and with the doctor's gender was studied.

The literature on the impact on health of separate and multiple roles is reviewed. The principles of women's health care are also described. Based on this literature hypotheses are formulated about the relationship between roles, health care and health problems presented in general practice.

LITERATURE AND HYPOTHESES

The Worker Role

Employment is generally a rewarding experience for women [4]. Employed women report better overall health [5] and fewer symptoms of psychological distress [6] than non-employed women [7]. So far, there has been little research into differences between women with part-time jobs and those working full-time, and findings to date are inconsistent. On the one hand, it was found that women working more hours enjoy a better health. This applies in particular to middle-aged women [8]. Paid employment is associated with reduced depression as long as working hours (job and housework together) do not exceed an upper threshold [9]. Young mothers in particular suffer from depression unless there are adequate financial resources to help with the burden of multiple roles. A more equal division of labor between the sexes in the home also contributes to a better mental health [10]. On the other hand, Kenekel found no significant differences between the effects of part-time and full-time employment on the health of women in general [11]. This finding contradicts the expectation that part-time employment is related to less role-overload and role-conflict than full-time employment.

The consistency of this "beneficial effect" has led other authors to look for the "healthy worker effect." Healthy people may be more willing and able to work—a social selection effect. However, two longitudinal studies reported a positive effect of employment on health. This effect was independent of baseline health status [5, 12].

The Partner Role

The relationship between the role of partner and physical and mental well-being is favorable to women, especially when they are employed [12-14]. One of the most consistent findings is that married women are happier and more satisfied than those who are not married, regardless of whether the latter are single, divorced, or widowed [15]. The partner role is a source of identity, social support, and self-esteem [5]. It was also found that the role of wife was not significantly associated with role conflict and role overload [16]. When the quality of the marriage is taken into account, the impact on well-being is even more pronounced [15], because marriage can be associated with suffering and stress, as well as with gratification [17]. However, a recent study did not support a health protective effect of marriage [18].

The Mother Role

The mother role, generally defined by the presence of (young) children at home, seems to have a positive relationship with the health of women [19]. Middle-aged women as well as younger women with a child enjoy better health than other women [8]. However, it has been argued that the quality of the mother role is also important with respect to the effect on well-being [13, 15]. Positive spill-over effects from job to parenting have been reported [20, 21]. Though, other studies have reported that labor force participation may increase a woman's vulnerability to the effects of parental stress [17]. The mental health advantage of the buffering or "spill-over" effect applies equally to single and to employed mothers with a partner [21]. There are contradictory findings about the associations of the number of children and the health of employed women. Some studies found no differences, except among single working mothers [16, 22]. Another study suggested a curvilinear relationship between parental responsibilities and health [23]. However, the hypothesis that persons with several young children or no children would have a poorer health status than persons with just one child, was only partially supported [18].

Multiple Roles

Two contrasting theories have been put forward to explain the relationship between multiple roles and health problems. The "role-conflict hypothesis" assumes that multiple roles are related to more health problems. The more recent "role-expansion hypothesis" assumes that multiple roles lead to fewer problems.

The traditional role-conflict hypothesis argues that additional roles create role strain, role conflicts, and role overload, subsequently causing illness as well as physical and psychosocial problems [3, 4, 8, 24, 25]. The role-expansion hypothesis focuses on the gratification derived from accumulating diverse roles [13]. Many studies have shown the generally positive relationship of a combination of paid employment and domestic responsibilities (caring for children and housekeeping) on women's mental and physical health. If the supportive circumstances are appropriate, multiple roles are associated with a lower level of psychological distress [14, 20, 26-30]. It is argued that in the past many women, and housewives in particular, were "underburdened." The absence of stimuli from the environment could lead a person to become introspective and, therefore, to have more problems [31]. Three major psychological factors have been proposed to explain this benefit of role combination on health (apart from the financial advantage): variety is healthier than monotony; multiple roles promote social contacts, satisfaction, self-esteem, a salient identity and therefore emotional health; and the consequences of stress arising in one area can be reduced by activities in another area (buffering effect) [9, 24, 27, 30, 31].

Some authors argue that the assumptions about the relationship between multiple roles and health tend to focus on the quantity of the roles rather than on the

nature and quality of a woman's experiences within a role. They argue that differences in health are related to the social context, the living situation, the way of thinking, judgment, and the reaction to aspects of the person's circumstances [10, 32, 33]. They emphasize that the nature and quality, and not merely the occupancy per se, are critical to understanding the processes affecting women's well-being. They also stress that the balance between the costs and the benefits of role involvement varies, depending on the specific characteristics of the role and the women considered [12, 16, 17, 21, 34, 35].

Hypotheses with Respect to Roles

It is clear that employment is most consistently connected with good health for women. Thus, our first hypothesis is:

1. *Employed women will consult the general practitioner less often with psychological, social, and somatic problems than unemployed women.*

The partner role is mostly favorable to women. Being a parent also tends to have a positive influence; the number and ages of the children seem to be of less importance. Being without a partner and having no children may have a negative influence on health and, as a consequence, increase the chance of psychological and social problems. Our second hypothesis is therefore:

2. *Women living without a partner and women without children who consult the general practitioner will present more psychological, social, and somatic problems than do women with partners and women who have children.*

Multiple roles are generally associated with good health. Therefore, our third hypothesis is:

3. *Women performing multiple roles will present less psychological, social, and somatic health problems as compared to other women who visit their doctor.*

Women's Health Care

Women's health originated from the second feminist wave at the end of the sixties, when women groups rebelled against "regular" medicine. These women argued that the social position of women was not taken into account, and they fought against the "women-unfriendly" treatment provided by doctors. The women's health movement was developed further in self-help groups and in independent women's health centres [36]. In the Netherlands, women's health care is provided exclusively by the general practice known as "Aletta." This practice was established in 1984 and it is named after Aletta Jacobs, the first Dutch female physician as well as the first Dutch feminist physician. It is the only general practice known to provide women's health care, in the Netherlands as well as in other Western countries. In the Aletta practice, three female general

practitioners provide women's health care. Women's health care is based on feminist philosophy and aimed at improving the quality of care [37]. The principles of women's health care are: 1) consideration of the patients' gender identity and gender roles, 2) consideration of the patients' personal and social situation, 3) respect for the patient, 4) encouragement of the patient's self-determination and ability to be responsible for herself, and 5) avoidance of medicalization (labeling physical problems and problems of daily life as biomedical problems) [3]. The first two principles are considered the most important and distinctive characteristics of women's health care. The other three principles are already part of the ideology being propagated by the Dutch College of General Practitioners. In addition, specific attention is said to be paid to information-giving, which is an important means for realizing the principles. Though, other doctors also pay attention to information-giving.

It has to be emphasized that the general practitioners of the Aletta practice have had the same vocational training as other doctors wanting to become general practitioners. The Aletta doctors take care of a fixed population of patients, and they provide care for all health problems, just like the other doctors. But, they lay certain specific emphases on their practicing in accordance with the principles of women's health care.

Hypothesis with Respect to Type of Health Care

On the basis of the first two principles of women's health care it may be expected that the Aletta general practitioners pay more attention to psychological and social problems, and that patients are encouraged to present these problems. However, on the basis of principles such as the prevention of medicalization and the encouragement of self-responsibility, one might assume that the women who attend the Aletta practice will present fewer problems than do women who attend regular practices. These considerations lead to our fourth hypothesis:

4. *Women visiting women's health care doctors will present more psychological and social problems and fewer somatic problems than do women visiting regular health care doctors.*

METHOD

Study Design

The study design is cross-sectional. Data was derived from a study conducted among three female general practitioners in the women's health care practice Aletta, in 1993. Also, data was used from the Dutch National Survey of Morbidity and Interventions in General Practice (1987-1988), a large-scale study among 161 general practitioners working in 103 general practices taking care of a fixed population of 340,000 patients [38]. For the present study, only data from the

twenty-one group practices with both female (total $n = 23$) and male (total $n = 27$) general practitioners were considered, in order to equalize patients' opportunity to choose between a female or male doctor [1]. In this way, distance to the practice location can be ruled out as a possible explanation for differences between female and male general practitioners, as well as other relevant factors such as the composition of the practice population, the particular characteristics of the neighborhood, and the availability of other health services in the surroundings. Written informed consent was obtained.

Data Collection

The data collection of the "Aletta study" and the "National Survey" was equal in all respects. The general practitioners recorded detailed information about all patient contacts during a three-month period. The data recorded included, among others, patient characteristics (sex, age) and problems presented, classified according to the International Classification of Primary Care (ICPC) [39]. The classification was done in both studies by the same qualified research-assistants. The doctors also assessed, on a 5-point scale the possible psychosocial character of the problem. Problems with a score of 1 are considered to be purely "somatic" health problems. This method of registration has been reported earlier [40]. To ensure maximal uniformity in the data collection process, all participating doctors were trained in the use of the classification systems. A written instruction with definitions was provided to keep at hand during the consultation. Before the registration period started, all elements of the registration form were tested in each individual practice to check the data for completeness and irregularities and to discuss problems that might have arisen. The doctors, also the Aletta doctors, received feedback on their practice profile compared to the "average" practice profile in the National Survey of Morbidity and Interventions in General Practice [38]. This service was highly appreciated by the doctors and provided an extra opportunity for data control.

Health problems were operationalized as the prevalence rate of health problems, with the prevalence being determined by counting the total number of health problems per patient; identical health problems were counted only once per patient. Patient characteristics, such as age, employment (unemployed, part-time, or full-time employed), living situation (alone, partner, children), and educational level (low or high) were derived from the practices' patient registration system.

Analysis

Only health problems mentioned during the routine consultation were included in the analyses; home visits, emergencies, and special consultations were excluded. The analyses were restricted to women aged between twenty and

forty-five years, because most women of the Aletta practice population are in this age range and because the issues of this study are relevant to this age group.

For each patient who visited the doctor within a three-month period was investigated whether she had presented at least once a psychological problem (ICPC chapter P), a social problem (ICPC chapter Z), or a purely somatic health problem (health problems from the other chapters of ICPC that were coded "1" on the scale somatic-psychosocial). The resulting groups consisted of 1006 patients of the Aletta practice, 3287 patients who consulted a female general practitioner, and 3793 patients who consulted a male general practitioner.

According to the "fixed-role hypothesis" [29, 41], people with a fixed role have more structure in their lives and as a result they are healthier. Therefore, women who followed daily educational courses were added to the category of employed women. Women who kept house or who did voluntary work were considered as having fewer fixed obligations and therefore having less structure in their lives. They were added to unemployed women.

The type of health care provided as well as the general practitioner's gender were included in the "type of general practitioner."

Last, the analyses were controlled for patients' age and education, and for the degree of urbanization of the practice setting (fewer or more than 100,000 inhabitants). Education was accounted for, because of the consistent relationship of the level of education to health, that is found in many studies. A higher education is generally associated with better somatic and mental health [19, 41-46]. The degree of urbanization was included because the Aletta practice is established in a rather large city, and large cities are known to be related to the presentation of more psychosocial problems, in the Netherlands as well as in other countries [47].

The correlations between the independent variables were not sufficiently high to warrant concerns of collinearity. The percentages presented were tested for statistical significance by the chi-square test. For age an *F*-test with pairwise comparisons was used. Logistic regression analyses were performed in order to explain differences in health problems presented.

RESULTS

Patient Characteristics

Table 1 presents the distribution of the independent variables for the women who consulted the Aletta doctors, non-Aletta female general practitioners, and male general practitioners. The women who attended the Aletta practice were different from the women of regular practices. Women who consulted the male or female general practitioners also differed from one another, but to a lesser extent. Women who had a job, who had no children, who lived without a partner, and who were highly educated chose a female doctor more often, and especially an Aletta doctor.

Table 1. Sociodemographic Characteristics of Women Patients Aged 20-45 by Type of General Practitioner^a

	Patients of Aletta GPs	Patients of Female GPs	Patients of Male GPs
Mean age	29.4 ^c	30.1 ^{d,e}	30.6
% not employed	13.5 ^c	40.1 ^{d,e}	44.3
% part-time employed (< 32 hours per week)	23.1 ^c	18.6 ^d	19.0
% full-time employed (≥ 32 hours per week)	63.4 ^c	41.3 ^{d,e}	36.7
% no partner	67.6 ^c	26.7 ^{d,e}	17.1
% no children at home	89.4 ^c	45.5 ^{d,e}	35.3
% highly educated ^b	64.8 ^c	20.2 ^{d,e}	12.8
<i>N</i>	1006	3287	3793

^a*P*-values for age come from an *F*-test with pairwise comparisons, other *p*-values come from chi-square tests.

^bLevel at which full-time education was finished: low (primary and secondary education) and high (higher vocational training and university).

^c*P* \leq 0.01 Aletta GPs' patients compared to women GPs' patients.

^d*P* \leq 0.01 Aletta GPs' patients compared to men GPs' patients.

^e*P* \leq 0.01 women GPs' patients compared to men GPs' patients.

Health Problems Presented

Comparison of the three groups of women who consulted their doctor, revealed that the Aletta patients over all presented more psychological and social problems to the general practitioner, and less purely somatic health problems than the other patients (Table 2). The level of employment, having a partner or children and educational level did not discriminate within the group of Aletta women patients. An exception was the relation between education and psychological problems. Less educated women presented the Aletta doctors with more of these problems than more highly educated women ($P \leq 0.05$).

There were few differences between the women patients who consulted the non-Aletta male and female general practitioners (Table 2). Women without a partner presented more psychological and social problems to male doctors than to female doctors. Both part-time and full-time employed women visited their male doctor more often with somatic health problems. Low educated women also presented more somatic health problems to male doctors. High educated women presented male doctors with more psychological problems.

Multivariate Analysis

Logistic regression analysis showed that, taking into account the roles of worker, partner and parent, the level of employment did not affect the prevalence

Table 2. Percentages of Women Patients Aged 20-45 with Health Complaints by Employment, Partner, Child(ren), Education, and by Type of General Practitioner^a

	Psychological	Social	Somatic	N
Aletta GPs	17.4	13.2	59.4	1006
Women GPs	8.1 ^b	4.9 ^b	74.2 ^b	3287
Men GPs	8.9 ^c	4.3 ^c	76.9 ^c	3793
Not Employed				
Aletta GPs	19.5	18.6	59.3	113
Women GPs	8.3 ^b	5.6 ^b	75.7 ^b	968
Men GPs	9.4 ^c	4.8 ^c	76.2 ^c	1160
Part-Time Employed				
Aletta GPs	19.2	9.3	58.0	193
Women GPs	10.0 ^b	6.3 ^b	69.9 ^b	448
Men GPs	10.1 ^c	5.2 ^c	76.1 ^{c,d}	497
Full-Time Employed				
Aletta GPs	15.9	12.7	61.1	529
Women GPs	7.2 ^b	4.1 ^b	76.5 ^b	995
Men GPs	7.4 ^c	3.7 ^c	79.2 ^{c,d}	961
No Partner				
Aletta GPs	17.3	11.9	59.9	579
Women GPs	11.2 ^b	5.2 ^b	71.0 ^b	717
Men GPs	15.3 ^d	7.0 ^{c,d}	69.8 ^c	484
Partner				
Aletta GPs	17.7	14.8	59.9	277
Women GPs	6.9 ^b	5.1 ^b	76.1 ^b	1972
Men GPs	7.5 ^c	3.9 ^c	78.3 ^c	2384
No Children at Home				
Aletta GPs	17.5	13.2	61.3	765
Women GPs	9.0 ^b	5.2 ^b	74.7 ^b	1223
Men GPs	9.4 ^c	4.2 ^c	76.6 ^c	1001
Children at Home				
Aletta GPs	16.5	9.9	48.4	91
Women GPs	7.3 ^b	5.1 ^b	74.8 ^b	1466
Men GPs	8.6 ^c	4.5 ^c	77.0 ^c	1831

Table 2. (Cont'd.)

	Psychological	Social	Somatic	N
Low Education				
Aletta GPs	21.4	14.7	61.2	299
Women GPs	8.3 ^b	5.5 ^b	73.7 ^b	2093
Men GPs	8.9 ^c	4.4 ^c	77.5 ^{c,d}	2625
High Education				
Aletta GPs	15.2	11.8	59.2	551
Women GPs	6.6 ^b	3.4 ^b	76.1 ^b	531
Men GPs	8.8 ^{c,d}	4.3 ^c	74.9 ^c	422

^a*p*-Values come from chi-square tests.

^b*P* ≤ 0.01 Aletta GPs' patients compared to women GPs' patients.

^c*P* ≤ 0.01 Aletta GPs' patients compared to men GPs' patients.

^d*P* ≤ 0.01 women GPs' patients compared to men GPs' patients.

of somatic, psychological, or social problems among women attending the general practitioner, with one exception (Table 3). The probability that part-time employed women present psychological problems was higher than for full-time employed women (OR = 1.35, 95% CI = 1.06, 1.73, data not in the Table).

Women who had a partner and women who had children at home were less likely to present with psychological problems than their counterparts. However, women with a partner were more likely to have somatic health problems. Living situation did not influence the presentation of social problems.

Interaction terms of the different roles did not contribute significantly to the explanation of the type of problems studied, with one exception (data not in the Table). Employed women were more likely to present social problems to Aletta doctors than to other doctors (OR = 1.45, 95% CI = 1.02, 2.04).

When accounting for roles and education, the probability that women who attend the Aletta practice present psychological problems was higher than for women consulting other doctors (OR = 0.57, 95% CI = 0.42, 0.78 respectively OR = 0.65, 95% CI = 0.47, 0.90). Aletta patients were also more likely to present with social problems. In contrast, non-Aletta patients were more likely to present with somatic health problems.

Patients of non-Aletta doctors did not differ in the probability of presenting psychological, social, and somatic problems (data not in the Table).

The probability that women with high education visit the doctor for psychological as well as social problems was lower compared to well educated women (OR = 0.63, 95% CI = 0.49, 0.81 respectively OR = 0.65, 95% CI = 0.48, 0.88). In contrast, well educated women presented more somatic problems.

Table 3. Odds and Confidence Intervals (95% CI) of Women Patients Aged 20-45 Presenting Psychological, Social, and Somatic Health Problems

	Psychological		Social		Somatic	
	Odds	(95% CI)	Odds	(95% CI)	Odds	(95% CI)
Employed: no	1.0		1.0		1.0	
Part-time	1.19	(0.92, 1.52)	0.92	(0.67, 1.27)	0.86	(0.73, 1.02)
Full-time	0.88	(0.69, 1.11)	0.86	(0.65, 1.15)	1.00	(0.86, 1.17)
Partner:						
No	1.0		1.0		1.0	
Yes	0.64	(0.51, 0.80)	0.87	(0.66, 1.16)	1.37	(1.17, 1.60)
Children:						
No	1.0		1.0		1.0	
Yes	0.76	(0.60, 0.97)	0.79	(0.59, 1.07)	0.96	(0.82, 1.28)
Type of GP:						
Aletta GPs	1.0		1.0		1.0	
Women GPs	0.57	(0.42, 0.78)	0.38	(0.02, 0.57)	1.51	(1.21, 1.88)
Men GPs	0.65	(0.47, 0.90)	0.31	(0.20, 0.47)	1.70	(1.35, 2.14)
Education:						
Low	1.0		1.0		1.0	
High	0.63	(0.49, 0.81)	0.65	(0.48, 0.88)	1.18	(1.01, 1.39)
Age (per year)	1.04	(1.02, 1.05)	1.04	(1.02, 1.05)	0.97	(0.96, 0.98)
> 100,000 Inhabitants						
No	1.0					
Yes	1.44	(1.10, 1.90)	1.16	(0.79, 1.68)	0.73	(0.61, 0.88)

DISCUSSION

The putative relationship between the presentation of health problems and multiple roles was investigated on the basis of three hypotheses. In contrast to other studies, the first hypothesis that there would be negative correlation between level of employment and health problems was not affirmed. One explanation may be that the present study involved women aged between twenty and forty-five years, whereas in some other studies younger [10] or older women were included [5, 12]. Younger women may more often suffer from depressions, especially if they have to work and to care for children at home. Also, the quality of work [34, 35] was not included in the present study.

It appears that employed women are more likely to present psychological problems to Aletta doctors than to other doctors, or Aletta doctors are more alert to psychological problems with employed than non-employed women.

The second hypothesis that women living without a partner and women without children more often present psychological, social, and somatic problems than do women with partners and women who have children is supported for psychological problems only. Both roles are related to fewer psychological problems, which is in agreement with other studies [12-17]. This relationship may reflect a buffering effect, meaning that the consequences of stress arising from one role can be reduced by another role [9, 24, 27, 30, 31].

The presentation of more somatic problems by women who have a partner was not hypothesized and has not been reported before. This finding may be related to their lower reporting of other health problems. It could also be due to the fact that partners may encourage women to see a doctor when they complain about a symptom.

Contrary to the hypothesis, women without a partner or children did not present more social problems than their counterparts. One explanation may be that the quality of the relationships of those with partners and with children was not included in the study. Quality includes the help of partners or other people, that is probably different for the roles of worker, partner, and parent. Quality and also other characteristics, such as the number of children and having a high income may be of major importance for the presentation of health problems.

The third hypothesis that multiple roles have a beneficial effect on the presentation of health problems, was true for psychological problems only. Thus, it can be concluded that the role-expansion hypothesis is relevant with regard to the presentation of psychological problems. However, the number and age of children were not taken into account, which may be why this study failed to find a negative effect of parenthood on mental health as other studies have [16, 22, 49]. It is also unknown to what extent employed mothers arrange for child care and to what extent there is social support. If employed mothers have enough help, their health may be less affected by having children than non-employed mothers' health [10, 50, 51]. In future studies the relationship between the three roles (worker, partner, and parent) and health should be investigated by taking into account both the burden and quality of the various roles.

The relationship between health and the multiple roles is weaker compared to the relationships of health and level of education. Education had a marked effect on the type of problem presented. Less educated women visiting their general practitioner present more psychosocial problems than their better educated counterparts, replicating findings in the literature [41, 42, 44, 52-54]. Well educated people may have a greater knowledge of medical care and use medical care more wisely than less well educated people [55]. Medical knowledge influences health and health behavior [11]. Leigh showed that education increases a person's chances of practicing healthy habits, resulting in better health [56]. Similarly, in

our study, less educated Aletta patients did have more psychological and social problems than more educated women. However, we also found that the more educated Aletta women visited their doctor for psychological and social problems more often than all other groups except the less educated Aletta patients.

Women using regular care did not differ in the presentation of psychological, social, and somatic problems, irrespective of whether they consulted a male or a female general practitioner. The literature on the prevalence of psychological and social problems presented to female and male general practitioners is very scarce. One study found no differences in morbidity pattern between female and male general practitioners other than for gender associated conditions [60]. In our earlier study [1] was found that female doctors saw more social problems, but no differences were found in the presentation of psychological problems.

One explanation may be that only women between twenty and forty-five years were selected in the present study. Older women may talk easier about social problems with female doctors than with male doctors. For younger women perhaps the doctor's gender makes no difference. But, why this would not be applicable to psychological problems too remains an intriguing question. Future studies with a broader age range examining the type of psychological and social problems might help to answer this question.

The equivalence of female and male doctors providing regular care in this respect is more interesting in view of the differences with women's health care doctors. Women who attended the Aletta practice presented a different pattern of problems than women who attended regular general practices. They presented with psychological and social problems more often, but with somatic problems less often. This is true even after taking into account their different living and working situation and their high level of education.

Thus, the differences in the type of health problems presented between women's health care and regular care seems to be related to the type of care rather than to the doctor's gender. One explanation for this could be that the women attending the Aletta practice are more receptive to signals from their body and that they are more inclined to "psychologize" their problems. Additionally, the Aletta patients might be clearer in indicating what their psychological and social problems are, instead of presenting them as somatic health problems. In combination with this different way of presentation of health problems, doctors who work in the Aletta practice probably label their patients' problems as being psychological or social sooner than their counterparts in regular general practices. Both explanations are consistent with the principles of women's health care. This is important because many doctors underestimate and do not recognize their patients' psychosocial problems [61-64].

Women's health care practices may attract women with relatively more psychological distress who expect to receive care consistent with their own health beliefs and attitudes, and in accordance with the principles of women's health care. These women expect attention to be paid to their own opinions and consideration

to be given to non-medical solutions. They also expect the doctor to take into account the relationship between the problem and patient's living and working situation [2]. It also is possible that these women have had a bad experience with the care given by doctors who work in regular general practices. The extent to which their expectations of women's health care will be fulfilled, and whether the general practitioners of women's health care treat their patients according to the principles of women's health care, will be subject of future studies.

This study showed that patient characteristics, like roles and education, are related to the type of health problems presented to general practitioners. The type of health care was also important in explaining differences in the problems presented to them. Future research in primary care should include doctor characteristics to better understand how these characteristics might relate to patient outcomes.

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Direct reprint requests to:

Atie van den Brink-Muinen
NIVEL (Netherlands Institute of Primary Health Care)
P.O. Box 1568
3500 BN Utrecht
The Netherlands