

SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA



ASSESSMENT OF PATIENT-PROVIDER RELATIONSHIP ON PATIENT'S
SATISFACTION AT THE ACHIMOTA HOSPITAL

BY

ADOMAH FRANCIS

(10339947)

A DISSERTATION SUBMITTED TO THE (SCHOOL OF PUBLIC HEALTH), UNIVERSITY
OF GHANA IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD
OF MASTERS OF PUBLIC HEALTH (MPH) DEGREE

JULY, 2019

DECLARATION

I, Adomah Francis, declare that; this dissertation is the result of my own original work. However, all references, which helped me in the development of my dissertation for the attainment of Master of Public Health degree have been duly acknowledged. The document contains no material already published by any other person for the award of a degree in any other university.

ADOMAH FRANCIS

(STUDENT NAME)

.....

SIGNATURE

.....

DATE

DR. GENEVIEVE CECILIA ARYEETEEY

(SUPERVISOR)

.....

SIGNATURE

.....

DATE

DEDICATION

This research study is dedicated to the Almighty God and family.

ACKNOWLEDGEMENT

My vision and aspiration to pursue this master's program at the University of Ghana was inspired by Dr. Ibrahim K. Asante, who offered me immense advice which aided me to go through, God bless you Sir.

More appreciation to my academic supervisor Dr. Genevieve Cecilia Aryeetey for her guidance, direction and knowledge she impacted on my life whiles working with her, not forgetting Dr. Augustine Adomah-Afari for his immense contribution to this work 'Dr., I salute you'. Many thanks goes to Mr & Mrs Otcher Duah for their emotional and financial support. Thank you Mr. Thomas Nii Teiko Tagoe, Regional officer, Nurses & Midwifery Council, Greater Accra for mentoring me. I also appreciate the work of the research assistants.

Finally, special thanks to the management and staff of Achimota Hospital especially Mrs Owusu Lilie of nursing administration for their immense support and to all respondents who willingly participated in this study.

TABLE OF CONTENT

DECLARATION.....	Error! Bookmark not defined.
DEDICATION.....	Error! Bookmark not defined.
ACKNOWLEDGEMENT.....	Error! Bookmark not defined.
LIST OF TABLES	viii
LIST OF FIGURES	ix
LIST OF ABBREVIATIONS	Error! Bookmark not defined.
DEFINITION OF TERMS.....	Error! Bookmark not defined.
ABSTRACT.....	Error! Bookmark not defined.
CHAPTER ONE	Error! Bookmark not defined.
INTRODUCTION.....	Error! Bookmark not defined.
1.0 Background	Error! Bookmark not defined.
1.1. Problem statement	Error! Bookmark not defined.
1.2 Justification of the study	Error! Bookmark not defined.
1.3. Objectives of the study	Error! Bookmark not defined.
1.3.1. General Objective	Error! Bookmark not defined.
1.3.2. Specific Objectives	Error! Bookmark not defined.
1.4. Research questions	Error! Bookmark not defined.
1.4.1. Research Questions.....	Error! Bookmark not defined.
1.5 Outline of the chapter	Error! Bookmark not defined.
CHAPTER TWO	Error! Bookmark not defined.
LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK	Error! Bookmark not defined.
2.0. Introduction	Error! Bookmark not defined.
2.1 Healthcare quality and satisfaction	Error! Bookmark not defined.
2.2. Patients' perception of patient-provider relationship.....	Error! Bookmark not defined.
2.3. Patient (socio-demographic/economic characteristics) factors	Error! Bookmark not defined.
2.4 Influence of patient- provider relationship on patients' satisfaction	Error! Bookmark not defined.
2.5. Conceptual framework of patient-provider relationship.....	Error! Bookmark not defined.

2.6. Summary of the chapter	Error! Bookmark not defined. 6
CHAPTER THREE	Error! Bookmark not defined.
METHODOLOGY	Error! Bookmark not defined.
3.0. Introduction	Error! Bookmark not defined.
3.1. Study design	Error! Bookmark not defined.
3.2. Study area.....	Error! Bookmark not defined.
3.3. Study population	Error! Bookmark not defined.
3.4. Sample size determination	Error! Bookmark not defined.
3.5 Sampling technique	Error! Bookmark not defined.
3.5.1 Inclusion criteria.....	Error! Bookmark not defined.
3.5.2 Exclusion criteria.....	Error! Bookmark not defined.
3.6 Study variables	Error! Bookmark not defined.
3.7 Data collection procedure.....	Error! Bookmark not defined.
3.8 Data processing and analysis.....	Error! Bookmark not defined.
3.9 Quality assurance	Error! Bookmark not defined.
3.9.1 Training of research assistants.....	Error! Bookmark not defined.
3.9.2 Pretesting of the questionnaire / Data collection tool.....	Error! Bookmark not defined.
3.9.3 Validity and reliability of the tool	Error! Bookmark not defined.
3.10 Ethical consideration	Error! Bookmark not defined.
3.11 Summary of the chapter	Error! Bookmark not defined.
CHAPTER FOUR	Error! Bookmark not defined.
RESULTS	Error! Bookmark not defined.
4.0. Introduction	Error! Bookmark not defined.
4.1 Socio-demographic background characteristics of respondents.....	Error! Bookmark not defined.
4.2 Proportion of patients satisfied with patient-provider relationship.....	Error! Bookmark not defined.
4.3 Bivariate Analysis: Association between patient (socio-demographic characteristics) factors and satisfaction with patient-provider relationship.	Error! Bookmark not defined.

4.4 Characteristics of patient-provider relationship by satisfaction	Error! Bookmark not defined.
4.5 Determining patient perceptions of patient-provider relationship	Error! Bookmark not defined.
4. 6 Logistic regression: Association between patient-provider relationship and patient satisfaction	Error! Bookmark not defined.
4.7 Summary of the chapter	Error! Bookmark not defined.
CHAPTER FIVE	Error! Bookmark not defined.
DISCUSSION OF FINDING	Error! Bookmark not defined.
5.0 Introduction	Error! Bookmark not defined.
5.1 Patient (socio-demographic characteristics) factors	Error! Bookmark not defined.
CHAPTER SIX	Error! Bookmark not defined.
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	Error! Bookmark not defined.
6.0 Introduction	Error! Bookmark not defined.
6.1 Summary of the study	Error! Bookmark not defined.
6.2 Conclusions of the study	Error! Bookmark not defined.
6.3 Recommendation	Error! Bookmark not defined.
6.4 Limitations to the study	Error! Bookmark not defined.
6.5 Future Research	Error! Bookmark not defined.
REFERENCE	Error! Bookmark not defined.
APPENDICES	Error! Bookmark not defined.
APPENDIX I: INFORMED CONSENT FORM	Error! Bookmark not defined.
APPENDIX II: QUESTIONNAIRE	Error! Bookmark not defined.
APPENDIX III ETHICAL CLEARANCE	Error! Bookmark not defined.

LIST OF TABLES

Table 3.1 Independent variables and their indicators	Error! Bookmark not defined.
Table 4.1 Socio-demographic characteristics of respondents.....	Error! Bookmark not defined.
Table 4.2 Bivariate Analysis: Association between patient (socio-demographic characteristics) factors and satisfaction with patient-provider relationship.....	Error! Bookmark not defined.
Table 4.3 Characteristics of patient-provider relationship by satisfaction	Error! Bookmark not defined.
Table 4.4 Determining patients' perceptions of patient-provider relationship	Error! Bookmark not defined.
Table 4.5 logistic regression: Association between patient-provider relationship and patient satisfaction	Error! Bookmark not defined.

LIST OF FIGURES

Figure 2.1 Conceptual framework of patient-provider relationship **Error! Bookmark not defined.**

Figure 4.1 Proportion of patients satisfied with patient-provider relationship **Error! Bookmark not defined.**

LIST OF ABBREVIATIONS

ERB	Ethical Review Board
GNHQS	Ghana National Healthcare Quality Strategy
HSMTDP	Health Sector Medium Term Development Plan
IOM	Institute of Medicine
LMICs	Low- and Middle-Income Countries
OPD	Out Patient Department
W.H.O	World Health Organization

DEFINITION OF TERMS

Patient-provider relationship -A consensual relationship in which the patient knowingly seeks the provider's assistance and in which the physician knowingly accepts the person as a patient

Patients' satisfaction- Patient's feelings of satisfaction or dissatisfaction as a result of healthcare service delivered at a point the patient needed that services

Quality of care-Means healthcare activities that, the medical, nursing, laboratory fields and others perform daily to benefit patients without causing harm to them

Process -The way and manner the provider communicates with the patients, attendance to patients and the time spent with them, appropriate diagnosis and treatment and timely referrals.

Outcome -Outcomes indicate the combined effects of structure and process on patient care

Structure -The physical setting where patients receive health care, as well as the qualifications of the care providers as well as the organization of care

ABSTRACT

Introduction: Over the years, there has been a significant improvement in diagnosis and treatment of patients due to the advancement and the use of medical sciences and technology in health care delivery. Nonetheless, the relationship between patients and their providers has gradually declined around the world. This has invariably affected the level of quality of care and the overall patient's satisfaction.

Objective: To assess the influence of patient-provider relationship on patient's satisfaction at Achimota Hospital.

Methods: A cross-sectional study was used. Exit interviews were conducted using a structured questionnaire. Data collection covered: socio-demography, care from doctors and nurses, and patient experiences with OPD services. The study population was adult patients who accessed the hospital's services at the time of data collection. Chi square test and logistic regression analysis were used to assess association between patient-provider relationships and satisfaction. The level of significance was accepted as $p < 0.05$

Results: The overall patient satisfaction was about 83.4%. However, 16.6% of the respondents were dissatisfied with patient-provider relationship at Achimota Hospital. A total of 154 male and 229 female respondents participated in this study. Majority of the respondents, 129 (33.9%) were within the age range of 21– 30 years. Most of the respondents had had tertiary education, 136 (35.6%). Those employed were 250 (67.2%) with average monthly income of between GHS 500 and GHS 1000. From the results, care from nurses (Excellent, odd ratio=40.4079, 95%CL=3.2721-49.8990, P value =0.004) and OPD services (Adequate, odd ratio=21.1912, 95%CL=0.0548-0.6166, P value =0.006) were statistically significant.

Conclusion: Patient-provider relationship on patients' satisfaction at Achimota hospital OPD was high as about 83.4% of the total respondents was satisfied with the relationship with the providers. Patients and health providers had a very healthy relationship and this can affect healthcare quality positively. To continually improve patient-provider relationship towards influencing patients' satisfaction, measures must be put in place to have more resources at the OPD to enable providers have ample time to provide care to patients.

Keywords: Healthcare quality, patient satisfaction, patient-provider relationship, Ghana

CHAPTER ONE

INTRODUCTION

1.0 Background

The concept of patient satisfaction has received an increasing awareness showing a progressing attention in health care delivery market (Umar, 2011). Recognizing and understanding patients' satisfaction and healthcare quality have been seen as key parameters to unearthing many improvement strategies in health care delivery (Yeddula, 2012). However, there has not been a universally accepted definition for satisfaction with healthcare due to the perspective, multidimensional and subjective nature of satisfaction, which influences individuals' expectations, needs or desires (Murante, 2010). Patient satisfaction places importance on the relationship with the service providers and how patients perceive the care received. Research has revealed that good customer relationship and quality care result in retaining existing customers and attract new ones, minimize costs, enhance corporate image, positive recommendations from customers, and eventually enhance profitability (Kang & James, 2004).

Quality healthcare is defined as the degree to which healthcare services for individuals and population increases the likelihood of desired healthcare outcomes (Aiken et al., 2012). In the global context for which World Health Organization (WHO) provides the basis for quality rests on two main school of thoughts for promoting a focus on quality in health systems today (WHO, 2006): First, even where health systems are well developed and resourced, there is clear evidence that quality remains a serious concern, with expected outcomes not predictably achieved and with wide variations in standards of health-care delivery within and between health-care systems. Second, where health systems – particularly in developing countries – need to optimize resource use and expand population coverage, the process of improvement and scaling up needs to be based

on sound local strategies for quality so that the best possible results are achieved from new investment (WHO, 2006).

The Ghana National Healthcare Quality Strategy (GNHQS) states that quality of health care is the degree to which health care services are delivered according to standards such that, the interventions are safe, efficient, effective, timely, equitable, accessible, client-centered, using appropriate technology and result in positive health outcomes, provided by an empowered workforce in an enabling environment (GNHQS, 2017).

It is important to note that, quality of care and patient's satisfaction cannot be holistically realized without considering the relationship between those providing health care services and the patients patronizing these services. Patient-provider relationship can either promote or impede individuals' healthcare in a short or long term whether for acute or chronic illnesses (Ciechanowski, Katon, Russo, & Walker, 2001). Sometimes when patients feel that health needs are not met and are mishandled by their health provider, some patients do register their displeasures in a violence way (Wang *et al.*, 2012)..

Some research conducted in public hospitals revealed considerable evidence that the quality of health care in Ghana was inadequate by objective measures and in the opinion of patients and health care providers (Ghana Health Service, 2007; MoH, 2007b). Locally, many of the studies on healthcare quality have focused on the quality award dimensions (Ghana Health Service, 2003; MoH, 2007b; Osei *et al.*, 2005) with little emphasis on the factors influencing patient-provider relationship on a patient's satisfaction. It was against this background that, this study assessed patient-provider relationship and their consequential influence on patient's satisfaction at the Achimota Hospital in the Greater Accra Region.

1.1. Problem statement

It is generally expected that, a positive relationship between patients and providers will result in quality and satisfactory health outcomes. However, patient-provider relationship has declined globally, which has adversely affected quality of healthcare (WHO, 2016).

The decline in patient-provider relations has resulted in many medical disputes between patients and healthcare providers, mainly doctors and nurses, where in some worse cases leading to violence towards providers (Wang *et al.*, 2012). Tagbel Waki (2013) reported that, the possibility of providers' attitudes and poor relationship with patients could negatively affect the demand for OPD healthcare services in public health facilities. For instance, according to the American Hospital Association Statistics (1999), poor patient-provider relationship leading to medical errors was responsible for causing between 44000 and 98000 patient deaths annually in American hospitals alone. Oluwadiya and colleagues (2010), reported that out of the 250 respondents, 21% recounted being shouted at by providers, 7% experienced rudeness while 5% encountered care givers who hit these patients.

Records from Ghana Health Service (2009) estimated that, 65% to 95% of dissatisfied but non-complaining patients/clients may never patronize the services of some public health facilities at a point in time due to several factors relating to poor relationship between providers and their patients (Boadu, 2011). These unsatisfied patients may resort to healthcare facilities that are not accredited or self-medication and this situation poses danger to them as well as the country as a whole. The situation becomes more challenging in terms of public health professionals managing health statistics and disease control, thus contributing significantly to morbidity and mortality (Tagbel, 2013). It is important to determine the level of patients' satisfaction with patient-provider relationship and the influence of patient factors (socio-demographic characteristics) on patients'

satisfaction. Once these are known based on evidence, the issues of patient dissatisfaction could be managed in a way that will reduce its adverse effects in healthcare delivery. Moreover, patients' perceptions of patient-provider relationship factors need to be assessed to know how to handle these patients with preconceived ideas about the providers and the health facility as a whole.

The Ghana Health Service (GHS) has instituted regulatory measures such as code of ethics for providers and patients' charter in an attempt to address the perceived poor patient care, providers' relationship with patients and satisfaction in public healthcare facilities (Boadu, 2011). However, in spite of these efforts made by the Ghana Health Service and other stakeholders to improve health care quality in Ghana, there is still perceived poor relationship between providers and patients resulting in unsatisfactory services being delivered by providers in many public health facilities (Boadu, 2011; MOH, 2004).

In an attempt to address the gap, this study sought to assess patient-provider relationship and how it influences patient's satisfaction with healthcare at the Achimota Hospital, Ghana.

1.2 Justification of the study

Poor patient-provider relationship has been one of the several factors that hinder quality of health care services needed to avert or reduce morbidity and mortality (Thielscher et al, 2016).

Tucker and colleague reported that, when providers are sensitive to factors relating to caring, empathy, reliability and responsiveness during the discharge of their duties, it is seen as positive relationship and may be considered in assessing patients' satisfaction (Tucker and Adams 2009).

Black, & Gruen, (2009) also noticed that, when patients deemed health care to be unsatisfactory, seeking of services was most likely to be negatively impacted in various ways such as reducing hospital total revenue. For instance, a study revealed that, lack of communication therapy and

negative words of mouth by providers may cost hospitals \$6,000-\$400,000 lost in revenues over one patient's lifetime. They further reported that, the yearly cost of dissatisfaction with hospital services for one hospital with yearbook discharges had been estimated to be more than \$750,000 (Pakdil & Harwood, 2005; Naidu, 2009).

It was imperative to note that, if much was not put into this area of study, the general public may continuously perceive services provided at public health facilities as being very poor and this may lead to an increase in self-medication, drug abuse, low health coverage as well as loss of trust and confidence in the health system (Jegede & Fayemiwo, 2010). It is observed in a facility where I worked that, patients suggestions are not usually incorporated in their health management and some patients are not able to freely ask questions concerning their health due to reasons known to them and these problems needed to be addressed hence the conduction of this study..

The outcome of this study was expected to assist management and stakeholders at Achimota Hospital to put measures in place to improve patient -provider relationship at the OPD. This study was also expected to be useful for the hospital management since it would provide data on whether patients who are accessing healthcare services are satisfied or not with the relationship between them and their providers at the OPD.

1.3. Objectives of the study

The objectives of the study are divided into general and specific as shown below.

1.3.1. General Objective

The general objective of this study was to assess the influence of patient-provider relationship on patients' satisfaction with services at the Achimota Hospital in the Greater Accra Region.

1.3.2. Specific Objectives

The specific objectives of the study included:

1. To determine the level of patients' satisfaction with patient-provider relationship.
2. To examine the influence of patient factors (socio-demographic characteristics) on patients' satisfaction.
3. To assess the influence of patient-provider relationship factors on patients' satisfaction.
4. To examine patients' perceptions of patient-provider relationship factors.
5. To determine the influence of healthcare provider factors on patients' satisfaction.

1.4. Research questions

1.4.1. Research Questions

Based on the specific objectives, the following questions were answered in the study:

1. What is the level of patients' satisfaction with patient-provider relationship?
2. What is the influence of patient factors (socio-demographic characteristics) on patients' satisfaction?
3. What is the influence of patient-provider relationship factors on patients' satisfaction?
4. What are patients' perceptions of patient-provider relationship factors?
5. What is the influence of healthcare provider factors on patients' satisfaction?

1.5 Outline of the chapter

The chapter commenced with background to the study by discussing what the study is about and what it sought to achieve, followed by the problem statement of the study. Thus what was the problem and the need to conduct the study. Next to that, was the justification of the study which

elaborated on some key reasons which were problematic that needed to be addressed. The objectives of the study were also clearly stated which included the general and specific objectives and the chapter ended with the research questions.

The next chapter which covered literature review and conceptual framework sought to discuss and analyse other relevant studies that contributed knowledge to this study as well as the theory that informed the development of the conceptual framework.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.0. Introduction

The chapter intends to review the existing literature on concepts and theories relating to patient-provider relationship, quality of healthcare and how this relationship influence patient's satisfaction. The chapter is organized into seven sections. The first section examines the concept of healthcare quality and satisfaction. Second section examines patient perceptions of patient-provider relationship on their satisfaction. Section three also examines the influence of patient (socio-demographic/economic characteristics) factors on patient-provider relationship. The forth section talks about the patient – provider relationship and satisfaction. Furthermore, section five dwells on the conceptual framework of patient-provider relationship on patient satisfaction to improving quality of care. The chapter ends with a summary in section six.

2.1. Healthcare quality and satisfaction

There have been several definitions of quality of health care by scholars and researchers (Campbell *et al.*, 2000). Campbell and colleagues (2000) defined quality of care as a component of health care systems and actions taken and designed to improve health or well-being of the population. They further added that quality of care for individuals is: Whether an individual is able to access the health inputs and activities of care as their needs and whether the care received is effective.

Quality healthcare demands that, attention is paid to the needs of patients and clients because patients have different perceptions of customer orientation in relation to service quality and satisfaction (Aiken *et al.*, 2012). Health professionals have to use methods that have been tested to be safe, affordable and can reduce deaths, illness and disability (Aiken *et al.*, 2012).

Quality of care cannot be overlooked in terms of patients' satisfaction and their informed decision. Patient satisfaction survey is an essential measure of quality of healthcare as it gives information on the provider's success in meeting patient expectations, values and matters on which the patient is the decisive authority (Sagaro, Yalew, & Koyira, 2015).

Donabedian (1988) proposed the triad structure, process and outcome as a framework for assessing a quality of care. Structure refers to the attributes of the settings in which care is provided. It includes such elements as resources, staff and equipment. Process on the other hand covers all aspects of delivering care and is related to interactions within and between practitioners and patients. Outcome focuses on the end result or the effect of the care provided. His model of quality of care is used to assess satisfaction based on factors incorporated in structure, process and outcome.

Hailu (2015) observed that, it is indispensable for health facilities to provide services to satisfy the needs of patients as providing healthcare services to meet the patients' expectations is very important. Due to these, it is therefore, imperative for healthcare service providers to understand the experiences that contribute to patients' satisfaction.

2.2. Patients' perception of patient-provider relationship

Many researchers support the fact that, positive perceptions of patients' relationship with providers result in an increased client satisfaction, improve healthcare delivery as well as recognize the value and trust in the healthcare provider (Boateng & Awunyo-Vitor, 2013; D'souza, 2012, Criel *et al.*, 2003). This eventually influences patients' demand and decision for healthcare services utilization as well as recommendation of such services to other patients (Criel *et al.*, 2003).

In order to ensure service improvement appropriate at hospital levels, it is important to understand patients' perceptions of the relationship with their providers, which influence their satisfaction with healthcare delivery. The rate at which patients use or patronize healthcare services is found to have a direct link with their perceptions in such a way that, when there is poor perception of providers' attitudes, patients tend to engage themselves in household activities that limit their demand (Alderman, Street, & Bank, 2006). In addition, when patients perceive that their relationship with their care givers is being poor, seeking healthcare services is likely to be negatively impacted (Black, & Gruen 2009). Again, patients may perceive their healthcare as poor depending on the relationship with their healthcare provider (manner of care provided) and the service delivery processes these patients receive at that particular hospital (Klemick *et al*, 2009).

Occasionally, some patients avoid health facilities perceived to have low quality services and poor customer relationship and search for high quality ones Jegede and Fayemiwo, (2010). Explicitly, patients' quality perceptions have been shown to account for 17-27% of difference in a hospital's financial measures such as earnings, net revenue and asset returns (Buttle, 2014). Generally, patients' perception of high quality healthcare as well as healthy relationship affect the use of healthcare services thereby increasing hospital attendance and revenue returns (Klemick *et al.*, 2009).

2.3. Patient (socio-demographic/economic characteristics) factors.

An earlier study suggests that, there are variations in patients' expectations, priorities and satisfaction among countries and are highly associated with cultural background and healthcare system (Enaikele, 2013). In most African countries, the socio-economic and living conditions of many people impact on assessment of health care outcomes (Ogunfowakan *et al.*, 2012). It is further noted that, most people find themselves in a precarious socio-economic living conditions

and this is attributed to a number of patients' socio-demographic characteristics such as sex, age, educational level, marital status, income, religion, poverty, general insecurity and poor political leadership (Ogunfowakan *et al*, 2012).

Cockerham and Wiley (2004) reported that, people with higher income are more likely than those with lower income to have received medical service especially in private doctors' office and group practice or over the telephone. Erinosh (2005) reported that, patients' socio-cultural factors influence the way in which illness is interpreted, perceived and responded to. Not only that but also, age, sex, ethnicity and socioeconomic status influence how the individual seeks and use health care services (Erinosh, 2005).

Another study argued that, patients who are younger, less educated, lower ranking, poorer health status and high-service use had an association with lower satisfaction (Tucker & Adams, 2009). Some researchers further asserted that, the patient's health quality evaluation appeared to change when patient's socio-demographic characteristics was introduced however, the effect produced only a 1% variation (Tucker & Adams, 2009).

2.4. Influence of patient- provider relationship on patients' satisfaction

According to Pollack (2008), people go to health facilities in search of healthcare services that are most suitable in solving their health needs as well as receiving the best customer care. Patient satisfaction is seen as one of the most important quality scopes and vital success indicators in health care (Pakdil & Harwood, 2005). Generally, the nature of patient-provider relationship quality and satisfaction association is observed as linear, postulating that, higher levels of relationship quality lead to higher levels of satisfaction (Pollack, 2008).

Patient-provider relationship has been defined as the relationship between a physician and his or her patient is created when the patient knowingly seeks the services of the physician, and the physician knowingly accepts him or her as a patient (Carol A. Schwab, J.D., & LL.M., 2007) as the relationship is consensual and mutual, and often described as “contractual”.

Conway and colleagues noted that, proportion of patients at various health facilities may not be in their right psychological mood due to many factors such as pain and so they anticipate good customer service as they seek for cure to their health problems and cure is a fundamental health care service expectation (Conway, Willcocks, Conway, Salford, & Willcocks, 1997).

When providers are sensitive to factors relating to caring, empathy, reliability and responsiveness during the discharge of their duties, it is seen as a positive relationship and may be considered in assessing patients’ satisfaction (Tucker & Adams, 2001). Oluwadiya et al, (2010) reported that, patient satisfaction has a direct correlation with providers showing genuine concern, overall nurses’ attitude, courtesy and provision of privacy during delivering care. They reported that, 21% of the respondents recounted being shouted at by providers, 7% experienced rudeness while 5% encountered care givers who hit these patients. The level to which patients are satisfied with their health care providers may be an important factor underpinning their health behaviour and level of health care utilization (Rizyal, 2012). Indispensably, Rizyal, 2012 further stated that, the nature and quality of the provider-patient relationship affect health outcomes. Hospital managers should make conscious efforts to maintain a warm relationship with patients in order to know their preference so as to provide services to meet their health needs. Thus, it is imperative for healthcare managers to continuously examine the factors associated with patients’ satisfaction with care provided so as to understand patients’ expectations, how the quality of care is interpreted by the

patient and to determine where, when and how service change and improvement can be made (Zideldin, 2006).

2.5 Conceptual framework of patient-provider relationship

Conceptual framework of the study as shown in figure 2.1 demonstrates patient-provider relationship factors that influence patients' satisfaction. It is based on this conceptual framework the problem of the study was investigated.

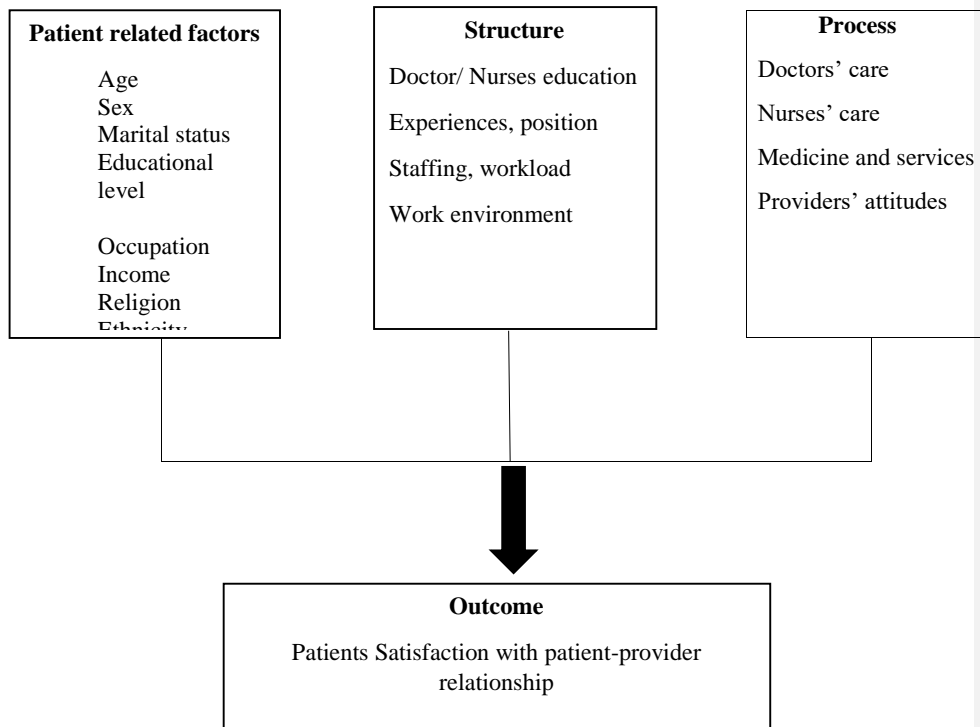


Figure 2.1 Conceptual framework of patient-provider relationship
(Donabedian's 1988, 1990 model).

Patients' level of satisfaction is purported to be directly influenced by socio-demographic characteristics of the patient such as age, sex, marital status, educational level, religion, ethnicity, occupation and income. There have been several arguments that, the most important aspect of health care delivery and its utilization by an individual is how the individual gets satisfied with the services provided at the health facilities and the manner these services are provided (Oluwadiya et al, 2010).

Globally, socio-demographic characteristics have been recognized to have influenced patient satisfaction most especially in developing countries like Ghana or Nigeria (Nwokocha, 2004).

Age may be seen as an accumulation of experience on the use of health care services, hence patients who are very old may be less likely to be satisfied with care because they have been exposed to different levels of service delivery than younger patients. However, younger patients may be more likely to be satisfied with service delivery and the relationship with their providers due to technological advancement and modern ways of health care delivery than the old patients who are used to out dated techniques (Erinosho, 2005). The sex of a patient may also be said to influence satisfaction, thus females are seen to be punctilious and will be less satisfied with services than males.

Cockerham and Wiley (2004) argues that, people with higher income are more likely than those with lower income to have received medical service because they are able to afford these services. On the contrary, lower income consumers are more concerned with costs and overall physical facilities, indicating their value orientation.

Marital status and occupation of patients can also influence satisfaction with care as it is known that, patients who are married or gainfully employed are less likely to be satisfied with services than those who are unmarried and unemployed. Religion and ethnicity can also positively or negatively influence satisfaction with care (Erinosho, 2005). The health status of the patient is also a client factor that can influence inpatients' satisfaction levels.

Service factors such as care from doctors and nurses significantly influence patient satisfaction. In addition, relationship factors like, staff being respectful, courteous and empathizing with patient situations help to determine whether a patient would decide to use that facility again or not. Hospital environment and patients' experiences are also important points influencing patient satisfaction (Jegede, 2010). Again, the quality of medicines and other services and how promptly the services are delivered are contributing factors determining patients' satisfaction. The framework illustrated how the various factors that constitute patient-provider relationship influence patients' level of satisfaction.

2.6. Summary of the chapter

The interpersonal patient- provider relationship is an indispensable part of health care quality. However, the literature did not make known to measure this relationship or its association with patients' satisfaction; and this was exactly what this study sought to do.

CHAPTER THREE

METHODOLOGY

3.0. Introduction

This chapter discusses the philosophical assumptions and also the design strategies underpinning this research study. In addition, the chapter discusses the research methodologies, and design used in the study including strategies, instruments, and data collection and analysis methods, while explaining the stages and processes involved in the study. The assumption underlying the choice of the research methodology was that this research method could be used to obtain information concerning the current status of the phenomena and to describe “what exists” with respect to variables or conditions in a situation.

3.1. Study design

Descriptive cross-sectional study design was employed in this study using quantitative techniques to collect and analyze data. A descriptive cross-sectional design may be used to assess the burden of a particular disease in a defined population (Hennekens CH. and Buring JE. 1987). On the other hand, quantitative techniques emphasize objective measurements and the statistical, mathematical, or numerical analysis of data collected through polls, questionnaires, and surveys, or by manipulating pre-existing statistical data using computational techniques (Babbie *et al.*, 2010). It

focuses on gathering numerical data and generalizing it across groups of people or to explain a particular phenomenon. This study design was considered appropriate because the study objectives and the sample size used in the study were appropriate for descriptive cross-sectional study. It also helped to determine the association between patient-provider relationship and patients' satisfaction.

3.2. Study area

Achimota is a town in the Accra Metropolitan district, a district of the Greater Accra Region of Ghana which is Ga West Municipal. Its capital is Amasaman.

The Municipality lies within latitude 5°48' North, 5°39' North and longitude 0°12' west and 0°22' West. It shares common boundaries with Ga East and Accra Metropolitan Assembly to the East, Akuapem South to the North and Ga South to the south and West. It occupies a land area of approximately 305.4sq km with about 193 communities. Its population is about 219788 with relatively more females (51.0%) than males (49.0%), giving a sex ratio of 96.2 (Ghana Statistical Service report, 2014).

Seven in 10 (71.2%) of the population aged 15 years and older are economically active while 28.8 percent are economically not active. Of the economically active population, 91.5 percent are employed while 8.5 percent are unemployed. Of the unemployed population, 59.1 percent are seeking work for the first time. For those who are economically not active, more than half (52.8%) are in full time education and 22.6 percent perform household duties (Ghana Statistical Service report, 2014).

The Achimota Hospital is the primary healthcare institution in Achimota. The study was conducted at the Achimota Hospital, which is located in the Ga West Municipal Assembly, in the

Greater Accra Region of Ghana. The study area was chosen because the facility provides health services to many communities made up of different socio-economic and educational background.

The Achimota Hospital is part of the Okaikoi Sub-Metro within the Accra Metropolitan Health Area. The hospital is located at the western part of Accra and covers the Achimota School area, Kisseman, Christian Village and Anunmle. The Achimota Hospital was founded in 1927 by the Achimota School authorities ten (10) years after the school was established. It is situated within the school and was purposely built to take care of the students' health needs, and other institutions within the catchment area. Ghana Ministry of Health took over the hospital in 1973 and has subsequently, served beyond its immediate environs. The hospital was declared a public facility by the Ministry of Health in 1983 and became a District Hospital in 1985 (Ashiagbor *et al.*, 2019).

The hospital has 88 bed capacity, Children's ward, male and female wards, VIP ward, and a Theatre/recovery ward. General outpatient care operates in the morning, afternoon and night sessions. The hospital provides wide range of services which include general OPD, emergency services, Obstetric care dental clinic, and ear, nose and throat (ENT) care, among others (Ministry of Finance and Economic Planning, 2019).

The study population was patients who accessed the hospital's services at the time of data collection. This comprised of all male and female adult patients who sought health services at the OPD working areas of the Achimota Hospital between June and July, 2019. The sample size was drawn from this study population.

3.4. Sample size determination

Based on Cochran's formula, the sample size for this study was calculated using the formula below:

$$n = \frac{Z_{1-\frac{\alpha}{2}}^2 P(1-P)}{e^2}$$

$$n = \frac{Z_{1-\frac{\alpha}{2}}^2 P(1-P)}{e^2}$$

Where,

n = is the minimum sample size required;

Z^2 = is an abscissa of the curve that cuts off an area α at the tail ($1 - \alpha$ equals the desired confidence level, i.e., 95%);

e = is the margin of error, i.e. desired level of precision;

P = is the estimated proportion of patients that is present in the population, which was assumed to be 50% since the current proportion of patients was unknown;

For a 95% confidence interval, $Z_{\alpha/2}$ is 1.96 and the level of precision e (margin error for the study) $\pm 5\%$. A minimum sample size was computed as:

$$n = \frac{(1.96)^2 \times 0.5 \times 0.5}{0.05^2} = 384.16 \approx 384$$

Thus, a sample size of 384 patients was recruited for the study.

A 5% non-response rate was added to the sample size (Nabbuye et al., 2011) to cater for patients who were not able to complete the questionnaires and questionnaires that were invalid.

Therefore, a sum of 403 patients was recruited in the study.

3.5 Sampling technique

Consecutive sampling method was used whereby every eligible persons were recruited till the desired sample size was reached based on the inclusion criteria applied in this study. Consecutive sampling seeks to include all accessible subjects as part of the sample. This non-probability sampling technique can be considered as the best of all non-probability samples for this study because it includes all subjects that are available that makes the sample a better representation of the entire population. Additionally, this method was appropriate because it addresses the objectives of the study. The selection of patients at the OPD was done at peak and non-peak working hours to avoid bias and to ensure even distribution of the respondents. The final selection involved simple random selection using balloting for those who took part in the study. The required number of 403 patients was all recruited from the OPD since all the units had one common place as a waiting area for patients.

3.5.1 Inclusion criteria

All patients aged 18 years and above who utilised the Achimota Hospital OPD services, and were sound and willing to participate in the study.

3.5.2 Exclusion criteria

Patients aged less than 18 years of age who utilised the Achimota Hospital. Patients who were not sound and willing to take part in the study were also excluded.

3.6 Study variables

The variables measured in the study have been categorized into dependent and independent as explained below.

Dependent variables

The dependent variable was patients' satisfaction.

Independent Variables

The independent variables measured in the study included the following:

Patient-provider relationship factors: care from doctors, care from nurses, patient perception and patient experiences.

Socio-demographic characteristics: age, gender, occupation, income, marital status, ethnicity and religion.

Table 3.1 Independent variables and their indicators

Independent variable	Characteristics	Description
Socio-demographic characteristics		
Age	Categorical	How old are you? (<i>Age at last birthday</i>)
Educational level	Categorical	What is your highest level of education
Marital status	Categorical	Are you currently married?
Occupation	Categorical	What is your current occupation?
Income	Categorical	What has been your average monthly income over the past year?
Healthcare provider factors		
care from doctors	Categorical	Do doctors treat you with respect, courtesy and empathize with your situation? Do doctors listen to you carefully? Do doctors explain procedures to your understanding? Do doctors respect your values and beliefs? Do doctors give you treatment options based on your economic status?

care from nurses	Categorical	Do nurses treat you with respect, courtesy and empathize with your situation? Do nurses listen to you carefully? Do nurses explain procedures to your understanding?
Patients' perceptions		
patient experiences	Categorical	Do you get help from staff? How often do you get help from staff? Do you get all the services you needed?

3.7. Data collection procedure.

Data for the study was collected from patients at the hospital's outpatient department (OPD) using a structured questionnaire, which was designed as closed ended questions. Data was collected from 27th June to 9th July, 2019. Four hundred and three (403) respondents accessing OPD services at the Achimota Hospital were recruited. Questionnaires were administered to patients after they had been taken care of at the OPD. The questionnaire was adapted from Ghana Health Service patient satisfaction survey tool, (GHS, 2004), PSQ 18 (Dabaghian et al., 2016), and a study by Yawson (2017) on patient satisfaction but it was modified to suit the purpose of this study. The written questionnaire for this study constituted 34- questions which was divided into sections. Section A centres on patient (socio-demographic characteristic) factors such as age, sex, income, marital status, level of education and socioeconomic status. Section B centres on patient-provider relationship (health care delivery/ service factors: Care from doctors and nurses, patient perceptions, hospital environment and patients' experiences at the OPD).

Satisfaction was a composite score of sum of three (3) questions; OPD services with 3 options (1.dissatisfied 2. satisfied 3. very satisfied), how patients were handled by providers with 3 options (1.dissatisfied 2. satisfied 3. very satisfied) and patients recommending OPD services to family

and friends with 4 options (1. definitely no 2. probably no 3. probably yes 4. definitely yes). The maximum score a respondent could get was 10 and a minimum of 3. Therefore satisfaction was generated by: if score was ≥ 7 , then “satisfied” and if < 7 , then “not satisfied”

Care from doctors. A 7 item questions were used with 3 options (1.always 2. Sometimes/usually 3. never) each. The maximum score was 21 and the minimum score was 7. If a score was; from 7 to 11= excellent care, from 12 to 16 = adequate care and from 17 to 21= poor care.

Care from nurses. A composite score was derive from 4 item questions with 3 options (1.always 2. sometimes/usually 3. never) each. The maximum score is 12 and minimum score was 4. A score from 4 to 6 =excellent care, from 7 to 9 = adequate care and from 10 to 12 =poor care.

Experiences with OPD services. Here, 5 item questions were used with 3 options (1.always 2. Sometimes/usually 3. never) each. A maximum score was 15 and a minimum score was 5. A total score from 5 to 8 =excellent, from 9 to 12 = adequate and from 13 to 15 = poor services.

Well trained four (4) research assistants helped to translate the questionnaires into local languages to the best of the understanding of the respondents in the presence of an independent witness in situations where the recruited respondent could not read and write. The questionnaires were administered by trained research assistants and lasted for a maximum of 20 to 30 minutes each. Both self-administered and interviewer-administered strategies were applied.

3.8 Data processing and analysis

The data was entered into Microsoft Excel to ensure easy data cleaning. Data set was then imported to STATA version 15 for further analysis.

The characteristics of respondents were based on the following variables: age, sex, education level, marital status, occupation and income. Each variable was summarised with the use of a table containing frequencies, and percentages. The association between the dependent variable and the

independent variables were tested using the chi-square test and simple logistic regression. The results were expressed as p values, odds ratios and confidence interval. A p-value of <0.05 at 95% confidence interval were considered as statistically significant.

3.9 Quality assurance

This comprises of sections where measures are put in place in order to ensure the study is free from biases to provide quality to the study.

3.9.1 Training of research assistants

Four research assistants (RAs) were given training for two days before the commencement of the data collection. The purposes of the training were: (i) to make sure the RAs understood the objectives of the study; (ii) to ensure the understanding of the survey tools and interpretation; (iii) to assess whether the RAs could perform the survey tasks. The research assistants were educated on ethical issues, how to effectively communicate and administer the questionnaires to the respondents. The researchers (PI and RAs) met at the end of each day's data collection to discuss problems encountered and addressed them accordingly before the start of the next day's data collection.

3.9.2 Pretesting of the questionnaire / Data collection tool

The study questionnaire was pretested at the Legon Hospital to determine its suitability.

Forty patients, thus, 10% of the sample size were sampled for the pretesting study. The questionnaires were administered to patients within 2 days. Efforts were made to avoid bias in order to go against ethical standards. The pretesting was intended to enhance understanding of the questionnaire, to ensure reliability and also helps in assessing the completeness, clarity and validity of the study. The outcome of the pre-test was shown and improved respondent understandings of the research instruments. The collected data were checked, cleaned and sorted to ensure that

partially filled questions were separated from completely filled ones as well as arranging them in order. Thereafter, necessary corrections at the various sections of the questionnaires were effected.

3.9.3 Validity and reliability of the tool

The questionnaire was adapted from Ghana Health Service patient satisfaction survey tool, (GHS, 2004), PSQ 18 (Dabaghian et al., 2016), and a study by Yawson (2017) but it was modified to suit the purpose of this study. These tools were considered because of the benefit of having good reliability and validity. The validity and reliability of the tools used to assess patient's satisfaction have been approved by different studies. In a survey done by Dabaghian, a Cronbach's alpha of 0.72 was reported (Dabaghian et al., 2016), and in another study by Ziaei, a Kappa's coefficient of 0.96 (Ziaei et al., 2011).

3.10 Ethical consideration

Ethical clearance

Ethical clearance was granted by Ghana Health Service Ethics Review Committee with approval No GHS-ERC: 071/04/19.

Approval and permission

A written introductory letter from the university was sent to seek permission from the Achimota Hospital before the commencement of this study. An approval to collect data from the hospital was granted and the OPD In-charge was duly informed prior to the commencement of the data collection.

Purpose of the study

The purpose of this study was to assess the influence of patient- provider relationship on patient satisfaction at Achimota Hospital, and so the subjects involved were patients at the hospital's OPD.

Eligibility criteria

The researcher recruited any patient of ages ranging from 18 years and above seeking healthcare services at Achimota Hospital and was willingly interested to take part in the study. However, visitors to the hospital, patients who were critically ill and those who refused to consent were not eligible to take part in the study.

Potential risk and benefits of the study

There was no conceivable risk to the respondents who were sampled and took part in the study. The patients had their normal healthcare services at the OPD and the study did not in any way interrupt the daily activities of the OPD. At the end of the study, the findings were expected to have positive consequences on healthcare delivery in the facility because the hospital management would have information about how the doctors and nurses give care to their patients, the relationship between them and whether the patients were satisfied or not with that relationship as well as OPD services. The patients on the other hand would benefit from the research as it would give them the opportunity to express their views and concerns about the relationship with their providers and healthcare services.

Anonymity

All information collected in this study was coded. No name or identifier was used in writing the report. Strict anonymity was adhered to throughout this study and the questionnaires did not bear the names of the patients.

Privacy and confidentiality

Respondents were provided with total privacy, however patients had the right to ignore or not to answer any questions that were deemed to be sensitive to their personal opinions.

Informed consent

The purpose and nature of the study, aims and objectives were explained in details on the participant information sheets and interpreted by the research assistants to the participants who could not read. The participant information sheets were given to respondents for their keep after they had signed or thumb printed indicating their understanding of the study. The explanations were all done in a local language they understood. Those who were willing to take part in the study were made to sign or thumb print the consent form. Copies of the participant information sheet and the signed form were attached to the questionnaire. Research assistants also signed indicating that they had given all the necessary information concerning the studies to the respondents.

Data Security, Storage and Usage

Collected data was used solely for the purposes specified for the study. Data files were password protected. Hard copy and electronic data were stored and locked securely in cabinets without the names of the respondents, and access was limited to the researcher and the supervisors of the study. The stored data would be destroyed after a minimum of three years according to the research protocol.

3.11 Summary of the chapter

The chapter examined the study design, study area as well as study population. It also discussed the studies sample size, sampling techniques, inclusion and exclusion criteria, study variables, data collection procedure and data processing and analysis. Additionally, the various sections of quality

assurance and ethical consideration were also discussed. The next chapter presents the results of the study.

CHAPTER FOUR

RESULTS

4.0. Introduction

This chapter presents the study results of the study which are categorized into sections, including socio-demographic background characteristics, patient satisfaction with patient-provider relationship, characteristics of patient-provider relationship, and patients' perception of patient provider relationship and level of satisfaction with patient – provider relationship.

4.1 Socio-demographic background characteristics of respondents.

A total of 383 out of 386 patients indicated their sex, made up of 154(40.2%) males and 229 (59.8%) females accessing the OPD services aged above 18years who took part in the study. The average age of the patients was 38 years (SD= 0.75). Majority were within the ages of 21 – 30 years (33.9%), followed by 31 - 40 (22.5%) and 41 -50 years (16.1%). The least age range was 18-20 years (7.5%).

Those married were 148 (38.8%), those who had not married were 148 (38.8%), those cohabiting, divorced and widowed were 29 (7.6%) each.

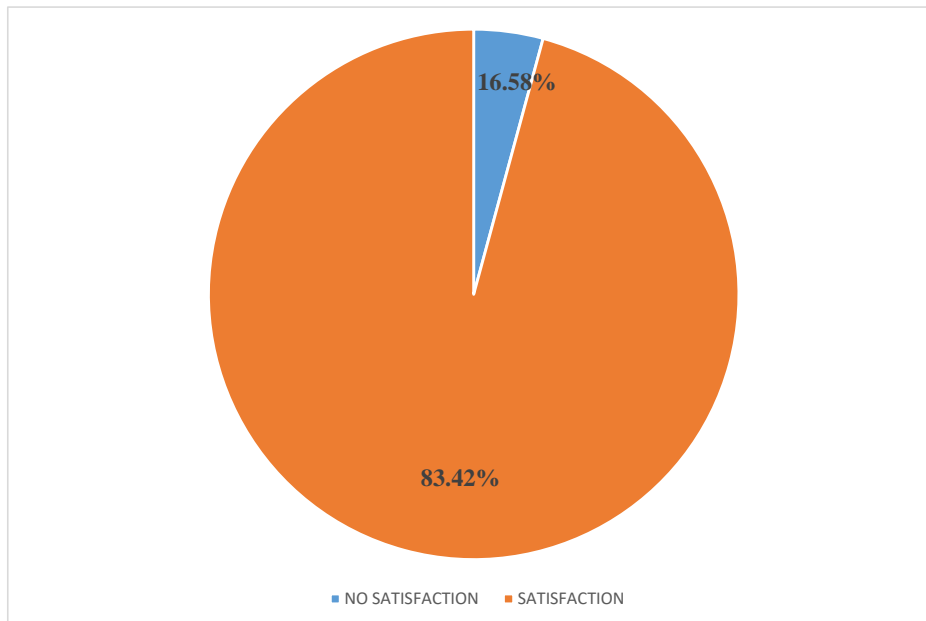
Most of the respondents had had tertiary education, 136 (35.6%) followed by those who had up to SHS, 105 (27.5%). Respondents who had no education and those who had up to primary level were about 25 (6.5%) each. Those who were employed were 250 (67.5%) followed by the unemployed 92 (23.9%) and 34 (9.0%) were students or apprentices. Out of the total number of 368, 62 (16.9%) respondents' average income as more than or equal to GHS 1500, followed by 49 (13.3%) who had between GHS 500 and GHS 1000. Those who earned averagely from GHS 200 to GHS 500 a month were 97 (26.36) and those whose average income was less than GHS 200 were 87 (23.4%). The results are shown in table 4.1

Table 4.1 Socio-demographic characteristics of respondents.

Variable	n=386	Frequency (%)	Percentage (%)
Age (years)			
18-20		29	7.51
21-30		129	33.94
31-40	n=384	87	22.54
41-50		62	16.06
51-60		42	10.88
60+		35	9.09
Sex	n=383		
Male		154	40.21
Female		229	59.79
Marital status	n=382		
Never married		147	38.48
Married		148	38.78
Cohabiting		29	7.59
Divorced		29	7.59
Widowed		29	7.59
Educational level	n=382		
No education		25	6.54
Primary		25	6.54
JHS		91	23.82
SHS		105	27.49
Tertiary		136	35.60
Occupational status	n=376		
Unemployed		92	23.96
Employed		250	66.50
Student/Apprentice		34	9.04
Average income (GHS)	n=368		
Less than 200		87	23.64
Between 200-500		97	26.36
500 but less than 1000		73	19.84
1000 but less than 1500		49	13.32
More than or equal to 1500		62	16.85

The study showed that, out of the 386 respondents who participated in the study, 322 (83.4%) were satisfied with the patient-provider relationship at the Achimota Hospital while 64 (16.6%) were dissatisfied. The result are detailed in figure 4.1

Figure 4.1 Proportion of patients satisfied with patient-provider relationship



4.3 Bivariate Analysis: Association between patient (socio-demographic characteristics) factors and satisfaction with patient-provider relationship.

Table 4.2 showed results of the association between patient (Socio-demographic characteristics) factors and satisfaction with patient-provider relationship.

Within the ages of 18-20 years, 25 (6.5%) were satisfied while 4(1.0%) were dissatisfied. Within the ages of 21-30 years, those who were satisfied were 124(32.3%) and 7(1.8%) were not satisfied. Respondents within the ages of 31-40 years, 86(22.4%) were satisfied while only 1(0.3%) was not satisfied. Those in the age range 41 years and above, 132(34.4%) were satisfied while 5(1.3%) were dissatisfied. However, the association between the age and patient satisfaction was not statistically significant ($\chi^2=8.950$ and $P=0.125$).

Out of the 383 respondents who indicated their sex, 124(80.5%) males were satisfied but 30(19.5%) were not satisfied and the relationship was not significant ($\chi^2=1.420$ and $p=0.233$). For the females, 195(85.2%) were satisfied while 34(14.9%) were not satisfied. With marital status, those who had never married, 122(82.9%) were satisfied while 25(17.0%) were not satisfied, 125(86.5%) of those who were married were satisfied while 23(15.5%) not satisfied. There was no statistical association ($\chi^2=2.473$; $p=0.649$). Again, 117(86.0%) respondents who had tertiary education were satisfied while 19(13.97%) were dissatisfied with providers' relationship with patients. For those who had SHS education, 90(85.7%) were satisfied while 15(14.3%) were not satisfied and those with no education, 14(56.0%) were satisfied while 11(44.0%) were not satisfied. The association was not significant ($\chi^2=114.5356$ and $p=0.006$). For those employed, those satisfied were 209(61.2%) while 41(32.8%) were dissatisfied. With those unemployed, 76 (82.6%) were satisfied but 16(17.4%) were not satisfied with providers' relationship. There was no statistical association ($\chi^2=0.6480$; $p=0.958$). Majority of the respondents, 77(79.4%) with average income between GHS200 and GHS500 were satisfied while 20(20.62%) were dissatisfied. The relationship was not statistically significant ($\chi^2=5.085$; $p=0.279$).

Table 4.2 Bivariate Analysis: Association between patient (socio-demographic characteristics) factors and satisfaction with patient-provider relationship.

Variable	n=386	Not satisfied (%)	Satisfied (%)	Chi Square(χ^2)	P value
Age (years)					
18-20	n=384	4(1.04)	25(6.51)	8.950	0.125
21-30		7(1.82)	124(32.29)		
31-40		1(0.26)	86(22.40)		
41-50		2(0.52)	60(15.63)		
51-60		2(0.52)	40(10.43)		
60+		1(0.26)	32(8.33)		
Sex					
Male	n=383	30(19.48)	124(80.52)	1.420	0.233
Female		34(14.85)	195(85.15)		
Marital status					
Never married	n=382	25(17.01)	122(82.99)	2.473	0.649
Married		23(15.54)	125(84.46)		
Cohabiting		3(10.34)	26(89.66)		
Divorced		6(20.69)	23(79.31)		
Widowed		7(24.14)	22(75.86)		
Educational level					
No education	n=352	11(44.00)	14(56.00)	14.5356	0.006
Primary		4(16.00)	21(84.00)		
JHS		15(16.48)	76(83.52)		
SHS		15(14.29)	90(85.71)		
Tertiary		19(13.97)	117(86.03)		
Occupational status					
Unemployed	n=376	16(17.39)	76(82.61)	0.6480	0.958
Employed		41(32.82)	209(67.18)		
Student/Apprentice		6(17.65)	28(82.35)		
Average income (GHC)					
Less than 200	n=368	15(17.24)	72(82.76)	5.0815	0.279
Between 200-500		20(20.62)	77(79.38)		
500 but less than 1000		6(8.22)	67(91.78)		
1000 but less than 1500		7(14.29)	42(85.71)		
More than or equal to 1500		10(16.13)	52(83.87)		

4.4 Characteristics of patient-provider relationship by satisfaction

Table 4.3 shows whether respondents were satisfied or not with the individual relationship factors. From the results, majority of the respondents were satisfied with all the categories except; 198 (52.08%) respondents who were dissatisfied with doctors considering treatment option based on patient's socio- economic status as against 184(47.92%) who were satisfied. Also 194 (50.52) respondents were not satisfied with nurses' explaining procedures more often to them while 190 (49.48) were satisfied.

Table 4.3 Characteristics of patient-provider relationship by satisfaction.

Variable	Category	Not satisfied Frequency/ %	Satisfied Frequency/ %	Chi- square
Care from doctors	Respect, courtesy, empathy	63(16.94)	309 (83.06)	16.0508
	Listen to patients	63 (16.94)	309 (83.06)	4.0267
	Physical & mental improvement after visiting doctor	63 (16.94)	309 (83.06)	13.2066
	Procedures explanation	63 (16.89)	310 (83.11)	17.1860
	Respect of values and beliefs	63(16.89)	310 (83.11)	13.6757
	Advice on health lifestyle	62 (16.58)	312 (83.42)	27.1573
	Consider treatment option based on economic status	198 (52.08)	184(47.92)	10.4327
Care from nurses	Respect, courtesy, empathy	63 (16.84)	311 (83.16)	45.2201
	Listen to patients	63(16.89)	310 (83.11)	24.3347
	Explain Procedures often	194 (50.52)	190 (49.48)	23.2058
Patient OPD experiences	Assistance from providers	43(13.83)	268(86.17)	16.1575
	Pain well controlled	43(15.47)	235(84.53)	4.5871
	Description of indication and side effects of medicines	55(15.90)	291(84.10)	39.9949
	Had needed OPD services	61(16.94)	299(83.06)	39.0094

4.5 Determining patient perceptions of patient-provider relationship

From table 4.4, about 245(67.5%) of respondents perceived to have had excellent care from doctors. Thus, they perceived doctors always met their expectations. Those who reported to have had adequate care from the doctors were 113(31.1%). However, 5 (1.4%) respondents were perceived to have had a poor care from the doctors. Out of the 365 respondents who received care from the nurses, 208 (56.9%) were perceived to have received excellent care, 142 (38.9%) also perceived that they had adequate care and 15 (4.1%) received poor care from the nurses. With OPD services, 161 (70.0%) perceived the services were excellent whereas 68(29.6%), 94 (24.5%) also perceived that the OPD services were adequate and 1(0.4%) perceived hat they received poor OPD services.

With hospital environment, 123(32.0%) respondents perceived the hospital environment was excellent, 210(54.7%) also perceived the hospital environment was adequate for care delivery while 51(13.3) respondents perceived the hospital environment was poor.

Table 4.4 Determining patients' perceptions of patient-provider relationship

Variable	Category		Frequency (%)	Chi Square(χ^2)	P value
Care from doctors	Excellent care		245(67.49)	33.1410	0.000
	Adequate care	n=363	113(31.13)		
	Poor care		5(1.38)		
Care from nurses	Excellent care		208(56.99)	37.2036	0.000
	Adequate care	n=365	142(38.90)		
	Poor care		15(4.11)		
OPD services	Excellent		161(70.00)	26.7410	0.000
	Adequate	n=230	68(29.57)		
	Poor		1(0.43)		
Hospital environment	Excellent		123 (32.03)	5.870	0.026
	Adequate	n=384	210 (54.68)		
	Poor		51(13.28)		

4.6 Logistic regression: Association between patient-provider relationship and patient satisfaction

Logistic regression was done to find out the association between patient-provider relationship and patient satisfaction and the results are shown in table 4.4

From the results, care from nurses (odd ratio=40.4079, 95%CL=3.2721-49.8990, $p = 0.004$) and OPD services (odd ratio=21.1912, 95%CL=0.0548-0.6166, $p \text{ value} = 0.006$) were statistically significant. The rest of variables were insignificant.

Table 4.5 logistic regression: Association between patient-provider relationship and patient satisfaction

Variables	Category	Odd ratio	95% CI	P value
Age (years)		0.9569	0.9139-1.0018	0.060
Sex	Female	0.6316	0.1935-2.0613	0.446
Marital status	Married	0.6258	0.1209-3.2389	0.576
	Divorced	0.6634	0.9409-4.6776	0.681
	Widowed	0.3045	0.0237-3.9131	0.361
Educational level	Primary	3..2390	11.0659-95.3941	0.494
	JHS	0.7804	0.05422-11.2323	0.855
	SHS	0.8233	0.0489-13.8631	0.893
	Tertiary	1.2256	0.0722-20.7862	0.888
Occupation	Employed	0.2791	0.0238-3.2709	0.310
	Students	0.1697	0.0091-3.1524	0.234
Care from doctors	Adequate	1.1473	0.3432-3.8350	0.823
Care from nurses	Excellent	40.4079	3.2721-49.8990	0.004
	Adequate	16..0140	1.2981-19.7552	0.031
OPD services	Adequate	21.1912	0.0548-0.6166	0.006

4.7 Summary of the chapter

The chapter presented the results of the study which were categorized into sections, including socio-demographic background characteristics, patient satisfaction with patient-provider relationship, characteristics of patient-provider relationship, and patients' perception of patient provider relationship and level of satisfaction with patient – provider relationship. A total of 383 out of 386 respondents specified their sex, made up of 154(40.2%) males and 229 (59.8%) females accessing the OPD services aged above 18years who took part in the study. The average age of the patients was 38 years (SD= 0.75). Bivariate Analysis was done to find the association between patient (socio-demographic characteristics) factors and satisfaction with patient-provider relationship. Additionally, characteristics of patient-provider relationship by satisfaction, patient perceptions of patient-provider relationship and logistic regression to find the association between patient-provider relationship and patient satisfaction were determined. The study showed that, out of the 386 respondents who participated in the study, 322 (83.4%) were satisfied with the patient-provider relationship at the Achimota Hospital while 64 (16.6%) were dissatisfied based on the analysis and the results of this study. The next chapter discusses the finding of the study presented in chapter four.

CHAPTER FIVE

DISCUSSION OF FINDING

5.0 Introduction

In Ghana like many other developing countries, patients' satisfaction with patient-provider relationship influences the outcome of the use of health facilities (Boadu, 2011). Therefore, this chapter presents discussion of the findings in comparison with findings from the previous studies.

5.1 Patient (socio-demographic characteristics) factors

From the univariate analysis, a total of 154 (40.2%) male and 229 (59.8%) female respondents making a total of 384 respondents participated in this study. The differences in males and females proportions could be attributed to health challenges related to maternal issues, which tend to affect females' utilization of health care services than males. This finding confirms the observations made by Jegede (2010) that, more women access hospital services for themselves, their children and other members of the family than men do.

From the age distributions, it was revealed that majority of the respondents 33.94% were within the ages of 21 – 30 years. The findings support the views that, majority of health care users in both developed and the developing countries are in their reproductive phases of life (Japipaul & Rosenthal, 2003). The least age range was 18-20 years (7.5%). This could be due to the hospital setting where students were writing their exams and so did not find them at the health facility.

For the study, most of the respondents had had tertiary education 35.6% followed by those who had up to SHS 27.5%. Respondents with no education and those who had up to primary level were about 6.5% each. On the basis of respondents' educational level distribution, it could be concluded that majority of the respondents had academic qualifications of different categories which positively influence their understanding and subsequently relationship with providers. This finding

defends Iliyasu *et al.*'s (2010) observation that, the majority of the healthcare users who possessed both secondary and tertiary levels of education tend to have good relationship with their providers. Again, this study revealed that, most patients were satisfied with patient-provider relationship and commending staff for their output despite limited resources. Similarly, Zeithaml and colleagues (2013) also reported that, patients who were satisfied with their providers tended to express intentions in positive ways such as commending the staff and choosing that facility over others, thereby increasing their revenue.

It was found that, for those employed, 209(61.2%) were satisfied while 41(32.8%) were dissatisfied. With those unemployed, 76 (82.6%) were satisfied but 16(17.4%) were not satisfied with providers' relationship. There was no statistical association ($\chi^2 = 0.6480$; $p = 0.958$). Most of the respondents, 67(91.8%) with average income between GHS 500 and GHS 1000 were satisfied while 6(8.2%) were dissatisfied. The relationship was not statistically significant ($\chi^2 = 5.085$; $p = 0.279$). Although majority of the respondents were employed, their average monthly income was between GHS 500 and GHS 1000. It could be inferred from their average monthly income that, most respondent were people of limited resources of income. Though respondents' monthly average income was low, their health care utilization was high and were satisfied with their relationship with providers. This finding contradicts a study which revealed that, low socio-economic status influenced the use of health care services thereby influencing their decisions and the relationship with other health workers (Jegede, 2010). Possible reasons for the high health care services utilization could be that, respondents were supported by health insurance or measures put in place by hospital management to support their patients financially (Asenso-Okyere *et al.*, 1997).

From the logistic regression results, care from nurses was significant (Excellent, odd ratio=40.4079, 95%CL=3.2721-49.8990, $p = 0.004$) and respondents were 40 times more likely to

be satisfied with excellent care from nurses as compared with adequate care which could be inferred that patients' satisfaction was high. This indicates that, respondents and providers cooperated to receive excellent care from them. These findings support Bennett et al.'s (2016) argument that a supportive and collaborative relationship between patients and providers could enhance patient adherence, health outcomes and his or her overall satisfaction.

However, it was revealed in this study that, 50.5% respondents were not satisfied with nurses' explaining procedures more often to them while 15.9% were also not satisfied with nurses describing indications and side effects of medicines. This dissatisfaction could be due to poor communication between nurses and patients and this could lead to undesirable health consequence. Similarly, a study reported that, poor communication was one of the leading causes of preventable deaths in hospitals in America (McPhee, Lo B, Saika, 1984). This could also contribute to the perceptions of patients that nurses have poor communication with their patients which affect health outcomes negatively. For instance, when patients perceive health care providers' communication as being poor, seeking services is likely to be negatively impacted (Black, & Gruen, 2009).

Furthermore, OPD services were also reported to be significantly related to satisfaction with patient-provider relationship (Adequate, odd ratio=21.1912, 95%CL=0.0548-0.6166, $p=0.006$) and respondents were 21 times more likely to be satisfied with adequate OPD services as against excellent services. This implies that, the hospital OPD provides almost all the services to meet the health needs of patients and this could positively influence patient attitudes towards health care utilization. These findings support a study conducted by Zeithaml and Bitner, (2013) which found that, patients who were satisfied with health care services were likely to exhibit positive behavioural intentions, which are beneficial to the healthcare providers' long-term success.

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary, conclusions of the study and some recommendations for continuous improvement of patient-provider relationship. Also, the chapter deals with the implications of the study, strength and limitations.

6.1 Summary of the study

From the analysis, a total of 40.2% male and 59.8% female respondents participated in this study. Majority of the respondents 33.9% were within the ages of 21– 30 years. The least age range was 18-20 years with 7.5%.

Most of respondents had had tertiary education (35.6%) and this might be due to the health facility situated within an educational institution (Achimota School). Those who were employed consisted 67.2% as against 23.9% unemployed and few students or apprentices 9.0% were recoded. Those married consisted 38.8% and the rest either not married or in other forms of relationship had average income between GHS 500 and GHS 1000.

Logistic regression analysis was done to find out the association between the categories and satisfaction with patient-provider relationship.

From the results, care from nurses (Excellent, odd ratio = 40.4079, 95%CL=3.2721-49.8990, p value =0.004) and OPD services (Adequate, odd ratio=21.1912, 95%CL=0.0548-0.6166, p value =0.006) were statistically significant. Respondents were 40 times more likely to be satisfied with excellent care from nurses as compared with adequate care because excellent care was highly significant (p value=0,004) than adequate care (p value=0.031).

With regards to OPD services, respondents were 21 times more likely to be satisfied with adequate OPD services as against excellent services.

6.2 Conclusions of the study.

This study results revealed that, majority of the respondents (83.4%) were satisfied with the relationship between them and their providers. This implies that, respondents were satisfied with the way and manner they received care at the Achimota Hospital OPD. Quality healthcare is positively intersected with satisfaction with patient-provider relationship. However, the direction and strength of the analytical relationship between quality and satisfaction remains unclear (Boateng & Awunyor-Vitor, 2013). According to Meredith and colleagues (2001), quality interpersonal relationship between patients and providers is significantly associated with adherence and better treatment outcomes as well as patient overall satisfaction. Therefore, it could be concluded on the basis of this assertion that, patients receiving care from Achimota Hospital's OPD are more likely to adhere to advice from their providers as well as receiving better health outcomes.

Nevertheless, 16.6% of the total respondents were dissatisfied with patients' relationship with providers. According to Atinga, Abekah-Nkrumah, and Domfeh (2011), poor health outcomes mostly emanate from compromised health factors including poor customer relationship. Similarly, the 16.6% respondents might have also received poor health outcome and so the hospital management should be concerned and institute measures to solve the communication problem from the nurses.

Some of the possible reasons that accounted for 16.6% dissatisfaction included doctors' inability to discuss treatment options based on patients' financial capacity with them. Not only that but also, some patients being not assertive before, during and after receiving care for the fear of being

abandoned by the provider. Rizyal et al., (2012) reported that, patient-provider relationship connotes a trusting relationship in such a way that, the provider comes to an understanding to respect the patient's autonomy, clarifies choice of treatments, gets informed consent, provide the highest standard of care, safeguards confidentiality and oblige not to abandon the patient without assisting the patient to find another provider.

Moreover, most doctors do not know how much the different treatments options cost patients in order to explain to them. As indicated earlier, respondents were not satisfied with nurses' explaining procedures, indications for medications as well as side effects more often to patients. According to Jegede and Fayemiwo (2010), when providers fail to explain procedures to patients, the general public may persistently perceive public hospital services as being very poor and this may affect health utilization by patients.

The level of satisfaction may be attributed to the fact that, Achimota Hospital has all the units of a general hospital services which including specialist services, laboratory and radiological facilities as well as computerized systems for data entry and storage which make patient information and recovery easily accessible.

Maternal characteristics which were recognized in literature could influence the extent to which women are satisfied with the quality of care and their relationship with providers as they receive care from health care facilities. Most common demographic characteristics often considered in literature include age, educational status, employment or income level and marital status (Cockerham and Wiley, 2004).

This study revealed that majority of the respondents who participated in this study were women. The reason could be as a result of health challenges related to maternal issues which tend to affect

females' utilization of health care services than males. This means that, the hospital management should factor issues and services affecting women such as labour wards, hostels for women who go on admission among others into the hospital's future plans.

The greater proportion of respondents in this study had secondary and tertiary education and either self-employed or formally employed, which is a very distinctive characteristic of an urban population. This may also account for the level of patient satisfaction with patient-provider relationship.

Providers being sensitive to patient-provider relationship factors relating to respect, courtesy, caring, empathy, reliability and responsiveness during the discharge of their duties was seen as a positive relationship and may be considered in patients' satisfaction. This helps to inform patients to decide whether or not to access that facility again. According to Council of Accountable Physician Practices (CAPP 2017) survey, consumers believe that patient-provider relationship is the single most important factor in quality care. Recognizing and understanding the influence patient-provider relationship on patients' satisfaction is a fundamental parameter to developing improvement strategies in health care delivery.

The results of the study showed how patients and health providers' relationship could be created to affect healthcare quality. That is, patients' involvement in care delivery was seen as an essential feature in healthcare services whereby he or she influences health outcome through adherence, being assertive by describing the right symptoms in order to make the right diagnosis and treatment. Patient loyalty in positive behaviours such as recommending health services to friends and family, compliance and high patronage of services depend largely on how providers handle them as well as establishing trustworthy relationship (Sagaro, Yalew, & Koyira, 2015).

Understanding and exploring patient-provider relationships is an important step toward developing and implementing interventions that could have the potential to improve the quality of care.

6.3 Recommendation

The study provides the following recommendations based on the results.

1. To continually improve patient-provider relationship towards influencing patients' satisfaction, measures must be put in place to have more resources at the OPD that providers will have ample time to provide care. Again, the nurses should be continually given in service training on the need to explain procedures, indications and side effects of medications to patients, especially those who cannot read and write.
2. Public health education should be encouraged, strengthened and done on regular basis to empower patients to be confident to ask the right questions and suggestive inputs in the course of receiving care in order to experience quality health outcomes.
3. Policies should be instituted to monitor and award providers who go a long way to maintain a very healthy relationship with patients and deliver quality care despite their heavy schedules and patient attendance in order to encourage other health professionals to emulate.

6.4 Limitations to the study

Consecutive sampling method employed in this study allowed respondents that were present at the OPD during the recruitment stage to have an equal chance of participating in the study. However, because the study was conducted within two weeks, it included only respondents who were present at the OPD within that period. The level of patient satisfaction with patient-provider relationship depicts how much efforts were being put in the delivery of quality care and improving patient-provider relationship even though respondents had different background and perception of patient-

provider relationship. In addition, measures put in place by management to technologically improve patients' data storage and easy access is commendable.

However, respondents answering the questionnaires at the facility though privacy was provided and signing of the consent form were seen to have influenced their judgment at that time for fear of being noticed by healthcare providers or other patients. Furthermore, interviews could have been conducted to help get enough information about patients' perceptions to support this study's findings.

6.5 Further research should be conducted to determine the relative strength of various factors underlying satisfaction with patient provider relationship with the focus on policy specific areas in public health facilities especially tertiary hospitals.

- Aiken, L. H., Sermeus, W., Van Den Heede, K., Sloane, D. M., Busse, R., McKee, M., ...Kutney-Lee, A. (2012). Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *BMJ (Online)*, 344(7851), 1–14. <https://doi.org/10.1136/bmj.e1717>
- Alderman, H. H., Street, H., & Bank, T. W. (2006). Employment . (June , 1999)
- Andaleeb, S. S. (2006). Determinants of customer satisfaction with hospitals : a managerial model.
- American Hospital Association. Hospital Statistics. Chicago. 1999.
- Asenso-Okyere WK, Osei-Akoto I, Anum A, Appiah EN: Willingness to pay for health insurance in a developing economy: a pilot study of the informal sector of Ghana using contingent valuation. *Health Policy* 1997, 42:223–237.
- Ashiagbor, George; Amoako, Clifford; Asabere, Stephen B.; Quayle-Ballard, Jonathan A. (2019). [*"Landscape Transformations in Rapidly*](#)
- Atinga, R. A., Abekah-Nkrumah, G., & Domfeh, K. A. (2011). Managing healthcare quality in Ghana: A necessity of patient satisfaction. *International Journal of Health Care Quality Assurance*, 24(7), 548–563. <https://doi.org/10.1108/09526861111160580>
- Babbie, Earl R. The Practice of Social Research. 12th ed. Belmont, CA: Wadsworth Cengage, 2010; Muijs, Daniel. Doing Quantitative Research in Education with SPSS. 2nd edition. London: SAGE Publications, 2010.
- Bennett, W. L., Cheskin, L. J., Cooper, L. A., Roter, D. L., Bleich, S. N., Washington Cole, K. O., & Gudzone, K. A. (2016). Providing prenatal care to pregnant women with overweight or obesity: Differences in provider communication and ratings of the patient-provider relationship by patient body weight. *Patient Education and Counseling*, 100(6), 1103–1110. <https://doi.org/10.1016/j.pec.2016.12.030>
- Black, N., Gruen R. (2009). Understanding Health Services. England. Open University Press.
- Boateng, D., & Awunyor-Vitor, D. (2013). Health insurance in Ghana: evaluation of policy holders’ perceptions and factors influencing policy renewal in the Volta region. *International Journal for Equity in Health*, 12(1), 50. <https://doi.org/10.1186/1475-9276-12-50>
- Boadu, F. (2011). An assessment of Consumer Care and Satisfaction in Government Healthcare Institutions in Ghana. The case of Juaben Government Hospital. A Thesis submitted to the Institute Of Distance Learning, Kwame Nkrumah University of Science and Technology. A Thesis submitted to the Institute Of Distance Learning. Kwame Nkrumah University of Science and Technology
- Buttle, F. (1996). SERVQUAL: review, critique, research agenda. *European Journal of marketing*, 30(1), 8-32.

- Campbell, S. M., Roland, M. O., & Buetow, S. A. (2000). Defining quality of care. *Social Science and Medicine*, 51(11), 1611–1625. [http://doi.org/10.1016/S0277-9536\(00\)00057-5](http://doi.org/10.1016/S0277-9536(00)00057-5)
- Carol A. Schwab, J.D., LL.M., (2007) Director of Medical/Legal Education, University of Tennessee Health Science Center, Memphis, TN.
- Ciechanowski, P., Katon, W., Russo, J., & Walker, E. (2011). The Patient-Provider Relationship Attachment Theory and Adherence to Treatment in Diabetes.
- Ciechanowski, P. S., Katon, W. J., Russo, J. E., & Walker, E. A. (2001). The patient-provider relationship: attachment theory and adherence to treatment in diabetes. *American Journal of Psychiatry*, 158(1), 29-35.
- Cockerham, W.C. 2004. *Medical Sociology*. London: Practice Hall. Inc.
- Cochran W. G. (1977). ‘Sampling Techniques.’ 3rd edn. (John Wiley & Sons: New York.)
- Conway, T., & Willcocks, S. (1997). The role of expectations in the perception of health care quality: developing a conceptual model. *International Journal of Health Care Quality Assurance*, 10(3), 131-140.
- Criel, B., & Waelkens, M. P. (2003). Declining subscriptions to the Maliando mutual health organisation in Guinea-Conakry (West Africa): what is going wrong?. *Social science & medicine*, 57(7), 1205-1219.
- Dabaghian, F. H., Khadem, I., & Ghods, R. (2016). Evaluation of Patient Satisfaction with Medical Services at Traditional Iranian Medicine Clinics in Tehran. *Patient Saf Qual Improv*, 4(1), 313–319
- D’Souza, S. C., & Sequeira, A. H. (2012). Measuring the customer-perceived service quality in health care organization: A case study. *Journal of health management*, 14(1), 27-41.
- Donabedian, A. (1990), The Quality of Care: How Can it Be Assessed? In Graham, N. O., ed.: *Quality Assurance in Hospitals*, 2nd Edition. Rockville, MD. *Aspen Publishers*.
- Donabedian A. The quality of care. How can it be assessed? *JAMA*. 1988;260(12):1743–8.
- Enaikele, M.D.2013.Social Action and Sociological explanation In Sociological theory for African Students Olutayo, A.O. and Olayinka, A. (eds) Ibadan University Press pg 91-104.
- Erinosho, A. O. (2005). Health sociology for University Colleges and related institutions. Sambookman. Ibadan.

- Ghana Health Service (2007), Quality Assurance Strategic Plan for Ghana Health Service (2007-2011), Accra.
- Ghana Health Service, 2009. Handbook on Customer Care. Accra, Ghana Health service.
- Ghana Health Service (2003). Annual Report. Accra: Ghana Health Service.
- The Ghana National Healthcare Quality Strategy (2017), The Strategy, Coordination and Accountability Framework (2017-2021), Accra
- Ghana Statistical Service (2014), Population and housing Sensus, District Analytical Report. Ga West Municipality.
- Hailu, A. (2015). Determinants of Patient Satisfaction in Outpatient Department; the case of Assosa Hospital, Benishangul-Gumuz Regional State, Ethiopia. Doctoral dissertation. Haramaya University.
- Hennekens CH, Buring JE. (1987), Epidemiology in Medicine, Lippincott Williams & Wilkins.
- Iliyasu, Z., Abubakar, I. S., Abubakar, S., Lawan, U. M., & Gajida, A. U. (2010). Patients' satisfaction with services obtained from Aminu Kano Teaching Hospital, Kano, Northern Nigeria. *Nigerian Journal of Clinical Practice*, 13(4).
- Jegede, A. S., & Fayemiwo, A. S. (2010). Cultural and ethical challenges of assisted reproductive technologies in the management of infertility among the Yoruba of southwestern Nigeria. *African journal of reproductive health*, 14(2), 115-127.
- Jaipaul , C. K. and Rosenthal, G. E. 2003. Are older patients more satisfied with hospital care than younger patients. *Journal general internal medicine*.1:23-30.
- Klemick, H., Leonard, K. L., & Masatu, M. C. (2009). Defining access to health care: evidence on the importance of quality and distance in rural Tanzania. *American Journal of Agricultural Economics*, 91(2), 347-358.
- Mayo Clinic Jacksonville, 2006 US Dist. LEXIS 33668, at *10 (ND Ill May 15, 2006
- McPhee, S. J., Lo, B., Saika, G. Y., & Meltzer, R. (1984). How good is communication between primary care physicians and subspecialty consultants?. *Archives of Internal Medicine*, 144(6), 1265-1268.
- Meredith, L. S., Orlando, M., Humphrey, N., Camp, P., & Sherbourne, C. D. (2001). Are better ratings of the patient-provider relationship associated with higher quality care for depression?. *Medical Care*, 349-360.

- Ministry of Health (2004). National health insurance policy framework for Ghana.
Ghana: Accra;
- Accra. MoH (2007b), Independent Review of Programme of Work – 2006, Accra.
- Murante, A.M. (2010). Patient satisfaction: a strategic tool for health service management. Doctor of Philosophy Thesis. Scuola Superiore Sant'Anna.
- Naidu, A.. (2009). Factors affecting patient satisfaction and healthcare Quality. *International Journal of Health Care Quality Assurance*.
- Nwokocha, E.E. 2004. Socio-cultural factors affecting Pregnancy-Outcomes among the Ibani of Rivers State, Nigeria. *Unpublished Ph.D thesis*. Ibadan: University of Ibadan, Nigeria.
- Ogunfowakan, O., Mora, M.2012. Time, Expectation and Satisfaction: Patients' experience at National Hospital Abuja. *Nigeria African Journal Prim Health care family med* 4 (1)398.
- oluwadiya, K., Olatoke, S. A., Ariba, A. J., Omotosho, O. A., & Olakulehin, O. A, (2010), patients' satisfaction with emergency care and priorities for change in university teaching hospital in Nigeria. *International Emergency Nursing*. 18(4), 203-209.
<http://doi.org/10.1016/j.ienj.2009.12.003>
- Osei, I., Garshong, B., Owusu Banahene, G., Gyapong, J., Tapsoba, P., Askew, I., Ahiadeke, C., Killian, R. & Bonku, E. (2005), The Ghanaian Safe Motherhood Programme: Evaluating the Effectiveness of Alternative Training Models and Other Performance Improvement Factors on the Quality of Maternal Care and Client Outcomes, Health Research Unit, Ghana Health Service, 23-38.
- Pakdil, F., & Harwood, T. N. (2005). Patient satisfaction in a preoperative assessment clinic: an analysis using SERVQUAL dimensions. *Total Quality Management & Business Excellence*, 16(1), 15-30.
- Pollack, B. L. (2008). The nature of the service quality and satisfaction relationship. *Managing Service Quality*.
- Pollack, B. (2008). The nature of the service quality and satisfaction relationship: empirical evidence for the existence of satisfiers and dissatisfiers. *Managing Service Quality: An International Journal*, 18(6), 537-558
- Priporas, C., Laspa, C., and Kamenidou, I. (2008). Patient satisfaction measurement for in-hospital services: A pilot study in Greece. *Journal of Medical Marketing*, Vol. 8, 4 325–340.
- Rizyal, A. (2012). Patients' satisfaction with eye care services at Nepal Medical College.
Nepal Med Coll J, 14(3), 172-5.
- Sagaro, G. G., Yalew, A. W., & Koyira, M. M. (2015). Patients' satisfaction

and associated factors among outpatient Department at Wolaita Sodo University Teaching Hospital, Southern Ethiopia: a cross sectional study. *Sci J Clin Med*, 4(5), 109-116. <http://doi.org/10.11648/j.sjcm.20150405.16>

Waki T., M. (2013). Hospital Waiting Time and Demand for Malaria Care.

A Case Study of the Kumasi Metropolis in Ghana. Doctoral Dissertation

Thielscher, C., & Schulte-Sutrum, B. (2016). Development of the Physician-patient Relationship in Germany during the Last Years from the Perspective of the Heads of Chambers and KVs. *Gesundheitswesen (Bundesverband der Ärzte des Öffentlichen Gesundheitsdienstes (Germany))*, 78(1), 8-13.

Tucker, J. III and Adams, S.R. (2009), "Incorporating patients' assessments of satisfaction and quality: an integrative model of patients' evaluations of their care", *Managing ServiceQuality*.

Turner, P. and Pol, L. (2012), "Beyond patient satisfaction", *Journal of Health Care Marketing*, 15(3). 45-53.

Umar, I., Oche, M. O., & Umar, A.S. (2011). Patient waiting time in a tertiary health institution in Northern Nigeria. *Journal of Public Health and Epidemiology*.78–82.

Wang, X. Q., Wang, X. T., & Zheng, J. J. (2012). How to end violence against doctors in China. *The Lancet*, 380(9842), 647-648

Wang LL, Wang C, Cao YL, et al. Analysis and thoughts on trend and harm of hospital violence. *Chinese Hospitals (Chinese)*. 2014; 3: 4–6.

WHO (2016). Mental Health, Ghana - Situational Analysis. Retrieved October, 2016.

WHO (2006). Quality of Care - A Process for Making Strategic Choices in Health Systems.

Retrieved October 2016, from http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf?ua=1

Yeddula, V.R. (2012). Healthcare quality: Waiting room issues. Dissertations and Student Research. Industrial and Management Systems Engineering. University of Nebraska – Lincoln

Zeithaml, V.A. and Bitner, M.J. (2013), *Services Marketing: Integrating Customer Focus across the Firm*, McGraw-Hill, New York, NY.

Zineldin, M. (2006), "The quality of health care and patient satisfaction: an exploratory investigation of the 5Qs model at some Egyptian and Jordanian medical clinics", *International Journal of Health Care Quality Assurance*, 19(1). 60-92.

Ziaei, H., Katibeh, M., Eskandari, A., Mirzadeh, M., Rabbanikhah, Z., & Javadi, M. A.

(2011). Determinants of patient satisfaction with ophthalmic services. *BMC Research Notes*, 4(7), 2–5.

Ministry of Finance and Economic Planning. (2019). Ga West District Analytical Report.

Retrieved 20 March, 2019, from:

http://www.mofep.gov.gh/sites/default/files/budget/2013/GR/Ga_West.pdf

APPENDICES

APPENDIX A: INFORMED CONSENT FORM

Title of study: Assessment of patient-provider relationship on patients' satisfaction at the Achimota hospital.

Introduction

The researcher is a postgraduate student of the School of Public Health, University of Ghana, Legon. As part of the programme, the university requires the study to carry out research work. This work was to assess relationship the relationship that exist between providers and their patient and how this relationship influence satisfaction at the Achimota hospital.

It is therefore imperative that this work was done to look at how providers relate to their patients at different levels of care and treatment and the factors driving their relationship and how these can patients' satisfaction.

It was hoped that the findings of this research was going to be useful in planning and of management different packages to deepen the relationship between providers and patients as well as improving patients' satisfaction.

Purpose of the study

The purpose of this study was to assess patient provider relationship on patient satisfaction at Achimota Hospital, and so the subjects involved were patients at the hospital OPD.

Eligibility criteria

Any patient of the ages ranging from 18 years and above seeking healthcare services at Achimota hospital and is willingly interested to take part in the study. However, visitors to the hospital,

patients who are critically ill and those who refuse to consent are not eligible to take part in the study.

Study Procedures

As part of the study, a short interview was conducted to obtain the contact information, age, sex, educational level, ethnicity, religious affiliations, occupation and average monthly income. Also, there would be questions on your knowledge and how they perceive patient-provider relations and quality of care.

Potential risk and benefits of the study

There was no conceivable risk to the respondents who were sampled and took part in the study. The patients had their normal healthcare services at the OPD and did not in any way interrupt the daily activities of the OPD. At the end of the study, the findings had positive consequences for healthcare delivery in the facility because the hospital management had information about how the doctors and nurses give care to their patients, the relationship between them and whether the patients were satisfied or not with that relationship as well as OPD services. The patients on the other hand benefited from the research as it gave them the opportunity to express their view and concerns about the relationship with their providers and healthcare services.

Anonymity

All information collected in this study was coded. No name or identifier was used in writing the report from this study. Strict anonymity was adhered to throughout this study and the questionnaire did not bear the names of the patients.

Privacy and confidentiality

Respondents were provided with total privacy, however patients had the right ignore or not to answer any questions that were deemed to be sensitive to their personal opinions.

Informed consent

The purpose and nature of the study, aims and objectives were explained in details on the participant information sheets and was interpreted by the research assistants to the participant who could not read. The participant information sheets were given to respondents for their keep after they have signed or thumb printed indicating their understanding of the study. The explanations were all done in local language they understood. Those who were willing to take part in the study were made to sign or thumb print the consent form. Copies of the participant information sheet and the signed form were attached to the questionnaire. Research assistants also signed indicating that they had given all the necessary information concerning the studies to the respondents.

Data Security, Storage and Usage

Collected data for the study was used solely for the purposes specified for the study. Data files were password protected. Hard copy and electronic data were stored and locked securely in cabinets without the names of the respondents, and access was limited to the principal investigator and the supervisors of the study. The stored data would be destroyed after a minimum of three years according to the research protocol.

Freedom to participate/ voluntary withdrawal.

Respondents were informed that, their participation in this study is absolutely voluntary and that at any point in time, they did not wish to answer a question or felt like discontinuing answering the questions, they were free to do so. That their decision was not going to result in any penalty. Also, refusing to participate was not going to affect them in any way.

Compensation

The study was completely voluntary and so respondents were not given any compensation for participation.

Funding information

The study was solely funded by the principal investigator, there was no sponsorship from any organization, department or institution.

Protocol Amendment

In case there were any form of changes and modifications which would have affected the conduct of the study such as the objectives, study design, sample size, data collection techniques etc., a formal protocol amendment application would have been made to the GHS-ERC. Any administrative updates like addresses, emails, would have been communicated to the ethical review committee.

Ethical clearance

Ethical clearance was sought from Ghana Health Service Ethics Review Committee with approval No GHS-ERC: 071/04/19.

Approval and Permission

Permission from Achimota hospital was sought for before the commencement of this study. Permission from the hospital management was necessary for data collection from the facility. Approval to collect data from the hospital was granted and the OPD In-charge was duly informed prior to the commencement of the data collection.

Dissemination of Results

The study results after analysis has been done will be communicated to the study to the hospital management for decision as well as participants.

Declaration of conflict of interest

I, Adomah Francis (Principal Investigator), declare that, to the best of my knowledge, there is no actual, perceived or potential conflict of interest that will or may arise as a result of my involvement with this study.

. If you have questions about your rights as a research participant, please contact the administrator

Who to contact

In cases of any questions regarding the research, you can contact researcher on 0245363640. Email-f.adomah@yahoo.com. This study has sought ethical clearance from the Ghana Health Service Ethical Review Board of the Ghana Health Service Ethical Review Board at: GHS-ERC Administrator: Hannah Frimpong (0302681109/0507041223 or Hannah.Frimpong@ghsmail.org)

APPENDIX B

CONSENT FORM FOR PATIENTS

PARTICIPANT STATEMENT AND SIGNATURE

I certify that I voluntarily agree to participate in the study and that the study has been explained to me. All my questions have been answered satisfactorily. I understand I am free to discontinue participation at any time if I so choose.

Signature or thumbprint of Participant

.....

Date.....

WITNESS STATEMENT AND SIGNATURE

I testify that I have personally witnessed that the purpose of the study, risks, and benefits of participation and all details have been explained satisfactorily to the respondent and the respondent has understood. She has agreed to participate in the study of her free will without any coercion.

Signature or thumbprint of witness

.....

Date.....

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Signature

Date.....

QUESTIONNAIRE

APPENDIX C: SOCIO-DEMOGRAPHIC INFORMATION

QUESTIONS	RESPONSE
1. How old are you? Age at last birthday	[]
2. Gender 1. Male 2. Female	[]
3. What is your ethnic back ground? 1. Akan 2. Ewe 3. Ga 4. Guan 5. Other, specify	[]
4. Marital status? 1. Never married 2. Married 3. Living together 4. Divorce/ separated 5. widowed	[]
5. What is your highest level of education? 1. Never Attended 2. Primary 3. Middle / JSS/JHS 4. SSS/SHS 5. Higher	[]
6. What is your current occupation? 1. Unemployed 2. Self-employed 3. Public sector 4. Private sector (formal) 5. Student/Apprentice	[]
7. Over the past year, what has been your average monthly income from all sources? 1. Less than GHS200.00 2. Between GHS200.00 and GHS500.00 3. GHS500 to less than GHS1000 4. GHS1000 to less than GHS1500 5. More than or equal to GHS1500	[]
8. What is your religious affiliation?	[]

1. Christian 2. Islam 3. Traditionalist 4. Others...

SECTION B. THE PATIENT-DOCTOR RELATIONSHIP AND CONSULTATION OUTCOME.

(CARE FROM DOCTORS)

9. Anytime you visit this hospital, how do doctors treat you with respect, courtesy and empathize with you situation? []

1. Always 2. Sometimes/usually 3. Never

10. Anytime you visit this hospital, how do doctors listen to you carefully? []

1. Always 2. Sometimes/usually 3. Never

11. Anytime you visit this hospital, how do your physical and mental state improved after the visit to the doctor?

1. Always 2. Sometimes/usually 3. Never []

12. How do doctors explain procedures to you in a way you understand?

1. Always 2. Sometimes/usually 3. Never []

13. How do doctors respect your values and beliefs anytime you visit the hospital?

1. Always 2. Sometimes/usually 3. Never []

14. The doctors not only treats, but also give advice on a healthy lifestyle.

1. Always 2. Sometimes/usually 3. Never []

15. The doctors gives me treatment options based on my socio-economic status.

1. Always 2. Sometimes/usually 3. Never []

SECTION C CARE FROM NURSES

16. Anytime you visit this hospital, how o do nurses treat you with respect, courtesy and empathize with you situation? []

1. Always 2. Sometimes/usually 3. Never

17. Anytime you visit this hospital, how do nurses listen to you carefully?

1. Always 2. Sometimes/usually 3. Never []

18. How do the nurses explain procedures to you in a way you understand?

1. Always 2. Sometimes/usually 3. Never []

19. How often are the nurses polite to you?

[]

1. Always 2. Sometimes/usually 3. Never

SECTION D THE HOSPITAL ENVIRONMENT

20. How are the environment and washrooms kept clean anytime you visit the hospital? []

1. Always 2. Sometimes/usually 3. Never

21. How are the consulting rooms clean and conducive for your care?

1 Always 2. Sometimes/usually 3. Never []

22. How is the hospital environment generally calm and conducive for your care?

1. Always 2. Sometimes/usually 3. Never []

SECTION E PATIENT EXPERIENCES WITH OPD SERVICES

23. At the hospital, did you need any help from nurses or other staff in the course of receiving care?

Yes 2. No, if no **skip** to question 25 []

24. How did you get help from nurses or other staff?

1. Always 2. Sometimes/usually 3. Never []

25. At the hospital, did you need medicine for pain?

Yes 2. No if no go to question 27 []

26. How was your pain well controlled?

1. Always 2. Sometimes/usually 3. Never []

27. At the hospital, were you given any medicine that you had not taken before?

Yes 2. No, if no go to question 30 []

28. Before giving you any medicine, how did the hospital staff tell you what the medicine was used for?

1. Always 2. Sometimes/usually 3. Never []

29. Before giving you any new medicine, how did the OPD staff describe the possible side effects in a way you could understand?

1. Always 2. Sometimes/usually 3. Never []

30. Did you get all the services you needed at the OPD? []

1. Always 2. Sometimes/usually 3. Never

**SECTION F PATIENT-PROVIDER RELATIONSHIP RATING
AND SATISFACTION LEVEL**

31. Using any number from 0 to 10, where 0 = worst patient-provider relationship and 10=best patient-provider relationship, what number would you use to rate this hospital during your visit?

(0). Worst patient-provider relationship (1). 2.3.4.5.6.7.8.9 (10). Best patient-provider relationship
[]

32 Were you dissatisfied, satisfied or very satisfied with the OPD services to you?

1. Dissatisfied 2. Satisfied 3. Very satisfied []

33. Were you dissatisfied, satisfied or very satisfied with how you were treated or handled by the doctor/nurses at the OPD?

1. Dissatisfied 2. Satisfied 3. Very satisfied []

34. Would you recommend this hospital to our friends and family?

1. Definitely no 2. Probably no 3. Probably yes 4. Definitely yes []

THANK YOU

APPENDIX III ETHICAL CLEARANCE

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this letter should be quoted.

MyRef: GHS/RDD/ERC/Admin/App/19/243
Your Ref. No.

Francis Adomah
University of Ghana
School of Public Health

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	GHS-ERC 071/04/19
Project Title	Assessment of Factors Influencing Patient-Provider Relationship on Patient's Satisfaction at the Achimota Hospital
Approval Date	19 th May, 2019
Expiry Date	18 th May, 2020
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
Dr. Cynthia Bannerman
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra