

UNIVERSITY OF CAPE COAST

PATIENT SATISFACTION WITH THE QUALITY OF HEALTH CARE
SERVICES PROVIDED BY SELECTED HEALTH FACILITIES WITHIN CAPE
COAST METROPOLIS, GHANA

HARRIET AMPOFO

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CAPE COAST METROPOLIS, GHANA

BY

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Health and Allied Sciences, University of Cape Coast, in partial fulfilment of
the requirements for the award of Master of Nursing Degree

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature..... Date.....

Name: Harriet Ampofo

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with guidelines on supervision of thesis laid down by the University of Cape Coast.

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Co-Supervisor's Signature Date.....

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ABSTRACT

Customer satisfaction is key in keeping any organisation in business. The satisfaction of patients who are the main customers of health care is very important to keep health care institutions relevant and in business. This study sought to determine patient satisfaction with quality of healthcare provided by three health facilities in the Cape Coast Metropolis. Data were collected using structured questionnaire on predisposing, need, enabling factors and quality of care from 385 randomly selected clients from the three health facilities. The data was entered into SPSS and analysed using Fishers exact test and Chi Square at 95% confidence interval ($p < 0.05$) was considered significant. The findings revealed the satisfaction level as follows; very satisfied (4.2%), fairly satisfied (91.4%) and not satisfied (4.4%). Patient satisfaction is dependent on the quality of care received ($p = 0.010$). The following factors were found to have contributed significantly to patient satisfaction; family income ($p < 0.001$), cost ($p < 0.001$), waiting time ($p = 0.016$), information disclosure ($p = 0.000$) and environmental cleanliness ($p < 0.001$). On the other hand the contribution of socio demographic characteristic of the patient and the major health problem the patient reported to the hospital with to the satisfaction of the patient were found not to be significant. The role of quality of care in patient satisfaction cannot be overemphasized. There is the need for management of health facilities in the metropolis to strive to improve upon the quality of care provided at their facilities in order to satisfy clients. Mechanisms should be put in place to decrease waiting time, provide useful information to patients and provide affordable services in a clean environment.

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DEDICATION

This work is dedicated to mother, husband and lovely son Fitzcharles.

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LIST OF ABBREVIATIONS

GHS	Ghana Health Service
GSS	Ghana Statistical Service
IOM	Institute of Medicine
MOH	Ministry of Health
NHIA	National Health Insurance Authority
OPD	Out-Patient Department
SPSS	Statistical Package for Social Sciences
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

This chapter gives the backdrop of the study, including the purpose, objectives and significance of the study. The chapter also presents the statement of the problem, research questions, delimitations of the study, and organization of the study.

Background to the Study

Patients are the main users of every hospital and their care is the primary function of every hospital (Ibrahim, 2008). According to Swamy (2005) patient satisfaction is the real testimony to the efficiency of hospital administration. Satisfaction is broadly defined as the human experience of being filled and enriched by an experience (Agosta, 2005). Additionally, Williams (1994) defines patient satisfaction as the client's personal and subjective evaluation of expectation fulfillment.

Patient satisfaction is a key determinant in quality of care among others such as the establishment of corporate hospitals equipped with the latest facilities; the advent of third-party payers (insurance companies, governments, companies); increasing awareness among patients; availability of information through the internet; higher expectations of patient care; and finally the increasing litigations by unsatisfied clients. All these factors have resulted in a challenging profile for the health care industry away from the traditional concept of a noble sector toward a service industry (Prakash, 2010).

These changing trends, the world over, have had significant impact on many countries of which Ghana has had its fair share. Healthcare financing in Ghana was reformed from the cash and carry system in 2003 with the passage

of the National Health Insurance Act 650, the financial barrier to accessing healthcare was consequently reduced. Health financing reforms brought sudden changes in healthcare seeking behaviors of the people. The number of clients seeking health services increased dramatically, and private healthcare service which hitherto was the preserve of a very few and the well-to-do in the society, became accessible to all and sundry (Boadu, 2011). The introduction of the National Health Insurance scheme provided a level playing field for healthy competition between the government healthcare institutions and the private healthcare providers to maintain existing clients and to gain as much market share as possible (Boadu, 2011).

Knowing the factors which affect customer care and satisfaction is key in maintaining and gaining a fair share of the market. The factors which largely affect customer care and satisfaction are waiting time, behavior of health care professionals, availability of specialists, behavior of other clinical staff and assistants, and a clean environment (Boadu, 2011). Cronin and Taylor (1992) realized the interrelated values of service quality and customer satisfaction and concluded that service quality and customer satisfaction “share a close relationship”. Quality of healthcare remains a problem to most people in Ghana. A survey conducted by Core Welfare Indicators Questionnaires Monitoring (CWIQM) in 1997 indicated that 51.1% of clients were dissatisfied with public hospitals and facilities, and 53.7% were dissatisfied with community Health Centers because of low quality services they rendered (Yeboah, 2014).

In addition, customer satisfaction is a key ingredient to the success of any business. It is the most important factor that creates loyal customers.

Many government healthcare facilities have downplayed the importance of customer care and this had negatively affected the image of such facilities (Boadu, 2011). If customers are satisfied with goods or services an organization offers, chances are that they will patronize more of their products, which will increase sales revenue and profitability. Accordingly, an improvement in service quality leads to customer satisfaction and loyalty as well as enhancement of corporate image. In the long run this impacts how the organization can effectively compete and succeed in an increasingly competitive environment (Boadu, 2011).

In the present healthcare environment, when competition has become quite keen, customer care and satisfaction have become the prime concerns of each and every healthcare facility. In contemporary time, companies are increasingly becoming customer focused. Satisfying the needs and wants of customers more efficiently and effectively enable them to secure a higher market share, increase sales, sales revenue and profitability as well as improve corporate image (Peprah, 2014).

When not satisfied, patients will eventually turn to other healthcare providers who will meet their needs. Poor customer care and satisfaction in this perspective are the leading indicators of future decline or growth of a healthcare facility. There is obviously a strong link between customer satisfaction and retention in the healthcare delivery system (Peprah, 2014). That is why many organizations are attempting to obtain increased customer satisfaction by focusing on the quality of their products and deliveries to consumers and customers.

Customer care and satisfaction and for that matter marketing relationship are relatively new concepts to many government healthcare institutions (Boadu, 2011). For years these institutions widely believed that their consumers who are mainly patients were the ones who needed their services and not the health facilities which needed the patients to stay in business. But now, healthcare institutions are beginning to recognise that the national health insurance scheme has made healthcare delivery quite competitive and institutions cannot survive without clients (Boadu, 2011).

Satisfaction with the hospital experience is a complex and multifactor phenomenon which incorporates but not limited to relationships with medical personnel, physical surroundings and/or the healthcare organization itself (Johansson, Oleni, & Fridlund, 2002; Findik, Unsar & Sut, 2004). Patient satisfaction is also considered a focal concern of quality assurance. It can serve as an outcome measure of the quality of health care and provides a consumer perspective that can contribute to a complete, balanced evaluation of the structure, process and outcome of services (Wagner & Bear, 2009).

According to Merkouris, Infantopoulos, Lanara, and Lemonidou (1999), the first study of patient satisfaction in nursing occurred in 1956. Assessment of patient satisfaction was viewed by the authors as vital and necessary in modern health care due to rising costs and the need for resourcefulness and efficiency in processes of health care delivery. Patient satisfaction was viewed as a significant and valid measure of efficiency in health care delivery. Patients were often active and discerning consumers capable of rendering opinions regarding care received. Satisfaction with health care was further viewed as a determinant of patient compliance and

subsequent health status outcome. For the provider satisfaction with health care was viewed as instrumental to attracting and maintaining patients within the competitive health care arena. Data generated from patient satisfaction surveys can provide scientific basis, much more compelling than mere tradition, upon which to effect positive changes within the health care sector.

Patient satisfaction levels are used by a number of health care credentialing bodies as a measure of care outcomes. Other than morbidity and mortality measurements, patient satisfaction is the most frequently measured health care outcome (Kilbourne, Keyser & Pincus, 2004). Patient satisfaction determinants frequently include individual expectations, subjectivity, and perceptions. Amid multiple theoretical definitions that have been proposed to operationalize the concept, a lack of consensus regarding the concept's specific defining elements currently exists.

The Ghana Health Service as part of its re-organization processes has taken some proactive measures by introducing important regulatory documents like code of ethics for staff, patients' charter, code of conduct and disciplinary procedures for staff (GHS, 2009). These are all attempts to address the perceived poor consumer care and satisfaction in public healthcare facilities. In spite of these measures and media criticisms, the attitudes of some health workers towards patients and fellow health workers are often negative. Patients and other clients often complain about poor quality of services in public healthcare facilities. These complaints are mostly centered on poor consumer care, unhealthy hospital environment, and apathy of health service providers.

The Ministry of Health (MOH) in Ghana has been concerned about quality of care, but improvements in quality have been slow partly because quality improvement activities have received inadequate priority (Doyle & Haran, 2000). There have been efforts to research into quality of healthcare and institutionalization of quality assurance in Ghanaian health facilities. These were initiated through a project from 1993–1996 and then 1998–1999 in the Upper West Region and some facilities in Eastern and Volta Regions (Doyle & Haran, 2000; Haran, Dovlo, & Offei, 1994). There continue to be complaints about the quality of care given by health workers or received by clients. Poor quality of healthcare results in loss of customers, lives, revenue, material resources, time, morale, staff, recognition, trust and respect (Bannerman, Offei, Acquah & Tweneboa, 2002) and in individual and communities' apathy towards health services, all of which contribute to lowered effectiveness and efficiency.

The MOH has identified improving the quality of healthcare as one of its five key objectives of health sector reforms in Ghana. It envisages that quality of care might be improved through paying more attention to the perspectives of clients, improving the competencies and skills of providers and improving working environment by better management, provision of medical equipment and supplies and motivation of staff (Ministry of Health, Ghana, 2002). It has been suggested that if health programs are to succeed in resource-poor countries, it is important to get the opinions of the local people in addition to their degree of satisfaction with available services (Newman, Gloyd, Nyangezi, Machabo & Muiser, 1998).

Patient satisfaction with care received is an essential criterion by which patients assess quality of medical care received. The new global trend in health care development requires the integration of subjective user satisfaction into the evaluation of medical service. Client satisfaction cannot be overlooked in any country and for that matter in Ghana. It is in line with this that the researcher sought to assess patient satisfaction level with the quality of care provided by the selected health facilities.

Statement of the Problem

A wealth of knowledge and experience in enhancing the quality of health care has accumulated globally over many decades. In spite of this wealth of experience, the problem frequently faced by policy-makers at country level in both high- and low-middle-income countries is knowing which quality strategies complemented by and integrated with existent strategic initiatives would have the greatest impact on the outcomes delivered by health systems (WHO, 2006). Increasingly, health care stakeholders such as governments, health authorities and consumers are attaching importance to health care quality (Lapsley, 2000; Smith et al., 2006). Patients' satisfaction has gained increased recognition as essential component in the evaluation of health care quality (Derose, Hays, McCaffrey & Baker, 2001).

Monitoring and evaluating patients' satisfaction with health care is crucial to improving the quality of the health system as well as providing feedback for health care professionals and policy makers (Bara et al., 2002). In fact, it has been suggested that patient satisfaction is a major quality outcome in itself (Derose et al., 2001). The extent to which health care users are satisfied with their local providers may be a key factor underpinning their

health behavior and health care utilization (Rakin et al. 2002). The health care system is basically a service based industry and customer satisfaction is of utmost importance just as in other service oriented sectors (Turhal, Efe, Gumus, Alivastagolu & Sengoz, 2002). In response, many organizations are directing strategies towards increasing customer satisfaction through improved service quality.

Despite the efforts by the Ghana Health Services, the government, donor funding agencies and other stakeholders to improve the quality of health care in Ghana, there is still perceived unsatisfactory services rendered by the staff of hospitals. Areas frequently reported about include care and treatment, relationship between patients and care givers, patients' consent and confidentiality, sanitation of working environment, access to basic information about their rights as constantly reported by the media.

In addition, the establishment of a medical school and a teaching hospital has attracted a lot of specialist doctors into the metropolis. Most of these doctors have set up their private practices. This trend has increased the options available to patients in the metropolis, hence, competition and the need to satisfy patients. It is in the light of this that the researcher decided to undertake this study to assess the level of satisfaction of patients who utilized the selected health facilities in the Central Region of Ghana.

Purpose of the Study

With patient satisfaction and quality of care being a topic of discussion for consumers and other stakeholders of health care, the purpose of this research is to assess the satisfaction level of patients who utilize both in-

patient and out- patient services provided by the selected health facilities with regards to the quality of care.

Objectives of the Study

The study objectives were:

1. To assess patients' level of satisfaction with services provided at the selected hospitals.
2. To determine predisposing factors that influence patient satisfaction.
3. To determine enabling factors that influence patient satisfaction level.
4. To determine need factors that influence patient satisfaction level.
5. To assess the quality of care provided by the selected health facilities

Significance of the Study

The outcome of this study will help managers of the facilities (University of Cape Coast Hospital, Ewim Polyclinic and Cape Coast Metropolitan Hospital) in diverse ways. The study will reveal system weaknesses and managers will address them accordingly. When the identified system weaknesses are addressed by managers' patient satisfaction scores will be higher and with that patients will maintain a consistent relationship with these service providers thereby ensuring better and quality care and more patients will also be attracted to these hospitals based on the good recommendations from existing patients. The recommendations that have been given will be an evidence based source of reference for the hospitals to improve quality of health care services. It is also expected that the outcomes of this research will help all stakeholders of the facilities used for the study

understand better the importance and benefits of quality of health care services and satisfaction in the growth and development of their hospitals. Again, the outcome will help policy makers to formulate policies that will benefit the facility. To crown it all, it is expected that the outcome of this research will serve as a guide for quality assurance purposes.

Organisation of the Study

This study discusses the elements that constitute quality of health care and satisfaction in the healthcare delivery system and how to improve it and other related issues. The study is organised into five chapters. Chapter one deals with the background of the entire study. It traced the events and examined the issues which provided the background to the study. Chapter two presents detailed review of relevant literature on the subject. It also examined the various theoretical issues and dimensions of the topic in relation to what other researchers and authorities have done to advance academic literature on satisfaction and quality care.

Chapter three of the study, looks at the methodologies used in the study. The main areas covered in this chapter include research design, research population, sampling methods, data collection instruments and data analysis methods. Chapter four looks at the results and the analysis. It also includes discussion of important findings Vis a Vis the literature. Chapter five concludes the entire study by presenting its findings and draws conclusions and recommendations for implementation.

Delimitation

The study was carried out in only three selected health facilities (Cape Coast Metropolitan Hospital, University of Cape Coast Hospital and Ewim Polyclinic) within Cape Coast Metropolis. Although the issue of patient satisfaction and quality health care is a national concern, this academic work was carried out only in Cape Coast Metropolis in the Central Region.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents a review of literature related to the study. The information was gathered from data bases such us: Medline, EBSCOhost, PubMed Central, Hinari, Emerald, Google Scholar and CINAHL. The main key words which were used in the search were quality of care and patient satisfaction. The studies were selected by titles and full text with a special focus on studies relevant to sub-Saharan Africa and more specifically Ghana. All searches were restricted to studies published in the English language. In addition, this chapter presents the conceptual framework for analyzing patient satisfaction

Patient Satisfaction with Health Care Delivery

There is no consensus in literature on how to define the concept of patient satisfaction in healthcare. In Donabedian's 1966 quality measurement model, patient satisfaction is defined as patient-reported outcome measure while the structures and processes of care can be measured by patient-reported experiences (Oyvind, Ingeborg & Hilde, 2011). Many authors tend to have different perceptions of definitions of patient satisfaction. Jenkinson, Coulter, Bruster, Richards & Chandola, (2003) and Iftikhar, Allah, Shadiullah, Habibullah, Muhammad, Muhammad, (2011) pointed out that patient satisfaction mostly appears to represent attitudes towards care or aspects of care. While Rama and Kanagaluru, (2011) referred to patient satisfaction as patients' emotions, feelings and their perception of delivered healthcare services. Other authors defined patient satisfaction as a degree of congruency between patient expectations of ideal care and their perceptions of real care

received (Iftikhar, Allah, Shadiullah, Habibullah, Muhammad & Muhammad, 2011).

In addition, there is no exact definition of patient satisfaction because it depends on several factors. The main problem is that some patients are satisfied with one factor while the others are not. However Linder-Pelz (1982) suggested the definition of patient satisfaction through content analysis of the satisfaction studies in which five psychological variables (occurrence, value, expectation, interpersonal comparisons, and entitlement) were proposed to be probable determinant of satisfaction in health care services.

- Occurrence: The outcomes of a result taking place and importance of the individual perceiving what has occurred.
- Value: Judgment of the quality perceived as good or bad or features of health care encounter as considered by the customer.
- Expectation: Patients belief that certain attributes might be attached to an object and judging importance of those attributes are the building blocks of satisfaction.
- Interpersonal comparisons: Evaluation of the individual experience of current health care encounter with what he/she has experienced previously.
- Entitlement: The individual thinking that he has a solid and sound basis for claiming a particular result. By evaluating these attributes patient satisfaction definition becomes the individual positive evaluation of distinct dimensions of health care (Linder - Pelz, 1982).

Whenever the customer is pleased with either the product or the service then it is considered as satisfaction. Sixam et al. (2008) explained

satisfaction as the state of pleasure or contentment with an action, event or service. It is determined considerably by the expectations of customers and their experiences. Oliver (1981) saw satisfaction as clients' emotional feelings concerning a particular consumption experience. By this, Oliver meant that satisfaction was a consequence of a mental assessment and evaluation of what clients experienced and the resulting outcome of the services provided. This therefore, implies that perceived service quality is considered as a cognitive construct. At the same time satisfaction is an affective reaction to a specific service experience as a consequence of an evaluation process (Peprah & Atarah, 2014). Kotler (2003) advanced a discussion that explained satisfaction as a person's feelings of happiness or displeasure as a result of comparing a product's outcome in relation to his or her expectations.

Satisfaction can be derived as happiness achieved from the consumption of goods or services offered by a person or group of people or it may be state of being happy with the situation. Sometimes it becomes very difficult to satisfy everyone or determine satisfaction among groups of individuals because people have different perceptions and expectations.

Satisfaction is similar to the other psychological words that are easy to understand but difficult to explain. The idea of satisfaction is similar to themes such as happiness, contentment, and good quality of life. Satisfaction is not the phenomenon waiting to be measured by people but is a judgment of people over a period of time as they reflect on their experiences (Irish society, 2003). “A simple and practical definition of satisfaction would be the degree to which desired goals have been achieved” (Irish, 2003 P.10). Satisfaction can be said

to be a positive response of individuals to a specific focus (consumer experience) that is determined at a particular time (Shemwell et al., 1998).

Researchers from the Centre for the Study of Social Policy in the United States of America (2007) stated that satisfaction is based on the customer's experience of both contact with the organisation and personal outcomes. According to these authorities, satisfaction can be experienced in a variety of situations and connected to both goods and services.

Customer satisfaction is generally described as the full meeting of one's expectations in a product. It is therefore the feeling or attitude of a customer towards a good or service after it has been used. At another level, customer care and satisfaction are described as a highly personnel assessment that is greatly influenced by individual expectations.

Brady and Robertson (2001) conceptualized customer satisfaction as an individual's feeling of pleasure or disappointment resulting from comparing a product's perceived performance or outcome to his or her expectation. Expectations are what the customer wants or requires from the product or service and perceived performance is the perception of the customer about the product or service before consumption. It is therefore an evaluation of the product or service after using it.

According to Pizam and Ellis, (2009), consumer satisfaction is a psychological state that involves the feeling of well-being and pleasure that results when obtaining what is expected from a product or a service. For Churchill and Surprenant, (2008) consumer satisfaction was the result of purchase and use of a product, which derives from the comparison between reward and the cost of the purchase considering anticipated consequences.

Westbrook, (2003) defines satisfaction as an emotional response to the experiences associated to products or services. Some authorities perceive consumer satisfaction process as subjective on the expectations, but objective on the product or results perceptions.

According to Woodruff and Gardial (2001), it has become more and more evident that it is important for consumer satisfaction measurement to capture not only the perception, but also the consumer's emotion. The greater the emotion (positive and negative) caused by the goods and services, the more motivated the consumers will be in terms of future behaviour, such as repeated purchase or complaints. For evaluating and making improvement in quality of health care, it is required to investigate the quality of care in the context of health care. Patient satisfaction is the substantial indicator in the health care. For this purpose, quality of work includes investigations that map out the patient satisfaction with several factors (Johansson, Oleni, & Fridlund, 2002).

Patient satisfaction is used as performance of measurement by different hospitals, principally on instrumental grounds such as adhering to treatment, recommendations and maintaining continuity of care (Thom et al., 2004). Different professionals influence patient satisfaction. Health care practices are considered as the key factor in patient assessment of satisfaction. Patient satisfaction assessment is important not only for patients but also for the health care organization as well (Johansson et al., 2002). Patient satisfaction is fundamentally a subjective judgment that results from the appraisal of health care experience and involves the explicit and implicit comparison of the actual events with the expectation of the individuals. Patient satisfaction shows the

degree to which the individual's actual experience matched with the preferences regarding their experience. Patient satisfaction is not only the judgment at the end of the care but also essential for the initial treatment decision for the future (Brenan, 1995).

Parasuraman et al. (1985) explained satisfaction in relation to service quality. They argued that service quality is defined as the gap between predicted or expected service (customer expectations) and perceived service (customer perceptions). If customers' expectation were greater than performance, then perceived quality was regarded less than satisfactory and a service quality gap arose. This in effect does not necessarily mean that the service is of low quality but rather customer expectations have not been met and therefore customer dissatisfaction occurred. This presents opportunities for improving service to meet customer expectations.

Satisfaction has been shown to predict important health-related behaviour, such as adhering to treatment recommendations and maintaining continuity of care. The findings of research conducted by Mehta, (2011) suggested that service quality and satisfaction level of patients will be important for improving the outcomes in health care settings. Working on patient satisfaction with health care is important for so many reasons. First and foremost, satisfied patients are more likely to maintain a consistent relationship with a specific provider. Secondly, by identifying sources of patient satisfaction, an organization can address system weakness thus improving its risk management. Thirdly, satisfied patients are more likely to follow specific medical regimen and treatment plans. Lastly, patient

satisfaction measurement adds important information on system performance, thus contributing to an organization's total quality management.

Stemming from these reviews, customer satisfaction is described as the result of a cognitive and affective evaluation, where some comparison standards are determined and compared to the actually perceived performance. If it happens that the expected performance exceeds perceived performance then, customers become dissatisfied. On the other hand, if the expectation is more than perceived performance, customers are happy and satisfied. Otherwise, when the perceived performance equals to expectations, customers are neither satisfied nor dissatisfied creating what can be termed as indifferent or neutral stage.

Determinants/Dimensions of Patient Satisfaction

A number of studies have reported that patient's satisfaction is influenced by a number of factors. According to Peprah (2014), the following factors play a critical role in the satisfaction of patients; the attitudes of nurses toward patients, the capacity to deliver prompt service without wasting time, ability to disseminate information to patients, and the availability of up-to-date equipment. Other factors included the hospital's ability to render 24 hour service, the patience of the doctor to clearly explain what was wrong with patients before giving treatment, providing patients with detail information about their medication, and attractiveness and cleanliness of the hospital.

Various dimensions of patient satisfaction have been identified, ranging from admission to discharge services, as well as from medical care to interpersonal communication. Well-recognized criteria include responsiveness, communication, attitude, clinical skill, comforting skill,

amenities, food services, (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003). It has also been reported that the interpersonal and technical skills of the health care provider are two unique dimensions involved in patient assessment of hospital care (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003).

Determinants of patient's satisfaction have been reported extensively. According to previous studies, patient characteristics such as age and education may influence a patient's assessment of hospital performance (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003). A patient's health status and the severity of illness are also important predictors of the patient's overall satisfaction level (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003).

Mannerman, et al. (2006) as cited in Boadu (2011) asserted that the ultimate expectation of consumers and their relations is to be satisfied with services rendered by healthcare institutions, and also to get well soon. Mannerman, et al. (2006) as cited in Boadu (2011) argued further that customer satisfaction is based on factors such as: affordable fee, promptness of attention, good staff attitude, respect for patients and their rights, providing privacy and confidentiality, providing adequate information, availability of drugs and logistics, and above all a healthy and clean environment.

Hospital features such as hospital size have been reported to be associated with consumer assessment of hospital quality (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003). The relationship between health care providers and patients (i.e. interpersonal skill) has been reported to be the most influential factor for patient satisfaction (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003) however, the findings were not totally conclusive (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003).

Burroughs, Davies, Cira and Dungan (1999) reported that, of the different settings of health care services (i.e. inpatient care, outpatient surgery, outpatient test/treatment, and emergency care), compassionate patient care, including personal attention, respect, and comfort were the most important factors influencing a patient's intention to recommend a provider or for that patient to return to the same provider in the future. Their findings are in agreement with previous reports indicating that patient's satisfaction is determined mainly by a provider's attitude and caring rather than technical skills (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003). Nevertheless, Shou-Hsia, Ming-Chin, and Tung-Liang, 2003 also found that physician care delivery (such as skill, frequency of checking, and explanation) was not associated with patient's recommendation or return.

Boudreaux, Ary, Mandry, & McCabe, (2000) analysed a small sample of 437 emergency department patients and reported that overall patient's satisfaction and the likelihood of recommendation were influenced by different factors. They found that respect, safety, and understandable instructions were common factors associated with satisfaction and recommendation. On the other hand, the technical skills of nurses and waiting time were associated with recommendations only. Patient's age and insurance status were associated with satisfaction only. Patient satisfaction was predicted by factors relating to caring, empathy, reliability, and responsiveness (Tucker & Adams, 2001). Other dimensions have been introduced to capture patients' healthcare evaluations (Fowdar, 2005), including: core services; customization; professional credibility; competence; and communications.

Naidu, (2009) identified other primary patient satisfaction determinants: admissions; discharge; nursing care; food; housekeeping; and technical services. Patients' perceptions, notably about physician communication skills are also significant satisfaction determinants.

Boadu (2011) also asserted that in the healthcare delivery sector, the factors which largely affect customer care and satisfaction are quality services, waiting time, behavior of doctors, availability of specialists, behavior of other clinical staff and assistants, clean environment. Powers and Bendall-Lyon (2003) determined that more highly satisfied patients tended to view their health status more positively. These individuals were also more likely to return for follow- up appointments. Multiple factors and aspects of care within the health care arena ultimately determined an individual client's opinion regarding satisfaction with services rendered. Of those factors interpersonal communication was often the most important determinant of satisfaction, demonstrating the importance of patient education, communication, and feedback in the delivery of health care. The amount of time required by patients to wait before seeing a health care provider was found to be inversely correlated with overall satisfaction. In a study involving subjects who were randomly assigned to groups either receiving or not receiving health education in the waiting room, Oermann, Masserang, Maxey, and Lange (2002) found that patient education delivered in the waiting room had no effect on overall satisfaction, but did result in increased satisfaction regarding health education received. Cole, Mackey, and Lindenberg (2001) conversely found no statistically significant relationships between wait times and patient satisfaction in a nurse practitioner clinic.

Satisfaction has also been demonstrated to vary and be affected by type of health insurance plan. Dellana and Glacoff (2001) concluded differences among health care consumers' satisfaction levels on the constructs of access to care, availability of resources, and financial aspects of care according to type of health insurance plan. Zoller, Lackland, and Silverstein (2001) demonstrated through multiple regression analysis that waiting time and understanding of explanations provided by health care providers were the only items which were statistically significant predictors of patients' intent to return for follow-up clinic visits. Patient satisfaction was additionally found to be influenced by the amount of time spent with the health care provider.

Satisfaction was also demonstrated to increase by chatting briefly about non-medical topics and allowing time for questions. Beach et al. (2004) stipulated that satisfaction varied by health care specialty. Self-disclosure by primary care physicians was demonstrated to have a negative effect on patient satisfaction, while self-disclosure by surgeons resulted in increased satisfaction (Beach et al. (2004)

Knudtson, (2000) examined the level of patient satisfaction with nurse practitioner services in a rural clinical setting in an effort to examine relationships between patient satisfaction, patient demographic characteristics, expectations of services, and the likelihood of patients to recommend nurse practitioner services to others. Significantly high levels of patient satisfaction with care delivered by nurse practitioners were demonstrated. In particular, clients were satisfied with the interpersonal aspects of nurse practitioner provided care. Other statistically significant indicators of patient satisfaction included younger age and higher educational levels of patients. In a separate

study of nurse practitioner acceptance in the rural setting, Baldwin et al.(2001)concluded that patients exhibited favorable acceptance of nurse practitioners and physician assistants when they worked in collaboration with physicians, functioned as coordinators of care, and made an effort to integrate into the community.

Safran et al. (1998) examined the relationship between primary care performance and clinical care outcomes of physicians. The study examined the relationships between clinical care accessibility, continuity, comprehensiveness, integration, clinical interaction, interpersonal treatment, trust with outcomes such as adherence to physician's advice, patient satisfaction, and improved health status. Results demonstrated that trust was the variable most strongly associated with patient satisfaction. Additional positively correlated variables to patient satisfaction included communication and personal knowledge of the patient. Phillips, Palmer, Wettig, and Fenwick (2000) demonstrated that higher education, higher income, and younger age were significant predictors of patient satisfaction.

In a retrospective observational study over a four-year time period, Roblin, Becker, Adams, Howard, and Roberts, (2004) reviewed over 41,209 responses from patients regarding level of satisfaction with care received. The researchers measured satisfaction at three levels; practitioner interaction, care access, and overall experience and concluded that patients in an outpatient health maintenance organization were significantly more satisfied with practitioner interaction during care delivery by physician assistants and nurse practitioners than by physicians. Patients reported higher satisfaction with interactions by nurse practitioners and physician assistants than by interactions

with physicians. Satisfaction with care access and overall experience did not differ significantly by type of practitioner in the study. For all practitioner types on all three scales, increased satisfaction was associated with visits by older males, hypertensives, and asthmatics. In the study a significant proportion of the variance in patient satisfaction was determined to be related to time spent with the practitioner and the accommodation of requests for visits with specific practitioners rather than type of practitioner actually present at the health care visit. Hooker, Potts, and Ray (2001) also found no difference by provider type, age, gender, and length of employment in a Kaiser Permanente study of physician assistants, nurse practitioners, and physicians, concluding that patient satisfaction depended on communication style and not on provider.

Greeneich, (2005) found that 35% of the variance in patient satisfaction could be attributed to nurse practitioner practice and personality characteristics. Differences in patient satisfaction also varied by the number of health care visits experienced by patients.

Measurement of Patient Satisfaction (Tools and Strategies)

Across the United States of America and Europe, consumer satisfaction is playing an increasingly important role in quality of care reforms and health-care delivery (WHO, 2009). However, consumer satisfaction studies are challenged by the lack of a universally accepted definition or measure (Sofaer & Firminger, 2005) and by a dual focus: while some researchers focus on patient satisfaction with the quality and type of health-care services received (Jackson, Chamberlin & Kroenke, 2001) others focus on people's satisfaction with the health system more generally (Blendon,

Leitman, Morrison, & Donelan, 2000). The importance of both perspectives has been demonstrated in the literature. For example, satisfied patients are more likely to complete treatment regimens and to be compliant and cooperative (Stewart & Roter, 2003).

The absence of a solid conceptual basis and consistent measurement tool for consumer satisfaction has led, over the past 10 years, to a proliferation of surveys that focus exclusively on patient experience, i.e. aspects of the care experience such as waiting times, the quality of basic amenities, and communication with health-care providers, all of which help identify tangible priorities for quality improvement. In the past, measures of patient experience, intended to capture the “responsiveness” of the health system, (Valentine, De Silva, Kawabata, & Darby, 2003) a concept developed by WHO, are likely to receive even greater attention as physicians and hospitals come under growing pressure to improve the quality of care, enhance patient safety and lower the cost of services. Health system responsiveness specifically refers to the manner and environment in which people are treated when they seek health care.

A critical aspect in the patient satisfaction’s measurement is that models and instruments sometimes reflect the providers’ perspective rather than the patients’ one (Calnan, 2001). For example, the patient capability to evaluate health services and professionals’ skills is frequently questioned (Rao et al, 2006), even when these items receive high satisfaction rates. According to Hopkins et al. (1994) patients are less capable of judging technical competence because of a real informative asymmetry and in any case they are more reserved in expressing critical comments with regard to the abilities of

doctors. As a consequence, the high satisfaction scores observed may depend on the confidence in doctors' capabilities.

Coulter, (2006) argued that well designed questionnaires allow to assess both the technical competence and interpersonal skills of health professionals. The patient satisfaction measurements have been generally used in order to provide researchers, health managers and professionals with valuable information for understanding patients' experience, promoting patient's compliance with treatment, identifying the weaknesses in services and evaluating health service performance (Sitzia & Wood, 1997). In fact, a satisfied patient is more aware of his care pathway and more willing to follow the physician prescriptions. As said before, the level of satisfaction depends on several and different elements. For instance, healthy people tend to be more satisfied when they receive general information on health services and on their quality; on the contrary, people with a chronic condition may be more satisfied if involved in the decision-making process (Cleary, 1997). Thus, the improvement of patient compliance requires adopting different actions depending on the patient's profile.

The assessment of patient satisfaction with the process of care is an important measure of the care quality and it allows identifying the phases of the process to be improved. Questionnaires using report style questions allow observing how the care is delivered (Wensing et al, 2003; Leeper et al, 2003). Some studies have highlighted that satisfaction strongly increases when care is provided in accordance with the clinical standard procedures (Lantz et al, 2005; Marchisio et al, 2006).

Furthermore, the patients' point of view may help managers to evaluate activities such as the purchase of new technologies or the test of new medical treatments (Ahmad et al, 2008; Van Koullil et al, 2009).

Basically, there are two approaches for evaluating patient satisfaction-qualitative and quantitative. The quantitative approach provides accurate methods to measure patient satisfaction. Standardized questionnaires (either self-reported or interviewer-administrated or by telephone) have been the most common assessment tool for conducting patient satisfaction studies (Lin, 2002; Jose et al. 2006).

There is a great variation in questionnaires as instruments of measuring patient satisfaction. The spectrum includes: instruments provided by private vendors, which are usually not published and their reliability and validity are not clear. Secondly, there are quite a number of publically and standardized instruments such as patient satisfaction questionnaires; PSQ-18 and consumer assessment health plans (CAHPS). Such instruments have the advantage of good reliability and validity; however, offer limited scope of survey questions (Aerlyn, & Paul, 2003). Thirdly, internally developed instruments which are mainly generated entirely de novo or import questions from other existing standardized instruments (Aerlyn, & Paul, 2003). A survey conducted in 16 academic medical centers across the USA in 2002 to determine the type of patient satisfaction instrument that was used at each center established that the majority of institutions use an internally developed instrument for outpatient satisfaction, while they used private vendor's instruments for inpatient satisfaction. Patient satisfaction measurement tools should be reliable and

valid in order to precisely function and to realize the main goal of collecting patient's feedback (Lin, 2002).

Another large survey conducted in major acute care hospitals in five countries (United Kingdom, USA, Sweden, Switzerland and Germany) to determine the applicability and relevance of short form questionnaire (PPEQ-15) from Picker Patient Experience Questionnaire for inpatient experience concluded that PPEQ -15 demonstrated a high correlation of selected items, high consistence validity across countries and a high association of the gold standard (Jenkinson, Coulter, & Bruster, 2002).

On the other hand, Yellen, Gail & Richardson, (2002) and Kilbourne et al. (2004) declared that based on many standardized, validated patient satisfaction instruments which have been developed primarily to assess patient satisfaction with specific aspects of care, these have little potential of validity and reliability in other settings of care. Therefore, selecting an appropriate patient satisfaction instrument is a critical challenge for healthcare organizations.

One critical literature review on survey instruments and other existing studies ascertained that the plethora of survey instruments measuring patient satisfaction in healthcare industries is heartening; however, core instruments need to be standardized and there needs to be centralized uniform information collection (Yellen, Gail & Richardson, 2002). Instruments used for measuring patient satisfaction therefore need to be standardized.

Service Quality

Customers usually visit organizations to benefit from the services provided. The intangible nature of a service makes defining its quality very difficult. Also, since service is experienced, perceptions can be highly subjective. Boadu (2011) asserted that customers, however, make inferences about the service quality on the basis of tangibles such as the buildings, the physical layout etc. that surround the service environment. Support for this argument comes from Wakefield and Blodgett (2009) as cited in Boadu (2011) that empirical evidence suggesting that the tangible, physical surroundings of the service environment can have a significant impact on customers' affective responses and their behavioural intentions. Dabholkar et al. (2003) reported of similar findings that go to buttress the point that the tangible aspects of service delivery organizations do influence customers' perceptions of service quality. Hence, there are reasonable grounds to assume that customer satisfaction is also related to customers' evaluation of physical surroundings of the service environment.

Service can be defined in many ways depending on which area the term is being used. Kotler and Keller (2009, p. 789) defined service as “any intangible act or performance that one party offers to another that does not result in the ownership of anything”. Service can also be defined as an intangible offer by one party to another with mutual consideration for pleasure. Consumers are mostly attracted towards a service by focusing on quality (Solomon, 2009).

Boadu (2011) argued further that in addition to the intangible factors, quality of services is often defined by perceptual factors which include

responsiveness to customer needs, courtesy and friendliness of staff, promptness in resolving complaints, and atmosphere. Other dimensions of quality in service delivery include time, which is the amount of time a customer has to wait for the service; while consistency is the degree to which the service is the same each time. For these reasons, defining quality in services can be especially challenging Boadu (2011).

Kotler et al., (2002) defined quality as the total features and characteristics of a product or services that bear on its ability to satisfy stated or implied needs. It is clear that quality is also related to the value of an offer, which could evoke satisfaction or dissatisfaction on the user's part. "A simple definition of quality in health care is the art of doing the right thing, at the right time, in the right way, for the right person – and having the best possible results" (Zineldin, 2006, p. 66).

According to Parasuraman et al. (1988) service quality is "the differences between customer expectations and perceptions of service". Among health care researchers the greatest consensus has been achieved on the definition provided by Institute of Medicine (IOM): "quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Lohr, 1990, p. 21). Organizations are now more focused on quality services and the aim is to satisfy customers. Measuring service quality to identify the difference between perceived and expected service is a valid way and enables the management to find gaps in the services they offer. In order to know whether customer's "will" is fulfilled or satisfied, organizations need to measure the service quality, a better way to understand

service quality in the context of customer satisfaction. A researcher listed in his study: “three components/dimensions of service quality, called the 3 “Ps” of service quality” (Haywood, 1988, p. 19). The author explained in the study, service quality is comprised of three elements (physical process, people’s behavior, professional judgment).

Dimensions of Quality

Parasuraman et al. (1991) initially developed ten dimensions and later categorize it into five dimensions. The earlier ten service quality dimensions developed by Parasuraman et al, 1985 are as follows:-

- i. Reliability: the service is carried out in the way it is promised
- ii. Responsiveness: services are carried out promptly according to the needs of the customers
- iii. Competence: the staff of the service provider have the knowledge and skills required for delivering the service in a proper way
- iv. Access : concerns, e.g. opening hours, physical location, etc;
- v. Courtesy:- the staff are polite, friendly, respectful, etc;
- vi. Communication : keeping the customers informed in a language that they can understand and listening to them
- vii. Credibility: the service provider is trustworthy, believable and honest;
- viii. Security: freedom from danger, risk or doubt;
- ix. Understanding the customer: the service provider makes an effort to understand the needs and wants of the individual customers;
- x. Tangibles: physical objects that are needed for carrying out the service such as facilities, equipment, etc;

Through an empirical test, the authors later condensed the ten dimensions into five (Parasuraman and Berry, 1991; Zeithaml et al, 1990). The five dimensions are as follows:

- i. Tangibles: the physical facilities, equipment, appearance of personnel;
- ii. Reliability: the ability to perform the desired service dependably, accurately, and consistently;
- iii. Responsiveness: the willingness to provide prompt service and help customers;
- iv. Assurance: employees' knowledge, courtesy, and ability to convey trust and confidence; and
- v. Empathy: the provision of caring, individualized attention to customers

Gronroos (1988) identified six criteria of good perceived service quality.

- i. Professionalism and skill: customers see the service provider as knowledgeable and able to solve their problems in a professional way.
- ii. Attitudes and behavior: customers perceive a genuine, friendly concern for them and their problems.
- iii. Access and flexibility: customers feel that they have easy, timely access and that the service provider is prepared to adjust to their needs.
- iv. Reliability and trustworthiness: customers can trust the service provider to keep promises and act in their best interests.
- v. Recovery: customers know that immediate corrective action will be taken if anything goes wrong.
- vi. Reputation and credibility: customers believe that the brand image stands for good performance and accepted values.

Quality dimensions, according to Gronroos (1990), can be classified into three groups: technical quality, functional quality and corporate image. This is similar to those proposed by Lehtinen and Lehtinen (1991) that is physical quality, interactive quality and corporate quality. The dimensions associated with technical quality are those that can be objectively measured regardless of customers' opinion, while those concerned with functional quality are related to the interaction between the provider and recipient of the service and are often perceived in a subjective manner.

Dimensions / Components of Quality in Health Services according to Khan, (2014) can also be grouped into the following,

1. Availability & Appropriateness: The availability of a needed test, procedure, treatment or service to the patient in his needs. The degree to which the care / intervention provided is relevant and appropriate to the patient's clinical needs, given according to the current state of knowledge.
2. Access & Affordability: Everyone should have access to quality health care. Access refers to the ability of the individuals, to obtain health services. Some of the factors that can affect access are: a) Distance: e.g. If the access to quality health care may become a problem due to far distance. b) Financial: e.g. where people cannot afford the services. c) Culture, beliefs and values
3. Equity & Equality: Quality services should be provided to all people who need them in a similar & equal way. Quality services should be available in all parts of the country, in villages, towns and cities without difference regarding race, gender, age, religion, nationality, sects, political issues, affordability, physical appearance or any other group, etc.

4. Technical competence & Skills: Technical competence as an indicator of quality assurance implies that we there should be adequate knowledge and skills to carry out our functions in order to provide quality services. With respect to what one cannot do, it is expected to refer them to other centers or personnel who are more competent to handle it. The practice should also be followed by- Standard Treatment Guideline.

5. Timeless & Continuity : The degree to which the needed test, procedure, treatment, service, or healthcare intervention is provided to the patient, at the most beneficial or necessary time, and is coordinated among service providers and organizations. Continuity means that the client gets the full range of needed health services, and that when the case is beyond one level, the client is referred to the right level.

6. Safety & Reliability: The safety of the patient and staff. The degree to which the risk of an intervention and the risks in the care environment are reduced for the patient and others, including the healthcare provider. Safety means that when providing health services, measures should be in place to reduce to the barest minimum injuries, infections, harmful adverse effects and other dangers to clients and to staff.

7. Respect and Caring (Interpersonal Relations) : The degree to which the patient or a designee is involved in his/her own care decisions and to which those providing services do so with sensitivity and respect for the patient's expectations and differences. It refers to the relationship among all stakeholders. Health workers should show respect to their clients; feel for their patients; not be rude with them; not disclose information they get from them to irrelevant people. This all will bring about good relations and trust. Clients

consider good interpersonal relationship as an important component of quality of care.

8. Efficiency: The efficiency with which services are provided. The relationship between the outcomes (results of care) and the resources used to deliver patient care. Efficiency is the provision of high quality care at the lowest possible cost. Health workers are expected to make the best use of resources and avoid waste of scarce resources.

9. Effectiveness and Efficacy: The degree to which the care/intervention is provided in the correct manner, given the current state of knowledge, in order to achieve the desired/projected outcomes. Type of care that produces positive change in the patient's health or his/her quality of life. The use of treatments and procedures that are known to be effective with best possible efficacy in relation to the patient's condition.

13. Amenities: These are indirect features that can be provided by health facilities to make life comfortable and pleasant for clients. They contribute to clients' satisfaction and make clients willing to use services. For example, cleanliness, comfortable seats and beds, television sets media, educational materials & videos, indication signs, best possible general facilities and physical environment in the healthcare entity.

Quality improvement organizations recognize several distinct dimensions of quality that vary in importance depending on the context in which a performance measurement effort takes place. These dimensions or characteristics introduce a useful framework to help healthcare organizations define, analyze, and measure the extent to which they are meeting program standards for clinical care and management of healthcare delivery.

Most recognized quality measurement dimensions built on the six Institute of Medicine (IOM) Domains which are:

Effectiveness: Relates to providing care processes and achieving outcomes as supported by scientific evidence.

Efficiency: Relates to avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equity: Relates to providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Patient centeredness: Relates to meeting patient's needs and preferences and providing education and support.

Safety: Relates to actual or potential bodily harm.

Timeliness: Relates to obtaining needed care while minimizing delays

Similarly, in the World Health Organization 2006 policy document on quality of care, it suggested that a health system should seek to make improvements in six areas or dimensions of quality, which are named and described below.

These dimensions require that health care be:

Effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need.

Efficient, delivering health care in a manner which maximizes resource use and avoids waste;

Accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need.

Acceptable/patient-centered, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;

Equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;

Safe, delivering health care which minimizes risks and harm to service users.

Models of Service Quality

SERVQUAL model

Researchers measure the service quality dimensions by using SERVQUAL (service quality) model that is the most popular and strong tool (Parasuraman et al., 1985). It is also called gap model. SERVQUAL model was created by Parasuraman et al. (1985). There were 97 attributes put into ten dimensions (Parasuraman et al., 1985). Through these dimensions, one can measure customer satisfaction level regarding the quality of service of an organization. The findings were subjected to further investigation and concluded that, among these 10 dimensions, some were correlated. After some refinement, 10 dimensions were later reduced to 5 dimensions (Laroche et al., 2004).

- Tangibility: This dimension consisted of physical facilities, equipment, and appearance of personnel of an organization.
- Reliability: This dimension dealt with the ability to perform the promised service dependably and accurately by the organization.
- Responsiveness: This dimension focused on the willingness to help customers and provide prompt service

- Assurance: This dimension explained how knowledge and courtesy of employees and their ability to inspire trust and confidence.
- Empathy: This dimension defined how much of an individualized attention the firm provides to its customers.

By the above dimensions, quality of service can be improved and the customer satisfaction level can be increased. Service environment in the health-care industry is determined by not only technology and new facility support, but also the performance of employees in the organization. “Various methods and tools are used by medical administrators, researchers, and healthcare policy makers in an effort to find a better way to provide high quality of service” (Lee et al., 2011, p. 20). Health care organizations need to emphasize every single aspect/dimension of service quality and not only on technology, facilities, and support.

Patient satisfaction is a cumulative combination of different constructs, summing satisfaction with various facets of the health care organization (hospital), such as technical, functional, infrastructure, interaction and atmosphere variables or items (Zineldin, 2006).

Patient satisfaction regarding service quality is always dependent on different factors/dimensions and with the passage of time the factors/dimensions are explored by different researchers. Zineldin (2006) expanded technical-functional and SERVQUAL quality models into framework of five quality dimensions, consist of quality of Object, quality of Process, quality of Infrastructure, quality of Interaction and quality of Atmosphere. This model is now considered an effective model for health care providers in order to evaluate patient’s satisfaction.

Attribute Service Quality Model

This model states that a service organization has high quality if it meets customer preferences and expectations consistently (Haywood- Farmer, 1988). According to this model, the separation of attributes into various groups is the first step towards the development of a service quality model. In general, services have three basic attributes: physical facilities and processes; people's behaviour; and professional judgment. Each attribute consists of several factors. Too much concentration on any one of these elements to the exclusion of others may lead to disaster. For example too much emphasis on procedures may give an impression to the customer that he will be processed as per his sequence.

Haywood- Farmer (1988) tried to map different types of service settings as per degree of contact and interaction, degree of labour intensity and degree of service customization in to this model. For example services, which are low in terms of customers' contact customization and labor intensity (utilities, transportation of goods), are closer to physical facility and process attribute of the model. Thus, the model suggested that special care at this instant must be taken to make sure that equipment is reliable and easy for customer to use Haywood- Farmer, (1988).

Synthesised Model of Service Quality

A service quality gap may exist even when a customer has not yet experienced the service but learned through word of mouth, advertising or through other media communications (Brogowicz et al., 1990). Thus there is a need to incorporate potential customers' perceptions of service quality offered

as well as actual customers' perceptions of service quality experienced. The synthesized model of service quality attempts to integrate traditional managerial framework, service design and operations and marketing activities. The purpose of this model is to identify the dimensions associated with service quality in a traditional managerial framework of planning, implementation and control. The synthesized model of service quality considered three factors, viz. company image, external influences and traditional marketing activities as the factors influencing technical and functional quality expectations (Brogowicz et al., 1990).

Performance only Model

Cronin and Taylor, 1992 investigated the conceptualization and measurement of service quality and its relationship with consumer satisfaction and purchase intentions. They compared computed difference scores with perception to conclude that perceptions only are better predictor of service quality. They argued on the framework of Parasuraman et al. (1985), with respect to conceptualization and measurement of service quality and developed performance only measurement of service quality called SERVPERF by illustrating that service quality is a form of consumer attitude and the performance only measure of service quality is an enhanced means of measuring service quality. They argued that SERVQUAL confounds satisfaction and attitude. They stated that service quality can be conceptualized as "similar to an attitude", and can be operationalized by the adequacy-importance model. In particular, they maintained that Performance instead of "Performance-Expectation" determines service quality. Service quality is evaluated by perceptions only without expectations.

5Qs Model

Health care service quality is not only affected by the technical and functional activities of the organizations but some other factors researchers have ignored, play an important role such as interaction, infrastructure and atmosphere (Zineldin, 2006). Zineldin (2006) designed and developed a comprehensive model regarding patient satisfaction from health care providers, also called the 5Q model.

Q1. Quality of object – The technical quality (what customer receives) for example, relates to the clinical procedures carried out and it focuses on the technical accuracy of medical diagnosis and procedures. This dimension of service quality measures the treatment itself; the main reason of why a patient is visiting a hospital in the context of his very basic need and want (Zineldin, 2006).

Q2. Quality of processes – This dimension deals with the functional quality that how the health care organization provides the core service (the technical). This dimension measures how well activities of the health care are implemented practically. It includes waiting times by the patients and speed of performing the health care activities by the staff. Sensitive issues are attached to the health care industry so process indicators should receive more attention. These indicators can be used to identify problems in service delivery and to suggest specific solutions. Front-line nurses/physicians/managers can use process indicators to supervise/monitor activity at their facilities and to improve day-to-day decision-making (Zineldin, 2006).

Q3. Quality of infrastructure – This dimension of service quality measures the essential and basic resources that are needed to perform the health care

services. This includes many attributes such as the quality of the internal competence and skills, know-how, experience, motivation, attitudes, technology, internal relationships, internal resources and activities and most important how these activities are managed, cooperated and coordinated. Researchers found that technology infrastructure can play a vital role in patient satisfaction and it has become a revolutionary key factor practicing in health care organization.(Zineldin, 2006).

Q4. Quality of interaction – communication/interaction among the people is always difficult to deal with. It is not communication/interaction among the machines, accounting systems or trading agreements, which can do it effectively with each other in order to exchange values. This dimension of service quality measures the quality of information exchange (e.g., the percentage of patients who are informed when to return for a check-up, amount of time spent by physicians or nurses to understand the patient's needs, etc.), and social exchange, etc. Perceived quality of interaction and communication reflects a patient's level of overall satisfaction (Zineldin, 2006).

Q5. Quality of atmosphere – This dimension is concerned with the relationship and interaction process between the two parties is influenced by the quality of the atmosphere in a specific environment where they cooperate and operate. The atmosphere indicators should be considered very critical and important because of the belief that lack of frankly and friendly atmosphere explains poor quality of care (Zineldin 2006).

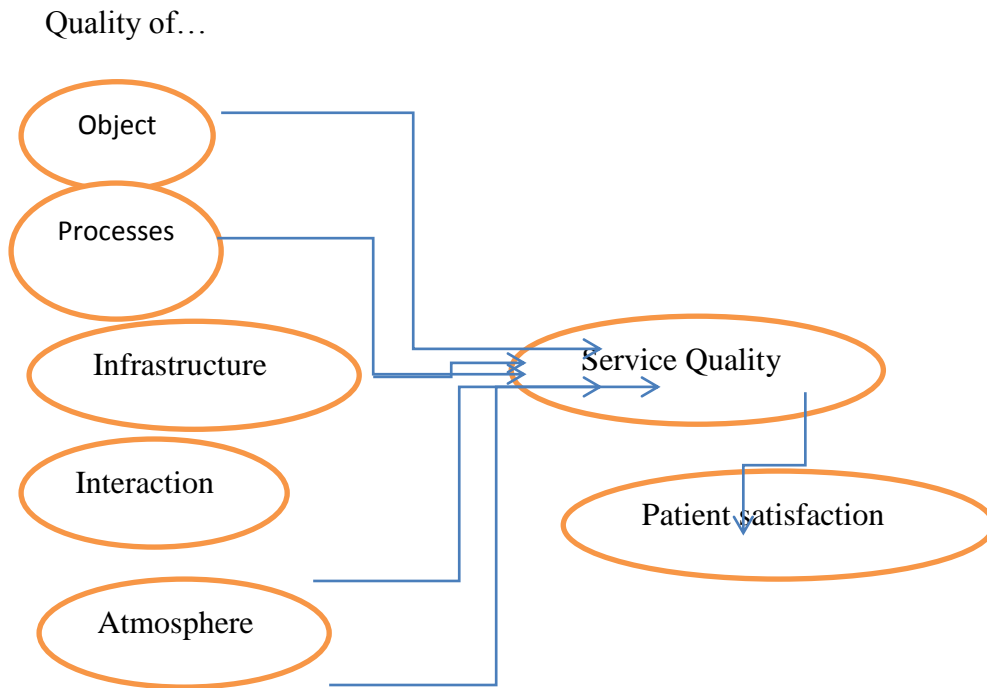


Figure 1: 5Q model (Zineldin, 2006)

Figure 1 illustrates the 5Qs model and its constructs, where the service quality of a health care is a function of Q1-Q5. The model consists of 5 dimensions of service quality, all together 5 dimensions result in health care service quality which can affect the level of patient satisfaction (Zineldin, 2006). According to Zineldin, all the dimensions are functions of service quality, which leads the patient to satisfaction.

Empirical Review

In today's fast-paced, complex and highly regulated health care environment, it is essential to achieve patients' recovery as rapidly as possible so that ultimately with full satisfaction patients leave the hospital (Sharma, 2013). In light of this, research into areas of patient satisfaction cannot be overlooked by stakeholders of the health care industry as it becomes imperative to research into factors that influence their consumers (patients)

satisfaction. In the increasingly competitive market of healthcare industries, healthcare managers should focus on achieving high or excellent ratings of patient satisfaction to improve the quality of service delivery; therefore, healthcare managers need to characterize the factors influencing patient satisfaction which are used as a means to assess the quality of healthcare delivery. In order to understand various factors affecting patient satisfaction, researchers have explored various dimensions of the perceived service quality, as meaningful and essential measures of patient perception of healthcare quality.

Overall Patient Satisfaction with Health Care Services

A remarkable outcome of four studies; Haddad et al, 2009; Sakkek et al, 2008; Peprah, 2014 & Oforu- Kwarteng, 2012 conducted in tertiary hospitals in different countries revealed that the nurses' courtesy, respect, careful listening and easy access of care was particularly the strongest driver of overall patient satisfaction. These aspects of nursing care are highly ranked by patients compared to other independent factors such as physician care, admission process, physical environment and cleanliness (Tonio, Joer, Joachim, 2011). In addition, a study carried out in 430 hospitals in the USA found the nurse work environment and patient-nurse staffing ratio had statistically significant effects on patient satisfaction and recommendations (Donna, 2009).

In 2011, Otani, Herrmann and Kurz surveyed 32 different large tertiary hospitals in the USA to identify the relationship of nursing care, physician care and physical environment to the overall patient satisfaction and the results showed that all attributes were statistically significant and positively related to

overall satisfaction; however, nursing care was the most critical to increase overall patient satisfaction. The researchers also found that the courtesy and respect of healthcare providers impact more on patient satisfaction while communication and explanation are the second most important aspect (Otani et al., 2011). In contrast, a survey conducted at 13 acute care hospitals in Ireland revealed that effective communication and clear explanation had the strongest impact in improving the overall patient satisfaction among other attributes of care (Mcarthy, 2003). These findings provide evidence of the importance of the nursing role as the most significant determinant of overall patient satisfaction.

While three other studies; Sung & Stan, 2004; Shou-Hisa, Ming-Chin & Tung-uang, 2003 found that interpersonal communication skills of physicians in terms of their attitude, explanation of conditions, level of care, emotional support, respect for patient preferences and involving patients in decision making were more influential factors than clinical competence and hospital tangibles on patient satisfaction. However, a survey conducted in a tertiary care academic hospital in the USA showed that only 33% of physicians were rated as excellent for their communication behavior which suggests that there is room for improvement in physician communication behavior in the hospital to improve quality of care (Lei, 2008). In addition, the main outcome of a study using the data of 202 participants from general acute care hospitals in the USA, concluded that most determinants of patient satisfaction was related to communication, empathy and caring from hospital personnel (Marchisio, 2004).

There are some contrary comments which were disclosed regarding the aspects of hospital environment and amenities which scored lowest for a patient satisfaction index in a study carried out in out-patients departments in South Korea (Kui-Son, Hanjoon, Chankon, & Sunhee, 2005). Correspondingly, a study conducted in a public hospital in France found the most common problems experienced by patients were related to hospital living arrangements and amenities (Nguyen, Briançon, Empereur, & Guillemin, 2002). Furthermore, in 2012 Andrabi, Hamid, Rohul, and Anjum reported that the major dissatisfaction in an out-patients department was the long waiting time and overcrowded registration. In contrast, a study carried out in five different hospitals in Scotland found that physical comfort had the highest satisfaction rate compared to other core dimensions: information, coordination of care and emotional support (Coulter & Jenkinson, 2005).

Renzi et al. (2001) in a study of dermatological outpatients correlated poor patient satisfaction with poor adherence to prescribed medical regimes and consequently poor health outcomes. Through the analytical techniques of factor analysis and multiple regression, client's age of 60 years or more, and visits lasting 10 minutes or more were the only factors that were significantly associated with overall satisfaction. They concluded that a health care provider's ability to provide clear explanations and display empathy and concern contributed positively to enhanced patient satisfaction. Furthermore, improving health care practitioners' interpersonal skills could affect patient satisfaction more positively. Additional findings of the study included higher documented satisfaction by men, those with higher education, higher severity of disease, and enhanced quality of life. Multiple factors and aspects of care

within the health care arena ultimately determined an individual client's opinion regarding satisfaction with services rendered. Of those factors, interpersonal communication was often the most important determinant of satisfaction, demonstrating the importance of patient education, communication, and feedback in the delivery of health care Donohue (2003).

In a comparative descriptive research conducted by Sharma(2013) the researcher found patients in private hospitals were more satisfied with nursing care as compared to government hospitals. Similar findings were also reported by Sreenivas and Prasad (2003), where it was found that patients were more satisfied in corporate managed hospitals, followed by private hospitals while there was least satisfaction among patients in government hospitals. In her study, Sharma, (2013) reported that higher satisfaction scores were recorded by patients who utilized private hospitals as they gave higher satisfaction scores on dimensions such as availability, attentiveness, emotional support, clinical skills, interpersonal relationship, communication and professional knowledge to the private facilities.

In 2012, Ofosu-Kwarteng conducted a case study at the Koforidua Regional Hospital in Ghana. In his study, 221 respondents were used for the study. His results showed mixed responses. In terms of Physician and Nurses human relations, the respondents rated Physicians far higher than Nurses. Responses from respondents about service provision and the environmental conditions of the hospital were varied. Results revealed that information given by Pharmacists on the issuance of drugs did not include side effects of drugs. In addition, the immediate surroundings of the hospital were clean but areas that needed improvements were the clients' toilet and urinals. Another area

that needed urgent attention was the waiting time, which was unbearable (Ofosu-Kwarteng, 2012). Ofosu-Kwarteng, (2012), reported that many of the respondents were aware of their rights however; the respondents did not know the avenues of seeking redress during violation. He therefore recommended that the hospital administrators work hard to intensify customer right awareness campaigns, improve efficiency and reduce waiting time, guide patients on drug administration and its side effects, ensure clean operational environment to enhance health care delivery services in the Koforidua Regional Hospital.

Baba, (2004) conducted a study at Bawku Hospital Eye Department in Ghana. In his study, 100 patients were interviewed in areas that covered the following:

Time taken to be seen, including patient's perceptions about unnecessary delay, communication by medical staff about the condition, instructions for care, and return visit, privacy, prescription of medicines and pharmacy instructions, attitude of staff, cleanliness of the clinic, promptness of emergency treatment and Overall satisfaction (Baba, 2004). The results showed patients to be very satisfied with the attitude of staff, the cleanliness of the clinic, the speed of treatment during an emergency and the overall satisfaction scores were over 90% (Baba, 2004).

Socio – Demographic Characteristics (predisposing factors) and Satisfaction

Iftikhar, Allah, Shadiullah, Habibullah, Muhammad, (2011) stated that measuring satisfaction should incorporate dimensions of technical, interpersonal, social, and moral aspects of care. Research of patient

satisfaction in advanced as well as developing countries has many common and some unique variables and attributes that influence overall patient satisfaction (Iftikhar, Allah, Shadiullah, Habibullah, & Muhammad, 2011).

Most of the studies in the literature review examined the correlation between demographic factors such as age, gender, health status and level of education with patient satisfaction; however, the findings from these studies are conflicting. Two studies, one conducted in Scotland whereby 650 patients discharged from four acute care general hospitals during February and March 2002, and the second study was conducted in 32 different large tertiary hospitals in the USA; both showed that male patients, patients older than 50 years of age, patients who had a shorter length of stay or better health status and those with primary level education had higher scores related to variable health service-related domains (José, Nerea, Amaia, Felipe, Antonio, Cristóbal, Emilio & Andrew, 2006; Otani, Herrmann, & Kurz, 2011).

On the other hand, a national survey performed in different accredited hospitals of Taiwan found that patient characteristics such as age, gender and education level only slightly influenced patient satisfaction but that the health status of patients is an important predictor of a patient's overall satisfaction (Shou-Hsia, Ming-Chin, & Tung-Liang, 2003). In addition, Nguyen et al. (2002) found from their studies that the two strongest and most consistent determinants of higher satisfaction are old age and better health status. While two studies reported contrary results regarding the influential effect of the two controlled variables (age and gender) on overall patient satisfaction in different aspects of healthcare services (Rama & Kanagaluru, 2011; Tonio, Joerg, & Joachim, 2011). In contrast, a 2006 national survey of 63 hospitals in

the five health regions in Norway showed that age, gender, perceived health and education level were not significant predictors of overall patient satisfaction (Oyvind, Ingeborg., & Hilde, 2011). These factors are not modifiable and are impractical for healthcare managers that are eager to improve patient satisfaction. Though these patient characteristics should be considered for fair adjustment of patient satisfaction studies in order to be utilized in benchmarking with other healthcare institutions (José, Nerea, Amaia, Felipe, Antonio, Cristóbal, Emilio & Andrew, 2006). On the other hand, the researchers extensively discussed the multidimensional attributes of healthcare settings that were shown to be the most potent determinants for improving the overall patient satisfaction. Healthcare managers need to direct more efforts towards those highly ranked attributes and initiate some improvement strategies in other areas of health services that are unsatisfactory from the patient's perspective.

In a descriptive study, Bryant and Graham (2002) found that affective support, health information received, decisional control, and technical competence all positively influenced client satisfaction with care. In a meta-analysis of nurse practitioners and nurse midwives in primary care, Brown and Grimes (1995) determined that the level of patient satisfaction with advanced practiced nurse delivered health services was significantly and statistically higher than that of physicians. Branson, Badger, and Dobbs (2003) concurred, relating positive satisfaction in 52 studies reviewed. Often, age, health status, and socioeconomic status were the most important determinants of patient satisfaction. Quintana, Bilbao, Aizpuru, Escobar, Esteban, San-Sebastián, De-la-Sierra, and Thompson in 2006 conducted a study among patients admitted

to one of four general acute hospitals in the Basque Health Care Service and a total of 650 discharged patients were used. In their study, patient satisfaction was measured by a validated questionnaire with six domains: information, human care, comfort, visiting, intimacy, and cleanliness. Each domain was scored from 0 to 100, with higher scores indicating higher levels of patient satisfaction. In a univariate analysis, Quintana et. al (2006) found that age was related to all domains except visiting; gender to comfort, visiting, and intimacy; level of education to comfort and cleanliness; marital status to information, human care, intimacy, and cleanliness; length of hospital stay to visiting and cleanliness, and previous admissions to human care, comfort, and cleanliness. The timing of the response to the mailing and who completed the questionnaire were related to all variables except visiting and cleanliness. The researchers further conducted a multivariate analysis which confirmed in most cases the previous findings and added additional correlations for level of education (visiting and intimacy) and marital status (comfort and visiting).

Quintana et. al (2006), concluded that their results confirmed the varying importance of some socio-demographic variables and length of stay, previous admission, the timing of response to the questionnaire, and who completed the questionnaire on some aspects of patient satisfaction after hospitalization. Therefore all these variables should be considered when evaluating patient satisfaction (Quintana et. al 2006).

Sakkak, Nowaiser, Khashn, Abdrabulnabi, and Jaber (2008) conducted a study in three PHC centers in Riyadh, Saudi Arabia. Their main objective was to assess the level of patients' satisfaction with primary health care PHC services in health centers affiliated to Riyadh Military Hospital. The

researchers collected their data collected administering questionnaire to 700 patients to assess their overall satisfaction with PHC services and their level of satisfaction with 5 PHC domains: reception services, accessibility, continuity of care, communication, and enablement (Sakkak, Nowaiser, Khashn, Abdrabulnabi, & Jaber, 2008). They found that, the domains of PHC with the highest level of reported satisfaction was enablement (70.6%). The poorest level of satisfaction was at the continuity of care (56.3%). The mean score of satisfaction with reception was 70.0%, communication 69.2%, and accessibility to care was 62.4%. The overall satisfaction level was 64.2%. There was no relation found between patients' satisfaction and their gender, marital status, occupational status, and their average monthly income (Sakkak, Nowaiser, Khashn, Abdrabulnabi, & Jaber, 2008).

In the year 2000, Tucker and Kelly conducted a research on the influence of patients' socio-demographic characteristics on their satisfaction. In the study, the patient satisfaction responses of active duty Army patients in military facilities were analyzed to determine if patients differed along socio demographic characteristics, the predictors of satisfaction, and the socio demographic characteristics that moderated patients' satisfaction. Regression results suggested that access, communication, outcomes, and quality predicted 42% of the variation in patients' satisfaction scores. Additionally, an analysis of variance suggested that patient satisfaction evaluations were significantly different along socio-demographic characteristics with the exception of marital status and duty location (Tucker & Kelly, 2000). Finally, patients' socio-demographic characteristics with the exceptions of gender and marital status, moderated patients' satisfaction. Their findings suggested that patients'

satisfaction differed significantly along age, rank, gender, education, race, health status, and utilization individually, but this difference predicted only 5% of patients' satisfaction ratings (Tucker & Kelly, 2000).

Kalarijani, Jamshidi, Heidarian and Korshidi (2014) found no significant difference regarding patients' gender and their satisfaction level. Ibrahim (2008) conducted a cross sectional study at Indrina Ghandi memorial Hospital, Male Maldives with the aim of determining the relationship between satisfaction and explanatory factors. In his study, data were collected from 251 patients' who utilized OPD services using structured questionnaire. Stratified sampling was used to draw the patients in order to get information from the various OPD units used for the study. His results showed that female patients were more satisfied than males and with regard to their age as a determinant of their satisfaction, the older groups were found to be highly satisfied with the services received. With marital status, the widowed/ divorced and married groups were highly satisfied when compared to other groups. About patients' education, Ibrahim (2008) study revealed that the secondary school group had higher satisfaction scores and the least was for no education group with only 3.5% recording higher satisfaction. There was no significant association between ones occupation and satisfaction level.

Enabling Factors (family income and mode of payment) and Patient Satisfaction

In 2014, Kalarijani, Jamshidi, Heidarian and Korshidi conducted a study at social security hospitals in Mazandaran province, North of Iran. In the study, from spring 2012 to summer 2013, all patients admitted to social security hospitals in Mazandaran province were entered in the study. In all 776

patients were involved in the study. Stratified random sampling method was employed based on the rate of hospital visitation in five hospitals. Data regarding patients' location, sex, income and patients' educational level and satisfaction with the hospital services were collected. The data were analysed using T-test and chi-square tests. The results showed that patient's inhabitant, educational attainment and income level had a significant relationship with patient satisfaction level ($p < 0.05$).

Ibrahim (2008) found a significant relationship between income of respondents and their satisfaction level as the results revealed that those who earned higher income were more satisfied than those who earned less income. There was however, no significant relationship between mode of payment and satisfaction and for this Ibrahim(2008) attributed it to the respondents higher income which made them not to bother about cost of services.

Gorman (2015) reported that in the year 2014 a survey conducted in California revealed that low-income Californians were more satisfied with their health care. Researchers surveyed more than 1,500 Californians between August and October of 2014. The margin of error was plus or minus 4 percentage points for the low-income sample. The survey included patients at community clinics, public and private clinics, as well as doctors' offices and other settings. According to the survey by the Blue Shield of California Foundation, more than half of low-income patients, 53% rated their quality of care as excellent or very good in 2014.

Jacobsen and Hasumi (2010) conducted a study on satisfaction with healthcare services in South Africa when the 2003 Demographic and Health Surveys suggested increasing rates of dissatisfaction with health services in

South Africa. A total of 25,548 households containing 95,918 individuals consented to participate in the 2010 General Household Survey (GHS), which was conducted between July and September through home visits by trained interviewers. Questions about use of and satisfaction with the healthcare system were asked at the household level. The GHS used a two-stage, stratified sampling design. First, primary sampling units (PSUs) were randomly selected from across the country. PSUs consisted of 100 to 500 households (called dwelling units, or DUs), and were based on the enumeration areas from the 2001 national census. After the DUs within the sampled PSUs were stratified by several socio-demographic characteristics, DUs were sampled from each PSU using a randomized probability proportional to size (RPPS). The results revealed that, 88.5% of participants were somewhat or very satisfied with their last visit to their usual healthcare provider, including 84.6% of those visiting a public provider and 97.3% of those consulting a private provider. Satisfaction rates were lower for black South Africans (87.0%) and low income households (86.3% of households with monthly incomes less than 2500 rands) than for white South Africans (96.0%) and high income households (94.0% of those with monthly incomes of at least 8000 rands) ($p < 0.001$).

Need Factors (health problem and expectation) and Patient Satisfaction

In a qualitative study comparing patient expectations of a nurse practitioner visit and degree to which those expectations were met, Donohue (2003) found several positive qualities of the nurse practitioner interaction. Among these were the provision of specific health information and adequate length of time of the nurse practitioner patient visit. Health status of patients

was determined to influence client's satisfaction with care. Powers and Bendall-Lyon (2003) determined that more highly satisfied patients tended to view their health status more positively. These individuals were also more likely to return for follow-up appointments.

Patients spend substantial amount of time in the hospital/clinic waiting for services to be delivered by physicians and other allied health professionals (Oche & Adamu, 2013). The degree to which health consumers are satisfied with the care received is strongly related to the quality of the waiting experience. Healthcare organizations that strive to deliver exceptional services must effectively manage their clinic waiting time (Rondeau, 2008). Failure to incorporate consumer-driven features into the design of waiting time experience could lead to patient and provider dissatisfaction. Waiting time refers to the time a patient waits in the hospital/clinic before being seen by one of the hospital/clinic medical staff (Rossiter, & Reynolds, 2010). Patient clinic waiting time is an important indicator of quality of services offered by hospitals (Renzi, 2004). The amount of time a patient waits to be seen is one factor which affects utilization of healthcare services. Patients perceive long waiting times as a barrier to actually obtaining services (Fernandes, Daya, Barry, & Palmer, 2004). Keeping patients waiting unnecessarily can be a cause of stress for both patient and doctor. Waiting time is a tangible aspect of practice that patients will use to judge health personnel, even more than their knowledge and skill.

The Institute of Medicine (IOM) recommends that, at least 90% of patients should be seen within 30 min of their scheduled appointment time (O'Malley, Fletcher, Fletcher & Earp, 2008). This is, however, not the case in

most developing countries, as several studies have shown that patients spend 2-4 hours in the outpatient departments before seeing the doctor (Ofilli & Ofowve, 2005; Ofilli & Ofowve, 2007; Singh, Haqq, & Mustapha, 2009). A source of dissatisfaction with health care reported by patients is having to wait a long period of time in the hospital or clinic, (Dansky, & Miles, 2007) and several studies have documented the negative association between increased waiting time and patient satisfaction with primary care (Huang, 2009).

The duration of waiting time varies from country to country, and even within country it varies from facility to facility. Long waiting times have been reported in both developed and developing countries. In the USA, an average waiting time of about 60 min was found in Atlanta, and an average of 188 min in Michigan (Dos Santos, Stewart & Rosenberg, 2008). In Nigeria, an average waiting time of about 173 min was found in Benin (Dansky, & Miles, 2007) while in University College Hospital Ibadan, a mean waiting time of 1 h 13 min was observed (Bamgboye, Erinoso & Ogunlesi, 2010). Time spent waiting is a resource investment by the patient for the desired goal of being seen by the physician and therefore may be moderated by the outcome (Oche & Adamu, 2013).

Oche and Adamu (2013) conducted a study at Usmanu Danfodiyo University Teaching Hospital, Sokoto, a Tertiary Health Institution in North Western Nigeria. The study revealed that out of the 96 respondents, 76 (79%) of them felt they had waited for too long and reasons adduced for the long waiting period included too many patients as revealed by 44.7% (34/76) of the respondents, availability of few doctors in the clinic to attend to the numerous

patients (36% [27/76]), few filing and record clerks (12% [9/76]), and jumping of queue by patients or staff members (8% [6/76]).

With regard to waiting time at the pharmacy, Afolabi & Erhun, 2003 conducted a study in an out-patient pharmacy in Nigeria. The study was carried out at the out-patient pharmacy department in a university teaching hospital situated in Ile-Ife - an urban community in south western Nigeria. A total of 100 out-patients were randomly selected from the population of patients who normally patronized the pharmacy by Afolabi and Erhun, (2003) to participate in the study. The data were collected by the use of questionnaire. Workflow analysis method and the stop watch techniques were used to measure patient waiting time. The dispensing procedure in the pharmacy was first studied and then divided into sub-components and a stopwatch was used to determine the time spent for each sub-component (Afolabi & Erhun, 2003).

Fifty-two percent (52.1%) of the respondents described the time they spent waiting in the pharmacy as adequate while the rest 47.9% of the patients that considered the waiting time as either long or too long gave "shortage of pharmacists" and "too many procedures involved in dispensing process" as reasons for the long waiting time. Over 20% of the patients were not satisfied with the waiting time while 78.9% considered it as either fairly satisfactory or very satisfactory. The workflow analysis revealed considerable delay in the dispensing procedure as a result of extended process components. The total waiting time for a dispensing process averaged 17.09 min, and 89.5% of this was due to delay components. Specifically, the major delay components included patient queues for billing prescription sheets and subsequent payment to the cashier (Afolabi & Erhun, 2003).

Afolabi and Erhun, (2003) asserted that patients are attended to in various units within the hospital system but almost invariably a high percentage of out-patient patrons visit the hospital pharmacy unit for their drug needs. These patients leave the doctors' consulting clinics and any of the other units at various times thus constituting a random arrival rate at the pharmacy, where the dispensing activities take place sequentially. Queues form when the rate of patient arrival at the pharmacy is greater than the service rate. Excessive patient waiting time undermines pharmacy efficiency. Such delay leads to patient dissatisfaction and thus may eventually result in loss of patronage in a competitive health care system. It can also lead to poor patient compliance with instructions given at the pharmacy (Afolabi & Erhun, 2003). It is therefore prudent for healthcare stakeholders to strive towards reducing waiting time at the pharmacy.

Perception of the Quality Of Care

Hussain and Rehman, (2012) conducted a study in Umea. The research focused on exploring the perceptions of patients who consume or undertook Umea hospital services. In the study, Hussain and Rehman, (2012) developed a hypothesis to investigate how 5Q model of the service quality, trust and reputation could affect patient satisfaction. Quantitative research strategy was adopted and convenience sampling technique was used to collect quantitative data from patients of Umea hospital to get their satisfaction levels. Hussain and Rehman, (2012) tested their hypothesis by using multiple regression analysis. The study revealed interesting results for patient satisfaction regarding the 5Q model of service quality, trust and reputation. 5Q model was used for service quality, which composes quality of object, quality

of process, quality of infrastructure, quality of interaction and quality of atmosphere. Out of the five dimensions, two gave positive effect and three gave no effect on result by the patient for their satisfaction from the Umeå hospital.

The researchers concluded that the 5Q model of service quality was not the only factor that could lead to patient satisfaction in health care sectors but trust and reputation are also factors of great importance. Organizations need to improve every dimension of service quality, creating trust in order to achieve high reputation to gain high level of patient satisfaction (Hussain & Rehman, 2012).

As calls are made for a more patient-centered health care system, it becomes critical to define and measure patient perceptions of health care quality and to understand more fully what drives those perceptions (Firminger & Sofaer, 2005). Alakija and Chira, (2005) conducted a study in Lagos, Nigeria. The study was carried out on in-patients at the National Orthopaedic Hospital Igbobi Lagos. A total of 214 in-patients chosen by systematic random sampling were used for the study. Areas where participants perception were assessed included; availability of drugs in the pharmacy, quality of time spent with the physician, level of co-operation between the healthcare providers, pharmacists explanation of drugs, period taken before admission and scheduling of operations, delay at the service points, uncleanliness of the restrooms, expensive bills and Hospital food. From their study, the majority of complaints centred on long delays at the service points, poor maintenance of infrastructures and expensive bills (Alakija & Chira, 2005). Alakija and Chira, (2005) suggested measures such as improved staffing, personnel training on

attitude to patients, upgrading of facilities, reducing the cost of services and curbing of unnecessary delays as well as better funding of the health sector to reverse those negative perceptions.

As consumerism continues to increase in healthcare, there has been a rise in awareness about how patients perceive the quality of the services they receive at a health-care institution (Kleeberg, Feyer, Gunther, & Behrens, 2008). As a consequence, patient satisfaction with service quality is becoming an increasingly important tool for providers to demonstrate patient focus and differentiation in the marketplace, as well as enhance patient loyalty. Furthermore, providers are using the information to make important decisions regarding operational and treatment plans (Crow, Gage, Hampson, Hart, Kimber, Storey, & Thomas, 2010). Evaluations of service quality provide important data on the patient's perception of the quality of care and treatment delivered by physicians, paramedical staff and the hospital as a whole (Cleary, 1999).

In view of this, Lis, Rodeghier and Gupta, (2009) conducted a study at a national oncology hospital network. A total of 2018 returning cancer patients treated at Cancer Treatment Centers of America (CTCA) responded to an internally developed service quality questionnaire, which covered the following dimensions: operations and services, treatment and care with a multidisciplinary team and patient endorsements. Items were measured on a 7-point Likert-type scale ranging from "completely dissatisfied" to "completely satisfied." Patient willingness to, "recommend this facility to friends and associates" was measured on an 11-point scale ranging from "not at all likely" to "extremely likely". Lis, Rodeghier and Gupta, (2009) findings showed that

helping a patient to understand her/his condition, caring for a patient as an individual, a whole-person approach to care, and satisfaction with the medical oncologist all contribute to willingness to recommend CTCA to friends and associates. On the other hand, speed of admission, timeliness with which care was delivered, involving a patient in decision-making, calling a patient by their name, and the amount of time spent with a patient were found not to be as critical in willingness to recommend, relative to the other measures studied. Their findings suggest that service quality that is central to the patient experience is critical for patient loyalty (Lis, Rodeghier & Gupta, 2009).

Haddad, Potvin, Robergea, Pineault and Remondina, (2009) conducted a study in Canada in a primary care unit. The survey was conducted on 473 patients who visited a physician in 11 primary care units in the Montreal region. Randomly selected patients received mailed questionnaires 5–7 days following their visit. Haddad, Potvin, Robergea, Pineault and Remondina, (2009) used various statistical procedures to assess the reliability and the validity of the global scale and the sub-scales, and to analyse patients' patterns of response. The results showed that, three-quarters (76%) of them perceived their health as good, very good or excellent. One out of 10 considered the health problem for which they had consulted their physician to be serious. The majority of them expressed the intention to return to consult the same physician (93%) and stated that they were ready to recommend the physician to others (93%). The results also revealed that the opinion expressed on the quality of care was favourable with regard to the various dimensions. Factor analyses suggested that, in their judgements, the respondents clearly distinguished what has to do with the doctor's interpersonal skills, the

technical process of care and the outcomes of the visit. In fact, the inter-factor correlations (factors resulting from the factor analysis) range from 0.43 to 0.71 and those between the scores of the three subscales fall between 0.53 and 0.76 (Haddad, Potvin, Robergea, Pineault & Remondina, 2009).

Relationship between Quality of Care and Patient Satisfaction

Boadu (2011) conducted a study in Ghana using Juaben Government Hospital as a case study. His study was a descriptive study in which a sample size of 150 made up of hospital staff, board and management, patients and civil society organization members were used. Boadu, (2011), found that customer care was ranked high by health service consumers at the Juaben Government Hospital. However, there were few consumer concerns which were sources of dissatisfaction to some of the patients. The study revealed that long waiting times, lackadaisical and disrespectful attitude of some hospital staff, unavailability of certain prescribed drugs, discrimination and favoritisms when it comes to who should be attended to first at the OPD and consulting rooms were some of the few areas respondents called for improvement (Boadu, 2011). Boadu (2011) asserted that in the healthcare delivery sector, the factors which largely affect customer care and satisfaction are quality services.

Summary of Literature Review

Literature reviewed revealed that similar patient satisfaction studies have been done in Ghana, Africa and the world at large. Some of the studies used either quantitative or qualitative design or both. Majority of the studies were quantitative in design and almost all the studies reviewed used the survey

method. There is no consensus in the literature on how to define the concept of patient satisfaction in healthcare. Many authors tend to have different perceptions of definitions of patient satisfaction. A review of the literature revealed that patient satisfaction is a key determinant of quality of care and an important outcome measure. Some of the studies found that patients' demographic characteristics such as age, gender, occupation and educational level affected their satisfaction level whereas other studies found no association between socio demographic characteristics and patient satisfaction. Some of the studies reviewed also showed that patients' satisfaction level was influenced by their income (enabling factors) whereas other found no association. Most of the studies showed an association between patients' experience and their satisfaction level. Key among the determinants of patient satisfaction in the literature review was factors such as communication, courtesy, empathy, efficiency, accessibility and cleanliness.

Conceptual Framework

The conceptual framework for this work was an eclectic one derived from Andersen's 1968 behavioral model. The Andersen model is a conceptual model aimed at demonstrating the factors that lead to the use of health services. According to the model, usage of health services (including inpatient care and outpatient care) is determined by three dynamics: predisposing factors, enabling factors, and need factors. Predisposing factors can be characteristics such as race, age, and health beliefs. For instance, an individual who believes health services are an effective treatment for an ailment is more likely to seek care. Examples of enabling factors could be family support, access to health insurance and one's community. Need represents both

perceived and actual need for health care services. This model was adapted because the researcher wanted to know how these three factors which influence utilization also influence satisfaction.

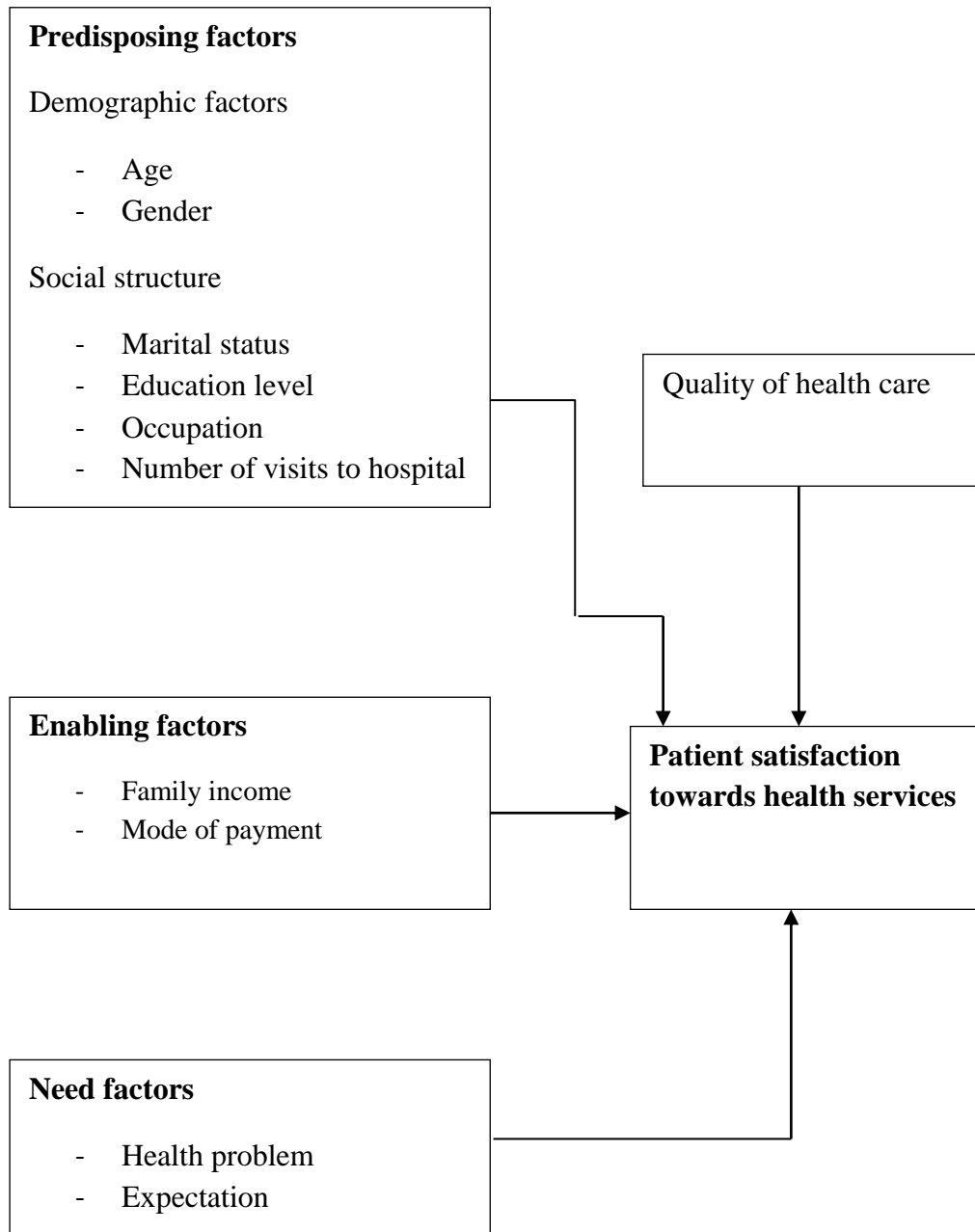


Figure 2. An eclectic model adapted from Ronald M. Andersen (1968)

CHAPTER THREE

METHODOLOGY

This chapter looks at the methodologies used in the study. The main areas covered in this chapter include research design, research population, sampling methods, data collection instruments and data analysis methods.

Study Design

The study was a quantitative descriptive cross - sectional survey. According to Cohen (2007), descriptive surveys gather data at a particular point in time when there is an intention of describing the nature of existing conditions or identifying standards against which existing condition can be compared. Descriptive surveys have the advantage of cost-effectiveness and also promote faster and easier way to collect data. In a descriptive survey, the collection of information typically involves one or more of the following data gathering techniques: structured or semi structured interview, self-completion or postal questionnaire and attitude scales. A descriptive survey involves collecting data in order to answer research questions concerning the participants of a study.

In a cross sectional research study, either the entire population or a subset thereof is selected. From these individuals, data are collected to help answer research questions of interest. The study is cross-sectional because the information that was gathered represented what was going on at only one point in time. Considering the objectives of the study, descriptive cross -sectional survey was the appropriate design to use.

Five parameters of satisfaction were used in assessing the satisfaction level of participants in this study and these parameters were convenience, courtesy, quality of care, out of pocket cost and physical environment.

Convenience refers to the ease with which services are received, availability of health care providers and receiving the services as wanted.

Courtesy refers to the way providers express respect and politeness to patients.

Quality of care refers to the superiority of care that patient's perceive from providers in terms of knowledge and skills.

Out of pocket cost refers to the amount of money spent out of pocket for registration, investigations, medication and other services.

Physical environment refers to the features of the facility in which the health services are provided. These include pleasantness of atmosphere, clear directional signs, clean toilet seats and hand washing solutions.

Research Setting

The research was conducted at the Cape Coast Metropolis. The Metropolis is served by the Metropolitan Hospital, University Hospital, Adisadel Health Centre, Ewim Polyclinic, with the Cape Coast Teaching Hospital as a referral Hospital. The metropolis is also served by other private health facilities such as DIS clinic, Baiden Ghartey Hospital and life sciences medical and diagnostic center. The study was carried out at Cape Coast Metropolitan Hospital, University of Cape Coast Hospital and Ewim Polyclinic. These three health facilities were used because patients from all areas of the Metropolis receive health care services from these facilities. These three health facilities provide both inpatient and outpatient services.

Study Population

The study population consisted of all patients who received services from the selected health facilities; Cape Coast Metropolitan Hospital, Ewim Polyclinic and the University of Cape Coast Hospital between March and April 2015. The estimated population for the two months period that data were collected was 4,524 for the Cape Coast Metropolitan Hospital (Cape Coast Metropolitan Hospital Records 2014) Ewim Polyclinic was 4,392 (Ewim Polyclinic Records, 2014), and that of the University Hospital was 5,083 (UHS record, 2014). The estimated total population for the two months period that data was collected for the three health facilities was 13,999.

Inclusion criteria were

1. All inpatients and outpatients between March and April 2015 who were 18years and above and received services from the selected health facilities.
2. Being able to give informed consent and participate
3. Being able to communicate verbally.

Exclusion criteria were

1. Patients who were below 18 and those above 65years.
2. Patients who were critically ill and as such unable to participate
3. Patients attending antenatal and postnatal clinics

Sampling and Sample Size

Stratified sampling was used to draw patients in order to get information about the selected health facilities mentioned in the study. As

required with this sampling technique the researcher identified the relevant stratum and their actual representation in the population.

Simple random sampling (where every other patient was chosen) was used to select sufficient number of participants from each stratum (patients' who receive services from Cape Coast Metropolitan Hospital, University of Cape Coast Hospital and Ewim Polyclinic) till the total number allocated to that stratum was reached. Simple random sampling was used to ensure that every member of the population had equal chance of participating in the study to avoid biases associated with non-probability sampling. Sample size was determined by the use of Yamane's 1967 formula for sample size determination.

$$n = \frac{N}{1 + N(e)^2}$$

Where n is the sample size, N is the population size and e is the level of precision. The estimated population for the two months period that data was collected was 13,999.

$$n = \frac{13,999}{1 + 13,999 (0.05)^2} = \frac{13,999}{36} = 389 = 390$$

From the calculations above a sample size of 390 was used for the study.

In performing the simple random sampling method, probability proportional to size was employed using a sampling fraction in each health facility that was proportional to that of the total number of patients across the selected health facilities. The size of the sample in each health facility was taken in proportion to the size of the number of patients who received care from that particular health facility. Facilities with larger number of patients had larger numbers selected to ensure proportionality.

The sample was distributed proportionally across the health facilities using stratified proportional allocation formula stated below:

$$nh = \left[\frac{Nh}{N} \right] n$$

Where

nh=stratum sample size for a particular health facility

Nh= population size for a particular health facility

N= Total population size

n= total sample size for the study

Therefore, the stratified sample size for University of Cape Coast Hospital (nUCCh) was calculated as:

$$nh = \left[\frac{Nh}{N} \right] n$$

$$nh_{UCC} = 390 \left[\frac{5083}{13999} \right]$$

$$nh_{UCC} = 142$$

$$nh_{Metro} = 390 \left[\frac{4524}{13999} \right]$$

$$nh_{Metro} = 126$$

$$nh_{Ewim} = 390 \left[\frac{4392}{13999} \right]$$

$$nh_{Ewim} = 122$$

Instrumentation

The data collection instrument that was used for the study was an adapted structured questionnaire from the Centre for Medicare and Medicaid Services (2014) Hospital Consumer Assessment of Health Care Providers and Systems (HCAHP) tool and Ibrahim (2008) outpatient assessment tool. Structured questionnaires were given to clients who could read and write and for those who could not read and write the questions were explained to them in the local dialect. Consistency was maintained as both researcher and assistants received training on the translation to the local dialect. Questionnaires provide a relatively cheap, quick and efficient way of obtaining large amounts of information from a large sample of people. Questionnaires can be effective means of measuring the behavior, attitudes, preferences, opinions and intentions of relatively large numbers of participants more cheaply and quickly than other methods (McLeod, 2014).

The questionnaire comprised of both open and closed questions which allowed both quantitative and qualitative data to be obtained. The questionnaires consisted of four parts/sections, A,B,C and D. Section A concentrated on predisposing/demographic data, section B on patients' expectations, section C on out - patients' satisfaction with health services, and section D on inpatients satisfaction assessment.

Pretest

The questionnaire was pretested using 30 patients from the Cape Coast Teaching Hospital because the hospital also provides outpatient and inpatient services similar to the facilities selected for the study. The pretest was carried

out to ensure understanding of the wording and validity of the statements. After the pretest, a reliability analysis was conducted on the key constructs of patient satisfaction. The results were generally within the threshold suggested by Cohen (as cited in Leech, Barrett & Morgan, 2005). The following were the outputs: patients' expectation = 0.845, out – patient satisfaction towards health services=0.966, care from doctors=0.856, hospital environment= 0.756 and rating of entire hospital= 0.811. The composite reliability score was 0.902

Data Collection Procedure

Data collection was carried out by the researcher with the help of three trained assistants who were also nurses. The training captured areas such as purpose of the study, how to observe office protocol, how to select the patients, informed consent seeking from clients and how to check and verify the questionnaire after completion by participants. The training also included the translation of the questionnaires for those who could not read and write to ensure consistency. They were also taken through the objectives of the study for them to appreciate what the study was about. In addition, the Research Assistants were taken through the research instruments to ensure uniform understanding of every single question on the questionnaire.

Data collection was conducted three times in a week that is Mondays, Wednesdays and Fridays to enable the researcher get “discharged” in- patients for the study. The questionnaires were distributed to respondents randomly. Respondents who could read and understand the questions were given the questionnaires for them to answer at that very moment. For those who couldn't fill the questionnaires on their own because they couldn't read and understand, the questions were interpreted in the local dialect by the researcher

or the research assistants for them to answer. Consistency was maintained as both researcher and assistants received training on the translation to the local dialect. The data were collected when patients had finished receiving services at the OPD and following discharge for inpatients.

Data Analysis

Data were processed by assigning numerical codes to participants' responses. The processed data were then analyzed by the use of the Statistical Package for Social Sciences (SPSS) Microsoft ware version 21. Frequencies and percentages were calculated for predisposing factors, enabling factors and need factors to determine basic patterns in data. Mean, median, and standard deviation were used to analyze the quantitative data generated. Chi square or Fishers exact test were also used to test relationship between some selected variables and the satisfaction level. The level of significance was set at 0.05 implying that the margin of error was 5%.

Ethical Considerations

Ethical considerations refer to procedures that are followed to protect the rights of the institution and the respondents to ensure scientific integrity (Polit& Beck, 2008). Permission was sought from the Institutional Review Board (IRB) of University of Cape Coast before the research was started. To ensure confidentiality names of respondents were not taken during data collection. Participants were assured of confidentiality and anonymity by telling them that data would be reported as aggregate data. Detailed information regarding the study and all procedures involved were explained to

them to seek informed consent and informed consent forms were signed. Participants were informed of their right to withdraw from the study at any stage without assigning reasons. During the actual data collection exercise, the researcher submitted an introductory letter and ethical clearance forms to the hospital management. This was done to seek permission from the management of the hospital to be able to carry out the study in their facilities.

CHAPTER FOUR

RESULTS AND DISCUSSION

This chapter presents the analysis performed on the data collected from the respondents in the study. The study assessed the quality of health care services provided by three selected health facilities in the Cape Coast Metropolis and patients' satisfaction levels of such services. Five research objectives were set. The researcher determined a sample size of 390 for the study made up of both inpatients and OPD patients. However, 385 of them completed and returned their copies of the questionnaire, a retrieval rate of 98.7%. Both descriptive and inferential statistical tools such as frequencies, percentages, tables, graphs, Fishers exact test and the Chi-square tests were employed in the analysis.

Socio-Demographic Characteristics of Respondents

Data on the socio-economic characteristics/ predisposing factors of the respondents were collected to help have a fair understanding of the background of the respondents in the study. The characteristics examined included gender, age, marital status, level of education, occupation, monthly family income, and the total number of visits to the facilities. The relationship of the socio- demographic information and patient satisfaction was also considered. Table 1 presents the details on these variables.

Table 1

Socio-Demographic/Predisposing Factors of Respondents (N=385)

Variables	Frequency	Percentage %
Gender		
Males	165	42.9
Females	220	57.1
Age (in years)		
18 – 28	149	38.7
29 – 39	107	27.8
40 – 50	88	22.9
51 and above	41	10.6
Marital Status		
Never married	143	37.1
Married	188	48.8
Divorce/separated	19	4.9
Widowed	30	7.8
Cohabitation	5	1.3
Educational Level		
None	32	8.3
Primary	17	4.4
JHS/Middle School	105	27.3
SHS/Secondary school	109	28.3
Tertiary	122	31.7
Occupation		
Farming	38	9.9
Business/Trading	91	23.6
Civil Service	120	31.1
Unemployed	40	10.4
Professional	23	6.0
Others	73	19.0
Average Family Income (GH¢)		
Less than 100	71	18.4
100 – 499	189	49.1
500 – 999	96	24.9
1000 or more	23	6.0
No stable income	6	1.6
Number of Visit		
Once	65	16.9
2 – 5	279	72.5
6 and above	41	10.6

The figures from Table 1 show that majority of the respondents (57.1%) were females compared to 42.9% males. The results also revealed that a greater proportion of the respondents (66.5%) were less than 40 years, 22.9% of them were 40–50 years as 10.6% were aged at least 51 years.

With regard to their marital status, more of them were married compared to other statuses. 37.1% reported of never being married, while others were divorced, separated, widowed and cohabiting. In terms of education, 8.3% of the respondents had no formal education. It was however seen that a greater percentage of the respondents had obtained formal education with as much as 31.7% having tertiary education. This could mean that the respondents were generally qualified to express objective views on the quality of services provided by these selected health centres and also give indications on their levels of satisfactions.

Among the respondents, 31.1% were civil servants, while there were farmers (9.9%), business people (23.6%) and professionals were 6%. The results also revealed that as many as 10.4% were unemployed. In terms of their monthly family income, 1.6% said they had no stable income. Meanwhile, 49.1% earned between GH¢ 500-999 per month. According to the results, majority of the respondents (72.5%) had attended the facilities for 2-5 times, 16.9% had been there for only once and 10.6% were there for health care for at least 6 times. The respondents were asked to indicate what brought them to the health facilities. Table 2 presents their responses.

Table 2

Reasons for Attending a Health Facility

Reasons	Frequency	Percentage%
Joint pains and body weakness	261	45.0
For review	85	14.6
Waist pains	63	10.8
Abdominal pains	53	9.1
Diarrhoea	42	7.2
Menstrual pains	29	5.0
Headache	18	3.1
Fever	18	3.1
Hernia repair	12	2.1
Total	581	100

**Frequency more than 385 because of multiple choice responses*

The respondents mainly went to the health facilities for treatment of various degrees of treatment for themselves and their relatives. Among them, 45.0% went to have treatments for joint pains and body weakness, 14.6% went for review, while 10.8% accessed waist pain treatments. Others were at the health facilities with abdominal pains, diarrhoea, menstrual pains, and headaches. There were 2.1% of the respondents who visited the health facilities for hernia repair.

Patient Satisfaction Level with Services Provided by the Selected Health Facilities

The aim of this objective was to determine the level of satisfaction of patients with the services provided by these selected health facilities in the

metropolis. Their satisfaction levels were assessed in five core areas, namely, convenience, courtesy, quality of care, out of pocket cost and physical environment, which analyses are presented in Tables 3-6.

Table 3

Respondents' Satisfaction with Convenience

Convenience items	Strongly disagree		Disagree		Agree		Strongly agree		Mean	Std. Dev.
	Freq.	%	Freq.	%	Freq.	%	Freq.	%		
Your disease condition was well explained by the physician.	5	1.3	0	0.0	321	83.4	59	15.3	3.13	0.435
Easy to navigate within the hospital	0	0.0	23	6.0	300	77.9	62	16.1	3.10	0.459
The process of accessing care was easy	0	0.0	59	15.2	278	72.3	40	19.5	2.97	0.527
Was received and attended to warmly at the laboratory	1	0.3	40	10.4	316	82.0	28	7.4	2.96	0.433
Pharmacist/dispensary staff educated you on how to take your medicine	6	1.6	48	12.5	287	74.7	43	11.2	2.95	0.548
Doctors/nurses are available	11	3.0	50	12.9	283	73.6	40	10.5	2.92	0.581
All medications prescribed were given at the pharmacy	27	6.9	52	13.6	284	73.9	21	5.6	2.78	0.650
Pharmacist/dispensary staff educated me on the side effects of my drugs.	14	3.7	89	23.2	260	67.5	22	5.6	2.75	0.613
The physician was satisfied with the test results provided	19	4.9	80	20.8	267	69.5	19	4.9	2.74	0.622
All tests requested were done at the facility	22	5.6	100	25.9	232	60.3	32	8.3	2.71	0.695
The waiting area is spacious	19	4.9	110	28.6	228	59.2	28	7.3	2.69	0.678
Short waiting time at records	33	8.6	183	47.5	143	37.1	26	6.8	2.42	0.743
I was served on time at the dispensary	49	12.6	158	41.1	158	41.1	20	5.3	2.39	0.773
Short waiting time before seeing a doctor	88	22.9	183	47.5	103	26.8	11	2.9	2.10	0.776
Grand mean									2.76	

*Mean=Strongly agree (4), Agree (3), Disagree (2), and Strongly disagree (1)

From Table 3, with a mean rating of 3.13 out of the maximum rating of 4.00 with variability of 0.435, majority of the respondents (98.7%) agreed that their disease condition was well explained by the physician. However, the remaining few said otherwise. 77.9% and 16.1% of them agreed and strongly agreed respectively that it was easy to navigate within the health facilities. This, they rated, relatively high with a mean rating of 3.10.

In assessing whether the process of accessing care was easy, no respondent strongly disagreed, while majority of them 72.3% and 19.5% indicated “agree” and “strongly agree”, respectively. This resulted in a mean rating of 2.97 with a standard deviation of 0.527. Furthermore, only 10.7% of the respondents were in disagreement with the assertion that they were warmly received and attended to at the laboratories.

With regard to whether pharmacist/dispensary staff gave education on how to take medicine or not, a larger majority of the respondents (85.9%) responded in the affirmative. However, the ratings of the respondents dipped when they were asked whether or not doctors and nurses were available. On whether all tests requested were done at the facility, as much as 31.5% of them were not satisfied. With a mean value of 2.69 out of the maximum of 4.00, a substantial proportion of them were of the view that waiting areas available in the facilities were not spacious enough. Majority of the respondents indicated that they waited for longer times before getting drugs as well before seeing doctors. On the whole, the grand mean rating of satisfaction with convenience was 2.76 out of 4.00. This means that the respondents were largely fairly satisfied.

In a follow up to classify the respondents, the study grouped them into very satisfied, fairly satisfied and not satisfied. Figure 3 presents the results of the classification.

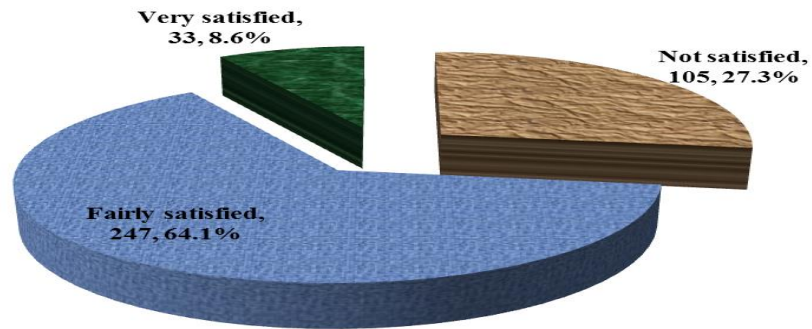


Figure 3: Respondents' satisfaction level with convenience at health facilities.

The results in Figure 3 show that 27.3% of the respondents were not satisfied with their convenience at the health facilities. However, a large majority of them (64.1%) were fairly satisfied, while the remaining 8.6% were very satisfied.

Table 4 presents the analysis on the satisfaction levels of the respondents on the courtesy exhibited at the health facilities. Frequencies, percentages, means and standard deviations were computed for discussions. The lowest and highest mean ratings were 2.30 and 3.00 respectively out of a range of 1.00 to 4.00.

Table 4

Respondents' Satisfaction with Courtesy

Courtesy items	Strongly disagree		Disagree		Agree		Strongly agree		Mean	Std. Dev.
	Freq.	%	Freq.	%	Freq.	%	Freq.	%		
Received nicely at the pharmacy	5	1.4	24	6.2	320	83.2	35	9.5	3.00	0.457
Received nicely at the consulting room	11	2.9	24	6.2	306	79.5	44	11.4	2.99	0.540
Doctors/nurses were attentive while asking your questions	10	2.6	21	5.5	319	82.9	35	9.1	2.98	0.500
Received nicely at the laboratory	5	1.4	39	10.1	304	79.0	37	9.5	2.97	0.502
Medical staff were friendly and courteous	9	2.3	44	11.4	308	80.0	24	6.2	2.90	0.511
Maintenance of privacy before doing any procedure	5	1.3	9	2.3	333	86.5	38	9.9	2.85	0.540
Doctors/nurses sought your consent before carrying out any procedure	13	3.4	47	12.1	313	81.3	12	3.2	2.84	0.517
No staff talked to you rudely	42	10.8	204	53.0	122	31.7	17	4.5	2.30	0.719
Grand mean									2.85	

**Mean=Strongly agree (4), Agree (3), Disagree (2), and Strongly disagree (1)*

Among the respondents, 83.2% and 9.5% of the respondents respectively indicated that they agreed and strongly agreed that they were received nicely at the pharmacy. Being received nicely at the pharmacy was the highly rated courtesy issue identified by the respondents as they rated it with a mean rating of 3.00 and a variability of 0.457. The respondents also agreed that they were accorded respects in the consulting rooms as reported by 90.9% of them.

On whether doctors/nurses were attentive while answering their questions or not, only 8.1% of respondents responded in the negative. They also agreed that courtesies were accorded them at the laboratories. This is because almost 89% of the respondents agreed that they were received nicely at the laboratories of the various health facilities. Similarly, with a mean rating of 2.90 and variability of 0.511, 13.7% of the respondents disagreed that the medical staff were friendly and courteous. They were, however, largely pleased with the extent to which their privacies were maintained before doing any medical procedures. A larger proportion of the respondents were also satisfied with doctors/nurses for seeking their consent before carrying out any procedure on them. On whether staff talked rudely to the respondents or not, the majority of them (63.8%) disagreed that staff talked to them rudely. This means that it appears that some of the respondents were rudely talked to when they attended the facilities. In conclusion, the respondents' satisfaction with courtesy accorded them, the grand mean of 2.85 which showed that they were fairly satisfied.

The respondents were further classified into those who were very satisfied, fairly satisfied and not satisfied. Figure 4 presents the details.

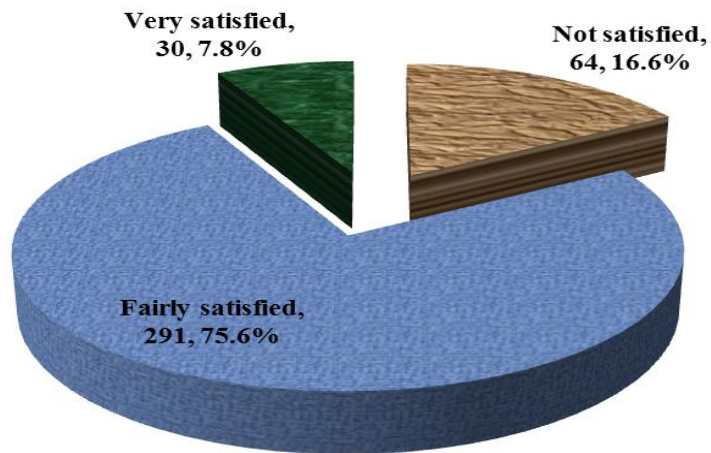


Figure 4: Respondents' satisfaction level with courtesy.

The results in Figure 4 show that only 7.8% of the respondents were very satisfied with the courtesy accorded them at the health facilities. Meanwhile, majority of them (75.6%) considered the courtesy as fairly satisfied. However, a good number of them (16.6%) were not satisfied with the courtesy given them by the staff of the various health facilities.

On their perceptions of quality of care and out-of-pocket charges that they received from the health facilities in the metropolis, the respondents were assessed on 9 items. The descriptive statistics are presented in Table 5.

Table 5
 Respondents' Satisfaction with Quality of Care and Out-of-Pocket Cost

Quality of care	Strongly disagree		Disagree		Agree		Strongly agree		Mean	Std. Dev.	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%			
Doctor was competent at treating you as he well explained your disease condition including its causes and complications to you	0	0.0	10	2.6	329	85.4	46	12.0	3.09	0.371	
My treatment regimen was well explained to me by the Doctor/ nurse	5	1.3	9	2.3	333	86.5	38	9.9	3.05	0.415	
Doctors examine patient carefully	8	2.1	32	8.3	311	80.8	34	8.8	2.96	0.504	
Pharmacists were skilful at dispensing drug as he educated you on the dosage, timing of medication, taking drug with or without food and contraindications	8	2.1	31	8.1	325	80.8	34	8.8	2.93	0.463	
Assured of confidentiality by nurses and doctors at the health facility	28	7.3	53	13.7	293	76.1	11	3.0	2.75	0.628	
Doctor explained the signs and symptoms you presented and management options of your condition to you.	44	11.3	69	17.9	268	69.7	4	1.1	2.60	0.699	
Doctors and nurses devoted all their time in your management	41	10.6	150	39.0	189	49.1	5	1.3	2.41	0.694	
Satisfied with the total time spent at the facility	121	31.4	105	27.2	154	40.6	3	0.8	2.11	0.862	
Grand mean									2.75		
Out-of-Pocket Cost											
Cost of medical services (record, pharmacy, laboratory) was affordable	14	3.0	27	6.9	304	78.9	41	10.5	2.96	0.564	
Grand mean									2.96		

*Mean=Strongly agree (4), Agree (3), Disagree (2), and Strongly disagree (1)

The respondents highly rated the competency of Doctors at the various health facilities. This is because as much as 97.4% of them agreed that doctors were competent at treating them as they well explained their disease condition including its causes and complications to them. On a whole, they rated this statement with a mean rating of 3.09 out of the maximum value of 4.00. In fact, despite the fact that overwhelming majority of them were satisfied with the competencies of the doctors, there was disagreement by the remaining 2.6% of the respondents. Similarly, they generally agreed that the doctors and nurses well explained their treatment regimen to them. It was generally accepted that the doctors examined patients carefully. This resulted in them rating this with a mean rating of 2.96 with a standard deviation of 0.504. 10.2% of the respondents disagreed that the pharmacists were skilful at dispensing drug. Also, it was found that the respondents were satisfied with the extent of confidentiality assured them. This was because as much as 79.1% of agreed to this statement. However, not too many of them were satisfied with the time devoted by nurses and doctors in their management. 10.6% and 39.0% strongly disagreed and disagreed with the assertion that doctors and nurses devoted all their time in their management. A similar rating was given to their perceived satisfaction with the total time spent at the facilities. The general impression is that the respondents were dissatisfied largely with time management at the facilities despite the relatively high quality services they provided. On the affordability of the cost of medical services as many as 89.4% agreed with the statement that medical services were affordable.

Table 6

Respondents' Satisfaction with Physical Environment

Environmental items	Strongly disagree		Disagree		Agree		Strongly agree		Mean	Std. Dev.	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%			
Clean and tidy hospital environment	27	7.0	19	4.9	302	78.4	37	9.7	2.91	0.647	
The laboratory, pharmacy, consulting rooms etc. are neat	24	6.2	31	8.1	292	75.8	38	9.9	2.89	0.647	
Clear signs and directions to indicate where to go in the service area and easy to follow	20	5.2	56	14.5	261	67.8	48	12.5	2.88	0.681	
The hospital has good ventilation	24	6.2	40	10.4	299	77.7	22	5.7	2.83	0.618	
Waiting area has enough seats	19	4.9	103	26.8	243	63.1	20	5.2	2.69	0.647	
Clean toilets seats and hand washing solution are available	17	4.3	119	30.9	226	58.6	24	6.3	2.67	0.659	
Grand mean									2.82		

**Mean=Strongly agree (4), Agree (3), Disagree (2), and Strongly disagree (1)*

Table 6 presents the summary of the results on the respondents' views on satisfaction about the physical environments of the various health facilities. The researcher assessed them on six items constituting physical environment. Their mean ratings ranged between 2.91 and 2.67. Clearly from Table 6, a large majority of the respondents (88.1%) were in agreement that the hospital environments were clean and tidy. Rating the proceeding statement with a mean rating of 2.91 meant that the respondents generally agreed that the facilities were kept clean. With respect to their assessment of the neatness of laboratories, pharmacies, consulting rooms, and wards among others, the respondents accepted that these places were neat.

Similarly, with a mean rating of 2.88 and a standard deviation of 0.681, more than half of the respondents (67.8%) agreed while 12.5% strongly agreed that the health facilities had clear signs and directions to indicate where to go in the service area and they were also easy to follow. The results also showed that 83.4% were satisfied with the level of ventilations in their respective health facilities. As to whether they had enough seats at the waiting area, 28.7% responded in the negative. This means that there might be the possibility of inadequate seats for respondents as they access health care from these facilities. The satisfaction of the respondents on the availability of clean toilets seats and hand washing solution fell as compared to the other items under study as they rated it with a mean rating of 2.67 and a standard deviation of 0.659.

From the responses, the respondents were classified into three distinct groups. These included very satisfied, fairly satisfied and not satisfied. Figure 5 presents the details.

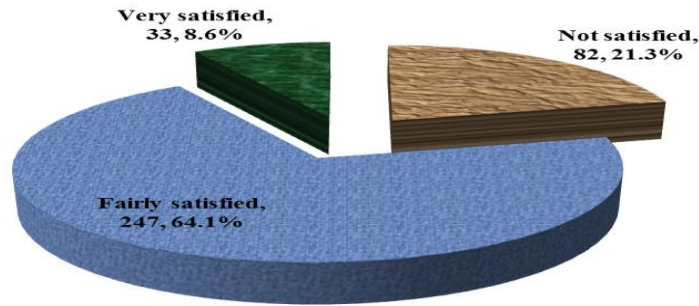


Figure 5: Respondents' satisfaction level with physical environment.

From Figure 5, it can be seen that as many as 21.3% respondents were not satisfied with the physical environment of the health facilities. The results also showed that 8.6% were very satisfied, while the remaining 64.1% were fairly satisfied. Based on the results from Tables 3-6 and also Figures 3-5, an index was created to determine the satisfaction levels of the respondents with regard to the five core areas. These areas included convenience, courtesy, quality of care, out of pocket cost and physical environment. The final results from the indexing are presented in table 7 and Figure 6.

Table 7

Satisfaction in all the Five Dimensions

Variables	Not satisfied	Fairly satisfied	Very satisfied
Convenience	27%	64%	9%
Courtesy	16.6%	75.6%	7.8%
Quality of care	23.2%	71.1%	5.7%
Out of pocket cost	10.6%	78.9%	10.5%
Physical environment	21.2%	70.2%	8.6%

The results from table 7 show that majority of the respondents were fairly satisfied with convenience, courtesy, quality of care, out of pocket cost and physical environment.

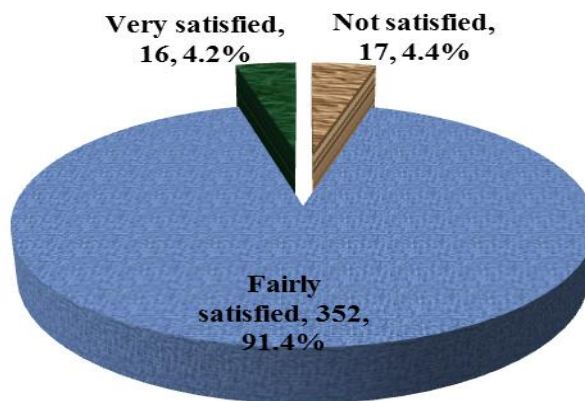


Figure 6: Respondents' general satisfaction level.

The results from Figure 6 showed that 4.2% of the respondents were very satisfied with the services provided at the selected health facilities. It was also found that as many as 91.4% of them were fairly satisfied, while 4.4% were not satisfied at all. Furthermore, the study sought to identify the performance of each facility in terms of client satisfaction rating. Therefore, the bar chart was used as shown in Figures 7, 8 and 9.

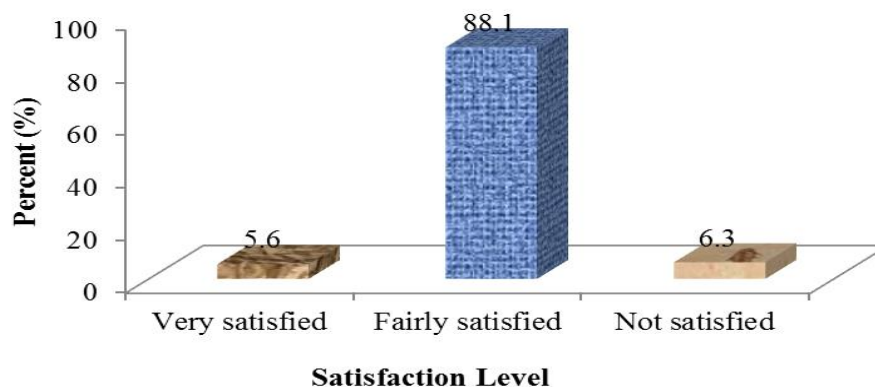


Figure 7: Satisfaction level among clients from Cape Coast Metro Hospital.

Among the 143 respondents at the Cape Coast Metro Hospital, 5.6% of them rated their satisfaction very high. About 88% of them reported fairly satisfied with the health services provided at the hospital, while 6.3% were not satisfied.

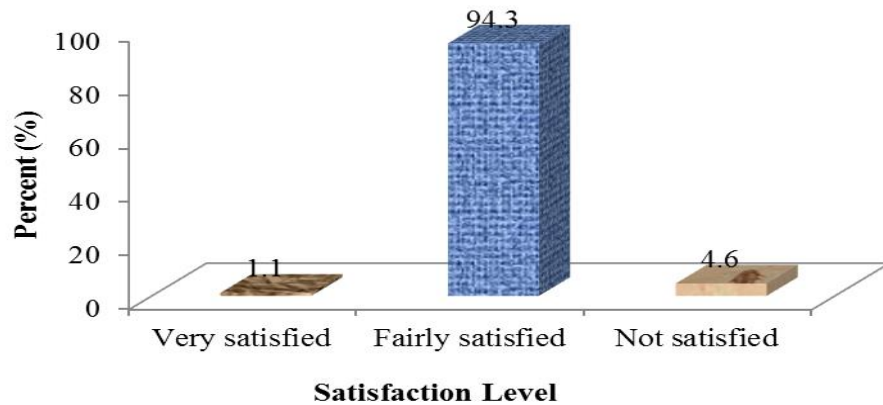


Figure 8: Satisfaction level among clients from Ewim Hospital.

From Figure 8, clients of the Ewim Hospital were generally relatively satisfied. This is because among them, 94.3% were fairly satisfied, while 4.6% were not satisfied at all. However, 1.1% of the respondents were very satisfied with the services provided by the Ewim Hospital.

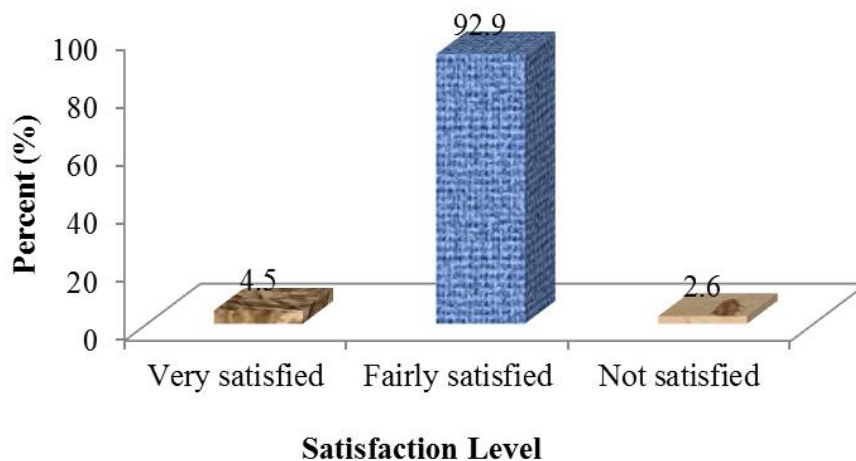


Figure 9: Satisfaction level among clients from UCC Hospital.

Out of the 155 respondents from the University of Cape Coast Hospital, 4.5% were very satisfied with their services, while majority of them (92.9%) were fairly satisfied. However, 2.6% were not satisfied with services that the UCC Hospital provided. In order to compare the performance of the three hospitals in terms of the satisfaction of their clients, Table 8 presents the results.

Table 8

Facility-Based Comparison of Client Satisfaction

Hospital	Level of Satisfaction						Total	Mean
	Very Satisfied		Fairly Satisfied		Not Satisfied			
	Freq.	%	Freq.	%	Freq.	%		
Metro	8	50.0	126	35.8	9	53.0	143	1.99
Ewim	1	6.2	82	23.3	4	23.5	87	1.97
UCC	7	43.8	144	40.9	4	23.5	155	2.02
Total/Average	16	100.0	352	100.0	17	100.0	385	1.99

$\chi^2 = 5.268, df = 4, p = .261$

As shown in Table 8 among the 16 very satisfied respondents, half of them accessed health care service at the Metropolitan Hospital. Seven representing 43.8% respondents went to the UCC Hospital, while the remaining respondent was at the Ewim Hospital. However, among those who were fairly satisfied, most of them (40.9%) were UCC Hospital clients, while 35.8% were Metropolitan Hospital and the remaining 23.3% were Ewim Hospital's clients. Again, out of the 17 respondents who were not satisfied with the services provided for them, majority of them (53.0%) accessed health

care at the Metropolitan Hospital, while four representing 23.5% each were at the Ewim and UCC Hospitals.

Mean rating was done and the UCC Hospital had 2.02, followed by the Metropolitan Hospital with 1.99 and Ewim Hospital with 1.97. With the minimum and maximum mean rating of 1.00 and 4.00 respectively, this ratings implied that the respondents were not generally satisfied with service delivery at all the facilities. A further test of significant difference showed that there were no significant differences among the satisfaction levels of the respondents from the three hospitals, since the associated *p*-value was greater than the significance level of .05.

The study also assessed differences in satisfaction according to client categories. There were 190 in-patients and 195 OPD attendants. Further analysis is presented in Table 9.

Table 9

Comparison of In-Patient and OPD Client Satisfaction

Hospital	Level of Satisfaction						Total	Mean
	Very Satisfied		Fairly Satisfied		Not Satisfied			
	Freq.	%	Freq.	%	Freq.	%		
In-Patients	14	87.5	175	49.7	1	5.9	190	2.07
OPDAttendants	2	12.5	177	50.3	16	94.1	195	1.93
Total/Average	16	100.0	352	100.0	17	100.0	385	2.00

p = .000

The results showed that among the 16 very satisfied clients, as much as 87.5% were in-patients, while only two representing 12.5% were OPD attendants. On the other hand, only an in-patient client was not satisfied

compared to 94.1% OPD attendants. In-patient clients collectively rated their satisfaction with a mean rating of 2.03 compared to 1.93 for OPD attendants. A test of significance difference revealed that there was a significance difference since a p -value of 0.000, respectively. This means that in-patient clients were much satisfied than their OPD attendant counterparts.

Socio-Demographic (predisposing) Variables and the Level of Satisfaction

This research objective sought to assess the influence of the respondents' socio-demographic characteristics (or predisposing factors) on their levels of satisfaction. The socio-demographic variables included sex, age, marital status, level of education, job designation and duration of service. Table 10 presents the summary of the test results.

Table 10

Influence of Socio-Demographic on Level of Satisfaction

Variables	Satisfaction Level			Total (N=385)
	Not Satisfied (n=17)	Fairly Satisfied (n=352)	Very Satisfied (n=16)	
Gender	$\chi^2=0.417$	df=2	p=.812	
Males	6	152	7	165
Females	11	200	9	220
Age (in years)	p=.187			
18 – 28	8	139	2	149
29 – 39	4	100	3	107
40 – 50	3	85	0	88
51 and above	2	36	3	41
Marital Status	p=.491			
Never married	4	130	9	143
Married	11	173	4	188
Divorce/separated	0	18	1	19
Widowed	2	26	2	30
Cohabitation	0	5	0	5
Educational Level	p=.922			
None	1	28	3	32
Primary	1	15	1	17
JHS/Middle School	4	98	3	105
SHS/Secondary school	5	100	4	109
Tertiary	6	111	5	122
Occupation	p=.250			
Farming	1	35	2	38
Business/Trading	5	82	4	91
Civil Service	5	114	1	120
Unemployed	4	32	4	40
Professional	0	22	1	23
Others	2	67	4	73
Number of Visit	p=.614			
Once	8	51	6	65
2 – 5	9	264	6	279
6 and above	0	35	4	41

Based on the gender of the respondents, among the males, only 7 (4.2%) out of the 165 were satisfied with the services provided, while 152 (92.1%) were fairly satisfied and the remaining were not satisfied at all. 4.1% were very satisfied, while the remaining of them were either fairly satisfied or not satisfied at all. The Chi-square test performed showed that the association between gender and satisfaction levels of the respondents was insignificant since the associated *p*-value was .812. This means that satisfaction among the respondents could not be linked to their genders.

With regard to age, out of the 149 respondents aged 18-22 years, only two of them were very satisfied. Similarly, as many as 139 (92.3%) were found to be fairly satisfied while the remaining eight were not satisfied. There was no one aged 40-50 years who was very satisfied with services provided at the facilities. Among the oldest group, three representing 7.3% were very satisfied. Also, 36 (87.8%) and two representing 4.9% were fairly satisfied and not satisfied, respectively. Furthermore, with a *p*-value of .187, it can be concluded that there was no statistically significant association between the two variables. This means that age of respondents could not determine their satisfaction levels, therefore, age was not an important factor in satisfactions of respondents.

Among the 143 never married respondents, only 96.3% were found to be very satisfied, similar to 2.1% of the 188 married respondents. Although there was no one among the 19 divorced and separated respondents found to be not satisfied, only one of them was very satisfied. Also, all the five cohabited respondents reported to be fairly satisfied. Again, the test for association revealed that there was no significant association between

satisfaction levels and marital status of the respondents, since the p-value obtained .491, was greater than a .05 significance level.

As to whether educational level influenced the satisfaction of the respondents, only one of those with no formal education was not satisfied, while 87.5% and 9.4% were fairly satisfied and very satisfied, respectively. Among those with primary and JHS/middle school education, only one and three of them out of 17 and 105, respectively. Out of the 109 SHS/secondary school education, 3.7%, 91.7% and 4.6% indicated “very satisfied”, “fairly satisfied” and “not satisfied” respectively. The results from the test revealed *ap*-value of .922, meaning there was no significant association between educational level and satisfaction of the respondents.

Furthermore, only two of the 38 farmers said they were very satisfied with service provided at the facilities, compared to 35 and one of them who were fairly satisfied and not satisfied, respectively. Similar trends were seen among the business people, civil servants as well as the professionals. With respect to the unemployed ones, four out of the 40 were very satisfied, 32 were fairly satisfied, while 4 were also not satisfied. However, the test results showed that there was no significant association between the two variables. This means that respondents’ satisfaction was no dependent on their occupations.

On the total number of visit to the facilities being a predictor of respondents’ satisfaction, the p-value indicated that they were not significantly associated. This is because the p-value obtained was greater the 5% significance level.

In conclusions, the analyses revealed that there were no significant associations between the socio-demographic (predisposing) variables and the satisfaction levels of the respondents accessing health care at the selected health facilities in the Cape Coast Metropolis. This means that gender, age, marital status, educational level as well as occupation of patients do not affect their satisfaction with health care services obtained.

Enabling Factors that Influence the Satisfaction Level

The study assessed the association between enabling factors and satisfaction of respondents. These enabling factors included monthly family income as well as the mode of payment for health services by the respondents. Fisher's exact test was employed and the results are summarised in Table 11.

Table 11

Test of Association between Enabling Factors and Level of Satisfaction among Respondents

Enabling factors	Level of Satisfaction			Total (N=385)
	Not satisfied (n=17)	Fairly satisfied (n=352)	Very satisfied (n=16)	
Family monthly income	p=.001			
Less than 100	5	62	4	71
100 – 499	8	175	6	189
500 – 999	2	93	1	96
1000 or more	2	16	5	23
No stable income	0	6	0	6
Mode of payment	p=.121			
Private insurance scheme	0	1	0	1
NHIS	14	300	14	328
Out of pocket	2	50	2	54
Others	1	1	0	2
Private insurance scheme	0	1	0	1

From Table 11, among the 71 respondents who earned less than GH¢100, five of them were very satisfied, while 62 and four were fairly and

not satisfied, respectively with services provided at the facilities. Also, two of the 23 respondents who earned at least GH¢1000 per month were said to be very satisfied. Among the six respondents who had no stable family income levels, none of them were very satisfied with services. To determine the association between the two variables using the Fisher's exact test, it was found that the p -value of .000 was less than the significance level of .05. This means that there was a significant association between the two variables; indicating that the satisfaction with service delivery was statistically dependent on respondents' monthly family incomes.

It is clear that family income was the enabling factor which significantly predicted respondents' levels of satisfaction. Thus, the monthly family incomes and not the modes of payment for health care determined the satisfaction of respondents.

Need Factors that Influence the Satisfaction Level

The study also examined the association between need factors and the levels of satisfaction of the respondents. The need factors basically looked at the health problems and expectations of recipients of health care services from the selected health facilities. The expectations included cost, quality of care, waiting time, environmental and information disclosure expectations. Chi-square and Fisher's exact test were used and the results are presented in Tables 12 and 13. Meanwhile, the data on the medical conditions brought to the health facilities were normalised and converted into frequencies to add up to 385 to enable the researcher to perform a Fisher's exact test.

Table 12
Test of Association between Health Problems and Level of Satisfaction among Respondents

Health problems	Level of Satisfaction			Total
	Not satisfied	Fairly satisfied	Very satisfied	
Joint pains and body weakness	3	166	4	173
For review	2	53	1	56
Waist pains	3	37	2	42
Abdominal pains	3	32	0	35
Diarrhoea	2	23	3	28
Menstrual pains	0	16	3	19
Headache	2	10	0	12
Fever	1	9	2	12
Hernia repair	1	6	1	8
Total	17	352	16	385

p=.910

The results from Table 12 showed that out of the 173 respondents who accessed treatments for joint pains and body weakness, only four of them very satisfied, while the remaining majority were either fairly satisfied or not satisfied at all. Also, none of the clients with abdominal pains and headache were very satisfied just as none of those with menstrual pains reported dissatisfaction. Fisher's exact tests revealed that the nature of health problem reported had no significant association with the level of satisfaction among the respondents. This is because the associated *p*-value (.910) was greater than the .05 significance level.

With respect to the association between the expectations of respondents and their satisfaction levels, Table 13 is a summary of the results. Chi-square and Fisher's exact tests were employed and conclusions drawn at a 5% significance level.

Table 13

Test of Association between Expectations and Level of Satisfaction among Respondents

Need factors	Level of Satisfaction			Total (N=385)
	Not satisfied (n=17)	Fairly satisfied (n=352)	Very satisfied (n=16)	
Cost expectations	p=.000			
Might not be affordable	1	23	0	24
Might be affordable	11	279	11	301
Might be enough to cover this visit	5	26	0	31
I didn't have any expectation	0	24	5	29
Quality of care expectations	p=.807			
Will not be good	0	13	0	13
Will not be acceptable	5	73	2	80
Will be excellent	12	263	14	289
I didn't have any expectation	0	3	0	3
Waiting time expectations	p=.016			
Long	2	65	7	74
Acceptable	7	205	3	215
Short	8	81	6	95
I didn't have any expectation	0	1	0	1
Environmental expectations	p=.000			
Not be good	0	8	0	8
Be accepted	9	267	5	281
Be excellent	8	72	10	90
I didn't have any expectation	0	5	1	6
Information expectations	p=.000			
I expected that some useful information might be obtained	10	268	4	282
I expected that a lot of useful information might be obtained	7	62	9	78
I didn't have any expectation	0	13	3	16

The results in Table 13 showed that with regard to cost expectations of the respondents, 301 said the cost might be affordable. Among these

respondents only 3.7% of them were very satisfied. With regard to 31 who responded “Might be enough to cover this visit”, none of them was very satisfied, while 29 said they did not have any expectation about the cost involved. The test result produced an associated p-value of .000, which is less than .05. This means that the association between satisfaction and cost expectation was statistically significant

On the quality of care expectation of respondents, 289 (75.0%) of the 385 were expecting excellent service delivery. Among them 14 (4.8%) were very satisfied, while 12 (4.1%) were not satisfied with the remaining of them being fairly satisfied. Eighty of them, however, were expecting unacceptable service provision. The Fishers exact test showed that the p-value was greater than the .05 significance level, therefore, there was no significant association between the two variables. In conclusion, the result meant that expectation of the quality of care was independent of the satisfaction of the respondents.

On the respondents’ expectations of waiting times, majority of them 55.8% expected an acceptable waiting time, 24.7% expected short waiting time, and 19.2% expected long waiting period. Only a respondent was not expectant. With p value of 0.016 it was concluded that there was a significant association between waiting time expectation and satisfaction level of the respondents.

The majority of the respondents (73.0%) expected the environment of the health facilities to be acceptable, 23.4% expected an excellent environment, 2.1% expected an unacceptable environment, while the remaining six of them had no expectations. Among those who expected an acceptable environment, 1.8% was very satisfied compared to 95.0% who were

fairly satisfied. Ten out of the 90 respondents with extremely high expectation were very satisfied. Furthermore, the Fisher's exact test results showed that the respondents' environmental expectation was significantly associated with their satisfaction since the associated p -value was less than the .05 significance level.

On the statistical association between satisfaction and information disclosure expectations of respondents, more than half (73.2%) expected that some useful information would be obtained, 20.3% expected that a lot of useful information would be obtained, while the remaining minority had no expectations. The p -value of .000 indicates that the satisfaction of respondents depends on their expectations of information disclosure.

Assessment of the Quality of Care

The study aimed at assessing the views of respondents on the quality of care provided them at the selected health facilities. The means and standard deviations were computed for each item and interpreted using the following ratings: Excellent (3.5-4.0), Very Good (3.0-3.4), Good (2.0-2.9) and Poor (1.0-1.9). Table 14 presents the details of the results.

Table 14

Quality of Care

Statement	Mean*	Std. Dev.	Interpretation
Doctor was competent at treating you as he well explained your disease condition including its causes and complications	3.09	0.371	Very Good
Treatment regimen was well explained by the Doctor/ nurse	3.05	0.415	Very Good
Doctors examine patient carefully	2.96	0.504	Good
Pharmacists were skilful at dispensing drugas he educated you on the dosage, timing of medication, taking drug with or without food and contraindications	2.93	0.463	Good
Assurance of confidentiality at the health facility by nurses and doctors	2.75	0.628	Good
Doctor explained the signs and symptoms you presented and management options to you	2.60	0.699	Good
Doctors and nurses devoted all their time in your management	2.41	0.694	Good
Satisfied with total time spent at the facility	2.11	0.862	Good
Grand mean	2.74		Good

**Mean=Strongly agree (4), Agree (3), Disagree (2), and Strongly disagree (1)*

From Table 14, on whether the doctors were competent and delivered quality care, the respondents assigned a mean rating of 3.09 and variability of 0.371. This means that the quality of care that the doctors delivered was of a very good standard. Also, on whether the doctors and nurses well explained their treatment regimen or not, the respondents assigned a mean rating of 3.05 which also means very good quality of care.

With a mean rating of 2.93 and variation of 0.463, the respondents perceived the skilfulness of the pharmacists at dispensing drugs as good. Similarly, the respondents rated their perception of “Assurance of confidentiality at the health facility by nurses and doctors” as good. This means that the respondents believed to some extent that their medical records would be protected and secured. They also rated as good the ability of these health facilities to churn out accurate information on their signs and symptoms and management options, doctors and nurses devotion of their time in management and total waiting time. A grand mean rating of 2.74 means that the respondents perceived the quality of care rendered by the facilities as good.

The results in Table 14 were categorised and a large majority of them (273 representing 70.9%) rated the quality of care provided as very good, while 112 (29.1%) rated it as good. None of them rated the quality of service as excellent or poor. Now, a crosstabulation was done between quality of care and satisfaction and the Fishers exact test was done. Table 15 presents the results.

Table 15

Test of Association between quality of care and general level of satisfaction among respondents

Quality of care rating	Level of Satisfaction			Total
	Not satisfied	Fairly satisfied	Very satisfied	
Excellent	0	0	0	0
Very Good	9	248	16	273
Good	8	104	0	112
Poor	0	0	0	0
Total	17	352	16	385

p=.010

The inferential test results as presented in table 15 above showed that there was a statistically significant association between level of satisfaction and quality of care, since the p -value obtained was less than the .05 significance level. This means that when respondents considered a facility's quality of care as high, they are likely to be generally satisfied with all other health services provided at the health facility and vice versa.

Discussion of Findings

Patient satisfaction has become an important indicator to measure the quality of care rendered to the patients while in hospital. Healthcare facilities have often used patients' outcome as measures to evaluate the health care services provided to patients. Patient satisfaction surveys can help identify ways of improving health care services (Sharma, 2013).

Level of Patient Satisfaction with Health Care Services

As postulated by Kotler (2003), satisfaction is based on several instinct and extinct factors. As shown in this study, the variables/constructs included in determining the level of satisfaction are encompassing, therefore, making their assessment portraying their actual positions. These constructs included convenience, courtesy, quality of care, out-of-pocket cost, and physical environment. With only a few respondents (16 representing 4.1% of the 385 respondents) reporting of being very satisfied with the services provided by the various health facilities studied, it stands to reason that they are calling for improvements in areas such as affordable fee, promptness of attention, good staff attitude, respect for patients and their rights, providing privacy and confidentiality, providing adequate information, availability of drugs and

logistics and above all a healthy and clean environment as found by Mannerman et al.(2006) as cited in Boadu(2011).

Treatment is the process of getting healthcare services by the patients. The treatment has to be according to the patients' requirements. Most importantly, the treatment has to be instant. Patients hate waiting for treatment for longer durations. The duration of time a patient has to wait to receive a particular service at a healthcare setting goes directly to affect his/her perceived satisfaction of the service (Baba, 2004). In a study conducted by Baba, (2004) at Bawku Hospital Eye Department in Ghana, the patients were satisfied with the attitude of staff, and speed of treatment during an emergency. This is inconsistent with the findings of this study which recorded lower scores for very satisfied clients in the facilities. This difference could be attributed to the facility under study. The study was done in only one specialised department of the hospital with fewer staff to monitor and control and also fewer patients, hence, could mean staff had ample time to attend to their needs timely.

In addition, the physical environment of the hospital or clinic is critical to the quality of services provided and major determinant of patient satisfaction. More than half of the respondents (67.8%) agreed while 12.5% strongly agreed that the health facilities had clear signs and directions to indicate where to go in the service area and they were also easy to follow. Many health facilities are extremely huge in structure and this makes navigation very difficult particularly for the aged. Even with the help of directional signs, many people both the literates and illiterates struggle to find their directions. Patients have a right to be cared for in a clean and safe

environment. The housekeeping teams are a vital part of the service. In a study conducted by Fathers and Steves in 2008 the respondents perceived the physical environment not so conducive for them however, in this study majority of the respondents were generally satisfied with the cleanliness of the various facilities

According to Bannerman et al. (2002), the likely effects of unsatisfactory service delivery is loss of customers, lives, revenue, material resources, time, morale, staff, recognition, trust and respect.

Socio-demographic/Predisposing Variables and Level of Satisfaction

Majority of the respondents (57.1%) were females compared to 42.9% males. This lends credence to the abundance evidences from several health reports from the Metropolitan Health Directorate indicating the high rate of OPD and inpatient cases among females who turn out to access health care. None of the socio-demographic characteristics of the respondents in this study was found to have had any significant associations with their satisfaction. This means that gender, age, marital status, educational level as well as occupation of patients do not affect their satisfaction with health care services obtained, which is consistent with the findings of Sakkak, et al., (2008) who concluded in their study that there was no relation found between patients' satisfaction and their gender, marital status, occupational status, and their average monthly income. The consistency between the findings of this study and that of Sakkak et al. (2008) goes to show that patient satisfaction levels no matter where they find themselves are not influenced by gender, marital status or occupational status. They all tend to demand the same level of quality care. Although

O'Neil, (2008) asserted that in most surveys higher educated patients tend to be less satisfied with the services and low educated patients are more satisfied with services, this study found no statistically significant relationship between educational level and satisfaction.

Ibrahim, (2008) found no significant association between ones occupation and satisfaction level which is also consistent with the findings of this study. This is however, inconsistent with the findings of Jackson et al. (2001) cited in Shou-Hsia et al. (2003) who revealed that patient characteristics such as age and education may influence ones assessment of hospital performance and by extension satisfaction.

Branson et al. (2003) also found in their study that age and socioeconomic status are the most important determinants of patient satisfaction. Phillips, Palmer, Wettig, and Fenwick (2000) demonstrated that higher education and younger age were significant predictors of patient satisfaction. However, this study found no such relationship or association between any of the socio-demographic factors and satisfaction among the respondents which could be attributed to the differences in the facilities, sex of the respondents as well as the sample size used by the various researchers.

Enabling Factors that Influence Satisfaction Level

Phillips et al. (2000) identified income to be significant predictor of patient satisfaction in their study which is consistent with the finding of this study. The analysis revealed that there was a significant association between income as an enabling factor of the respondents and their satisfaction. The finding of this research is also consistent with the findings of Kalarijani, Jamshidi, Heidarian and Korshidi, (2014), Jacobsen and Hasumi, (2010) and

Ibrahim, (2008) who found income level as a significant predictor of patient satisfaction. These researchers concluded that patient who earned higher income does not worry too much about the cost of healthcare. This could be attributed to the fact that the disposable income or percentages of healthcare cost in relation to total income of respondents were not much for the higher income earners.

The findings of this research is inconsistent with the findings of Sakkaket al. (2008) who concluded in their study that there was no relation found between patients' average monthly income and their satisfaction. The findings of this research implies that although participants expected health care services to be affordable, their satisfaction was greatly influenced by their monthly income and not the mode of payment for medical services.

Need Factors that Influence Satisfaction Level

Customer satisfaction equates meeting of one's expectations. The need factors, which include the expectation and health problems of patients, are to be considered in a bid to delivering satisfactory health care services. Peprah (2014) mentioned that patients expect no wasting of time, dissemination of information, the availability of up-to-date equipment, rendering of 24-hour service, doctors having the patience to clearly explain what was wrong with patients before giving treatment, providing patients with detail information about their medication, and attractiveness and cleanliness of the hospital as key to their satisfactions. Ofosu-Kwarteng (2012) also reported of similar findings in his study. The test of association between waiting time expectation and respondents satisfaction was statistically significant. This means that if patients had a favourable waiting time expectations, they are likely to be

satisfied with the services provided at the facility and vice versa. The test of association between satisfaction and cost expectation was statistically significant meaning that when patients perceived medical cost to be affordable, they would be satisfied with the services provided for them, and vice versa. These findings are consistent with the findings of Peprah (2014) and Ofosu-Kwarteng (2012). These studies by Peprah and Ofosu-Kwarteng were conducted at Sunyani Regional Hospital and Koforidua Regional Hospital respectively. The settings in these hospitals are similar with the health facilities researched in this study, hence consistent findings.

According to Shou-Hsia et al. (2003), a patient's health status and the severity of illness are also important predictors of the patient's overall satisfaction level. This study however found that there is no such association when the association between satisfaction and health problem (need factor) was estimated.

Quality of Care

As calls are made for a more patient-centered health care system, it becomes critical to define and measure patient perceptions of health care quality and to understand more fully what drives those perceptions (Firminger & Sofaer, 2005). Respondents in this study had positive perception about the quality of care received as 70.9% rated the quality of care provided as very good, while 29.1% rated it as good. The findings of this research is consistent with the findings of Haddad, Potvin, Robergea, Pineault and Remondina, (2009) who reported that opinion expressed by respondents on the quality of care was favourable with regard to the various dimensions they measured. This consistency exists because Haddad et al, used similar perception variables

such as staff communication skills and competencies in their study. The findings of this research is however not consistent with Alakija and Chira, (2005) who reported of poor perception by respondents in their study conducted at Lagos, Nigeria which could be attributed to the facility in which the study was conducted.

Jackson et al. (2001) as cited in Shou-Hsia et al.(2003) reported of a significant relationship between quality of care and satisfaction among patients. This is consistent with the finding of this study, which reported of a statistically significant association between the two variables. According to Wagner and Bear (2009), patient satisfaction is considered a focal concern of quality assurance and it can serve as an outcome measure of the quality of health care and provides a consumer perspective that can contribute to a complete, balanced evaluation of the structure process and outcome of services.

In addition, Parasuraman et al. (1985) asserted that organisations are now more focused on quality services and the aim is to satisfy customers. They said that in order to know whether customer's "will" is fulfilled or satisfied, organisations need to measure the service quality, a better way to understand service quality in the context of customer satisfaction. The finding of the service quality gap between predicted or expected service (customer expectations) and perceived service (customer perceptions) is a giant effort in satisfying a patient. The findings of this research are also congruent with Boadu (2011) who also asserted that in the healthcare delivery sector, the factors which largely affect customer care and satisfaction are quality

services. These consistencies could be attributed to the fact that universally users of health facilities expect the services they receive to be of high quality.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

In this chapter, the most important findings are highlighted from the data analysis. It also includes the conclusions drawn based on the findings as well as the recommendations offered to draw attention to patient satisfaction with the quality of health care services provided in some selected health facilities in the Cape Coast Metropolis.

Summary

This study examined patient satisfaction with the quality of health care services provided in three selected health facilities in the Cape Coast Metropolis. It specifically assessed the level of patient satisfaction with services provided, socio-demographic variables that influence the level of satisfaction, enabling factors that influence the satisfaction level, need factors that influence the satisfaction level and the quality of care.

In analyzing the data, the SPSS version 21.0 was used and both descriptive and inferential statistical tools were employed. The profile of the respondents showed that they were more females compared to the male respondents in the study and also more than half (66.5%) of them were less than 40 years. There were 48.8% of the respondents who were married and 17.1% were never married. About 32% of the respondents had obtained tertiary education compared to 8.3% who were uneducated. They were mainly civil servants, farmers, professionals and business people. With regard to their monthly incomes, a large proportion of them (49.1%) earned between GH¢ 100-500, while 24.9% earned between GH¢ 500-999.

Key Findings

The following were the major findings that emerged from the study:

1. Only 4.2% of the respondents were very satisfied with health care services provided to them, while an overwhelming majority of them 91.4% were fairly satisfied and the remaining 4.4% were not satisfied at all.
2. There was no significant difference in patient satisfaction level with respect to facilities.
3. There were no significant associations between the socio-demographic (predisposing) variables and the satisfaction levels of the respondents accessing health care at the selected health facilities in the Cape Coast Metropolis. This means that gender, age, marital status, educational level as well as occupation of patients do not affect their satisfaction with health care services obtained.
4. Monthly family income was a significant enabling factor which predicts respondents' levels of satisfaction. However, the modes of payment for health care did not determine the satisfaction of respondents.
5. The expectation need factors that significantly influenced respondents' satisfaction were cost, waiting time, environmental and information disclosure expectations. However, the quality of care expectation was independent of respondents' satisfaction levels.
6. The health problem need factors were statistically independent of the satisfaction of the respondents as the p -value was greater than .05.

7. A large majority of them 70.9% rated the quality of care provided as very good and 29.1% rated it as good meaning that they had a positive perception of the quality of care provided at the facilities.
8. There was a statistically significant association between satisfaction and quality of care, since the *p*-value obtained was less than the .05 significance level.

Conclusions

It was found out that majority of the respondents were not very satisfied with services provided at these facilities. It therefore calls for improvements in waiting time, staff attitude, respect for patients and their rights, hospital environment and information disclosure.

With no socio-demographic characteristics of the respondents not significantly associated with general satisfaction, it means that all patients irrespective of their gender, age, educational level desired the same amount of satisfaction when accessing health care services as observed in this study. The enabling factor family income was a determinant of satisfaction. Thus, the monthly family incomes and not the modes of payment for health care determined the satisfaction of respondents. Respondents generally expected the cost of health care to be affordable as majority believed that the National Health Insurance Scheme will bear the cost.

Until the cost, waiting time, environmental and information disclosure expectations, coupled with quality care for patients are met, the levels of satisfaction among patients will remain very low with the nature of services rendered by these health facilities in the metropolis.

Recommendations

The following recommendations were made for practice, policy and further research:

Recommendation for Practice

1. The management of health facilities in the metropolis should, as matter of urgency, take drastic steps to improve upon the quality of care given at their facilities in order to improve upon the satisfaction level of patients because they are generally not satisfied with their services.
2. Quality of care as a key determinant of the satisfaction among patients should be given the necessary attention in all satisfaction improvement activities and strategies.
3. All the three selected health facilities must all strive to satisfy their clients better by working towards scoring higher average satisfaction scores of not less than 3.50 out of 4.00.
4. The managers of all the three selected health facilities should ensure that their health care services are very affordable so that it meets the cost expectations of clients. This stems from the fact that the cost expectation of patients will influence their satisfaction; affordable health care cost will increase satisfaction and vice versa.
5. Efforts should be made to reduce the waiting time at the various health facilities. The expectation of patients is that they spent reasonable length of time when queued for services especially at consulting rooms, laboratories and pharmacies; therefore, anything on the contrary would cause dissatisfaction among them. This could be

significantly reduced through effective management and planning of manpower, equipment and time.

6. Since the expectation of patients towards the facilities' environment is high, they tend to be disappointed and dissatisfied about the general services provided when their surroundings are poorly kept, there are poor ventilations and inadequate health-related messages. Efforts should be put in place to always keep these facilities neat.
7. There should be regular assessment of the adequacies and the state of physical infrastructure of the various health facilities. This is to create convenience for clients in order to boost their satisfactions.
8. Patients expect that some amount of useful information about their conditions will be disclosed to them by their doctors and nurses, therefore, when this is not done, they will be dissatisfied. Hence, some minimal (reasonable) amount of their health-related information should be made known to them in order to improve upon their satisfaction levels.
9. The Quality Assurance Departments of the various health facilities should ensure that the activities in the various units and departments are meeting the desired standards towards clients' satisfaction.
10. There should be "Suggestion Boxes" at all health facilities so that the concerns and complaints of clients will be revised and addressed promptly.

Recommendations for Policy

11. The Ministry of Health and the Ghana Health Service through the Central Regional and Cape Coast Metropolitan Health Directorates

should regularly monitor and evaluate the activities of health facilities to ensure that they operate strictly according to best standards.

12. The National Health Insurance Authority (NHIA) should continue to work towards the sustainability of the schemes. This is because many patients have the expectation of accessing free health care as registered members and not to pay for health care cost from their pocket.

Suggestions for Future Research

The scope of this study should be extended to include more health facilities within the metropolis for more generalised conclusions about patient satisfaction with the quality of care. The Quality Assurance Departments of each facility should conduct regular studies to evaluate activities of the various units/departments for better service delivery. Also, a study to estimate the average waiting times for each unit and department can be done. Again, a study to look at inpatients and out- patients' satisfaction separately can be done.

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APPENDICES

APPENDIX A

QUESTIONNAIRES FOR HEALTH SERVICE CONSUMERS ON
PATIENT SATISFACTION WITH THE QUALITY OF HEALTH CARE
SERVICES PROVIDED BY SELECTED HEALTH FACILITIES WITHIN
CAPE COAST METROPOLIS.

Introduction

My name is Harriet Ampofo, a student of University of Cape Coast. I am conducting a study on the topic- **patient satisfaction with the quality of health care services provided by selected health facilities within Cape Coast Metropolis, Ghana** as part of the requirement for the award of the Master of Nursing degree.

I will be very grateful if you will spend a few minutes to answer this questionnaire about the services you have just obtained from the hospital. Information obtained will be used for the hospital service improvement. This is purely an academic exercise and information provided will be treated as confidential. Your honesty in responding is most helpful.

Thank you in advance for your response.

Date of data collection..... serial number

Facility.....

Tick (√) as appropriate in the box or fill in the blank as required

Part A Predisposing factors (Socio- demographic characteristics of respondents)

1. Age Group a. 18-28 b. 29-39 c. 40-50 d. 51 and above

2. Gender

1. Male 2. Female

3. Educational Background

1. None

2. Primary ()

3. JHS/Middle School

4. SHS/Secondary school 80

5. Tertiary (specify).....

4. Marital status

1. Single 2. Married

3. Divorce/ separated 4. Widowed

5. Cohabitation

5. Occupation

1. Farming

2. Business /Trading

3. Civil Service

4. Unemployed

5. Professional (specify).....

6. Other(s) Specify.....

6. Average family (immediate) income per month

7. Total number of visits to this hospital (during last four months including present visit).....

8. Why have you come to the hospital today?.....

9. How are you going to pay for this visit?

- 1. Private insurance scheme
- 2. National health insurance scheme
- 3. Out of pocket
- 4. Other (specify).....

SECTION B: Patients' expectation towards health services

Before utilizing the services, what were your expectations towards the services of this hospital?

10. What did you expect the total cost to be?

I expected the total cost out of pocket;

- 1. Might not be affordable.
- 2. Might be affordable.
- 3. Might be enough to cover this visit
- 4. I didn't have any expectation

11. What was your expectation towards the quality of care?

I expected that the quality of care

- 1. will not be good
- 2. will not be acceptable
- 3. will be excellent
- 4. I didn't have any expectation

12. What was your expectation towards waiting time?

I expected that the waiting time will be

- 1. long
- 2. acceptable
- 3. short
- 4. I didn't have any expectation

13. What was your expectation towards the surrounding of the hospital
(eg.Cleanliness, ventilation, health messages)?

I expected that the condition of the hospital surrounding might

- 1. not be good
- 2. be accepted
- 3. be excellent
- 4. I didn't have any expectation

14. What was your expectation about the information that you would acquire from
doctors/nurses/pharmacists concerning your illness

- 1. expected that any useful information might not be obtained
- 2. I expected that some useful information might be obtained
- 3. I expected that a lot of useful information might be obtained
- 4. I didn't have any expectation

Section C Outpatient Satisfaction towards health services

This section seeks to assess your satisfaction level to the services you received from this hospital.

Strongly Agree= 4, Agree=3, Disagree =2, strongly disagree= 1

	Convenience	SD	D	A	SA
15	Easy to navigate within the hospital				
16	My disease condition was well explained by the physician.				
17	The waiting area is spacious				
18	Short waiting time before seeing a doctor				
19	Short waiting time at records				
20	Doctors/nurses are available				
21	The process of accessing care was easy				
22	Was received and attended to warmly at the laboratory				
23	All tests requested were done at the facility				
24	The physician was satisfied with the test results provided				
25	I was served on time at the dispensary				
26	Pharmacist/dispensary staff educated you on how to take your medicine				
27	Pharmacist/dispensary staff educated me on the side effects of my drugs.				
28	All medications prescribed were given at the pharmacy				
	Courtesy				

29	Medical staff were friendly and courteous				
30	Doctors/nurses were attentive while asking your questions				
31	Received nicely at the consulting room				
32	Received nicely at the pharmacy				
33	Received nicely at the laboratory				
34	No staff talked to you rudely				
35	Doctors/nurses sought your consent before carrying out any procedure				
36	Maintenance of privacy before doing any procedure				
	Quality of care				
37	Doctor was competent at treating you as he well explained your disease condition including its causes and complications to you				
38	My treatment regimen was well explained to me by the Doctor/nurse				
39	Doctors examine patient carefully				
40	Pharmacists are skillful at dispensing drug as he educated you on the dosage, timing of medication, taking drug with or without food and contraindications				
41	Doctor explained the signs and symptoms you presented and management options of your condition to you.				

42	Satisfied with the total time spent at the facility?				
43	Doctors and nurses devoted all their time in your management				
44	Assured of confidentiality by doctors and nurses at the health facility				
	Out of pocket cost				
45	Did you have to pay cash for any service? If yes was it affordable?				
	Physical environment				
46	Clean and tidy Hospital environment				
47	Waiting area has enough seats				
	The laboratory, pharmacy, consulting rooms etc are neat				
48	Clean toilets seats and hand washing solution are available				
49	Clear signs and directions to indicate where to go in the service area and easy to follow				
50	The hospital has good ventilation				

SECTION D: INPATIENTS SATISFACTION

Please answer the questions in this survey about your stay at this hospital. Do not include any other hospital stays in your answers. Please tick (√) your response in the boxes provided.

YOUR CARE FROM NURSES

51. During this hospital stay, how often did nurses treat you with courtesy and respect?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

52. During this hospital stay, how often did nurses listen carefully to you?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

53. During this hospital stay, how often did nurses explain things in a way you could understand?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

YOUR CARE FROM DOCTORS

54. During this hospital stay, how often did doctors treat you with courtesy and respect?

- 1. Never
- 2. 2. Sometimes
- 3. Usually
- 4. Always

55. During this hospital stay, how often did doctors listen carefully to you?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

56. During this hospital stay, how often did doctors explain things in a way you could understand?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

THE HOSPITAL ENVIRONMENT

57. During this hospital stay, your room/cubicle and bathroom were kept clean

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

58. During this hospital stay, how often was the area around your room quiet at night?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

YOUR EXPERIENCES IN THIS HOSPITAL

59. During this hospital stay, did you need help from nurses or other hospital

staff in getting to the bathroom or in using a bedpan? 1 Yes 2 No If No,

Go to Question 61

60. How often did you get help in getting to the bathroom or in using a bedpan as soon as you needed?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

61. During this hospital stay, was there a time you needed medicine for pain? 1

Yes 2 No If No, Go to Question 64

62. During this hospital stay, how often was your pain well controlled?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

63. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

64. During this hospital stay, were you given any medicine that you had not taken before? 1 Yes 2 No If No, Go to Question 67

65. Before giving you any new medicine, how often did hospital staff explain to you what the medicine was for?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

66. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

- 1. Never
- 2. Sometimes
- 3. Usually
- 4. Always

67. Did you have to pay cash for any service?

1 Yes ()

2 No ()

68. If yes, was it affordable?

1. Never

2. Sometimes

3. Usually

4. Always

69. How would you rate the general attitude of staff at the facility?

1. Poor

2. Good

3. Very good

4. Excellent

70. How would you rate the hospital's environment in terms of cleanliness?

1. Poor

2. Good

3. Very good

4. Excellent

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital. Do not include any other hospital stays in your answers.

71. Using any number from 0 to 5, where 0 is the worst hospital possible and 5 is the best hospital possible, what number would you use to rate this hospital during your stay? 0 0 Worst hospital possible 1 1 2 2 3 3 4 4 5 5 Best hospital possible

72. How will you compare the services of the hospital to others?.

1. This hospital is better than others

2. This hospital is as good as others

3. This hospital is bad as others

4. This hospital is worst

73. Are you satisfied with the services received?

(a) Yes

(b) No

74. If, No state why

(i).....

(ii).....

75. Name departments whose services were better

(i).....

(ii).....

(iii).....

76. Name departments whose services were poor

(i).....

(ii).....

(iii).....

77. What do you think should be done to make the hospital services better?

1.

2.

78. Would you recommend this hospital to your friends and family?

1. Definitely no

2 Probably no

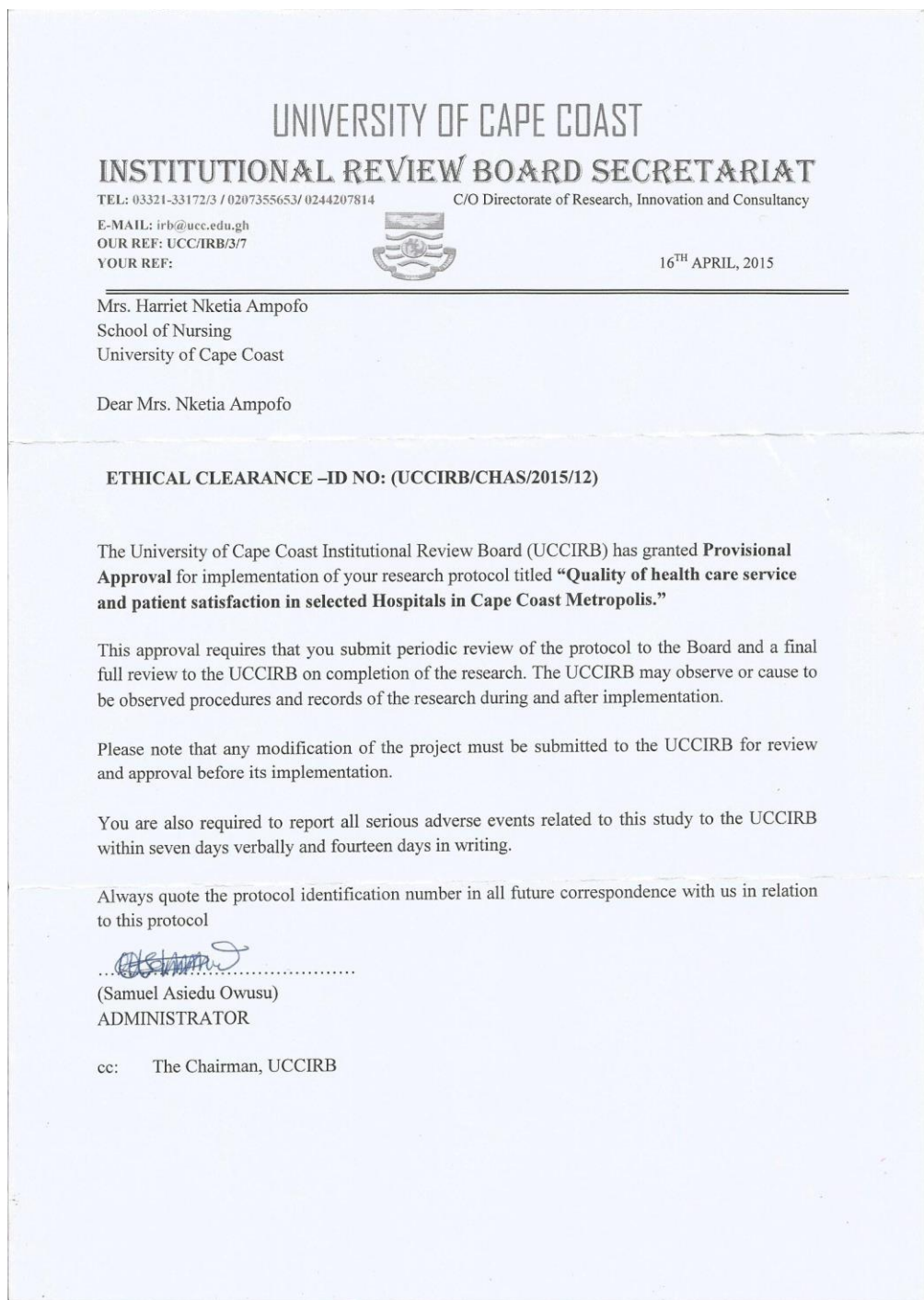
3 Probably yes

4 Definitely yes


79. Any general comment from you.....
.....
.....
.....

THANKS FOR YOUR COOPERATION

APPENDIX B




APPENDIX C



UNIVERSITY OF CAPE COAST
SCHOOL OF NURSING

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh



UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

SN/77/Vol.2/39

Our Ref: _____

Your Ref: _____

UNIVERSITY HOSPITAL
RECEIVED
[09 DEC 2014]
UNIVERSITY OF CAPE COAST

8th December, 2014

The Administrator
University of Cape Coast Hospital
Cape Coast

Dear Sir,


INTRODUCTORY LETTER

This is to introduce Ms. Harriet Nketia a level 850 Master of Nursing student of the School who is conducting a research on the topic: *Quality Care and Patient Satisfaction in Three Selected Health Facilities within Cape Coast Metropolis.*

We will therefore be grateful if you could grant her the necessary help she needs.

Thank you.

Yours faithfully,


Mrs. Theresa Maison
Principal Administrative Assistant

SCHOOL OF NURSING
UNIVERSITY OF CAPE COAST
CAPE COAST

*Nae 2 pls
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*Sen Ms
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BT 10/14*

APPENDIX D



UNIVERSITY OF CAPE COAST
SCHOOL OF NURSING



Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SN/77/Vol.2/39
Your Ref:

8th December, 2014

The Administrator
Cape Coast Metropolitan Hospital
Cape Coast

Dear Sir,

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Thank you.


Yours faithfully,

Mrs. Theresa Maison
Principal Administrative Assistant

UNIVERSITY OF CAPE COAST
SCHOOL OF NURSING
CAPE COAST

Biostatistics/Aggyone
He assist her
to get the total
attendance 2010-2013
JA
9/12/14

APPENDIX E




UNIVERSITY OF CAPE COAST
SCHOOL OF NURSING

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

Our Ref: SN/77/Vol.2/39

Your Ref:



UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

8th December, 2014

The Administrator
Ewin Polyclinic
Cape Coast

Dear Sir,

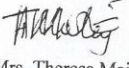
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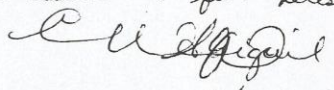
We will therefore be grateful if you could grant her the necessary help she needs.

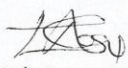
Thank you.

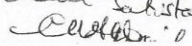
Yours faithfully,


Mrs. Theresa Maison
Principal Administrative Assistant

SCHOOL OF NURSING
UNIVERSITY OF CAPE COAST
CAPE COAST

1) Attention BABS, Mabel
The request is to submit
Informed Consent form, Ethical
clearance for necessary action.

11/12/14

2) 
Please assist the
bearer of this letter
to carry out her research
as stated above.
Thank you very much
for your usual cooperation.
20/12/15

(3) BABS
Kindly assist accordingly.
Let's consider possibility of
clearing Sabastachia Linder.


APPENDIX F



UNIVERSITY OF CAPE COAST
SCHOOL OF NURSING



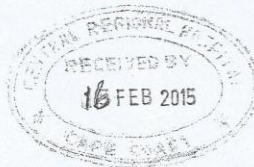
Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@uacc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SN/77/Vol.2/39
Your Ref:

8th December, 2014

The Administrator
Cape Coast Teaching Hospital
Cape Coast



Dear Sir,

INTRODUCTORY LETTER

This is to introduce Ms. Harriet Nketia a level 850 Master of Nursing student of the School who is conducting a research on the topic: *Quality Care and Patient Satisfaction in Three Selected Health Facilities within Cape Coast Metropolis.*

We will therefore be grateful if you could grant her the necessary help she needs.

Thank you.

Yours faithfully,

Mrs. Theresa Maison
Principal Administrative Assistant

SCHOOL OF NURSING
UNIVERSITY OF CAPE COAST
CAPE COAST

① Q/A chair person

Please refer the above request to be referred for your personal and assistance if possible

② 16/2/15
SCHOOL OF NURSING
UNIVERSITY OF CAPE COAST
CAPE COAST

To all ward Incharges and
OP D Incharge

Kindly assist the bearer of this note
for the needed information Thanks

③
16/02/15

Nursing Manager
CENTRAL REGIONAL HOSPITAL
CAPE COAST