



University of Ghana Business School

**DEPARTMENT OF PUBLIC ADMINISTRATION**

**PATIENT PERCEPTION OF QUALITY OF  
CARE AT GREENLAWN HOSPITAL**

**BY**

**CISLEEN NANA AMA YEBOAH**

**(10638187)**



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**DECLARATION**

I hereby declare that this submission is my own work towards the award of MBA Health Services Management and that to the best of my knowledge it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University except where due acknowledgement has been made in the text.

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Date.....

YEBOAH NANA AMA CISCLEEN (10638187)  
(Student)

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Date.....

Dr. ROGER ATINGA  
(Supervisor)

**DEDICATION**

I dedicate this work to my dear husband, Mr. Godwin Kwaku Dankwa without whose effort I would not have been where I am now and to my three sons, Stanley Kofi Dankwa, David Kwaku Dankwa and Daniel Kofi Dankwa for their understanding.

## ACKNOWLEDGEMENT

I wish to express my sincere gratitude first and foremost to the ALMIGHTY GOD who granted me the grace to complete this work successfully to His glorious name.

The next gratitude goes to all those who helped in diverse ways and contributed immensely to the success of this research work, especially Dr. Roger Atinga and colleagues at my workplace without whose help, this work would not have been successful.

I wish to thank the Management and Staff of Greenlawn Hospital for making it possible for me to administer my questionnaire for this thesis.

I owe a great debt of gratitude to my mother Mrs. Theodora Kissi for her relentless efforts in giving the necessary prayers and guidance. God richly bless her and I love you mummy.

I also thank my Friends, Amma Anpobeng and Frederick Kumah for their morale support granted me during this research work. God bless you all. AMEN

## **ABSTRACT**

The health sector in Ghana has undergone much change over the past decades to improve the quality of care. This research sought to find patients perception of care at the Greenlawn hospital

An exploratory research design was adopted in the conduct of this research work. A sample size of eighty-five (85) patients were chosen and took part in this survey. Donabedian's structure, process and outcome theory for service quality evaluation underpinned the conceptual framework in this study and evaluated using the SAMI method. Qualitative data were analysed, with SPSS primary data and secondary data were used extensively in this research. Primary data was gathered through the data collection instrument of a questionnaire which contained both open-ended and closed-ended questions. Secondary data was also obtained from books and academic journals.

The research revealed that patients were satisfied with the structure, process and outcome of care at the Greenlawn hospital. Patients generally had excellent perception of the overall service received from the Greenlawn hospital.

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## **CHAPTER ONE**

### **BACKGROUND**

#### **1.1 Introduction**

Health is a need for wellbeing and growth of every nation (Greve, 2008). There is an increasing demand for healthcare services worldwide especially in the developing nations like Ghana. Health as defined by the World Health Organization is “the condition of complete physical, mental and social well-being and not just the absence of disease” as expressed (WHO, 1948).

In some decades past, there was no need to improve upon the quality of health service in Ghana, now there is increasing competition between the private health sector and the public health services (Atinga et al., 2011), along with increasing expectations from patients; who are conscious of what they need and what quality to expect in terms of medical care. Ghana’s health sector is undergoing a tremendous improvement in the areas of innovative approaches to better the healthcare delivery system.

The main objective of providing quality health care to health seekers is to offer health service with high competence, reasonable charges, and high-quality medical care that will meet patients’ satisfaction and loyalty. Other parameters such as accurate diagnoses and effective treatment services to meet patients’ expectations, hygienic and fully equipped hospital settings, and friendly healthcare professionals are estimates for quality in healthcare (Aytekin et al, 2012). The attitudes and behaviors of the healthcare providers and the past experiences and expectations of the service recipients constitute quality perception of patients (Ataguba and McIntyre, 2012).

Perceptions of patients on the quality of health services has been evaluated and supported by numerous academic works; Peterson (1988), suggested that, how the patient felt is more significant than the health provider's views of quality care. Many scholars in this field have concluded that positive quality perceptions of care lead to patient's satisfaction; that is the service quality is the precursor of the patient's satisfaction (Cronin and Taylor, 1992). Nevertheless, it is more technical to evaluate quality of care and the factors contributing to patients 'satisfaction from health service providers perspective' (Peterson, 1988).

In most developing countries for that matter Ghana, health sector resources and financing are mostly concentrated on the public healthcare providers than the private ones, nevertheless, there are huge gaps of good patient perceptions between them. (Bloomberg, 2006; McIntyre, 2007, McIntyre et al., 2009). Patients generally have good perceptions about the quality of care at private health centers, for example, in the many research works regarding poor quality of services in public hospitals, resource shortages, staff attitudes, broken/limited medical equipment, poor cleanliness, etc are some of the outcomes of patients in the public health centers (Holthof, 1991; Kalda et al., 2003; Sandoval et al., 2007).

Knowledge of how patients' perceived quality of care can make a meaningful input to the healthcare planning, development and to the healthcare provider improve decision-making processes (Kalda et al., 2003; Sandoval et al., 2007). Additionally, understanding such perceptions can assist in targeting the desires of specific patient class/groups. Patients' with good perception about a health service provider may inform the patients choice of care and these are important in the Ghana Health Service context of policy reform, which seeks to overcome the public-private split (Ghana Health Service, 2016).

## 1.2 Problem statement

Because of poor economic situation and declining health resources many countries in Sub-Saharan Africa lack the ability to provide adequate quality of healthcare services. This has led to the implementation of many reforms in the health sector in view to making the optimum use of resources available in improving access, efficiency and quality of healthcare services provided. In Analeeb (2001) work, he concluded that, the recent health reforms in the developed countries emphasizes the importance of the patient's perspective. It is in spite of this that hospital administrators, insurance companies, community groups and researchers in this field have all begin to recognize the value of the insights that patients can provide to the quality of care provided by services providers (Shewchuk and Carney, 1994; Analeeb, 2001; Turkson, 2009; WHO, 2013).

In Ghana, several of the studies on healthcare quality have often focused on the quality award dimensions (GHS, 2003; Osei et al., 2005; MOH, 2007; Atinga et al, 2011). Studies conducted in the area of public hospitals over the years have provided substantive evidence that the quality of health services is inadequate both by objective measures in the opinion of health seekers and by healthcare providers (GHS, 2008; MOH, 2007). Furthermore, research works on quality healthcare has usually suggested poor service delivery in terms of; long waiting time, a frequent shortage of drugs and the poor attitude of health providers as factors affecting patients' satisfaction with quality healthcare (Turkson, 2009; Atinga et al, 2011). In spite of this, constant monitoring and evaluation of the policy holder's views on the quality of healthcare is necessary for quality improvement purposes, which will provide some kind of feedback to health professionals and policy makers (Bara et al., 2012).

In Ghana, such challenges and many others problems are obstructing the smooth delivery of healthcare but lack of adequate research on the issue/s has ensured that these challenges remain unchanged about and unresolved effectively. Furthermore, the differences in operation between public and private hospitals in Ghana gives rise to the conception that both institutions could not be hampered by the same set of challenges. Since there has been little or no research into this area, there appears to be a research gap which this thesis aims to fill by examining what the case is regarding patient's perception of Greenlawn hospital

### **1.3 Purpose of the study**

Quality of care received, most often plays a critical role in satisfying the expectations of patients and making them thus more loyal. It therefore significant that healthcare providers emphasize on the scope of service quality and hence ensure services delivered are of a very high professional standard and practice. Up until now, no definite research has been done to provide the private hospitals in this country guidance to further better on doings, concerning providing of quality service. Understanding the scopes of quality of care provided by private hospitals in Ghana would assist in solving the gap of research that exists in the healthcare system of Ghana. As receivers of health care services, as well as funders there of (through, for instance, out-of-pocket payments) to these private hospitals. Our perceptions and evaluations must be explored and understood to facilitate prudent decision making and designing of effective service delivery schemes that meet our expectations and satisfaction/s (Andaleeb, 2001).

This study is significant in that it will provides useful information about how patients perceive private hospitals and their choice of health care providers. It may also provide useful insights into what the patients expectations about private health facilities are to the easily accessible

public health facilities and what patients satisfaction means to the perceived quality healthcare. Exploring the perceptions, feelings and images that people have around private hospitals can provide insight into what the public expect from the private health system, especially considering current policy reform and the ailing NHIS system.

#### **1.4 Objective**

- 1) To investigate the general perceptions of patients on healthcare delivery at the Greenlawn Hospital.
- 2) To make recommendations on what might be done to strengthen service quality at the Greenlawn Hospital.

#### **1.5 Research question**

For this reason, the research aimed to answer the following questions in this study:

1. How are the quality perceptions of patients?
2. What are the medical outcomes from the perceptions of patients?
3. What are the occupational factors affecting the quality perceptions of patients?
4. What are the organizational factors affecting the quality perceptions of patients?

#### **1.6 Limitations of the study**

Patients experiences and perceived perception of care will be the only source of data for this work. Only outpatients were contacted for data for this study. Data for this study was patients response questionnaires from the experience/expectations of care at the Greenlawn hospital.

### **1.7 Theoretical frame work**

The study will also adopt perceived quality of care frameworks, several of which have been developed to help assess users and providers of health care services' perception of quality care delivery (Papp et al,2010: Atinga and Baku, 2013), to guide our study. In this description, a study by Ameh and co-workers assessed the Quality of integrated chronic disease care in rural South Africa: user and provider perspectives. In their work the Donabedian's structure, process and outcome theory for service quality evaluation underpinned the conceptual framework in that study. In this study the Donabedian's theory will be used to evaluate the quality of care at the Greenlawn hospital. Which gives the relationships between structure, process and outcome of the care;

- Structure: Organizational resources needed to provide care e.g. drug supply
- Process: Things done to and for the patient e.g. defaulter tracing
- Outcome: Desired result of health care e.g. waiting time

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

#### 2.1 Definition of Service Quality

It is vital to note that, a service bears intrinsic attributes such as: perishability (Zeithaml and Bitner, 2000), intangibility, heterogeneity and inseparability and these distinguishes it from goods (Parasuraman et al., 1988). According to Zeithaml and Bitner (2000) service quality refers to deeds, processes and performances. Berry et al. (1988) also defines it as meeting customer specifications. In defining service quality, Park et al. (2005) argue that, it is a consumer's overall mental picture of the relative inferiority or superiority of the organization and its services. Pui-Mun Lee (2006) defined it with special attention on expectation by arguing that, it deals with meeting or exceeding customer expectation. Zineldin (2006) suggest that, the delivery of quality hovers around the service provider; he argues that, it relates to doing the right thing at the right time, in the right way for the right person. Whiles the definition of quality by some researchers accentuate the satisfaction of customer needs (Bergman and Klefsjo, 1994), Bojanic (1991) expands the definition beyond satisfaction of customer needs by comparing satisfaction derived from one service provider with another service provider. Gronroos (1984) defines service quality as a subjective concept from the view of the customer by describing it as the result of what customers received and how they receive it. Essentially, a number of researchers have defined service quality in relation to gaps between customer expectation and perception of a service (Parasuraman et al., 1985).

## **2.2 Definition of Service Quality in the Health Sector**

A number of studies on service quality have been carried out in the health sector; however, there is no single definition that can properly delineates what health is all about (Al-hawary et al., 2011). The Constitution of World Health Organization defines health as a complete physical, mental, social well-being and not merely the absence of disease or infirmity (Syed Amin, 1996). Donabedian (1980) also defined health care quality as the kind of care which is anticipated to maximize an inclusive measure of patient welfare, after one has taken account of the process of care in all its parts. The 1984 definition by the American Medical Association, defines health care quality by underscoring the importance of life; stating that, it is that which consistently contributes to the betterment or maintenance of the quality or duration of life. The association further highlights the relevance of issues such as: disease prevention, health promotion, informed participation of patients and efficient use of resources as key variables in healthcare quality. The definition of health quality postulated by the Institute of Medicine (1990) highlights desired outcome consistent with professional knowledge. According to the Institute, it is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Blumenthal, 1996). Ovretveit (1992) in defining quality considered the needs of patients and the financial resources of a facility; and argued that, it is fully meeting the needs of those who need the service most, at the lowest cost to the organization within bounds and directive of higher authorities and purchasers. According to Gronroos (2000), even though there are several definitions on quality of healthcare service in literature, it is still a complicated and an indistinct concept. Fuentes (1999) concurs to Gronroos' (2000) opinion by stating that, the quality of healthcare service is a multidimensional

concept which reflects a judgment about whether services provided for patients were appropriate and whether the relationship between doctors and patients was proper. One of the traditional medical approaches to the definition of quality of healthcare focuses on the outcome of healthcare services from the point of view of the service provider while another approach emphasizes the process of healthcare from the patient's perspective (Newcome, 1997). In general, researchers define quality of healthcare services along two dimensions; technical service and interpersonal care of service (Goldstein and Schweikhart, 2002).

## **2.3 Types of health service quality**

### **2.3.1 Technical Quality**

The Institute of Medicine (USA) defines quality of healthcare in technical terms as the degree to which health services for individuals and population increase the probability of desired health outcomes which are consistent with current professional knowledge (McGlynn, 1995). However, Brook, et al. (1975) place more emphasis on the attainment of high health standards as they argue that, technical quality relates to the ability of hospitals to achieve high standards of patients' health through medical diagnosis, procedures and treatment geared at creating physical or physiological effects on patients. This definition has been expounded by Tomes and Ng (1995) who maintain that, it includes the competence and clinical skills of doctors, nurses, laboratory technicians (with expertise in running test) etc. However, Donabedian (1982) conceptualizes the salient aspects of clinical quality as the qualifications of the provider; using the proper diagnostic equipment and selection, timing and sequencing of the medical diagnosis and treatment. The elements of technical quality are usually quantitative and somewhat straightforward to measure. Examples include: mortality and morbidity rates, treatment errors,

average length of stay, readmission rates, and infection rates (Anderson and Zwelling, 1996; Fitzsimmons and Fitzsimmons, 2000).

### **2.3.2 Functional quality**

Client quality generally deals with the functional or interpersonal processes and skill exhibited by health professionals in the discharge of their duties. Brook et al. (1975) define client quality as "how" a service is delivered and the interactive relationship existing between the service provider and the patient. This definition is re-echoed by Ovretveit (1992) who states that, client quality deals with a patient's perception of the service- friendliness of the service provider, timely delivery and information given by the service provider. Although in broad terms, technical and client quality has gained immense prominence in health literature, a number of researchers such as Zeithaml and Bitner (2000) and Weitzman (1995) have suggested that besides the technical and interpersonal aspects of healthcare services, elements such as amenities in health facilities must not be ignored in measuring healthcare services. However, in the opinion of Harrington and Pigman (2008), healthcare quality comes under three elements namely; structure, process and outcome and this three-element model serves as an authentic standard for evaluation since it adequately encapsulates all aspects of technical and client quality elements. Structure deals with elements of the healthcare setting; it includes: its design, management and procedures (Campbell, et al., 2000). Physical and staff characteristics are the two domains defined under structure. The physical characteristics capture elements such as: personnel, equipment and building, organization of resources and management - opening hours and existence of booking systems for appointment. Staffs characteristic on the other hand are made up of education, certification and experience of health professionals (Campbell et al., 2000). The process element examines the appropriateness of an action taken and determines how they were

executed. The process of care is significantly intertwined with the technical and interpersonal aspects of care (Donabedian, 1988; Blumenthal, 1996; Stefen, 1988). The last element which is outcome borders on the consequences of healthcare delivery. This is based on health status of patients as well as an assessment of care. It is worth noting that, structure as well as process of care has an influence on the outcome of healthcare. For instance, a patient with breast cancer might have died because a screening test (structure) was unavailable or the test was misread (process) (Campbell et al., 2000).

## **2.4 Patient Satisfaction**

The advent of the patient's rights movement fueled the debate over the relationship between patient satisfactions as a valuation of the process of care versus the standard of technical care (Williams, 1994). As a result, the use of patient satisfaction measures in the health sector became increasingly widespread. For example, assessing patient satisfaction has been mandatory for French hospitals since 1998; this is used to improve the hospital environment, patient amenities and facilities in a consumerist sense, but not necessarily to improve care (Boyer et al., 2006; Gill and White, 2009). However, it is extremely difficult to categorically define patient satisfaction due to the inconclusive evidence in literature (Larsson and Wilde-Larsson, 2009; Naidu et al, 2009; Peakash, 2010; Gosh, 2013). Crowe et al. (2002), in their work identify thirty-three studies investigating methodological issues and a hundred and thirty-eight studies investigating the determinants of satisfaction. They indicate that there is an agreement that the definitive conceptualization of satisfaction with healthcare has still not been achieved and that understanding the process by which a patient becomes satisfied or dissatisfied remains unanswered. More so, they suggest that satisfaction is a relative concept and that it only implies adequate service. Furthermore, Crowe et al. (2002) and Urden (2002), separately point out that

patient satisfaction is a cognitive evaluation of the service that is emotionally affected, and it is therefore an individual subjective perception. However, patient satisfaction is grounded as part of health outcome quality, which encompasses the clinical results, economic measures and health related quality of life (Heidegger et al., 2006; Gill and White, 2009).

## **2.5 Quality Dimension in Medical Care**

Diversity arises when examining the meaning of quality in medical care. Medical quality consists of a mixture of hard technical elements such as correct diagnosis, appropriate intervention and effective treatment as well as soft element such as good communication, patient's satisfaction and consideration for the patients' preferences (Gill, 1993). It is therefore not sufficient to consider only the technical competence of those providing care, but also care provided more effectively, efficiently and humanely. Ovretveit, (1990) stated that "Professional quality has two parts:

- (1) Whether the service meet professionally assessed needs of its clients and
- (2) Whether the service correctly select and carries out the techniques and procedures which professionals believe meet the needs of the clients".

Contributing to the research on quality, Brown et al. (1990) also describes nine quality dimensions of health service delivery: effectiveness, efficiency, technical competence, interpersonal relations, and access to service, safety, continuity, and physical aspect of health care. The table below vividly described Brown et al (1990) quality dimension

**Table 2.1: Quality dimensions (Brown et al, 1990)**

Quality dimensions	Description
Effectiveness	The degree to which desired results (outcomes) of care are achieved through appropriate diagnosis and treatment
Efficiency	The ratio of the outputs of services to the associated costs of producing those services (taking into consideration both materials and time resources)
Technical competence	The degree to which tasks carried out by health workers and facilities meet expectations of technical quality (according to clinical guidelines)
Interpersonal relations	The Level of respect, courtesy, responsive, empathy, effective listening, and communication exhibited between clinic personnel and clients.
Access to service	The degree to which healthcare services are unrestricted by geographic, economic, social organizational or linguistic barriers
Safety	The level of trust, confidentiality and privacy in the service and the degree to which the risks of injury, infections or other harmful side effects are minimized
Continuity	The degree to which consistent and constant care is provided, including the value of visiting the same provider and continuing treatment
Physical aspects	The physical appearance of the facility and the level of cleanliness, comfort, and amenities offered
Choice	It is the client's choice of appropriate provider, insurance plan, or treatment.

All these dimensions according to Brown et al (1990) constitute a holistic approach to ensuring quality health care delivery that ensures total customer satisfaction.

## **2.6 Theories of Healthcare service quality**

Current trends in quality assurance of health care has two central strands of inquiry. One seeks definition of the object of scrutiny: What exactly is to be studied? The other seeks methods: How to study quality. The dominant figure in the first areas is Avedis Donabedian, considered by many the father of the academic enterprise of quality assessment in health. According to Donabedian, the structure of care relates to the organization of health care delivery, whether at the level of the health care system, the organizational or corporate unit, or the individual practice. Donabedian, among others, offered the categories of "structure," "process," and "outcome" as the three classes of potential objects of investigation (Donabedian, 1966). "Structure" is a general term for the nature of the resources that, assembled, provide health care, including, for example, the mix of manpower, the credentials of the providers, the facilities, and the rules of procedure. "Process" refers to intermediate products of care, such as patterns of diagnostic evaluation, access to care, rate of utilization, and choice of therapies. "Outcomes" are end products of care, the health status, longevity, comfort, and, perhaps, the satisfaction of its clients

An example of a structural defect in healthcare is the lack of accessibility of care to those who are unable to afford it. On the micro level, the inability of a patient to access a physician's office that was not wheelchair accessible also would represent a structural impediment. Similarly, the organization of quality measurement, data infrastructure, and the nature of quality assessment or improvement activities are all structural aspects of care. The process of care includes what is done and not done to or for the patient or by members of the health care system. Traditionally

this was divided into 2 categories: interpersonal and technical. The interpersonal aspects of process related to how a patient was treated on a human level: was the encounter with the health care system characterized by respect for the patient, his or her needs, desires, and privacy, and so forth. The technical aspects of health care can further be divided into medical decision making and technical skill in implementing medical decisions.

The second major theme in the quality assessment literature deals with methods of investigation: Having chosen an object of scrutiny, how good is the performance? Three general methods have been explored over time: implicit review (Moorehead et al., 1964), explicit review (Brook and Appel, 1973), and the use of sentinels (Lembcke, 1967). Implicit review processes use experts who are able to recognize good care (structure, process, or outcome) when it occurs, or, in some cases, groups whose joint knowledge or judgment is thought better than any individual's. Implicit review procedures may assign scores to records of care or otherwise judge in global terms how well a system or provider dealt with individual cases or groups of patients. Both explicit and implicit reviews may involve sophisticated group techniques for selecting problems for review and for forming consensus on the quality of care. Explicit review involves specifying criteria for care and review of records or observations to check on the degree to which what happens conforms to these prior criteria. By its nature, explicit review is better suited than implicit review to using nonprofessional staff to conduct the actual reviews of care.

Brook and colleagues introduced the construct of appropriateness and necessity of care, based on the relative balance of risk, benefits, and importance. The recent field of patient safety has emerged to focus on the technical quality of care, specifically related to medical errors. The failure to deliver a planned or necessary service represents another type of medical error, as does failure to notify or provide appropriate follow-up, as might occur after an abnormal cervical

cancer screen is victimized by a medical error. It is axiomatic that, in aggregate, health care impacts health, that its processes variably impact outcomes. Process is inherently more sensitive to measure change than are outcomes. Process measurement suffers in practice because of uncertainty in the link between specific processes and specific outcomes.

## **2.7 Conceptual framework of study**

Patients satisfaction is a major determinant of quality of healthcare delivery. Perceptions about health care delivery can be examined along various dimensions, including service quality, responsiveness, patient satisfaction, staffing, and cleanliness of facilities (Kalda et al., 2003; Sandoval et al., 2007).

Ghanaians perceive the quality of health services as sub-standard and therefore choose alternative sources of treatment (Turkson, 2009). The trust and confidence is undermined by frequent shortages of drugs and medical supplies, long queues, the absence of emergency services and poor staff behaviour. This has resulted in low utilization of health services despite the substantial investment aimed at improving access to health services in Ghana (Shield Workpackage Report, 2007; Gyapong et al, 2007).

However, others perceive the quality of healthcare in Ghana to be high. Turkson (2009), looked at the quality of healthcare delivery in a rural district of Ghana and found that generally the quality of healthcare delivery was perceived to be high for most of the indicators used. That is ninety percent of the respondents were satisfied or very satisfied with the care given during their visit to the health facility. The participants however perceived poor attitude of some health workers, long waiting times, high cost of services, inadequate staff, policy of payment for health

services, frequent referrals to hospitals, and lack of ambulances at facilities as being detrimental to effective delivery of quality healthcare.

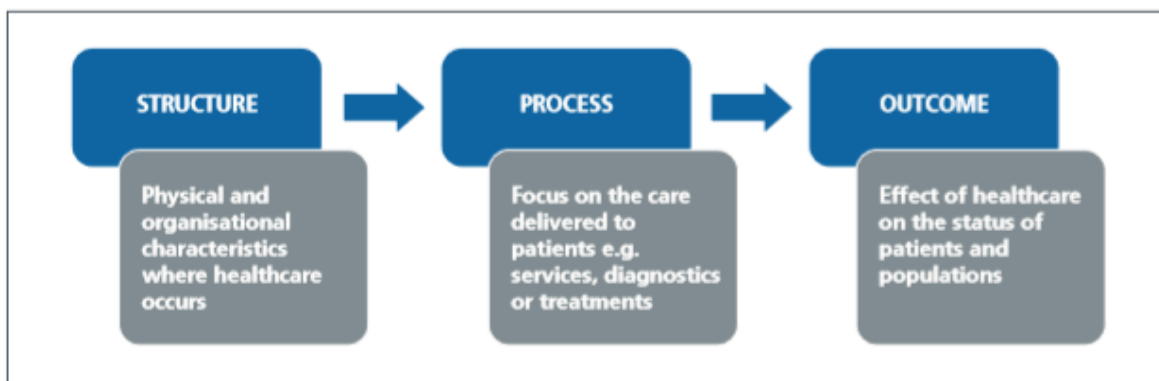
Furthermore, another study by Atinga et al (2011), examined how communication, provider courtesy, support/care, environment of the facility and waiting time significantly predict patients’

satisfaction with the quality of healthcare in two hospitals located in northern Ghana. They observed that the five-factor model, support/care, environment of the facility and waiting time determine patients’ satisfaction with quality of healthcare delivery. The explanatory power of the dependent variable was explained by 51 percent in the regression model.

Peprah (2014) conducted a study at Sunyani Regional Hospital in Ghana to assess patients’ satisfaction using the SERVQUAL model by Parasuraman et al, (1998). The SERVQUAL instrument was adapted and modified to capture the relevant data. A total of 214 patients were sampled for the study. The study analysed for descriptive statistics and patient’s satisfaction were determined by the service quality gap. The study results indicate that the overall satisfaction of the patients concerning service quality of the hospital was good. Again, the study recommends policy action to improve service delivery in communication/interpersonal relationship, assurance and responsiveness dimensions. However, tangibility and empathy were esteemed high by patients in their satisfaction in assessing quality healthcare at Sunyani Regional Hospital.

Models can be used on a regular basis to track patients’ perceptions of healthcare quality of a hospital. This work will adopt the Donabedian's quality measurement model, which explains patient satisfaction “as patient-reported outcome measure while the structures and processes of

care can be measured by patient-reported experiences”. Donabedian’s definition of quality of care can be assessed as a triad of structure, process and outcome (SPO).



**Figure 2.0: The Donabedian model for quality of care (Donabedian, 2005)**

Structure refers to the attributes of the settings in which care occurs. This includes the attributes of material resources (such as facilities, equipment and money), of human resources (such as the number and qualifications of personnel), and of organizational structures (such as medical staff organization, methods of peer review and methods of reimbursement) (Brook et al,2012). Burns, 2007 concluded that, the inability for any patients to access a healthcare facility is a structural defect in health care delivery. On the micro level, the inability of a patient to access a physician’s office that was not wheelchair accessible also would represent a structural impediment (Kirschner et al,2012). A study of quality systems conducted among department managers and quality coordinators in 386 hospitals in Sweden showed statistically significant relationships between SPO constructs, using Donabedian’s theory (Kunkle, Rosenqvist and Westerling, 2007).

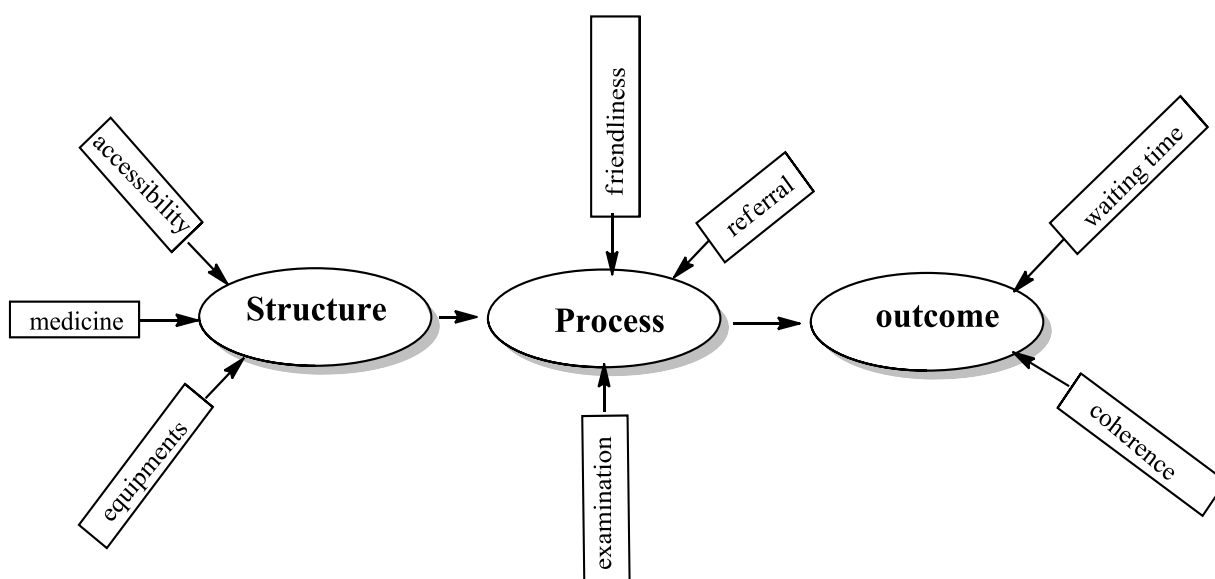
The failure to deliver a planned or necessary service represents another type of medical error, as does failure to notify or provide appropriate follow-up, as might occur after an abnormal cervical cancer screen is victimized by a medical error (Kahn et al,1988). It is axiomatic that, in aggregate, health care impacts health, that its processes variably impact outcomes.

Process denotes procedures in giving and receiving care. It includes the patient's activities in seeking care and carrying it out as well as the practitioner's activities in making a diagnosis and recommending or implementing treatment (Park and Brook,1994).

Outcome denotes the effects of care on the health status of the patients and the populations. Improvements in the patient's knowledge and salutary changes in the patient's behaviors are included under a broad definition of health status, and so is the degree of patient's satisfaction with care. Outcomes of health care are defined as what actually becomes of the patient and may represent ultimate consequences: the degree of health or illness or mortality or intermediate aspects of care such as the need for an emergency department visit (Kahan et al,2009). In general, the better the evidence linking the intermediate outcome to the ultimate outcomes (or the more important the intermediate outcome is considered in and of itself), the more confident one can be using intermediate outcomes to describe the quality of care. Because outcomes are the most visible and intuitive component of quality, there has been a large move toward emphasizing outcomes in policy decisions (Kleinman et al,1997). When doing so, one must recognize that because of the resiliency of individuals and populations, and because of the indefinite relationship between processes and outcomes, outcomes are an insensitive way to measure changes in the quality of care (Brook,2009).

The intentions for the present study are the relationship type (Coulter and Ligas, 2000). The positions take into consideration the extent to which the dimensions of service quality (medicine,

examination and competence) predict patients' satisfaction with overall quality of services provided in the Greenlawn hospital.



**Figure 2.1: The 8 dimensions of care for which the structure, process and outcome constructs will be intended.**

The study hope to access eight dimensions of care on quality of care at the Greenlawn hospital the priority areas for enhancing quality of care will be: supply of critical medicines, equipment, accessibility, hospital referral, examination, friendliness of the staff, patient waiting time, and coherence of integrated chronic disease care, these were identified as critical area within the Greenlawn hospital care delivery system.

## **CHAPTER THREE**

### **3.0 METHODOLOGY**

#### **2.1 Research Design**

In the quest to achieve the objectives of this research, a suitable research design must be chosen to serve as a framework upon which the research methodology may be based. According to Yin (2003), research can be classified as exploratory, descriptive or explanatory. A discussion of the various research types are discussed below:

According to (Hair, Bush and Ortinan 2006), Exploratory research refers research intended to develop initial ideas or insights and to provide direction for any further research needed. It is a preliminary investigation of a situation. McDaniel and Gates (2004) further defined exploratory research as a preliminary research conducted to increase understanding of a concept, to clarify the exact nature of the problem to be solved, or to identify important variables to be studied. Adding their voice to the growing literature expatiating on exploratory research, Dillon, Madden and Neil, (1993) stated that exploratory research is a research design that provides the marketing manager with ideas and insights about broad and vague research problems.

Descriptive research as posited by Hair, Bush and Ortinan (2006) refers to research that describes what is happening in a market. Their findings describe what is happening but generally do not explain what is happening. McDaniel and Gates (2004), defined descriptive research as research studies that answer the questions who, what, when, where and how. (Dillon, Madden and Neil 1993), defined descriptive research to be research designs that attempt to determine the frequency with which something happens or the extent to which two or more variables are related.

Causal research refers to research designs that attempt to determine the extent to which changes in one variable cause changes in another variable (Dillon, Madden & Neil 1993). This type of research also examines whether one variable causes or determines the value of another variable (Hair, Bush, & Ortinan, 2006).

Based on the above definitions and clarifications on the various types of research, and with consideration for the topic under research, the researcher has opted to use exploratory research.

The justification for the choice of research type is down to the fact that exploratory research will provide the researchers with the opportunity to unearth information about the problem, using probing and open-ended questions. This research type will also help in understand the research concept and to clarify the problem well.

## **2.2 Sample area**

Greenlawn hospital is a private healthcare facility established somewhere in July 2016. It is situated in the Ga East Municipal District. The hospital has six administrative staff, four medical officers in which two are specialist and one surgeon, twenty-one nurses, two pharmacist and one laboratory technician. The hospital has out-patients unit, a theatre, physiotherapy unit, maternity unit, laboratory and a pharmacy.

In 2017, five hundred patients/client accessed the hospital for various medical conditions.

## **2.3 Population and Sample size**

According to (Burns & Bush 2000), a sample is a subset of the population that should represent that entire group; a sample begins with a population definition. (Aaker, Kumah & Day 1995) referred to a sampling frame as a list of population members used to obtain a sample. (Malhotra 1996) also refers to sample size as the number of units or elements to be included in the study.

(Dillon, Madden & Firtle 1993) defined a sample as a subset of a population to be studied. The sample size for this study was 85 patients.

This was determined using the mathematical formula below.

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

Source: Saunders et al, 2009

Where  $n$  is the sample size,  $N$  is the sampling frame and  $e$  is the margin of error.

$N$ =Number of patients (108)  $e$ = 5% margin of error (95% confidence interval)

$$n = \frac{108}{1+(108(0.05^2))} = 85, \text{ Therefore the sample size is } 85$$

## 2.4 Sampling techniques

Sampling methods are classified as either probability or nonprobability. Probability sampling is a sampling procedure in which each element of the population has a fixed probabilistic chance of being selected for the sample. Nonprobability sampling relies on the personal judgment of the researcher rather than on chance to select sample elements (Malhotra, 1996).

Subjects will be chosen based on judgmental sampling as this will enable the researcher to select respondents who will be able to contribute constructively to the research by providing informed insights and opinions. Judgmental sampling is a common non-probability method. The researcher selects the sample based on judgment (Wong 1999).

In view of the above and in relation to the research being conducted, the researcher would opt for the non-probability sampling technique of judgmental sampling. The researcher opts for convenience sampling in the study, in that it has been found to be relevant in other research

efforts in the field (Hall and Lockshin, 2000; Blankson and Stoke, 2002; Osuagwu, 2006; Mahmoud et al., 2010)

## **2.5 Data Collection**

The study used questionnaire as the primary data collection instrument. Questionnaire includes all data collection techniques in which each person is asked to respond to the same set of questions

in a predetermined order (Saunders, 2009). To solicit information from patients which might not be divulged on the questionnaire, the researcher himself was involved in the data collection. The use of questionnaires in this research was for measuring attitudes and getting additional content from research participants. Also, the questionnaires design and administration was not expensive, gave information about participants' internal meanings and ways of thinking, being reliable, providing accurate information and in-depth information and it was helpful for exploration as well as confirmation.

The primary data sources for this survey will be semi-structured interview questionnaires, which will give a broad scope of baseline about patient perception and the quality of healthcare provided. This will be based on interviews and questionnaires answered by the clients or patient the considered respondents will be the direct patient of the hospital. The significance of this is enormous, which includes seeking and understanding the relevant factors.

## **2.6 Research instrument**

Research instruments refers to the instruments with which information are gathered for the research work. Amongst data collection instruments, there are personal interviews, telephone

interviews, commercial surveys which comprises of three types: periodic, panel and shared surveys, and questionnaires.

For the purpose of this research, questionnaires will be used because they represent a good opportunity to gather information with ease. Questionnaires refer to a structured technique for data collection consisting of a series of questions, written or verbal, that a respondent answer. It is a formalized set of questions for obtaining information from respondents (Malhotra, 1996).

Secondary data will be obtained through internet articles and publications, newspapers, and books relating to the topic. Primary data will be obtained through the use of the data collections instrument of questionnaires. The questionnaire was designed to include close-ended and open-ended questions.

## **2.7 Analytical Model**

All analyses were tailored towards achieving the set research objectives. Data collected were analyzed both quantitatively and qualitatively. The Statistical Package for Social Sciences (SPSS) version 18 was used. The responses as contained in the questionnaires were coded and input into SPSS to form a database for the study. Analysis was conducted on the database to generate the measures of central tendencies (mean, mode and standard deviations), tables and figures based on which statistical analysis of findings relating to opinions shared by respondents were arrived at. This, to a large extent is quantitative. The SAMI method was used to give respondents a wide range of options to rate the perception of performance of the hospitals by the respondents. This method consists on classifying the observations into four levels of evaluation: 1: Satisfactory, 2: Acceptable, 3: Medium, and 4: Insufficient. (El Ayadi, 2007).

**Table 3.1: Evaluation by SAMI method (El Ayadi, 2007)**

	<b>Appreciation</b>	<b>Note</b>	<b>Definition and justification</b>
Non-Significant difference felt by the customer	Satisfactory (Conformity)	<b>4</b>	Good Control of Quality Management -No differences. -Adequate Formalism
	Acceptable (Observation)	<b>3</b>	-Good control of Quality Management elements. -Discrepancy of Formalism leading to minor differences
Significant difference felt by the customer	Medium (Minor nonconformity)	<b>2</b>	-Some mistakes in controlling quality management elements. -Risk of difference with limited consequences.
	Insufficient (Major non conformity)	<b>1</b>	-Out of control: Major differences leading to serious consequences at the customer level

Descriptive responses mainly emanating from the interview guides and interactions with the hospital management formed basis for the analysis. Content analysis and pattern matching were crucial in the quantitative analysis. The pattern matching helped to identify the challenges common to the public and private hospital healthcare delivery, while the content analysis tend to examine and extract the relevant data from the

## **CHAPTER FOUR**

### **4.0 RESULTS AND DISCUSSION**

#### **4.1 Socio-demographic characteristics**

A total of 85 respondents were sampled for the study as indicated in table 4.1. Females constituted a larger proportion of the sample size (61.2%) and the males were 38.8 percent. The results indicate that 60 percent of the respondents are college/graduates, while 25.9 percent and 3.5 percent were secondary school/advance level leavers and postgraduate/primary leaver respectively. The results further revealed that 2.4 and 4.7 percent of the respondents had junior high school and non-formal education respectively. Again, the demographic results indicated that (63.5%) of the respondents were Christians, 28.2% were Muslims and 5.9% were traditionist. 2.4% were of other religious faith. However, farmers constituted 2.4 percent and 69.4 percent were engaged in commerce/business, 4.7 percent and 11.8 percent were involved in construction and teaching respectively. 9.4 percent were unemployed and 2.4 percent had other occupations. A total of 48.2% were married and the rest either single, divorced, widowed or separated.

**Table 4.1: Socio-demographic Characteristics of Respondents (N=85)**

<b>Gender of respondent</b>		
	<b>Frequency</b>	<b>Percentage (%)</b>
Male	33	38.8
Female	52	61.2
<b>Marital status of respondent</b>		
	<b>Frequency</b>	<b>Percentage (%)</b>
Single	20	23.5
Married	41	48.2
Divorced	9	10.6
Widowed	10	11.8
Separated	5	5.9
<b>Educational background</b>		
	<b>Frequency</b>	<b>Percentage (%)</b>
None	4	4.7
Primary	3	3.5
Junior high school	2	2.4
Senior high school/advance level	22	25.9
College / graduate	51	60.0
Postgraduate	3	3.5
<b>What is your Occupation?</b>		
	<b>Frequency</b>	<b>Percentage (%)</b>
Commerce/business	59	69.4
Farming	2	2.4
Construction	4	4.7
Mining	0	0.0
Teaching	10	11.8
Unemployed	8	9.4
Other	2	2.4
<b>What is your religious affiliation?</b>		
	<b>Frequency</b>	<b>Percentage (%)</b>

Christian	54	63.5
Muslim	24	28.2
Traditional	5	5.9
Other	2	2.4

Source: Field data (2019)

#### 4.2 Hospital attendance

A total of 38.8 percent of the respondents visits the hospital monthly and 31.8 percent were first timers at the hospital, 11.8 always visits the hospital when they were sick and 12.9 percent visits the hospital weekly. On the other hand, 74.1% percent visited the hospital less than a year and 23.5% visited the hospital a year ago, this was the responds from the respondents when we asked them When was the last time, they visited the Greenlawn hospital? 65.9% of the respondent agreed that the distance of the hospital was far from their house/home etc. and the rest agreed it was near.

**Table 4.2: Hospital attendance of Respondents (N=85)**

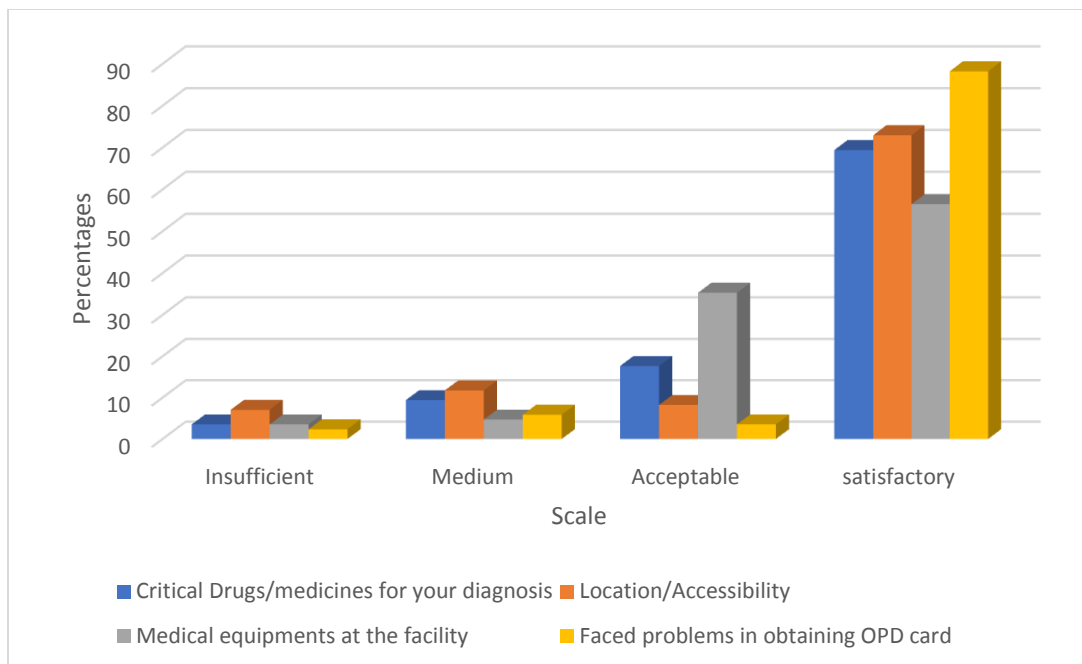
How often do you visit the Greenlawn hospital?		
	Frequency	Percentage (%)
First time	27	31.8
Yearly	4	4.7
Monthly	33	38.8
Weekly	11	12.9
Daily	0	0.0
When I fall sick	10	11.8
When was the last time you visited the Greenlawn Hospital?		
	Frequency	Percentage (%)
2+ years ago	2	2.4
A year ago	20	23.5
Below one year	63	74.1
Distance between hospital and place of residence?		
	Frequency	Percentage
Far	56	65.9
Near	29	34.1

Source: Field data (2019)

### **4.3 Structure of the health care**

Structure of the care includes all of the factors that affect the context in which care is delivered. This includes the physical facility, equipment, and human resources, as well as organizational characteristics such as staff training and payment methods. These factors control how providers and patients in a healthcare system act and are measures of the average quality of care within a facility or system. Structure is often easy to observe and measure and it may be the upstream cause of problems identified in process (Donabedian,2003).

Patients generally were satisfied with the structure-related dimensions of care at the Greenlawn hospital. Patients noted with satisfactory of been given critical drugs, medical equipment at the facility, accessibility of the facility and the acquiring of OPD cards. Results of patient's structure-related experience of health care at the Greenlawn hospital is summarizes in **figure 4.1**.



**Figure 4.1: Perception on structure-related dimension of care at the Greenlawn hospital**

The researcher noted that 69.41% were satisfied with drugs/

medicines for their diagnosis, 72.94% were satisfied with the accessibility of the facility. The researcher asks the respondent their perception on the medical equipment at the facility; 56.47% of the respondent said it was satisfactory, 35.29 said it was acceptable, 4.71% and 3.53% said it was medium and insufficient respectively. Patient didn't faced problems in acquiring OPD cards; 88.24% said it was satisfactory in obtaining out-patient cards.

#### 4.4 Process of the health care

Process of the care is the sum of all actions that make up healthcare. These commonly include diagnosis, treatment, preventive care, and patient education but may be expanded to include actions taken by the patients or their families. Processes can be further classified as technical processes, how care is delivered, or interpersonal processes, which all encompass the manner in

which care is delivered. According to Donabedian, the measurement of process is nearly equivalent to the measurement of quality of care because process contains all acts of healthcare delivery (Donabedian,2003). Information about process can be obtained from medical records, interviews with patients and practitioners, or direct observations of healthcare visits (Donabedian,1980).

On the question of doctor was courteous towards me; the respondent responded 69.4% satisfactory,17.7% acceptable,9.4% medium and 3.5% insufficient. I was given the opportunity to talk about my illness on such question the response of the respondents was 72.9% satisfactory,8.2% acceptable,11.8% medium and 7.1% insufficient. The researcher asked the question 'doctor listened to your problems attentively', the respondent responded with 56.5% satisfactory,35.3% acceptable,4.7% medium and 3.5% insufficient. On the question of I was given adequate time during consultation respondent overwhelmingly responded with 88.2% satisfactory, 3.5% acceptable,5.9% medium and 2.4% insufficient. On the other hand, when asked 'I was given information regarding my health condition';48.2% of the respondent said they were satisfactory, 35,3% said they were acceptable, 12.9% said they were medium and 3.6% said they were insufficient. Similarly, on the question of the doctor provided instruction regarding dose and medication; 73.6% of the respondent responded satisfactory, 20.5% acceptable,2.4% medium and 3,5% were insufficient.

Table 4.3 below shows that patients satisfactory results with all process-related dimensions of care at the Greenlawn Hospital. Patients noted with satisfactory of been listened to attentively, given the opportunity to talk of their health problems and they were given information about their health problems.

**Table 4.3: perception of process- related dimension of care**

Variables	Response			
	Insufficient (%)	Medium (%)	Acceptable (%)	Satisfactory (%)
Doctor was courteous towards me	3.5	9.4	17.7	69.4
I was given the opportunity to talk about my illness	7.1	11.8	8.2	72.9
Doctor listened to my problems attentively	3.5	4.7	35.3	56.5
I was given adequate time during consultation	2.4	5.9	3.5	88.2
I was given information regarding my health condition	3.6	12.9	35.3	48.2
The doctor provided instruction regarding dose and medication	3.5	2.4	20.5	73.6

Source: Field data, May,2019

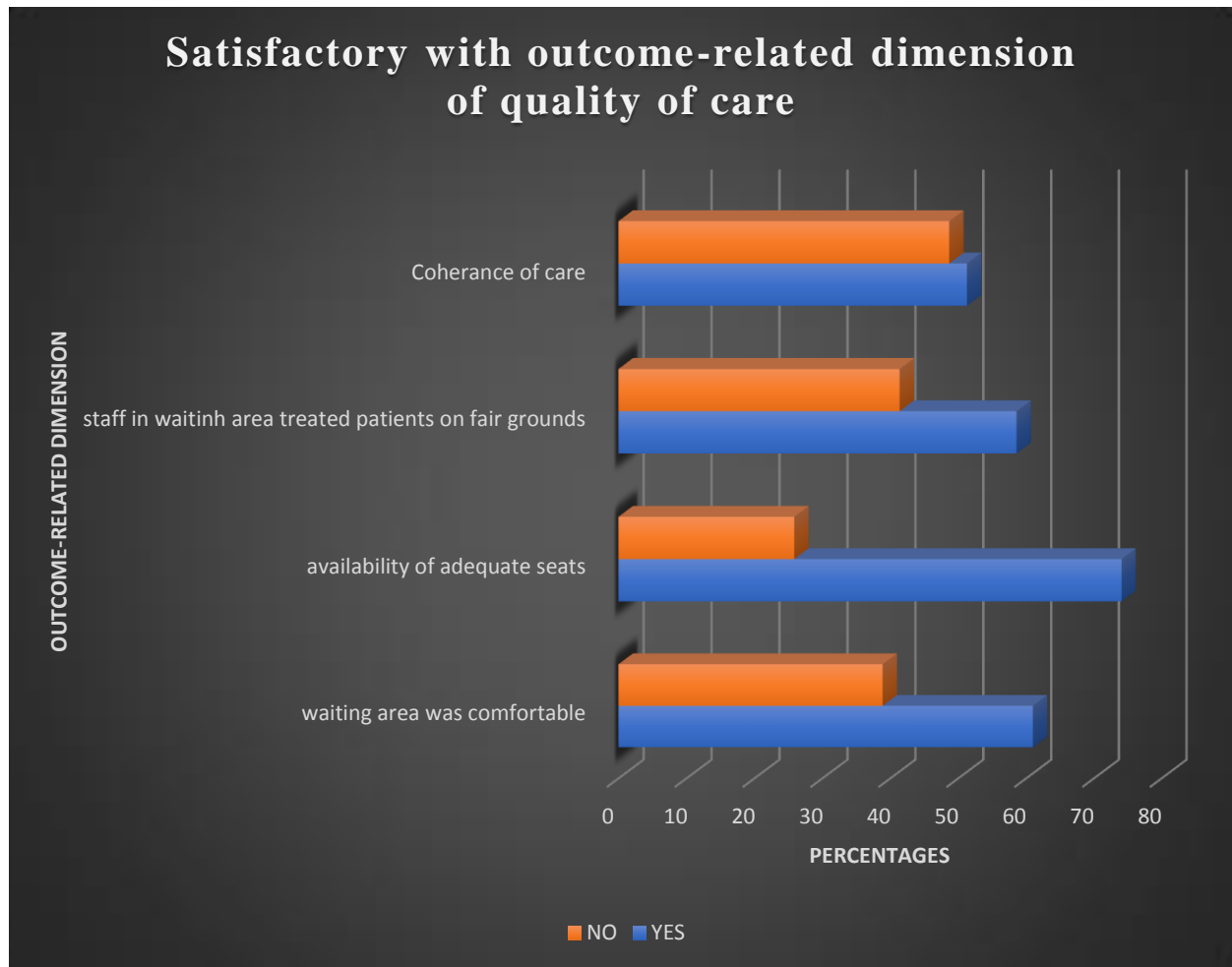
#### 4.5 Outcome of health care

Outcome of care contains all the effects of healthcare on patients or populations, including changes to health status, behavior, or knowledge as well as patient satisfaction and health-related quality of life. Outcomes are sometimes seen as the most important indicators of quality because improving patient health status is the primary goal of healthcare. However, accurately measuring outcomes that can be attributed exclusively to healthcare is very difficult. Drawing connections between process and outcomes often requires large sample populations, adjustments by case mix, and long-term follow ups as outcomes may take considerable time to become observable (Donabedian,2003;1980).

Although it is widely recognized and applied in many health care related fields, the Donabedian Model was developed to assess quality of care in clinical practice. The model does not have an implicit definition of quality care so that it can be applied to problems of broad or narrow scope

(Andersen, Rice and Kominski,2007). Donabedian notes that each of the three domains has advantages and disadvantages that necessitate researchers to draw connections between them in order to create a chain of causation that is conceptually useful for understanding systems as well as designing experiments and interventions.

Patients were asked 'YES' or 'NO' for their response of their experience on the outcome of the care at the Greenlawn hospital. They were question on Comfortability of the waiting area, Availability of seats at the waiting area, their treatment received by the staffs at the waiting area and coherence of the care received. The researcher noted that 59.1% of the respondent said yes and 40.9% said no when they were asked if the waiting area was comfortable. On the availability of adequate seats at the waiting area; 72.9% said yes and 27.1% said no. 56.8% of the respondent responded yes and 43.25 responded no when asked if the staff in the waiting area treated them on fair grounds. On coherence of care/outcome of care 51.8% of the responded yes and 48.2 said no. Most of the response, the researcher noted from the patients were satisfactory (Figure 4.2).



**Figure 4.2: Perception on outcome-related dimension of care at the Greenlawn hospital**

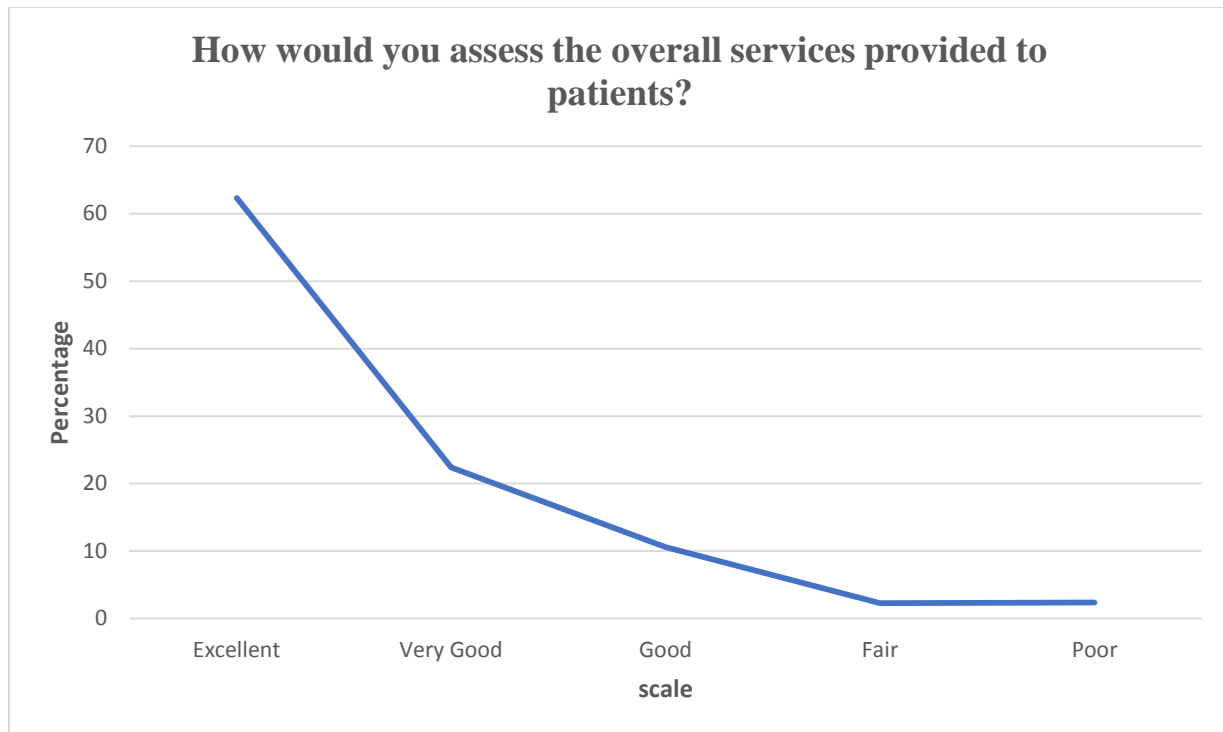
Khali (2009), provided evidence that good patients were given special treatment while difficult patients were left unnoticed or their desired requests intentionally deferred. Non-cooperating patients could incur the displeasure of health staff and mar the kind of relation the staff would have offered ‘patients sometimes behave like children’, a hospital staff indicated. This is yet not a justifiable reason for a hostile attitude of health workers towards patients ‘there are even instances where patients who are of no fault got treated poorly by health workers’ one patient indicated. In reality, non-cooperating patients should be highly expected by health workers. It

has shown that a patient in pain may be pre-occupied with what get him/her relieved and so may not heed to simple instructions

#### **4.6 General perception and impression**

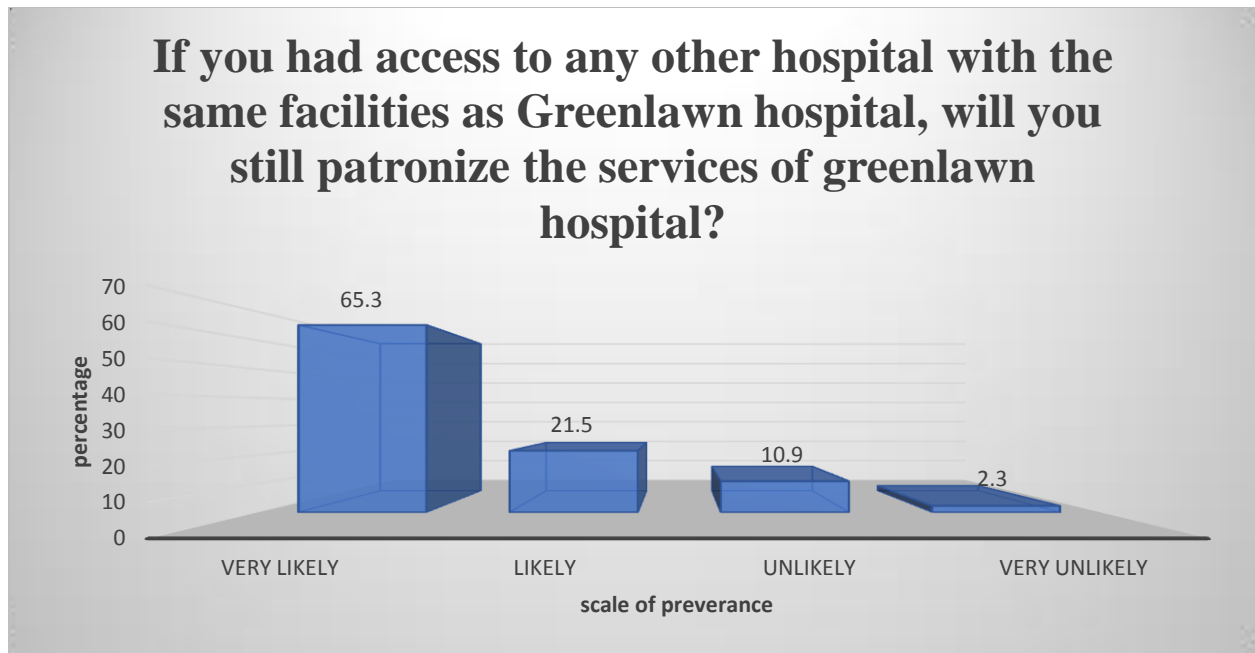
The study understands efficacy of treatment to have a relation with and /or as a factor of quality of healthcare. Studies have outlined indicators for assessing quality healthcare to have included 1) attitude of health workers as perceived by patients (Turkson, 2009) termed as friendliness of staff by Fenny et al. (2014), 2) waiting time 3) customers' satisfaction about the consultation process (Fenny et al, 2014), operationally defined by Turkson (2009) as whether patients were allowed to explain their problems well enough; patients were physically examined; were told what was wrong; were given instructions about illness; and whether other people were in the consultation room privacy reasons.

Respondent were asked their overall assessment of quality of care at the Greenlawn hospital. 62.3% of the respondent said excellent,22.4% said very good,10.6% said good, 2.3% and 2.45 said it was fair and poor respectively (figure 4.3).



**Figure 4.3: Overall perception on service provided at the Greenlawn hospital**

On the question of, if the respondent had access to any hospital with the same facilities as the Greenlawn hospital, if they will still patronize the services of Greenlawn hospital?; 65.3% of the respondents said very likely to patronize, 21.5% said likely to patronize again, 10.9% said unlikely and 2.35 said very unlikely to patronize the services of Greenlawn hospital again (Figure 4.4).



**Figure 4.4: Patients satisfaction of facilities at the Greenlawn hospital**

The study uncovered no significant difference in the perception of patients about care at the Greenlawn Hospital. Healthcare cost was perceived higher in Greenlawn hospitals relative to the other private hospitals.

In addition, hospital operations are undermined by frequent power outages and breakdown of equipment, inadequate staff and logistics. Congestion, however, was found eliminated from the Greenlawn hospital. Non-availability of doctors at certain hours was not a challenge at the hospital. Despite all, proximity to health facilities was found favorable by patients. This enhances physical access to the hospitals at all times. Patients were joyous to use the facility again.

## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATION

#### 5.0 Introduction

In this chapter, the research work is concluded and the results of the data analysis conducted in the previous chapter are examined and discussed as findings of the research. Based on these findings recommendations are made.

#### 5.1 Summary of Findings

This research work sought to achieve certain objectives namely: 1) To investigate the general perceptions of patients on healthcare delivery at the Greenlawn Hospital. 2) To make recommendations on what might be done to strengthen service quality at the Greenlawn Hospital.

The study assessed patients' perception along the parameters of perception of 1) structure-related dimension of care, 2) process-related dimension of care, 3) outcome-related dimension of care, 4) general perception and impression of the care, these were evaluated with the Sami's method (1=insufficient;2=medium;3=acceptable;4=satisfactory).

The data analysis conducted in the previous chapter revealed the following findings:

##### 5.1.1 Patients' perception of healthcare delivery

Majority of the respondent were female with most of them married and educated. Majority of the respondents were engaged in business with most of them visiting the Greenlawn hospital

monthly. Most of the respondent last visited the Greenlawn hospital less than a year with majority of them staying far from the Greenlawn hospital.

This study was based on the Donabedian quality of care model where we investigated all the three part of the model to access patients perceived perception of care at the Greenlawn hospital. Variables within the structure, process and outcome-related dimension of care of the Donabedian model were accessed for patient's perception of care at the Greenlawn hospital and evaluated using the SAMI evaluation method. Majority of the respondent were satisfied with the structure-related dimension of care at the Greenlawn hospital. Most of the respondent were completely satisfied with the process-related dimension of care at the Greenlawn hospital, similarly, majority of the respondent were satisfied with the out-come dimension of care.

The general perception and impression by the patients were satisfactory in nature with majority of the respondent satisfied with the overall service provision of the Greenlawn hospital and most of the patients are very likely to patronize the services and use the facilities of the Greenlawn hospital again even if similar opportunity is presented to them.

This revelation, however, appears to be an improvement upon what was observed as a general bad behavior of health workers towards patients (Ambler et al., 2006). Generally, poor attitude of health personnel towards patients is seen as a likely source to tarnishing the image of the health service and frustrating efforts in enhancing quality and accessible healthcare for all Ghanaians. It is important therefore that hospitals become patient-friendly (Asante et al., 2006). The expectation of the findings of this study therefore is that health personnel patient relations will be enhanced as a form of doing away with human barriers of access to health service in the hospitals.

## **5.2 Recommendation**

### **5.2.1 Documentary on patients and staff behavior at hospitals**

The Health Ministry and the Ghana Health Service in conjunction with the Ghana Medical Association and the media could compile a documentary on patients and staff interaction at hospitals or health facilities. The essence of this documentary will be to show instances that result into poor attitude either from the patients or staff towards the other. And more importantly, establish the strategies some health personnel has been using to successfully manage difficult patients and to maintain cordial staff-patient relations. This could be shown on Television and/or uploaded on a Compact Disc (CD) and distributed to health facilities to be played for awaiting patients.

### **5.2.2 Organize a periodic patient management workshop for health workers**

The study sees the need for a periodic workshop that train and elicit feedbacks from health personnel on staff-patient relations within the health facilities. This is to equip personnel with better patient management skills and for them to learn from experience for the achievement of optimum staff-patient relations within the facilities.

### **5.2.3 Improve upon quality of consultation and communication between staff and patients about illness and lifestyle**

Physical examination of patients was not too high from the study and it emerged also that most patients were not told what was wrong after diagnoses. The study recommends that doctors ensure that patients are physically examined. At least, this will give patients the confidence that they have been properly diagnosed and that prescriptions are not based on guess work. It is also

important that doctors ensure the patient know exactly what is medically wrong for them to manage their lifestyle. This study acknowledge that health personnel know these but, perhaps, due to the pressure as a result of the large number of patients, would want to speed processes by overlooking this all-important requirement. This study emphasize that doctors inform patients always about their health conditions, not just because of its requirement by the Patients' Charter of the Ghana Health Service but more importantly, the practical benefit it will be for the patients to manage their lifestyle.

### **5.3 Suggestion(s) for Further Research**

The variables used in the study were not exhaustive. Further research could integrate other challenges such as worker morale, incentives, competence, training, etc. Other researches can continue to explore further, the impact of these stated challenges on quality, effectiveness and efficiency of healthcare in Ghana.

Further research can be explored with the hospital staffs and patients alike to give a wholistic view on the perception of care at the Greenlawn hospital.

### **5.4 Conclusion**

The study achieved the first research objective by showing patients general perception about the quality of healthcare delivered at the Greenlawn hospital. Donabedian model provided us with a wholistic view on the patients experience with regards to structure of the care, process of the care and outcome of the care. Various dimensions of care within the structure of care, process of care and outcome of care were evaluated with Sami's method. There was no significant difference within the structure, process and outcome of care at the Greenlawn hospital, patient's perception on the quality of care at the Greenlawn hospital were satisfactory.

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**APPENDIX**



**DEPARTMENT OF PUBLIC ADMINISTRATION**

*Project:*

***PATIENT PERCEPTION OF QUALITY OF CARE AT GREENLAWN HOSPITAL***

**INTRODUCTION**

Dear Respondent,

I wish to seek your candid opinion about the level of satisfaction you received from the Greenlawn hospital. The rationale for the study is to contribute to stock of research conducted on patients' perception/satisfaction of health care facilities in Ghana. The findings will help inform policy makers and implementers to initiate measures to ensure quality service. Your response will be kept confidential. Do not write your name

**SECTION A**

**DEMOGRAPHIC DATA**

**Please tick where appropriate (√)**

1) Gender?

Male {1}

Female {2}

2) How old are you?

Below 20 {1}

20-40 {2}

40-60 {3}

Above 60 {4}

3) Marital status: Are you now?

Single {1}

Married {2}

Divorced {3}

Widowed {4}

Separated {5}

4) Level of education you attained?

None {1}

Primary {2}

Junior high School {3}

Senior High School /Advance level {4}

College/graduate {5}

Postgraduate {6}

5) What is your Religious Affiliation?

Christian {1}

Muslim {2}

Traditional  {3}

Others (specify)  {4}

6) What is your Occupation/Profession?

Commerce/Business  {1}

Farming  {2}

Construction  {3}

Mining  {4}

Teaching  {5}

Unemployed  {6}

Others specify  {7}

## **SECTION B: CUSTOMER HOSPITAL ATTENDANCE**

7) How often do you visit the Greenlawn hospital?

This is my first time  {1}

Yearly  {2}

Monthly  {3}

Weekly  {4}

Daily  {5}

When I fall sick  {6}

8) When was the last time you visited the Greenlawn hospital?

2+ years ago  {1}

1 year ago  {2}

Below 1 year  {3}

9) Distance between hospital and place of residence?

far  {1}

near  {2}

**SECTION C: STRUCTURE OF THE HEALTH CARE**

*Please tick the appropriate response of your l experience at the Greenlawn hospital.*

**1- insufficient; 2- medium; 3- acceptable; 4-satisfactory;**

	1	2	3	4
10) Critical drugs/medicines for your diagnosis.				
11) Location and accessibility				
12) Medical equipment at the facility.				
13) Reception desk was easy to locate				
14) Faced problems in obtaining OPD card				

**SECTION D: PROCESS-RELATED DIMENSION OF CARE**

*Please tick the appropriate response of your experience at the Greenlawn hospital.*

**1- insufficient; 2- medium; 3- acceptable; 4-satisfactory;**

<b>Doctor-patient interaction</b>	1	2	3	4
15) Doctor was courteous towards				

me				
16) I was given the opportunity to talk of his/her illness				
17) Doctor listened to patients problem attentively				
18) I was given adequate time during consultation				
19) I was given information about regarding his/her health condition				
20) Doctor provided instruction/s regarding dose and medication				

**SECTION E: OUTCOME RELATED DIMENSION OF CARE**

*Please tick the appropriate response of your experience at the reception desk of Greenlawn*

*Please tick the appropriate response of your experience at the waiting area of Greenlawn hospital.*

<b>Waiting area</b>	<b>Yes 1</b>	<b>No 2</b>
21) Waiting area was comfortable		
22) Availability of adequate seats		
23) Staff in waiting area treated patients on fair grounds		
24) Coherence of care		

**SECTION F: GENERAL PERCEPTION AND IMPRESSION**

25) What do you like and dislike about the Greenlawn hospital?

.....  
.....  
.....  
.....

26) How would you assess the overall services provided to patients?

Excellent  {1}

Very Good  {2}

Good  {3}

Fair  {4}

Poor  {5}

27) If I had access to any other hospital with the same facilities as the Greenlawn Hospital, I will still patronize the services of Greenlawn hospital?

Very Likely  {1}

Likely  {2}

Unlikely  {3}

Very Unlikely  {4}

28) What suggestions would you recommend to the hospital for improved services?

.....

.....

.....

.....

29) Source of admission

Specialist  {1}

General practitioner  {2}

Emergency  {3}

Self-admission  {4}

Transfer from another clinic  {5}

30) Length of stay

Too short  {1}

Appropriate  {2}

Too long  {3}

Do not know  {4}

36) Use facility again?

Yes  {1}

No  {2}

Do not know  {3}

**THANK YOU FOR YOUR PATIENCE AND CO-OPERATION**