Perception and Patient satisfaction: A case study of Olabisi Onabanjo University Teaching Hospital Sagamu, Nigeria.

By

Olusoji Daniel

Supervised by: Klaus Solberg Søilen

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ABSTRACT

Patients view about health care service delivery is a neglected subject in many developing countries. Patients are viewed as passive beneficiary of health care service without a voice. However, the views and opinions of patient on perception of service quality and satisfaction of health care service can assist management and policy makers in the design, implementation and evaluation of services which in turn assist to better improve and deliver qualitative health care service to the populace. This study was aimed at assessing patient perception of service quality and satisfaction with health services received at Olabisi Onabanjo university teaching hospital, Sagamu, Nigeria. A cross-sectional study was carried out at the outpatient clinics of the hospital during the study period. A total of 349 patients were interviewed using a pretested questionnaire to collect information on several dimensions of perceived quality and patient satisfaction. The data collected was analysed using SPSS statistical software. Factor analysis and multiple regressions were used to develop an 18-item scale having good reliability and validity identify. Four important dimensions of quality and satisfaction including doctor’s behavior and communication, supportive staff behavior, health infrastructure and waiting time were described. A total of 290 (83.1%) patients were satisfied with the overall service received at the hospital. The level of satisfaction was statistically significantly associated with female sex and employment status. Patient who were satisfied with the service significantly had a shorter waiting time than those not satisfied. Also patients who were satisfied with service had a longer consultation time compared with those not satisfied. In conclusion patient perception of quality and satisfaction are associated with the four important dimensions of quality. Long waiting time negatively affected satisfaction. If this is improved upon it will lead to increase patient satisfaction of health care service delivery.
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1.0 INTRODUCTION

The WHO constitution states that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition (WHO 2007). In realization of the right to health, government of countries are urged to make health care available, accessible, acceptable and of good quality. Quality of health care have described as the consistent delivery of a product or service according to expected standards. Quality in health care delivery addresses both technical and non technical dimensions. Patient perception has been described as an important measure of perceived quality of health care services. In fact according to O’ Connor et al., (1994), “it’s the patient perspective that increasingly is being viewed as a meaningful indicator of health service quality and may in fact represent the most important perspective. An understanding of the patients perception of service is seen as key components of both a process and outcome evaluation and the effectiveness of health care services is determined to some degree by patients satisfaction with the services provided.

It has been observed that patient perception of quality and the general patient satisfaction are sometimes used interchangeably but taking a closer look at them they are different. Patient satisfaction reflects the extent to which expectations of service standards are met and is usually operationalised by asking patients about general satisfaction with care received. Perceptions of quality however, records patients’ ratings about specific aspects of quality. Satisfaction reflects personal preferences much more than ratings of specific aspects of quality. According to Zeiithaml &Biner 2000), though patient perception of service quality and satisfaction have
certain things in common, satisfaction is generally viewed as a broader concept while patient perception of service quality focuses on dimensions of service. (Williams & Calnan 1991) noted that patient perception of service quality is a key determinant of health care organizations success due to its primary role in achieving patient satisfaction and hospital profitability (Koska 1990; Donabedian 1996). Empirical evidence exist that supports the causal relationship between perception of health care quality and patient satisfaction (Bowers et al., 1994; Woodside et al., 1989)

Patient satisfaction has been observed to lead to higher rates of patient retention because satisfied patients become loyal clients to the organization who serve to promote the organization further through word of mouth advertising referrals (Zeithaml & Bitner 2000). This in turn leads to increase profitability to the health institution. Also patient’s satisfaction has been directly linked to utilization of health services. In addition patient’s satisfaction is an invaluable perspective in the design and redesign of health care delivery system especially in developing countries. Patients are the end users of health care service and should have an input in the assessment of the overall quality of service.

In developed countries, Patient satisfaction surveys have been used to address issues of access and performance. They have been used to help government agencies identify target groups, clarify objectives, define measures of performance and develop performance information system. However in most African countries including Nigeria, the patient view is not taken into consideration in the planning, implementation and evaluation of health care services. Patients are seen as passive beneficiary of health service without a voice especially in public health institutions. The few elite who can afford qualitative health care patronize private health care
institution which is steadily on the increase. However for highly specialized services, the
majority of the populace still patronizes public tertiary health facilities which are more
affordable. This study is therefore aimed at assessing patient perception satisfaction of health
care service at the Olabisi Onabanjo university teaching hospital. This study will assist
management of the hospital and policy makers including government to review the factors
associated with patient satisfaction or dissatisfaction so as to improve the quality of health care
service delivered to the people of the state.

1.1 MOTIVATION
I am a medical doctor and consultant public health physician at Olabisi Onabanjo university
teaching hospital, Sagamu, Nigeria. The facility provides specialised services to patients in Ogun
state and neighbouring states in the south west geopolitical zone. In comparison to developed
countries, the provision of health services in developing countries is suboptimal as it relates to
incorporating patients view and opinions in the delivery of qualitative health care service. I
therefore embarked on this study to assess the perception of service quality and patients
satisfaction of health care service. A better understanding of the determinants of patient’s
satisfaction will help policy and decision makers to implement programmes tailored towards
patients needs and also to help patients get the best from their encounters with the health care
delivery system. The results from this study will be disseminated to management, fellow
colleagues and staff of the hospital during clinical meetings and the Ogun State Government.

1.2 OBJECTIVE
The broad objective of the study is to assess patient perception of service quality and satisfaction
with health services received at Olabisi Onabanjo university teaching hospital Sagamu, Nigeria.
The specific objectives are

1. To assess the influence of socio-demographic variables such as age, sex, education and marital status etc on patients level of satisfaction

2. To determine whether good communication between patient and provider influence level of satisfaction with service

3. To assess if waiting time before patient is attended to by the physician is associated with satisfaction

4. To examine if the physical environment of the hospital is associated with satisfaction with service

5. To assess if the patient perception of skill and competence of the physician is associated with satisfaction

1.3 RESEARCH HYPOTHESIS

The thesis will explore the following hypothesis:

**Hypothesis 1**: Socio-demographic variables such as age, sex, education and marital status of the patient’s influences patient satisfaction of health care service significantly

**Hypothesis 2**: Good quality communication between the hospital staff and the patients will lead to greater level of satisfaction

**Hypothesis 3**: The longer the waiting time before they see the physician the lower the level of satisfaction
**Hypothesis 4:** patients perceived responsiveness of the hospital staff to her needs (such as caring, courteous, non irritating etc) influence patients satisfaction

**Hypothesis 5:** patients perception of the skill and competence of the health care provider influence patients satisfaction significantly

**Hypothesis 6:** the physical environment of the hospital influence patients satisfaction significantly

**Hypothesis 7:** There is a considerable difference between patient perception and how the service really is?

**Hypothesis 8:** Our findings at the hospital on patient satisfaction deviate from the theory in the field

1.4 **OUTLINE OF THE THESIS**

The thesis is organised in to seven chapters. Figure 1 shows the outline of the thesis.

- Chapter-1 is already presented in the current section. The contents of the subsequent chapters are described below.
- Chapter-2 provides an overview of the existing body of literature on the subject matter
- Chapter-3 describes the materials and methods including the procedures adopted in carrying out the study.
- Chapter 4 presents the results of the data collected, collated and analysed.
- Chapter 5 documents a critical analysis of the result in relation to the body of available literature.
- Chapter-6 contains the conclusions and recommendation from the study.
- Chapter-7 outlines the various references cited in the thesis.
At the end of the document, there is a section on appendices which include the questionnaire used for primary data collection.

Figure 1: outline of the thesis
CHAPTER TWO:

2.0 LITERATURE REVIEW

2.1 DEFINITION

Tse & Wilton (1988 p. 204) defines satisfaction as “the consumer's response to the evaluation of discrepancy between prior expectations and the actual performance of the product as perceived after its consumption”. This description envisages that expectations and disconfirmation are the two variables that best explain consumer satisfaction. Disconfirmation can be defined as the difference between expected and perceived product performance, and expectations as predictions of future performance (Oliver 1980). The inclusion of expectations suggests that products that fulfill high expectations are predicted to generate greater consumer satisfaction than products that meet low expectations.

Oliver (1997; p 101), defined satisfaction as the consumer’s fulfillment response. It is a judgment that a product or service feature, or the product of service itself, provided (or is providing) a pleasurable level of consumption-related fulfillment, including levels of under- or over-fulfillment…”

The definition focuses first on a consumer who uses the product or service rather than a “customer,” who necessarily may not be the user of the service though he or she pays for it. Thus satisfaction with a product/service is a construct that requires experience and use of a product or service (Oliver, 1997). Individuals who pay for a product/service but who do not use this product/service are not be expected to have the type of (dis)satisfaction that a product/service user (the consumer) will have. So we need to realize that the concept of customer satisfaction is about consumer satisfaction (that is, user satisfaction), rather than about buyer satisfaction (which may include non-users). Second, satisfaction is a feeling. It is a short-term
attitude that can readily change given a constellation of circumstances. It resides in the user’s mind and is different from observable behaviors such as product choice, complaining, and repurchase. Third, satisfaction commonly has thresholds at both a lower level (insufficiency or under-fulfillment) and an upper level (excess or over-fulfillment). This means that a consumer’s satisfaction may drop if she/he “gets too much of a good thing.” Many people focus upon the lower threshold and neglect the potential for an upper threshold (William 2000).

Sitzia & Woods (1997), defined Satisfaction as fulfilling expectations, needs, or desires. It also viewed satisfaction as a function of expectations and the degree to which the experienced performance differs from expectations.

In their extensive review of the literature on patient satisfaction, Crow et al., (2002), concluded that:

\( (a) \) Satisfaction does not imply superior service, only adequate or acceptable service; and

\( (b) \) Satisfaction is a relative concept—therefore, what satisfies one person may dissatisfy another.

Linder-Pelz (1982), approached a definition of patient satisfaction through content analysis of satisfaction studies. Five social-psychological variables were proposed as probable determinants of satisfaction with health care which are a) occurrences--the event which actually takes place, and, perhaps more importantly, the individual's perception of what occurred; b) value--evaluation, in terms of good or bad, of an attribute or an aspect of a health care encounter; and c) expectations--beliefs about the probability of certain attributes being associated with an event or object, and the perceived probable outcome of that association; d) interpersonal comparisons--an individual's rating of the health care encounter by comparing it with all such encounters known.
to or experienced by him or her; and e) entitlement--an individual's belief that s/he has proper, accepted grounds for seeking or claiming a particular outcome.

It could in fact be argued that the last two are simply types of expectations, described by Linder-Pelz (1982) as the building blocks of satisfaction. This definition rests on social-psychological theory that expression of satisfaction is an expression of an attitude, an affective response, which is related to both the belief that the care possesses certain attributes--components/dimensions-and the patient's evaluation of those attributes; patient satisfaction thus becomes defined as "the individual's positive evaluations of distinct dimensions of health care" (Linder-Pelz, 1982, p. 580).

2.2 PATIENT PERCEPTION OF SERVICE QUALITY VS SATISFACTION

Patient satisfaction is considered an important outcome of hospital care. It has been distinguished from perception of service quality in that “While they have certain things in common, satisfaction is generally viewed as a broader concept while service quality assessment focuses on dimensions of service” (Zeithaml & Bitner, 2000, p. 74). Moreover, perception of service quality measures have been linked to satisfaction with hospital services in studies by Reidenbach & Sandifer-Smallwood, (1990), Taylor & Cronin, (1994) suggesting that delivering satisfaction is one of the major goals of any enterprise. Organizations that focus on customer satisfaction are able to build loyal clients who, then, serve to promote the organization further through vital word-of-mouth advertising referrals (
Service quality and satisfaction and are unique concepts. However, distinctions in their definitions are not always made clear. The construct of satisfaction, as in the case of service quality, has largely been interpreted within the expectancy disconfirmation paradigm which looks at the difference between expected and perceived product performance, and expectations as predictions of future performance as illustrated by Oliver (1993) and Johnston (1995). In an attempt to provide conceptual and operational distinctions between these two constructs, Boulding et al.,(1993) propose that the ideal expectation (or should) be used as the referent in the expectancy disconfirmation involving service quality and the desirable expectation (or will) as the referent in the case of satisfaction. However, confounding of these two constructs is evidenced in other recent writings. For instance, Iacobucci et al.,(1994) argue that both service quality and satisfaction are attitudinal constructs. Others go further by suggesting that service quality and satisfaction are almost interchangeable evaluations (e.g., Kleinsorge and Koenig, 1991).

The lack of clarity in the definitions of service quality and satisfaction is linked to the ongoing controversy surrounding the causal order of service quality and satisfaction. A dominant view on this issue illustrated by Oliver, (1993) and Oliver (1997). is that service quality represents a cognitive judgment, whereas satisfaction is a more affect-laden evaluation The cognitive status of service quality is strongly implied in the SERVQUAL scale, which is based on the assumption that consumers apply a mental calculus to reach an evaluation (Taylor, 1994; and Pascoe, 1983). The majority of past studies on satisfaction, view it as an affective response to an expectancy disconfirmation that involves a cognitive process. For instance in the definition of satisfaction by Tse & Wilton (1988) as “the consumer's response to the evaluation of discrepancy between
prior expectations and the actual performance of the product as perceived after its consumption” (p. 204) illustrates that a cognitive process is involved in the evaluation of this discrepancy.

Distinguishing between service quality as a cognitive construct and satisfaction as an affective construct suggests a causal order (consistent with the traditional multi-attribute attitude model framework (Wilkie, 1986) that positions service quality as an antecedent to satisfaction. There is empirical evidence supporting this causal linkage between health care service quality and patient satisfaction (Bowers et al., 1994; Reidenbach & Sandifer-Smallwood, 1990; Woodside et al., 1989 and Kui-Son Choi et al., 2002).

2.3 IMPORTANCE OF PATIENT SATISFACTION MEASUREMENT

The importance of patient satisfaction studies were put forward by Fitzpatrick (1984). These include —understanding patients' experiences of health care, promoting cooperation with treatment, identifying problems in health care, and evaluation of health care. However, Sita & Wood (1997) regrouped this to be essentially three. These include:

i. satisfaction work can simply describe health care services from the patient's point of view;

ii. In terms of Donabedian's (1996) framework for health care evaluation, patient satisfaction may be thought of as a measure of the "process" of care. Problem areas can be isolated and ideas towards solutions may be generated and

iii. Evaluation of health care is regarded by many as the most important function of patient satisfaction research. Bond & Thomas, (1992) proposal for the functions of patient satisfaction work, for example, was wholly concerned with evaluation.
iv. Also, consumer satisfaction has been described as an important factor in the delivery of health care service in developed countries because it affects purchase decisions as described by Bennett & Mandell (1969) which ultimately leads to higher rates of patient retention as illustrated by Peyrot et al., (1993), and word-of-mouth referrals by customers as expressed by Peterson (1988) and Kui-Son Choi et al., (2002).

v. Patient satisfaction also influences the rate of patient compliance with physician advice and requests as illustrated by (Pascoe, 1983). Thus, satisfaction actually affects the outcome of medical practices. For these reasons, patient satisfaction assessment has become an integral part of health care organizations strategic processes (Reidenbach & McClung, 1999).

vi. There is evidence that the public is inclined to pay more for care from quality institutions that are better disposed to satisfy customer needs (Boscarino, 1992).

vii. As a management tool, satisfaction surveys have been used widely to address the problems of access and performance. They have also been instrumental in helping government agencies identify target groups, clarify objectives, define measures of performance, and develop performance information systems (Langseth et al., 1995).

2.4 CONCEPTUAL MODELS OF PATIENT SATISFACTION

2.4.1 The "need for the familiar" model
Fitzpatrick (1984) described the model termed "the need for the familiar". This model argues that socially created expectations are the primary determinant of the degree of satisfaction. Within this model, expectations, due for example to cultural differences, directly influence satisfaction; patients from non-Western cultures, for example, are not familiar with the Western approach and so are unlikely to be happy with it. Fitzpatrick (1994) supported the model using examples from both U.S. and U.K. contexts.
2.4.2 “Goal of help seeking” model
The second model proposed by Fitzpatrick (Fitzpatrick 1984), "the goals of help seeking", proposed that the major concerns for most patients are not "satisfaction" but some resolution to their health problem; that is, patients judge a health professional or a treatment simply by whether it helps achieve goals in relation to their health problem. In practice, this aim is not achieved by many satisfaction studies where patients' own perceptions of changes in health status are not addressed (Wensing et al.,1994).

2.4.3. The “importance of emotional needs” model
The third model, "the importance of emotional needs", stressed that most medical problems involve for patients an emotional experience, partly due to the fact that uncertainty and anxiety accompany many problems, but also because many patients only feel able to judge health professionals' competence on non-technical aspects of care. Patients therefore judge "satisfaction" by observing affective behaviour and communication skills.

2.4.4. Discrepancy model
The "discrepancy model" was proposed by Fox & Storms (1981). He argued that the lack of variability in satisfaction responses should prompt a shift in focus from obtaining stability of results to understanding the conditions under which discrepant findings can be predicted. This implies that a concentration upon areas of expressed dissatisfaction is more valuable than obtaining consistency of expressed satisfaction. Williams & Calnan (1991) argued that patient expectations were the key to understanding the reasons for expressed dissatisfaction.
2.4.5. Value expectancy model

Perceived value is conceptualized as the consumer's evaluation of the utility of perceived benefits and perceived sacrifices as expressed by Zeithaml, (1988). That is, consumers may cognitively integrate their perceptions of what they get (i.e., benefits) and what they have to give up (i.e., sacrifices) in order to receive services. In health care, benefits are largely the results of good quality service in both outcome and process domains. Although superiority of service performance is the major component of perceived benefits, Holbrook & Corfman (1985) described the fact that customers may consider other factors such as prestige or reputation as benefits. Also sacrifices from the patient's perspective was divided into two types: the price that patients have to pay, and the non-monetary costs such as time spent and the mental and physical stress experienced in receiving the care.

Finally, Oliver (1999), noted that the model highlights the concept of value as a driving force in product choice and satisfaction’s relationship, as a brief psychological reaction to a component of a value chain (or “hierarchy”). The important point about this model is the use of gross benefit minus cost judgments by consumers.

2.4.6. Disconfirmation expectancy

The disconfirmation expectancy theory found that the consumer’s level of satisfaction with a service can determine long term attitude about service quality. Consumer satisfaction depends on the difference between their required adequate and desired satisfaction levels. If a service does not meet their minimal performance criteria they become dissatisfied and develop negative image of the service (Parasunaman et al., 1994). The model has consumers using pre-consumption expectations in a comparison with post-consumption experiences of a
product/service to form an attitude of satisfaction or dissatisfaction toward the product/service. In this model, expectations originate from beliefs about the level of performance that a product/service will provide. This is the predictive meaning of the expectations concept.

2.4.7 Multi-attribute model
The multi attribute model of patient satisfaction separate the many components of the service transaction. Woodside et al., (1989) formulated the multi-attribute model linking perceptions of service quality to patient satisfaction and behavioral intentions. Their model was based on the concept of a "service script" described by Smith & Houston (1983) and Solomon et al.,(1985), tracing the sequence of acts constituting the service encounter. For hospital stays, the script included admission and discharge as well as several ongoing service events: nursing, technical services (physician and lab), food and housekeeping. The service script concept is supported by research showing that access to care described by Roberts & Tugwell (1987), ease of making appointments and receptionist behaviour as illustrated by Kingsley & Hodges (1988) are important determinants of satisfaction.

Attribution Models integrate the concept of perceived causality for a product/service performance into the satisfaction process. Consumers use three factors to determine attribution’s effect in satisfaction. These are locus of causality, stability, and controllability. The locus of causality can be external (that is, the service provider gets the credit or blame) or internal (that is, the consumer is responsible for the product/service performance). Stable causes would tend to have more impact in satisfaction because consumers tend to be more forgiving of product/service failures that appear to be rare events. Finally, controllability affects attribution in that a poor outcome in a consumption experience may mean that the consumer will be unsatisfied with the
product/service provider if the consumer believes the provider had the capacity, that is, control, to perform in a better fashion.

2.4.8 SERVQUAL model
The model is based on the expectancy disconfirmation model, which states that evaluation of service quality results from comparing the perception of service received to prior expectations of what the service should provide (Parasuraman et al., 1985). It analyses the impact of nontechnical factors on patient satisfaction. This approach emphasizes global characteristics such as communication, respect, and staff courtesy/helpfulness. Perceptions of these qualities are related to overall satisfaction as described by Anderson (1982), Cleary & McNeil (1988), Feletti et al., (1986) and MacKeigan & Larson (1989). Satisfaction, in turn, is related to intention to reuse the provider (Andreasen 1979; Woodside & Shinn 1988) as well as outshopping and provider switching behavior as described by Andrus & Kohout (1984-85) and Ware & Davies (1983).

2.5 DETERMINANTS OF SATISFACTION
2.5.1 Expectations
Stimson & Webb (1975) were among the first to suggest that satisfaction is related to the perception of the benefits of care and the extent to which these meet the patient's expectations. They identified three categories of expectations: "background", "interaction" and "action". "Background" expectations are explicit expectations resulting from accumulated learning of the consultation/treatment process. Although background expectations vary with the illness and particular circumstances, certain patterns of activity or routines are expected, and much criticism centers on behaviour which is at odds with these expectations. "Interaction" expectations refer to
patients' expectations regarding the exchange which will take place with their doctor, for example the manner and technique of questioning and the level of information released by the doctor. Expectations about the action the doctor will take—such as prescribing, referral or advice—are "action" expectations. Of the three, Stimson & Webb regarded interaction expectations as the most important.

A far more prescriptive conceptual framework was provided by Linder-Pelz (1982), who proposed that satisfaction could be mathematically calculated using measurements of (1) the degree of a patient's "belief" that care possesses certain attributes, and (2) the patient's evaluation of those attributes. In essence these frameworks associate satisfaction with the fulfilment of positive expectations.

There is, however, evidence that expectations vary according to knowledge and prior experience, and are therefore likely to change with accumulating experience. Bond & Thomas (1992), for example, noted that increasing quality of care raises expectations. In this analysis, as a result of increasing expectations "high" levels of quality of care may gradually become associated with "lower" levels of satisfaction. Furthermore, if the models associating satisfaction with the fulfillment of positive expectations are valid, then the high levels of satisfaction which are constantly reported from just about every sphere of health care suggest that the large majority of patients are either very happy with almost everything, or that patients' expectations are generally low.

2.5.2 Age of patient
The most consistent determinant characteristic of patient satisfaction is patient age. Evidence by Houts et al., (1986) and Zahr et al., (1991) suggest that older people tend to be more satisfied with health care than do younger people. Savage et al., (1990) found out that older patients tend
to be less ready to criticize and have more modest expectations. Cartwright & Anderson (1981) found that older respondents expected less information from their doctor. Hopton et al., (1993) found that younger patients were less satisfied with issues surrounding the consultation in the primary care setting. Younger patients were also less likely to comply with prescriptions or medical advice. Williams & Calnan (1991) older people have also been found to be far more satisfied with most aspects of their hospital care than younger or middle aged people

2.5.3 Level of Education
Educational attainment has been identified as having a significant relationship on satisfaction, the trend being that greater satisfaction is associated with lower levels of education (Hall & Dornan, 1990). Much of this evidence is from the U.S. Anderson & Zimmerman (1993) found level of education to be the only variable significantly related to patient satisfaction with consultations in two Michigan clinics, patients with lower levels of education being most satisfied. Schutz et al., (1994) similarly found that higher educational attainment was strongly associated with dissatisfaction in patients undergoing colonoscopy. However, there is a notable lack of supportive evidence from the United Kingdom for this determinant, and it may be that other factors--such as income--are confounding the U.S. evidence.

2.5.4 Social Class
The relationship between satisfaction and social "class" is less consistent, the problem being that socioeconomic variables are often simply not assessed. Hall & Dornan (1990; p. 816) viewed social status as having "nearly significant relations" with satisfaction, but as greater satisfaction was associated with higher social status the authors added that it was "perplexing, to say the
least," that results for social status and education went in opposite directions. This may be partly explained by evidence from the U.S. by Hall & Dornan (1990), that more affluent patients simply receive better treatment from physicians than less privileged patients, even within the same health care facility. In the U.K., Savage et al., (1988), found that people in the "higher" social classes were better informed as regards available specific community services.

2.5.5 Gender
It has generally been found as described by Doering (1983), Delgado et al., (1993) that patient gender does not affect satisfaction values. In the meta-analysis conducted by Hall & Dornan, (1990), it was concluded that gender was not associated with patient satisfaction. However, Khayat & Salter reported that significantly more men than women were satisfied overall with their General Practitioner. Another British study by Williams & Calnan, (1991), found that female inpatients were far more likely to complain of rigid timetables and lack of privacy than men. An American study by Hall et al., (1994), reported that in the context of routine medical consultations lower satisfaction was associated with younger female physicians and the least satisfied were male patients examined by younger female physicians.

2.5.6 Ethnicity
Ethnic origin is perhaps one of the most complex determinant characteristics. From the United States there is evidence by Pascoe & Attkisson (1983), that whites on the whole are more satisfied than non-whites. However, Doering, (1983) identified the interaction of ethnicity and socioeconomic status to confuse results and be a cofounder. In the U.K., much of the work examining ethnicity as a determinant has focused on British Asian patients. Jones et al.,(1987)
identified as key problems language difficulties, principally with GPs, hospitals' staff attitudes to Asian patients, and hospital catering. The cultural standards and expectations of women from Asian communities are prominent in these studies; in particular, the examination of Muslim women by male doctors was highlighted as a source of distress. Evidence still suggests that the problems persist as illustrated by Madhok et al., (1992). In another study of the importance of ethno-cultural differences in the U.K. General Practice context presented a different conclusion Jain et al., (1985), found that choice of doctor was determined more by the proximity of the patient's home to the practice premises than by ethnic considerations. There was also little evidence that Asian women in the sample preferred to be examined by a female doctor.

2.6 COMPONENTS OF PATIENT SATISFACTION

Several classifications of components have been proposed, some appropriate only for specific health care contexts, others aiming at broad applicability. The key components described by Abdellah et al., (1965) and Risser (1975). These include the following:

2.6.1 Atmospherics or hospital environment and infrastructure

The general appearance of the hospital facilities and the staff provides to some extent tangible cues about the quality of services that patients can expect as illustrated by Andaleeb (2001). Rubin (1990), found that hospital environment and support services (such as catering) are emerging as important factors of patient satisfaction. Atmospheric factors such as comfort and appearance has been described by Anderson (1982) and Woodside et al., (1989) to influence patient satisfaction. Other factors that have been considered under atmospherics include issues like the general cleanliness of the facility, condition of the toilet facility, adequacy of water and the general appearance of the staff in the hospital.
2.6.2 Effectiveness of the organizational structure

This comprise of accessibility/convenience-factors involved in arranging to receive medical care (e.g. waiting times, ease of reaching provider); Rubin (1990), listed the ward management and discharge procedure as important consideration of satisfaction. McIver (1991), proposed accessibility, waiting times, waiting environment, attitude of staff, and patient information as critical components. Pascoe & Attiksson, (1983), also described accessibility of the facilities, and waiting times as key components. (Abdosh (2006), Singh et al., (1999) and Oljira (2001) all noted that short waiting time for registration and being seen by a health provider are associated with high satisfaction scores.

Andaleeb (2001), described discipline in the hospital environment as having the greatest impact on customer satisfaction. Poor discipline is reflected in staff members who are rude and argumentative, and who shirk routine duties that hospitals can most ill-afford, especially when suffering patients are entrusted to their care. While this finding is contrary to models in developed countries, the generally state of indiscipline in the service environment, and the poor management and administration of service delivery seem was observed as key component of satisfaction. Andaleeb (2001) suggests that greater gains in patient satisfaction can be realized by attending to discipline in the hospital environment.

2.6.3 Professional qualifications and competency of personnel

Ware et al.,(1983) identified technical quality of care for example competence of providers and adherence to high standards of diagnosis and treatment (e.g. thoroughness, accuracy, unnecessary risks, making mistakes) have been identified as key components of patients
perception of quality of care and satisfaction. Ben-Sira (1976), found that patients' views about the technical skill and medical competence of doctors were largely determined by their perceptions of quite different qualities of the doctor, primarily the extent to which the doctor was friendly and reassuring. There is, however, some evidence that patients are generally fairly good at assessing technical aspects of care or have a reasonable level of medical knowledge. Fitton & Acheson (1979) found a positive correlation between doctors' and patients' ratings of the seriousness of their medical condition; only a handful of patients misjudged the seriousness of their problem. Williams & Calnan (1991) attempted to assess the relative importance of various dimensions of satisfactions in a number of U.K. health care settings-- general practice, dentists, and hospital inpatients. Irrespective of medical context, the most important criteria were (1) professional competence and 2) the nature and quality of the patient/health professional relationship.

2.6.4 The provider's personal qualities and the nature of the interpersonal relationship

The interpersonal aspects of care (e.g. respect, concern, and friendliness, courtesy) are regarded as the principal component of satisfaction as illustrated by Blanchard et al.,(1990). Two aspects are regarded as particularly important: communication and empathy as described by Melver, 1991). There is evidence, however, to show that while nurses perceive technical competence as the mainstay of "high quality patient care" as described by Fitzpatrick et al.,(1992), Hogston (1995) and Kadner (1994), patient satisfaction in these studies were strongly influenced by nurses' interpersonal skills. Tishelman (1994), for example, found that almost all encounters described by patients as "exceptionally good" focused on aspects such as kindness, friendliness and emotional support.
rather than technical care. The importance of empathy and reassurance in the patient/health professional relationship in the coping strategies of patients with cancer was well-recognised by Krause (1993). This evidence seems to suggest that the health professional is perceived as communicating well when the patient feels he/she shows individualised interest, understanding and reassurance. For a service that is so salient and steeped in credence properties, the importance of patient-provider communication cannot be stressed strongly enough. At a minimum, patients want to know about their health condition, test results, and treatment procedures. Unfortunately, providers often fall short here, failing to communicate with patients and leaving them in a state of uncertainty and vulnerability. The impact of responsiveness and communication on patient satisfaction cannot be overemphasized. One study designed specifically to rank components was conducted with outpatients at an urban hospital in the United States (Pascoe & Attkisson, 1983). Six chosen components were each printed on cards which were then sorted and ranked by patients. Patients then rated both the absolute and relative quality of the six dimensions by placing each card along a continuum representing "service quality". The most important dimension was found to be the behavior of doctors and nurses. Andaleeb (2001), identified assurance, defined by Parasuraman et al., (1988), as knowledge and courtesy, and the ability to inspire trust as having the second greatest impact on patient satisfaction. In an environment where the professional demeanor and performance of the hospital staff, especially doctors, have often come under severe criticism, it is not surprising that patients were more satisfied when they felt more assured of their health outcomes. There is also evidence that for services with credence properties, assurance plays an important role in patient satisfaction (Zeithaml & Bitner, 2000).
2.6.5 Other factors

Abramowitz et al., (1987) proposed key areas for hospital care which included medical care, housekeeping, nursing care, nurses' aides, staff explanations of procedures and treatments, noise level, food, cleanliness, portering services, and overall quality. Baker (1991), identified five components of satisfaction in the U.K. primary care setting: continuity of care, accessibility of the surgery, quality of medical care, premises, and availability of doctors. Meredith et al., (1993), described that in the context of outpatients, the key elements of patient satisfaction listed by a group of surgeons included: information and informed consent, risk perception and preference Pascoe & Attkisson (1983) described clinical outcome and the attitudes of ancillary staff. Rao et al., (2006) described medicine availability, medical information as major determinants of patient satisfaction. Peyrot et al., (1993), observed that patient satisfaction and willingness to recommend the provider of the service were significantly related to the perceived worth of the service by the patient. The level of satisfaction is also related to the payment status as paying patients are less satisfied than non-paying patients with the overall quality of the service as observed by Oljira (2001).
CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1 STUDY DESIGN

A cross-sectional (snap shot study) survey was conducted at the Olabisi Onabanjo university teaching hospital Sagamu for two consecutive weeks to assess patient perception and satisfaction with health care service using a pre-tested, structured questionnaire.

3.2 ORGANISATION OF HEALTH CARE SERVICES IN NIGERIA

The health system in Nigeria (FMoH 1998) is organized at three levels namely:

- Primary health care which is the sole responsibility of the Local Government. This is the lowest level of care and the point of entry into the formal health system. This includes primary health centers, dispensary, maternity centers and health post.
- Secondary Level. This is the sole responsibility of the state government. This include general hospitals
- Tertiary level. This is primarily in the purview of the federal government. However because health is in the concurrent list of the Government, some state government like Ogun state have state owned teaching hospitals. other facilities offering tertiary care are Federal Medical Centres and Federal university teaching hospitals

Over the years there have been some major challenges in the delivery of health services in Nigeria (WHO 2002). These include:

- Inadequate decentralisation of services: PHC facilities offer a limited package of services. Most health services can only be accessed at secondary and tertiary levels that are concentrated in urban areas thus limiting access by rural populations.
• Weak referral linkages: There are weak referral linkages between the levels of health care, limiting the provision of health services across a continuum of care.

• Dilapidated health infrastructure: Dilapidated buildings and equipment are in need of repairs and maintenance or replacement to deliver even the basic services.

• Weak institutional and capacity: Currently, there is no effective system for supervision of health services in the public and private sectors.

3.3 STUDY LOCATION

3.3.1 Sagamu Local Government Area.

The study was carried out in Sagamu Local Government area in Ogun State, Nigeria. The town is a semi-urban area with an estimated population of 200,000 people (Federal Government of Nigeria 1998). It is located about 50km from Lagos and Ibadan. The predominant tribe is Yoruba. There is also a substantial Hausa settlement in the Sabo area of the town. There are three primary health centres, nine registered health dispensary/maternity homes, four registered private maternity homes, fourteen registered private hospitals, twenty registered clinics and one tertiary hospital (Olabisi Onabanjo University Teaching Hospital). The major occupation of the people is trading and farming. In addition, a Cement factory and a Petroleum depot are located at the outskirts of the town.

3.3.2 Olabisi Onabanjo University Teaching Hospital

The hospital was established in January 2, 1986 when the state government upgraded the then state general hospital Sagamu into a teaching hospital to serve Ogun State and its adjoining states. It was then named Ogun State University Teaching Hospital but it was later in 1999 renamed and is known as Olabisi Onabanjo University Teaching Hospital in 1999. The hospital
is funded solely by the Ogun State Government who pays staff salary and provides some running cost to the hospital. The hospital also generates funds from patients who pay for the services rendered.

The hospital management team consist of the Chief Medical Director (CMD) who is the chief executive of the hospital and a medical practitioner, the Chairman Medical Advisory Council (CMAC), who is the head of clinical services in the hospital, the Director of Nursing Services (DNS) and the Director of Administrative (DA). The state government appointed a board headed by a chairman to perform oversight function on the management of the hospital. There are 6 major clinical departments in the hospital. These include:

- **Department of Surgery**: this consist of sub-specialties like general surgery, radiology, ophthalmology, Ear Nose and throat (ENT) and orthopaedics, paediatric surgery and plastic surgery
- **Department of Internal Medicine**: this includes sub-specialties like Rheumatology, Endocrinology, Cardiology, Gastroenterology, Neurology and chest medicine.
- **Department of Obstetrics and Gynaecology**
- **Department of Paediatrics**.
- **Department of Community Medicine and Primary Care**
- **Department of General Medical Practice**

Each of the department has a Head of Department which oversees the activities of the department.

3.3.3. **Department of General Medical Practice**: This department is responsible for running the outpatient department of the hospital. The department is currently staffed with 5 doctors (4
resident doctors and one consultant) and six nurses. An average of 60 patients (ranges from between 50-70) is seen at the outpatients department daily. It must be however noted that not all the doctors are available at any point in time because some of them are on rotation to other departments as part of their residency training programme. At any given point in time at least 2 doctors are on duty. The commonest presentation at the outpatient includes diseases such as malaria, typhoid fevers, chest infections, diarrheal diseases and some non communicable disease such as hypertension, diabetes etc. when a patient requires to be attended to by a specialist they are referred to the consultant outpatient department. Patients pay for service at the hospital which include the cost of registration and consultation, investigations and for medicines.

3.3.4. The patient flow at the outpatient clinic includes:

- Medical records: this is usually the first point of call. The patients are then referred to the cash point where they pay N500 ($4-5) for registration and consultation. The patient pays this amount at every consultation. After payment at the cash point the patient brings the receipt to the medical records where a case folder is opened for the patients and the personal data of the patient is obtained.

- Nurses Station: At the nurse’s station, the vital signs such as the respiratory rate, Pulse rate, temperature and Blood pressure are taken from the patient and recorded. Other activities include weight and height measurement. Thereafter the nurses transfers the case note to the physician on duty

- Consulting room: Here the patients are seen by a physician who prescribes medicines to the patients and often orders for investigation in the laboratory or at the radiology unit depending on the condition of the patient. Some patients who need specialist care are
referred from here. When the patients are through from here, they are seen by the nurse who directs the patient appropriately to whatever next steps that needs to be carried out.

3.4 SAMPLE & DATA ANALYSIS

As a result of time constraints, only 349 interviews were conducted. A convenience sampling method was used to identify clients eligible to participate in this study. All adults (15 years and above) seeking medical attention at the outpatient clinics of the Olabisi Onabanjo university teaching hospital Sagamu, who consented to participate during the study period were enrolled into the study.

3.4.1 Questionnaire design

A preliminary version of the questionnaire was developed in English based on items from past research and insights from the in-depth interviews from 10 patients. The questionnaire was divided into three parts. The first section consist of demographic characteristics of the patient such as patients age, sex, marital status, education etc. the second section consist of questions relating to expectation of patients concerning the quality of health care delivery. The last section consists of measures depicting perceived service quality and patient satisfaction. The questions were translated into the local language and back into English to ensure standardization of terms for those who will need translation of the original English version into the Major local language (Yoruba). Each item was rated on a five –point Likert scale anchored at the numeral 1 with the verbal statement “Strongly Disagree” and at the numeral 5 with the verbal statement “Strongly Agree.” This format has been recommended for healthcare surveys (Elbeck, 1987; Steiber, 1989). The questionnaire was pre-tested to ensure that the wording, format, length, and sequencing of questions were appropriate.
In assessing general patient satisfaction, three questions were introduced which were a) overall how satisfied were you with the service you received at the hospital today (answers vary from very unsatisfied to very satisfied), b) How willing would you be to recommend the hospital to a friend (answers vary from very unwilling to very willing) and c) how willing will you be to return to the hospital in future if there is a need (answers vary from very unwilling to very willing). The responses were also rated on a Likert five scale point.

Data was collected from the respondents by 4 trained interviewers who were not workers of the hospital and had no medical training or qualifications to avoid introduction of bias in the study.

3.4.2 Data analysis
During analysis, Patients who respond as 1 (very dissatisfied), 2 (dissatisfied) and 3 (Neutral) will be classified as dissatisfied while those who respond 4 (satisfied) and 5 (very satisfied) will classified as satisfied. All data was analyzed by computer using SPSS, Version 10 statistical package (SPSS 1999). Frequency distribution and other descriptive statistics will be presented in tables. Significant associations between independent variables and patient satisfaction will be tested using multiple logistic regressions.

Principal component analysis was done on the data to identify important dimensions of patient perception. During analysis, those factors that loaded substantially on more than one factor were dropped.

3.5 LIMITATION OF STUDY

Time was a major constraint to the comprehensiveness of the study. Many patients did not disclose their income and as such this variable was removed from the analysis.
## 4.0 RESEARCH FINDINGS

### 4.1 TABLES

Table 4.1: Socio-demographic characteristics of respondents

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency</th>
<th>Percentage</th>
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<tr>
<td><strong>Age group (in years)</strong></td>
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<td></td>
</tr>
<tr>
<td>≤20</td>
<td>27</td>
<td>7.7</td>
</tr>
<tr>
<td>21-30</td>
<td>169</td>
<td>48.4</td>
</tr>
<tr>
<td>31-40</td>
<td>93</td>
<td>26.6</td>
</tr>
<tr>
<td>41-50</td>
<td>48</td>
<td>13.8</td>
</tr>
<tr>
<td>51-60</td>
<td>9</td>
<td>2.6</td>
</tr>
<tr>
<td>&gt;60</td>
<td>3</td>
<td>0.9</td>
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<td><strong>Sex</strong></td>
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<td></td>
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<td>75</td>
<td>21.5</td>
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<tr>
<td>Female</td>
<td>274</td>
<td>78.5</td>
</tr>
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<td></td>
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<tr>
<td>No formal education</td>
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<td>1.7</td>
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<td>Primary</td>
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<tr>
<td>Secondary</td>
<td>108</td>
<td>30.9</td>
</tr>
<tr>
<td>Post Secondary</td>
<td>190</td>
<td>54.4</td>
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<td><strong>Marital Status</strong></td>
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<td>Married</td>
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<td>72.5</td>
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<tr>
<td>Not employed</td>
<td>105</td>
<td>30.1</td>
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<td><strong>Place of Residence</strong></td>
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<td>Within Sagamu</td>
<td>220</td>
<td>63.0</td>
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<td>Within Ogun state</td>
<td>81</td>
<td>23.2</td>
</tr>
<tr>
<td>Outside Ogun State</td>
<td>49</td>
<td>13.8</td>
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<td><strong>Gender of Health worker</strong></td>
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<tr>
<td>Male</td>
<td>274</td>
<td>78.5</td>
</tr>
<tr>
<td>Female</td>
<td>75</td>
<td>21.5</td>
</tr>
<tr>
<td><strong>Type of visit</strong></td>
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<td></td>
</tr>
<tr>
<td>Accessing care for the first time</td>
<td>169</td>
<td>48.4</td>
</tr>
<tr>
<td>Accessed care more than once</td>
<td>170</td>
<td>51.6</td>
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Table 4.2: Socio demographic characteristics associated with satisfaction with health care service

<table>
<thead>
<tr>
<th>Factors</th>
<th>Satisfied N= 290</th>
<th>Not satisfied N=59</th>
<th>Chi square</th>
<th>O.R(95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>163</td>
<td>33</td>
<td>0.000</td>
<td>1.01(0.55-1.84)</td>
<td>0.969</td>
</tr>
<tr>
<td>&gt;30</td>
<td>127</td>
<td>26</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>51</td>
<td>24</td>
<td>15.49</td>
<td>0.31(0.16-0.59)</td>
<td>0.0001*</td>
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<tr>
<td>female</td>
<td>239</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
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<td>Marital status</td>
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<td></td>
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<tr>
<td>Married</td>
<td>227</td>
<td>26</td>
<td>28.77</td>
<td>4.57(2.45-8.56)</td>
<td>0.0001*</td>
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<tr>
<td>Not married</td>
<td>63</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employ. Status</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>204</td>
<td>30</td>
<td>11.04</td>
<td>2.59(1.4-4.79)</td>
<td>0.0001*</td>
</tr>
<tr>
<td>unemployed</td>
<td>76</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal edu/primary</td>
<td>39</td>
<td>12</td>
<td>5.5</td>
<td>-</td>
<td>0.06</td>
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<tr>
<td>Secondary</td>
<td>85</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post secondary</td>
<td>166</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Sagamu</td>
<td>185</td>
<td>35</td>
<td>0.82</td>
<td>-</td>
<td>0.66</td>
</tr>
<tr>
<td>Within ogun state</td>
<td>66</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside ogun state</td>
<td>42</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First time</td>
<td>146</td>
<td>23</td>
<td>2.53</td>
<td>1.89(0.86-2.92)</td>
<td>0.111</td>
</tr>
<tr>
<td>More than once</td>
<td>144</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>99.24±82.4 min</td>
<td>151.67±108.19 mins</td>
<td>3.358</td>
<td></td>
<td>0.001*</td>
</tr>
<tr>
<td>Consulting time</td>
<td>14.59±8.8min</td>
<td>11.07±5.9</td>
<td>2.55</td>
<td></td>
<td>0.011*</td>
</tr>
</tbody>
</table>

*=statistically significant p<0.05
### Table 4.3: Multiple Logistic Regressions of socio-demographic predictors of patient satisfaction

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.013</td>
<td>.176</td>
<td>.006</td>
<td>1</td>
<td>.940</td>
<td>.987</td>
</tr>
<tr>
<td>sex</td>
<td>1.104</td>
<td>.349</td>
<td>10.018</td>
<td>1</td>
<td>.002*</td>
<td>3.015</td>
</tr>
<tr>
<td>marital</td>
<td>.391</td>
<td>.371</td>
<td>1.115</td>
<td>1</td>
<td>.291</td>
<td>1.479</td>
</tr>
<tr>
<td>employed</td>
<td>.951</td>
<td>.358</td>
<td>7.055</td>
<td>1</td>
<td>.008*</td>
<td>2.588</td>
</tr>
<tr>
<td>education</td>
<td>.321</td>
<td>.200</td>
<td>2.571</td>
<td>1</td>
<td>.109</td>
<td>1.378</td>
</tr>
<tr>
<td>residence</td>
<td>-.014</td>
<td>.227</td>
<td>.004</td>
<td>1</td>
<td>.952</td>
<td>.986</td>
</tr>
<tr>
<td>Constant</td>
<td>-2.183</td>
<td>.944</td>
<td>5.345</td>
<td>1</td>
<td>.021</td>
<td>.113</td>
</tr>
</tbody>
</table>

a Variable(s) entered on: age, sex, marital, employed, education, residence.
*statistical significance p<0.05

### Table 4.4: overall regression of factors associated with patient satisfaction

<table>
<thead>
<tr>
<th>Mode</th>
<th>R Square</th>
<th>Adj R Square</th>
<th>Std. Error of the Estimate</th>
<th>R Square Change</th>
<th>F Change</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F Change</th>
<th>Durbin-Watson</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.830</td>
<td>.689</td>
<td>.668</td>
<td>.566</td>
<td>.689</td>
<td>33.278</td>
<td>20</td>
<td>301</td>
<td>.000</td>
</tr>
</tbody>
</table>

a Predictors: (Constant), waitingtimetoolong, informationillness, payingpolite, water, medrecordstoolong, staffwelldressed, waitingroom, toiletsgood, docskillful, medrecordpolite, cleanliness, nursecourteous, informationtreatment, telleverything, nursetrained, docwaspolite, adequatetime, examined, nursehelpful, docanswerquest

b Dependent Variable: satisfaction
Table 4.5: Descriptive statistics of the final scale items

<table>
<thead>
<tr>
<th>Scale items</th>
<th>Mean (SD)</th>
<th>Strongly disagree (%)</th>
<th>Disagree (%)</th>
<th>Neutral (%)</th>
<th>Agree (%)</th>
<th>Strongly Agree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information illness</td>
<td>4.04 (1.13)</td>
<td>24(6.9)</td>
<td>18(5.2)</td>
<td>15(4.3)</td>
<td>154(44.1)</td>
<td>138(39.5)</td>
</tr>
<tr>
<td>Information treatment</td>
<td>4.03(1.08)</td>
<td>18(5.2)</td>
<td>24(6.9)</td>
<td>18(5.2)</td>
<td>160(45.8)</td>
<td>129(37.0)</td>
</tr>
<tr>
<td>Doc was polite</td>
<td>4.18(0.99)</td>
<td>21(6.0)</td>
<td>3(0.9)</td>
<td>9(2.6)</td>
<td>175(50.1)</td>
<td>141(40.4)</td>
</tr>
<tr>
<td>Doc answer quest</td>
<td>4.15(0.96)</td>
<td>18(5.2)</td>
<td>6(1.7)</td>
<td>12(3.5)</td>
<td>184(52.7)</td>
<td>129(37.0)</td>
</tr>
<tr>
<td>Adequate time</td>
<td>4.10(0.90)</td>
<td>15(4.3)</td>
<td>9(2.6)</td>
<td>9(2.6)</td>
<td>208(59.6)</td>
<td>108(30.9)</td>
</tr>
<tr>
<td>Examined properly</td>
<td>4.21(0.84)</td>
<td>12(3.4)</td>
<td>6(1.7)</td>
<td>3(0.9)</td>
<td>202(57.9)</td>
<td>126(36.1)</td>
</tr>
<tr>
<td>Tell everything</td>
<td>4.17(1.00)</td>
<td>15(4.3)</td>
<td>15(4.3)</td>
<td>15(4.3)</td>
<td>154(44.1)</td>
<td>150(43.0)</td>
</tr>
<tr>
<td>Doc skillful</td>
<td>4.33(0.87)</td>
<td>12(3.4)</td>
<td>3(0.9)</td>
<td>12(3.4)</td>
<td>154(44.1)</td>
<td>168(48.1)</td>
</tr>
<tr>
<td>Nurse courteous</td>
<td>4.09(1.03)</td>
<td>15(4.3)</td>
<td>21(6.0)</td>
<td>18(5.2)</td>
<td>157(45.0)</td>
<td>138(39.5)</td>
</tr>
<tr>
<td>Med record polite</td>
<td>3.99(1.12)</td>
<td>24(6.9)</td>
<td>21(6.0)</td>
<td>12(3.4)</td>
<td>169(48.4)</td>
<td>123(35.2)</td>
</tr>
<tr>
<td>Paying polite</td>
<td>3.84(1.19)</td>
<td>33(9.5)</td>
<td>19(5.4)</td>
<td>24(6.9)</td>
<td>168(48.1)</td>
<td>105(30.1)</td>
</tr>
<tr>
<td>Med records too long</td>
<td>2.49(1.42)</td>
<td>99(28.4)</td>
<td>129(37.0)</td>
<td>18(5.2)</td>
<td>48(13.8)</td>
<td>52(14.9)</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>3.92(1.09)</td>
<td>21(6.0)</td>
<td>21(6.0)</td>
<td>21(6.0)</td>
<td>184(52.7)</td>
<td>102(29.2)</td>
</tr>
<tr>
<td>Toilets good</td>
<td>3.07(1.42)</td>
<td>72(20.7)</td>
<td>69(19.8)</td>
<td>27(7.7)</td>
<td>127(36.4)</td>
<td>54(15.5)</td>
</tr>
<tr>
<td>Water adequate</td>
<td>2.91(1.39)</td>
<td>84(24.1)</td>
<td>58(16.6)</td>
<td>51(14.6)</td>
<td>111(31.8)</td>
<td>42(12.0)</td>
</tr>
<tr>
<td>Staff well dressed</td>
<td>4.27(0.81)</td>
<td>9(2.6)</td>
<td>6(1.7)</td>
<td>6(1.7)</td>
<td>190(54.4)</td>
<td>138(39.5)</td>
</tr>
<tr>
<td>Waiting room comfortable</td>
<td>3.54(1.31)</td>
<td>51(14.6)</td>
<td>24(6.9)</td>
<td>39(11.2)</td>
<td>157(45.0)</td>
<td>78(22.3)</td>
</tr>
<tr>
<td>Waiting time too long</td>
<td>2.15(1.10)</td>
<td>99(28.4)</td>
<td>168(48.1)</td>
<td>24(6.9)</td>
<td>43(12.3)</td>
<td>15(4.3)</td>
</tr>
</tbody>
</table>
Table 4.6: Final scale items and rotated factor loadings

<table>
<thead>
<tr>
<th>Scale items</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Doctor communication and behaviour</td>
<td>Hospital infrastructure</td>
<td>Hospital staff behaviour</td>
<td>Waiting time</td>
</tr>
<tr>
<td>Adequate time</td>
<td>.886</td>
<td>.087</td>
<td>.128</td>
<td>.022</td>
</tr>
<tr>
<td>examined</td>
<td>.874</td>
<td>.077</td>
<td>.160</td>
<td>-.008</td>
</tr>
<tr>
<td>Tell every thing</td>
<td>.863</td>
<td>.125</td>
<td>.143</td>
<td>-.075</td>
</tr>
<tr>
<td>Doc was polite</td>
<td>.826</td>
<td>.117</td>
<td>.247</td>
<td>-.006</td>
</tr>
<tr>
<td>Doc answer quest</td>
<td>.817</td>
<td>.120</td>
<td>.310</td>
<td>.014</td>
</tr>
<tr>
<td>Doc skillful</td>
<td>.811</td>
<td>.002</td>
<td>.186</td>
<td>-.101</td>
</tr>
<tr>
<td>Information treatment</td>
<td>.735</td>
<td>.358</td>
<td>.096</td>
<td>.063</td>
</tr>
<tr>
<td>Information illness</td>
<td>.691</td>
<td>.368</td>
<td>.019</td>
<td>.066</td>
</tr>
<tr>
<td>Toilets good</td>
<td>.014</td>
<td>.774</td>
<td>.118</td>
<td>.022</td>
</tr>
<tr>
<td>Water adequate</td>
<td>.046</td>
<td>.632</td>
<td>.071</td>
<td>-.050</td>
</tr>
<tr>
<td>Waiting room</td>
<td>.338</td>
<td>.577</td>
<td>-.168</td>
<td>-.029</td>
</tr>
<tr>
<td>cleanliness</td>
<td>.322</td>
<td>.547</td>
<td>.219</td>
<td>.416</td>
</tr>
<tr>
<td>Staff well dressed</td>
<td>.108</td>
<td>.543</td>
<td>.146</td>
<td>-.016</td>
</tr>
<tr>
<td>Paying polite</td>
<td>.181</td>
<td>.127</td>
<td>.856</td>
<td>.050</td>
</tr>
<tr>
<td>Nurse courteous</td>
<td>.422</td>
<td>.102</td>
<td>.727</td>
<td>-.018</td>
</tr>
<tr>
<td>Med record polite</td>
<td>.398</td>
<td>.256</td>
<td>.494</td>
<td>-.304</td>
</tr>
<tr>
<td>Med records too long</td>
<td>.029</td>
<td>-.051</td>
<td>-.092</td>
<td>.792</td>
</tr>
<tr>
<td>Waiting time too long</td>
<td>-.084</td>
<td>.033</td>
<td>.039</td>
<td>.787</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Eigen Value</th>
<th>% variation</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>7.211</td>
<td>40.061</td>
<td>40.061</td>
</tr>
<tr>
<td>Factor 2</td>
<td>1.822</td>
<td>10.121</td>
<td>50.182</td>
</tr>
<tr>
<td>Factor 3</td>
<td>1.478</td>
<td>8.208</td>
<td>58.391</td>
</tr>
<tr>
<td>Factor 4</td>
<td>1.198</td>
<td>6.654</td>
<td>65.045</td>
</tr>
</tbody>
</table>

**Rotated Component Matrix (a)**

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 5 iterations.
Items in bold suggest the significant domain
Table 4.7: Scale reliability and perceived quality and general patient satisfaction

<table>
<thead>
<tr>
<th>Scale items</th>
<th>Cronbach’s alpha coefficients</th>
<th>Mean(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General patient satisfaction (3 items)</td>
<td>0.89</td>
<td>3.89±0.1</td>
</tr>
<tr>
<td>Overall perceived quality (21 items)</td>
<td>0.89</td>
<td>3.78±0.61</td>
</tr>
<tr>
<td>Perceived quality subscales</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors communication and behavior (seven items)</td>
<td>0.94</td>
<td>4.15±0.08</td>
</tr>
<tr>
<td>Hospital infrastructure (five items)</td>
<td>0.66</td>
<td>3.53±0.34</td>
</tr>
<tr>
<td>Supportive staff behavior (three items)</td>
<td>0.74</td>
<td>3.97±0.01</td>
</tr>
<tr>
<td>Waiting time (two items)</td>
<td>0.51</td>
<td>2.32±0.05</td>
</tr>
</tbody>
</table>

Table 4.8: Patients expectations of service quality

<table>
<thead>
<tr>
<th>Expectations</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal consultation time</td>
<td>20±8.0 mins</td>
</tr>
<tr>
<td>Optimal waiting time</td>
<td>33.3±20 mins</td>
</tr>
<tr>
<td>Politeness</td>
<td>98%</td>
</tr>
<tr>
<td>Privacy</td>
<td>82%</td>
</tr>
</tbody>
</table>
4.2 FIGURES

Figure 4.1: percentage of satisfaction for the different factors

![Bar chart showing percentage of satisfaction for various factors.](image-url)
Figure 4.2: Boxplot showing waiting times according to level of satisfaction
Figure 4.3: Boxplot showing consultation time according to level of satisfaction
4.3 RESULTS NARRATIVE

A total of 349 persons attending the hospital during the study period were interviewed. Table 4.1 illustrate that majority of the respondents were females (78.5%) and in the age group 21-30 years (44.8%). The females were significantly younger than males (31.02±7.399 vs 35.14±14.88; p=0.000). Most of the users were married (72.5%), had post secondary education (54.4%), employed (69.9%), lived within Sagamu (63%) and was seen by a male doctor (78.5%). The overall mean waiting time was 106±88.4 mins, while the average consultation time reported by the patients was 13.98±8.49 mins. A total of 290 (83.1%) patients were satisfied with overall service received at the hospital.

Table 4.2 describes the socio-demographic characteristics associated with patient satisfaction. On bi-variate analysis; females, married and employed patients were significantly more satisfied compared to males, unmarried and unemployed patients respectively. Patient who were satisfied spent comparably shorter waiting time than patients who were not satisfied. Patients who were satisfied spent significantly more time with the physician compared with those not satisfied with the service. However, during multivariate analysis in Table 4.3, only sex and employment status were significantly associated with patient satisfaction.

Table 4.4 shows the overall regression of specific factors of perceived quality of care and patient satisfaction. Analysis of residuals indicated that the model fit was good. All the perceived quality dimensions such as information on illness, availability of water, general cleanliness of the facility, politeness of cashier at pay point, nurses courteous etc were significantly related to overall satisfaction. However waiting time both at the medical records and before being attended to by a physician were negatively associated with patient satisfaction.
Table 4.5 shows the descriptive statistics of the final scale after factor analysis. The mean for waiting time scale at the medical records (2.49±1.42) and before being attended to by the physician (2.15±1.19) were below the average of 2.5 points of the Likert scale.

Table 4.6 describes the final scale items and their rotated factor loadings. The relative impact of the four factors on overall patient satisfaction was analysed using factor analysis, multiple regression and correlation analysis. The factor analysis helped in identifying four significant predictor variables responsible for patient satisfaction which are doctor communication and behaviour, hospital infrastructure, hospital staff behaviour and waiting time. The factor analysis was the key tool used to identify the key determinant of patient satisfaction and thus provided answer to the second to fifth research question. The percentage of variance explained by these four variables was 0.40, 0.10, 0.82 and 0.67 (Table 6). The factors are described in detail below:

**Doctors Communication and Behaviour**

This factor accounts for 40 percent of the total variance. The study has identified 8 items out of 18 on the basis of a factor loading values greater than 0.50 (ranging from 0.69-0.88), which explains the degree of satisfaction with regards to doctors communication and behaviour. These items include doctor had adequate time, examined me well. Had time to tell doctor everything, doctor was polite, doctor was skilful, doctor gave me information about my illness and doctor gave me information about my treatment.

**Hospital infrastructure or Atmospherics**

This factor accounted for 10% of the total variance. Out of the questions asked, five variables were identified on the basis of factor loading which were toilets in good condition (0.77), availability of water (0.63), waiting room was comfortable (0.58), cleanliness and staff properly
dressed (0.54). This factor mainly emphasizes the general environmental condition of the hospital facility.

**Supportive hospital staff behaviour**

The variables identified under supportive staff behaviour were staff at the paying counter were polite, medical record staff were polite, nurses were courteous. This factor accounted for 8.2% of the total variance.

**Waiting time**

The variables identified on the last variable on waiting time were two. Waiting time at the medical records (0.792) and waiting time before being attended to by a physician (0.787). These two accounted for 6.7% of the total variance.

Table 4.7 demonstrates the scale reliability and validity. The Cronbach’s alpha coefficients ranged from 0.51 to 0.94. This demonstrates a high level of internal consistencies of the scale and sub scales. The Cronbach’s alpha for doctor communication and behaviour was 0.94, hospital infrastructure 0.66, supportive hospital staff behaviour 0.74 and waiting time 0.51.

Table 4.8 demonstrates that the average consultation time considered as optimal was 20±8.0 mins while the optimal waiting time was 33.3±20 mins. Almost all patients expected politeness from all hospital staff (98%) and privacy (82.8%).

Figure 4.1 illustrates that the least degree of satisfaction was observed for waiting time between registrations and being seen by the provider and waiting time at the medical records. This is followed by adequate water in the facility and the general condition of the toilet in the facility. However, the satisfactions level related to doctor communication and behavior were higher.
Figure 4.2 shows that there is a statistically significant relationship between waiting time and patient satisfaction. Those satisfied had a shorter waiting time compared with those not satisfied.

Figure 4.3 describes that those who were satisfied spent a longer time of consultation with the physician compared to those who were not satisfied. The relationship was statistically significant.
CHAPTER FIVE:

5.0 DISCUSSIONS

5.1 Overall satisfaction level
The overall satisfaction level of the patients in this study was 83.1%. This is similar to the 88% obtained in similar study by Peyrot et al., (1993), but was higher than 68% reported in Bangladesh by Aldana et al., (2001), 74% reported by Singh et al., (1999) in Trinidad and Tobago and 54% by Abdosh (2006) in Ethiopia. The high overall satisfaction may be as a result of the type of facility under study, which is a tertiary hospital that offers both general and specialized health care services. In Nigeria any patient can access service in a tertiary facility without referral from a lower health care level. This is possible because there are no strict criteria for accessing care at the tertiary hospital. Also with the current situation in the country where primary health care centers and some General hospitals (providing secondary care) are in a state of coma as a result of inadequate staff, essential medicines and dilapidated health infrastructure to mention a few, patients rather seek care at the tertiary health facility as their first option most especially when the hospital is located close to their place of residence. The patients view the tertiary hospital as the “final arbiter” where quality care can be obtained by the masses. However, with the increasing number of patients accessing care at the tertiary facilities, the facilities in the hospital are overstretched and may have contributed to the long waiting time experienced by patients.

5.2 Waiting time
The reported average waiting time in this study was 1 hour 46 mins. This is lower than 2 hours 40 mins observed in a similar study by Singh et al., (1999) and higher than 30 mins obtained by
Ortola P et al., (1993) in developed countries. The longer waiting time could be as a result of the disparity in the doctors/patient ratio which is prevalent in most developing countries including Nigeria. In addition it was noted that the average reported waiting time was far more than the expected optimal waiting time expressed by the patients. This could have led to the strong dissatisfaction expressed with regards to waiting time. In agreement with Singh et al., (1999) and Oljera (2001), this study reported that patients who experienced a shorter waiting time were significantly more satisfied with the service. Some patients commented that in order to shorten waiting time at the clinic, management should employ more physicians and enforce physicians to resume working on time.

5.3 Consultation time

The average consultation time reported was 14 min. This was more than the 3 mins or less reported by Singh et al., (1999). The longer consultation time in this study allowed more time for provider-patient interaction and thus may be responsible for the higher satisfaction rate reported. It was also noted that patients who had longer consultation time with the provider were significantly more satisfied compared with those not satisfied. The increase in consultation time may have offset the weaknesses observed in other parameters of perceived quality and satisfaction. Zyzanski et al., (1998) and Margolis SA et al., (2003) reported that increase in consultation time between the patient and the provider tends to increase patient satisfaction with health care service. In addition, the perceived optimal average consultation time of 20 mins was a more realistic figure than 2 mins experienced by patients in Bangladesh reported by Aldana et al., (2001). The consultation time in this study is fairly reasonable for providers to allow for interpersonal interaction and make correct diagnosis and treatment. Other studies (Hashemi S et al., 1995; Hossain et al., 1991) assessing performance of providers have confirmed that a short
consultation time did not allow for correct diagnosis or proper management of patients. Our study suggests that the expectations of patients are more likely in line with provider’s judgment than the study in Bangladesh.

5.4 Satisfaction and socio-demographic variables

The level of satisfaction was related to sex. Women were significantly more satisfied with the quality of health care services compared with men. In our society men are bread winners who carters for the needs of the family. Women are majorly self employed or unemployed and as such they have no pressure on time compared to men. Men are less likely to be comfortable spending the major part of the day in the health care centers. Daniel et al., (2003) observed that Nigerian women are more likely to seek health care service and comply with treatment compared with men who are breadwinners. Hansen et al., (2008) reported that patient sex is not associated with satisfaction. However, Al Qatari G (1999) found an association of sex on patient satisfaction. In agreement with other studies Hansen et al., (2008) and Al Qatari G (1999) there was no significant relationship between level of patient satisfaction and age, educational status, marital status and place of residence. Surprisingly the study observed a significant relationship between employment status and satisfaction. This may be due to how employment in public service is structured. Wages are paid on a monthly basis not putting into consideration the amount of hours the individual have put into work. This is contrary to developed countries where individuals are paid only for the amount of work done. Thus patients can afford to spend the whole day in the clinic without any negative financial implication.

5.5 Perceived service quality

This study described the development of an 18-item scale that can be used to measure perceived quality of out-patients in a tertiary hospital in Nigeria. The analysis identified four distinct
dimensions of perceived quality: (i) doctor communication and behaviour, (ii) hospital infrastructure or atmospherics, hospital supportive staff behaviour and waiting time. These dimensions provide information on the process of care which includes getting an appointment to see the physician, being attended to by the nurse for vital signs and eventually being attended to by the physician. The scale items were found to be reliable and valid with a high alpha coefficient of the overall quality perception scale. The study shows that patient satisfaction and perception of quality are favourable on the average except for issues around waiting time. Interpersonal skills of the medical personnel such as communication and behavior have a large influence on patient satisfaction. Many other studies (Haddad et al., 2000; Rao KD et al., 2006; Hansen et al., 2008; Doung DV et al., 2004) concurred with these findings. The higher scores on the doctor behavior subscale have been observed by Lewis (1994) to be due to acquiescence bias and by Thi et al., (2002) to be as a result of gratitude bias.

On the ‘health infrastructure’ subscale, respondents scored less than optimal. It has been established by Andaleeb SS (2001), Abdosh et al., (2004) among others that the physical environment of health settings can impact on client perceived quality of care. Although clients may not be able to evaluate whether a specific technical procedure is appropriate, they can, however, assess quality according to the availability of general cleanliness, proper dressing of health care workers, adequacy of water and the condition of the conveniences in the health facility. This finding is also corroborated by Hardip Chahal et al., (2004) suggest that health infrastructure sometimes called atmospherics contribute to patient satisfaction.

In agreement with other studies (Aldana et al., 2001; Ehiri et al., 2005) and Hansen et al., (2008), It was observed from that longer waiting time both at the medical records and before being attended to by a physician had a negative effect on client perception of quality and
satisfaction. These are important areas in which health services need to strengthen. Other studies have also identified this as an important contribution to patient satisfaction especially in studies carried out in developing countries.

The last scale item described in this study was the behavior of supportive hospital staff. The interpersonal behavior of supportive staff is an important determinant of patient satisfaction. The interpersonal attributes of these frontline staff right from when the patient enters the facility until when the patient exit from the facility is very important. However in many public hospitals in developing countries this aspect of service quality is not usually addressed. Andaleeb et al., (2001) observed that front-line employees and the support staff are among the most vital to the success of any service organization. This is true because from research, it has been suggested that satisfied employees make for satisfied customers (Zeithaml & Bitner, 2000). It was also stressed that employee satisfaction and customer satisfaction feed off each other: satisfied employees reinforce customer satisfaction, which in turn reinforces employee satisfaction.

In conclusion, the study has stressed the importance of incorporating patient views into quality assessment which offers one way of making health services more responsive to people’s needs. It also gives users an opportunity to voice their opinion about the status of the health services. Involving patients in evaluating their health services will make providers more sensitive and alert to patient needs.
CHAPTER SIX:

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

The study was set out to test the following hypothesis:

Hypothesis 1:

The present study demonstrates that patient satisfaction was significantly associated with sex and employment status. However educational status, age marital status and place of residence were not significantly associated with patient satisfaction.

Hypothesis 2:

The study highlights that good quality communication was significantly associated to patient satisfaction. Good communication was one of the main domains identified by factor analysis to be related to patient satisfaction.

Hypothesis 3:

The study identified long waiting time at the medical records and before being attended to by the physician as the most powerful factors that negatively affected patient satisfaction. Patients who had a shorter waiting time were more satisfied with health care service compared with those who had a much longer waiting time.

Hypothesis 4:

The study reveals that patient satisfaction was related to the perceived responsiveness of the hospital staff (expressed by questions such as doctor, nurse, staff at medical records and paying centres were polite was courteous). Supportive behaviour from the doctor and other staffs were
identified by factor analysis as a major domain that was significantly related to patient satisfaction

**Hypothesis 5:**

The study demonstrates that the most important factor on patient satisfaction was related to the perceived skill and competence of the physician (expressed by questions such as doctor was skilful, physician examined properly). This could be particularly so because the study took place in a tertiary hospital facility.

**Hypothesis 6:**

The study identified a separate domain for health care infrastructure. Items such as clean toilets, adequate water supply, staffs well dressed and general cleanliness maintained throughout the facility were associated with patient satisfaction.

**Hypothesis 7:**

The study identified four significant predictor variables responsible for patient perception of quality which are doctor communication and behaviour, hospital infrastructure, hospital staff behaviour and waiting time. The highest score of patient satisfaction was related to issues surrounding the competence and skill of the physician. On the other hand it was observed that the department is staffed with 5 doctors though many times 2 or 3 of them are always on seat. The patient description of long waiting time is not far from reality due to the lackadaisical behaviour of doctors who do not report to work on time thereby keeping patients waiting for long hours before being attended to. The study however, was restricted to the views of users of health service and it identified bottlenecks in the health care delivery system which are actual and concrete. These issues need to be addressed in order to improve the quality of health care service delivery at the outpatient clinic of the Olabisi Onabanjo University Teaching Hospital.
Hypothesis 8:

The study mostly agrees with other theory on the subject of patient satisfaction. It identified four major domains that affect satisfaction of patients. However, unlike other studies in literature waiting time at the medical records and waiting time before being attended to by the physician came out as a distinct domain associated with patient satisfaction. This finding needs to be validated by other studies in similar settings. Also the high percentage of overall patient satisfaction observed in this study concur with the observation by Bond & Thomas (1992), that the high levels of satisfaction which are constantly reported from just about every sphere of health care suggest that the large majority of patients are either very happy with almost everything, or that patients' expectations are generally low especially in developing countries where patients rights are still non existence or at best at the infancy stage. Furthermore Fitzpatrick (1984) argued that socially created expectations are the primary determinant of the degree of satisfaction. When expectations are not high patients are likely to be satisfied at about anything. Patients are likely to judge the health care provider simply by the resolution of their ailment or illness rather than issues such as waiting time, health infrastructure and staff behavior etc. Other comparison between what was obtained in this study and the theories in literature were fully discussed in the previous chapter.

6.2 RECOMMENDATIONS

Based on the findings of the study, the following recommendations are hereby made:

1. To the management of Olabisi Onabanjo University Teaching Hospital:
a. To address the long waiting time experienced by patients, there is a need for management to employ more staff at the clinic. Also management should enforce that doctors resume at the clinic on time to shorten waiting time. In line with this, we recommend that a Television set should be installed at the reception area while patients are waiting to be attended to by the physician. This could be used as a medium to disseminate health information and keeps the patient busy while waiting to see the physician. Also the constant supply of electricity is necessary to power the mechanical ventilation at the reception area which will in turn increase the comfort of patient while waiting.

b. The management also need to place emphasis on some element that are associated with patient satisfaction such as the general cleanliness of the hospital, the condition of the toilet facility and the adequacy of water in the facility. Patients were averagely satisfied with these and there will be need to improve on these in order to increase satisfaction of patients.

c. The need for hospital staff (doctors and other supportive staff) to be trained in interpersonal skills such as communication, respect, politeness etc. these elements are observed to be important determinant of patient satisfaction.

2. To the Government:

a. There is the need to strengthen the primary and secondary health care levels in the country by the provision of adequate skilled manpower and medicines. This will decrease the number of people accessing care at the tertiary health facility for non-specialized care. This will invariably decrease waiting time of patients.

b. The government in addition may need to establish a referral system mechanism where only patients with referral from a lower level of health care can access services
at the tertiary facility. This will also lead to fewer number of patients visiting the tertiary health facility and allow physicians have more interaction with patients.

c. Appropriate motivation of hospital staff at all levels. it is only when staff are happy with their work that they can re-enforce patient satisfaction.

d. Government should undertake satisfaction surveys regularly at the different level of health care i.e. primary, secondary and tertiary. This will enable the government to evaluate these hospitals from the patients’ point of view and therefore compel the management of these hospitals to make necessary amendment to better serve the people the services were meant for in the first instance.

3. To the patients:

   a. The patients need information on what the ideal or minimum standards of health care service delivery should be. It is only after such information that they can make demand on government and hospital authorities to provide minimum standards of care.

**Recommendations for Future Research**

The results of the current study provide some understanding of the effects of socio-demographic factors on patient satisfaction. It also identified the impact of 4 factors on the overall patient satisfaction such as doctor communication and behaviour, hospital infrastructure, hospital staff behaviour and waiting time before accessing the service. However, the results may not be generalized to other settings because patients were not randomly selected. The study needs to be replicated in other settings to examine the reliability and validity of the findings. The study
focused on the processes the patient goes through from the reception until when the patients exit from the consulting room of the doctor. Further research is therefore needed to investigate the effect of other variables such as interaction of the patients with pharmacy, laboratory or radiology investigations and the experiences of in-patients on satisfaction.
CHAPTER SEVEN:

7.0 REFERENCES


74. Peterson, K. (1988), Guest Relations: Substance or Fluff ?. Healthcare Forum, 31 (March/April), 23-6


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**APPENDIX**

**QUESTIONNAIRE ON PATIENT’S SATISFACTION WITH SERVICES AT OLABISI ONABANJO UNIVERSITY TEACHING HOSPITAL, SAGAMU.**

Dear patient, we will kindly appreciate, if you can take off some minutes to answer few questions on your experience at the hospital today. This study is not in any way to victimise anyone, but to assist management to improve services at this hospital so as to serve you better. Thank you for your cooperation.

<table>
<thead>
<tr>
<th>S/N</th>
<th>SECTION A: Socio-demographic characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age: as at the last birthday (specify)...........</td>
</tr>
<tr>
<td>2</td>
<td>Sex: male O female O</td>
</tr>
<tr>
<td>3</td>
<td>Marital status: single O married O divorced/separated O widowed O</td>
</tr>
<tr>
<td>4</td>
<td>Are you currently employed yes O no O</td>
</tr>
<tr>
<td>5</td>
<td>Occupation please specify........................</td>
</tr>
<tr>
<td>6</td>
<td>What is your average monthly income specify?...</td>
</tr>
<tr>
<td>7</td>
<td>What is the highest education you attained: no formal O pry O secondary O post sec O</td>
</tr>
<tr>
<td>8</td>
<td>Where do you live: within Sagamu O outside Sagamu but within ogun state O outside ogun state O</td>
</tr>
<tr>
<td>9</td>
<td>What clinic did you come for? GOPD O MOP O SOP O Obs and Gyne clinic O For in patients medical ward O surgical ward O O/G ward O</td>
</tr>
<tr>
<td>10</td>
<td>Is this your first time of accusing any form of service in this hospital? yes O no O</td>
</tr>
<tr>
<td>11</td>
<td>What is the sex of the doctor that attended to you? male O female O</td>
</tr>
<tr>
<td>12</td>
<td>Is it the same doctor that attended to you the first time that attended to you? yes O no O N/A O</td>
</tr>
<tr>
<td>13</td>
<td>Do you know the name of the physician that attended to you? yes O no O</td>
</tr>
</tbody>
</table>
For interviewers only: classify the category of physician: house officer O registrar/Snr reg O consultant O

<table>
<thead>
<tr>
<th></th>
<th>SECTION B: USERS EXPECTATION OF SATISFACTORY SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>For interviewers only: classify the category of physician: house officer O registrar/Snr reg O consultant O</td>
</tr>
<tr>
<td>15</td>
<td>What do you think is the optimum time for a patient to wait before being attended to by a doctor? (estimate)</td>
</tr>
<tr>
<td>16</td>
<td>How long did you have to wait today before being attended to? (estimate)</td>
</tr>
<tr>
<td>17</td>
<td>What do you think is the optimum time a patient should spend with the doctor in the clinic? (estimate)</td>
</tr>
<tr>
<td>18</td>
<td>How long did you spend with the doctor? (estimate)</td>
</tr>
<tr>
<td>19</td>
<td>What were your expectation from the doctor</td>
</tr>
<tr>
<td></td>
<td>politeness O, respect O, privacy O mention others?</td>
</tr>
<tr>
<td>S/N</td>
<td>Question</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Did the doctor give you complete information about your illness?</td>
</tr>
<tr>
<td>2</td>
<td>Did the doctor give you complete information about your treatment?</td>
</tr>
<tr>
<td>3</td>
<td>Was the doctor polite?</td>
</tr>
<tr>
<td>4</td>
<td>Is the doctor always ready to answer your questions?</td>
</tr>
<tr>
<td>5</td>
<td>Did the doctor give you adequate time?</td>
</tr>
<tr>
<td>6</td>
<td>Did the doctor check/examine you properly</td>
</tr>
<tr>
<td>7</td>
<td>Were you given enough time to tell the doctor everything?</td>
</tr>
<tr>
<td>8</td>
<td>Is the doctor skilful and experienced in his work?</td>
</tr>
<tr>
<td>9</td>
<td>Were the nurses courteous and talked politely?</td>
</tr>
<tr>
<td>10</td>
<td>Were the nurses helpful?</td>
</tr>
<tr>
<td>11</td>
<td>Are the nurses well trained?</td>
</tr>
<tr>
<td>12</td>
<td>Were the staff(s) at the medical records polite and respectful?</td>
</tr>
<tr>
<td>13</td>
<td>Were the staff(s) at the paying centre polite and respectful?</td>
</tr>
<tr>
<td>14</td>
<td>Was the time spent at the medical records to get card too long?</td>
</tr>
<tr>
<td>15</td>
<td>Is the cleanliness of the hospital adequate?</td>
</tr>
<tr>
<td>16</td>
<td>Is the condition of the toilets good?</td>
</tr>
<tr>
<td>17</td>
<td>Is drinking water easily available in the hospital?</td>
</tr>
<tr>
<td>18</td>
<td>Are the staff(s) of the hospital well dressed and neat?</td>
</tr>
<tr>
<td>19</td>
<td>Is the waiting area conducive and comfortable?</td>
</tr>
<tr>
<td>20</td>
<td>Did you consider the time you had to wait before seeing the doctor not</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>21</td>
<td>Was your overall visit satisfactory?</td>
</tr>
<tr>
<td></td>
<td>1 = strongly unsatisfactory to 5 = strongly satisfactory</td>
</tr>
<tr>
<td>22</td>
<td>With your experience at the hospital today, are you willing to recommend this hospital to a friend?</td>
</tr>
<tr>
<td>23</td>
<td>With your experience at the hospital today, are you willing to return to access its services if need be?</td>
</tr>
<tr>
<td>24</td>
<td>Is there anything else you think would have made you better satisfied with the services rendered at this hospital? You can comment freely.</td>
</tr>
</tbody>
</table>