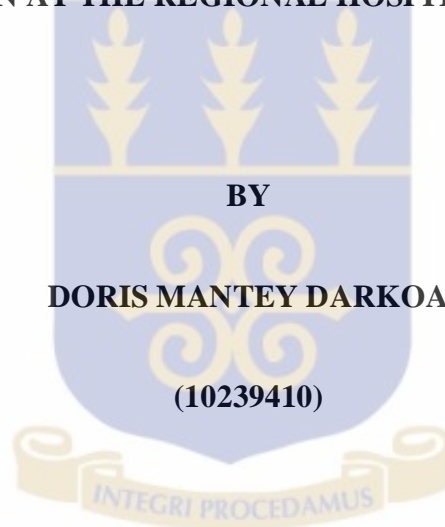


SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

**ASSESSMENT OF FACTORS INFLUENCING LONG-TERM RELATIONSHIP
AMONG PROVIDERS AND PATIENTS: EFFECTS ON PATIENT
SATISFACTION AT THE REGIONAL HOSPITAL, KOFORIDUA**



**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
AWARD OF MASTER OF PUBLIC HEALTH DEGREE**

JULY, 2015

DECLARATION

I, Doris Mantey Darkoa, hereby declare that this is the result of my own hard work and that no previous submission for a Masters degree has been done here or elsewhere. Also, works of others, which served as references, have been duly acknowledged.

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.....

DORIS MANTEY DARKOA

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.....

.....

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DATE

(SUPERVISOR)

DEDICATION

This work is first and foremost dedicated to God Almighty for His protection and guidance throughout the period of the study. It is also dedicated to my mother, Juliana Darko, Mr K. A. Amoah, Mercy and Bro. Gyampo, for the support and love they gave me throughout the course of study.



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GOD RICHLY BLESS YOU ALL!!

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LIST OF ABBREVIATIONS

AHRQ	Agency for Healthcare Research and Quality
APPIS	Adolescent Patient Provider Interaction Scale
DTC	Direct-to-Consumer
FDA	Food and Drug Administration
GHS	Ghana Health Service
NHQD	National Healthcare Quality and Disparities
NHQR	National Healthcare Quality Report
NHSC	National Health and Safety Commission
SPH	School of Public Health
WHO	World Health Organization

DEFINITION OF TERMS

- Assessment:** An evaluation of performance.
- Long term relationship:** A bond or link between provider and patient where they understand each other.
- Provider:** Someone who renders a service to a person in need.
- A patient:** Any person who needs either physical, psychological, spiritual or any form of treatment.
- Quality:** Being given the best of treatment or care in the hospital.
- Satisfaction:** When a patient is happy about services rendered to him or her.

ABSTRACT

Background

Patient satisfaction is a crucial indicator in assessing the progressive challenges of quality health care delivery in the country. Patients who visit various health care services providers have different understandings to share regarding the care they receive. The long term relationship assessment study provides the data on their experiences interacting with health professionals at the Koforidua Regional Hospital during provision of service.

Objective

The main objective of the study was to determine how long-term relationship among health providers and patients enhance patients' satisfaction with health delivery.

Methods

The study was a cross sectional, which employed quantitative data collection approach. Two hundred and eighty eight (288) participants of which 170 were patients and 118 were providers responded to the study. Statistical analysis used was SPSS version 20. Chi-square analysis was used to determine the association between the independent variables and the dependent variable.

Results

The study observed that the strongest explanatory variables for predicting services rendered to meet patient satisfaction were waiting time with an odds ratio of 1.787, competence and expertise of staff with an odds ratio of 1.537 and hospital environment with an odds ratio of 1.187, whilst the least among the predictor variables were reception of staff with an odds ratios of 0.864 and providers' attitude with odds ratios of 0.887. The implication of this is that the strongest predictor variables; waiting time (1.787) and competence and expertise of staff (1.537) are most likely to enhance patient satisfaction.

Conclusion

Generally, the study concludes that patients' satisfaction with healthcare provision (based on the patient factors/indicators used) has substantial influence on long-term relationship among health providers at the Koforidua Regional Hospital. The study revealed that patients' satisfaction is not based on only receiving treatment in the facility, but rather there should be mutual trust and a good interpersonal relationship. This will influence patients' satisfaction as well as long term relationship with health providers. Subsequently, the study also concludes that health providers' perception of satisfaction with performance (based on the provider factors/indicators used) is enhanced with consequential influence on long-term relationship with patients.

CHAPTER ONE

INTRODUCTION

1.0 Background

The World Health Organization (WHO) is undergoing a lot of reforms to improve upon health care delivery system globally; and to ensure delivery of holistic quality of care for all (WHO, 2000, 2013). There is a problem as to how to ensure delivery of holistic quality of care for all. The problem could be considered against the perspective that sometimes what constitutes quality of care is poorly defined (Kumbani, Chirwa, Malata, Odland, & Bjune, 2012). For example, a study documented that some women in Malawi, did not know the quality of care to expect because they were not well informed, they were not critical of the care they received because they were not aware of the standard of care: they had low expectations (Kumbani *et al.*, 2012). Turkson (2009) reports from a study in Ghana, that even as the quality of healthcare delivery was generally, perceived to be high for most of the indicators used, there were some concerns that patients were not told about the diagnosis or informed about the management of their illness. Consequently, some researchers suggest that health workers have a responsibility to inform women and their families about the care that women should expect; and there was also the need for standardization of the antenatal information provided (Kumbani *et al.*, 2012).

Since many of the interventions to improve on patient satisfaction seem to have yielded little effect (Turkson, 2009) some analysts have suggested the adoption of long-term relationship based on the concept of relationship marketing as a new strategy to help revamp health care delivery in resource constraint economies (Kumbani *et al.*, 2012). This is also based on the concept of service marketing as a discipline (Maibach *et al.*, 2006). Maibach *et al.* (2006) make a compelling case for the important role that marketing can

play in public hospitals and clearly define key constructs of marketing. These researchers indicate that marketing activities of conducting customer research, building sustainable distribution channels, and improving access to healthcare facilities could be used to enhance the adoption and implementation of health behaviours and practices. These could enhance patients' satisfaction or quality of care (Maibach *et al.*, 2006). Thus, it is expected that quality of care in the healthcare environment, could be measured in respect of patient satisfaction with health care services accessed (Yen-kolin *et al.*, 2013). For instance, some analysts argue that patients' expression of satisfaction or dissatisfaction is a judgment on the quality of hospital care in all of its aspects (Wan-lee *et al.*, 2010).

A study found that the level of satisfaction with quality of healthcare was high (Turkson, 2009). Therefore, it is expected that close collaboration between patients and providers is key to creating and sustaining demand for hospital services on a long term basis (Sewell, 1997). Ideally, Sewell (1997) recommends that a network of mutually rewarding relationship should form the foundation of any plan for patient care services; and should take into account the readiness and ability to pay for medical care. Since the main beneficiaries of a good healthcare system are clearly the patients, it is important to make them the focus of the healthcare delivery system (Sewell, 1997). The anticipation is that the relief or cure of ill health is universally vital and this must result in the imperative to provide high quality services in response to developments in health and the desire of the providers to care for patients (Sewell, 1997). According to Duggirala *et al.* (2008) a healthy population is characterized by balanced birth and death rates and a low incidence of disease, which will bring improvement in the health sector so as to help in the development and prosperity of the nation.

Some analysts also postulate that the relationship between health providers and patients brings understanding among them, which in effect, will help in delivering quality care (Kumar & Ph, 1986). Kumar and Ph (1986) believe that customers or patients who develop a relationship with a service provider come to trust and depend on that provider; and believe that his or her needs will be fulfilled and will live the premises well satisfied. The idea is that trust binds two parties together, helps to moderate their risk and implicitly guarantee a better long lasting relationship (Kumar & Ph, 1986).

It is for this reason that Maibach *et al.* (2006) suggest that public health resources should include: training and a focus on health marketing strategies, which would cultivate opportunities to blend marketing and public health. Furthermore, these researchers call on partners in public health and health marketing at all levels from all sectors to be involved and advocate for the advancement and proliferation of this discipline. They believe that this perspective could help to enhance quality of care and also draw attention to the usefulness of long-term relationship based on the concept of relationship marketing and its potentials in advancing the field of public health (Maibach *et al.*, 2006).

1.2 Problem Statement

Delivering quality health care services in hospitals remains a critical issue for many countries in the developing world (Alan *et al.*, 2008). Despite numerous attempts to improve on quality of care, there appears to be little or no positive outcomes due to lack of strategies to ensure effective and efficient implementation (Samah, Ibrahim, & Amir, 2013). It is in view of this that the World Health Organisation document (WHO, 2006) notes that the success of interventions regarding quality of care in the health care sector

depends on maintaining a clear focus on implementation, sustaining interest and commitment, and having the capacity to make tactical decisions to modify activities in order to retain the patients. It continues that all of this is critical for sustainability, as many quality-improvement initiatives encounter ‘decline-results’ because they lack sustained focus on implementation (WHO, 2006).

Invariably, the lack of sufficient financial investment; the fragmentation of the delivery of health services; and poor quality of care are considered key obstacles to the successful implementation of health programmes (WHO 2006). The health delivery system of Ghana is undergoing reforms to improve standards by improving on quality of health care (Lagomarsino, Garabrant, Adyas, Muga, & Otoo, 2012). However, establishing and maintaining long-term relationship between health providers and patients is one of the missing links in the various programmes implemented in the health system (Lagomarsino *et al.*, 2012).

It could be argued that health providers have inadequate understanding of long-term relationship and its importance towards enhancing patients’ satisfaction or quality of care (Turkson, 2009). This could be attributed to the fact that they are not given any orientation on long-term relationship, which is based on the concept of relationship marketing in school or on the job training while in employment (Naik, Gantasala, & Prabhakar, 2010). As a result, most of the health personnel do not show any sense of establishing long-term relationship in their dealings with patients. Consequently, they fail to understand that the health facility is supposed to operate as a business entity. Thus, a

review of the school curricula and orientation procedures in health facilities to include elements of long-term relationship could help to resolve this problem (Naik *et al.*, 2010).

Waiting time has become an issue worldwide (Hicks, 2014). Indeed, patient satisfaction of health care is becoming an issue in most public healthcare facilities as most of the patients complain of waiting time (Bell *et al.*, 1997; Kelsey, 2001). One criterion that patients use to access their satisfaction with health care services at health facilities is the time they spend before seeing a doctor or visit a department of the hospital. In most cases, patients would prefer that health providers spend some time to ask questions and conduct proper examination before diagnoses were made (Turkson, 2009). It would be recalled that a study from Ghana, found that even though about 98% of respondents said that they were asked to explain their problem, lower proportions were recorded for the following: physically examined (74%), told what was wrong (43%) or given advice about their illness (46%) [(Turkson, 2009)].

Turkson (2009) notes that about 90% of respondents in a study conducted in Ghana, were satisfied or very satisfied with the care given during their visit to the health facility. Undoubtedly, patients complain of poor sanitary hospital environment, especially the wards: these make them very uncomfortable. The unhygienic conditions could worsen their condition as there is poor maintenance system in the health facilities. As the adage goes: 'cleanliness is next to Godliness'.

The filthy and contaminated hospital environment has the potential to transfer hospital acquired infection to both inpatients and their relatives in the long run. These problems are persisting due to the fact that the health providers lack understanding of long-term relationship and have not yet considered the effect that unhygienic hospital environments could have for their facilities in terms of the number of clients who visit for health care (Turkson, 2009).

The poor staff attitudes could affect patients' satisfaction or quality of care, which could lead to increased mortality and morbidity in most of the public hospitals in Ghana (Turkson, 2009). For instance, Kumbani and colleagues (2012) identified two themes from their study on how Malawian women critically assess quality of care. These were 'good care' and 'unsatisfactory care' from which they also identified other sub-themes. The following were identified under 'good care': respect, confidentiality, privacy and normal delivery. The following were also identified under 'unsatisfactory care': providers' attitude, delay in providing care, inadequate care, and unavailability of delivery attendants (Kumbani *et al.*, 2012).

A similar study conducted in Ghana, revealed that participants 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 (Turkson, 2009).

Different forms of communication channels could be used to promote the services of a health care facility in a positive light as well as portray it in a negative light (Gronos, 1984). This is against the background that medical practitioners and public health

providers are not required by law to advertise their services through the media (Gronos, 1984). Nonetheless, while traditional marketing strategy, which is the ‘word of mouth’ could be used to damage the hard-earned reputation of a health institution, it is apparent that a negative media reportage of a hospital’s services could also lead to low patronage of its services, which is likely to affect its internally generated funds (Gronos, 1984). In other words, the way the media will report of bad practices and inefficiencies of a health facility could damage the reputation of such a facility (Gronos, 1984).

This study evaluates how long-term relationship among health providers and patients could enhance patients’ satisfaction (in other words, quality of care) of health care services in hospitals. Thus, it seeks to highlight effects of long-term relationship on delivery of health services from the perspectives of providers and patients at the Regional Hospital, Koforidua in the Eastern Region, Ghana.

1.3 Justification of the Study

The kind of attitude and relationship that health personnel exhibit towards their clients go a long way in enhancing patients’ satisfaction of health care services (Turkson, 2009). However, in most cases, since health personnel seem to lack understanding of long-term relationship, they fail to realise that providing a friendly and good reception towards patients could help soothe them of their ill-health or conditions (Kumbani *et al.*, 2012). It is believed that poor quality of care could lead to reduced attendance at hospitals. This could also have consequence for increased morbidity and mortality amongst the people as there would be low patronage of health services. It is anticipated that understanding long-term relationship on the part of health personnel could help them (health personnel) to communicate in a friendly manner to patients while they wait. This would help to reduce

the boredom and frustrations that patients go through whenever they visit the hospital to access health care. These facts have minimally been explored (Turkson, 2009).

Studies have been conducted on long-term relationship between nurses and patients (CMR, 2007). Though many hospitals report of using good relationship, Ghana has not been able to reach its ultimate aim as health providers have inadequate knowledge of how to establish long-term relationship with patients (Turkson, 2009). Thus, it could be argued that health providers have inadequate understanding of long-term relationship and its importance towards enhancing patients' satisfaction. Arguably, the adoption and application of long-term relationship strategy by health providers would help them to realise that the customer is supreme in any services sector, including health. Not many studies have explored this fact (Turkson, 2009).

As a result, it is important to examine health providers' understanding of long-term relationship and factors, which influence patients' satisfaction with health care delivery at hospitals (Cronin & Taylor, 1992). When applied to health care delivery, long-term relationship on the part of health providers could enhance patients' satisfaction with health care delivery at hospitals (Cronin & Taylor, 1992). This notwithstanding, it appears that no study has examined this with particular reference to the Regional Hospital, Koforidua (Turkson, 2009). This study seeks to explore this phenomenon so that findings could be used to improve on health care services, which would equally lead to patients' satisfaction.

In most cases, few studies have examined the effect of long-term relationship on satisfaction (quality of care) with healthcare delivery at hospitals (Turkson, 2009). Patients' positive assessment of a health facility and its environs could enhance their level

of satisfaction with health care accessed (Lohr & Schroeder, 1990; Hughes, 2014). Therefore, it is viewed that if the hospital environments were made very clean, they would help in soothing the patients of their ill-health conditions. However, it is presumed that few studies have examined the effect of a serene hospital environment (as a long-term relationship indicator) on patients' recovery processes (Turkson, 2009). This study examines how an aesthetic environment could enhance patients' attraction to a hospital and thereby enhance their satisfaction (quality of care).

Due to increasing number of private institutions in the country, there is increasing competition in the health services sector as some of the hospitals are changing from a seller's market strategy to a buyer's market strategy, where the patient has become more important (Turkson, 2009).

The researcher having worked in Ghana's health sector for a considerable period of time has the knowledge and experience needed to throw more light on the topic under discussion so as to contribute to literature accordingly.

Therefore, the purpose of this study is to investigate the above identified gaps in the literature such that the findings would help health providers to understand the need to establish long-term working relationship with their patients as no study has yet been conducted in this regard, especially at the Regional Hospital, Koforidua.

1.4 General Objective

The general objective of the study was:

To determine how long-term relationship among health providers and patients enhances patients' satisfaction with health care delivery at the Regional Hospital, Koforidua.

1.4.1 Specific Objectives

The following specific objectives helped in achieving the main objective of the study:

1. To determine factors influencing long-term relationship among health providers and patients and their effect on patients' satisfaction at the Regional Hospital, Koforidua.
2. To examine health providers' perception of performance and its influence on patients' satisfaction at the Regional Hospital, Koforidua.

1.4.2 Research Questions

The following questions helped to find answers to the specific objectives:

What factors influence long-term relationship among health providers and patients and their effect on patients' satisfaction at the Regional Hospital, Koforidua?

What is health providers' perception of performance and its influence on patients' satisfaction at the Regional Hospital, Koforidua?

1.5 Outline of the Dissertation

The dissertation is presented under six chapters. Chapter one presents the introduction to the study where the background, problem statement, justification, general objective, specific objectives and research questions are presented. Section two presents discussion of the literature and conceptual framework informing the study. Chapter three is where the methods applied to collect primary data for analysis are presented. Chapter four presents the results of the study as analysed based on the data collected from the Koforidua Regional Hospital. Chapter five is where the discussion of the results and findings of the study are related to existing literature. Chapter six presents the summary, conclusions and recommendations of the study. Here, limitations to the study and directions for future research are also presented.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.0 Introduction

The literature review presents discussion and analysis of the key concepts of the field of study. In section one, quality of care is defined in relation to areas where patients' satisfaction or poor quality of care is assumed to be manifesting in the healthcare environment. In section two, a review of some studies conducted in the area of patient satisfaction and long term relationship between health providers and patients are presented. The health provider factors, influencing their perception of performance with associated influence on patient satisfaction as well patient factors, influencing long term relation with consequential influence on patient satisfaction are presented. Section three presents the chapter summary.

2.1 Quality of Care

Quality health care has been defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Lohr & Schroeder, 1990; Hughes, 2014). Gronos (1984) suggests that there are two types of quality of care: technical and functional. This researcher explains that while the 'technical quality of care' measures the accuracy of procedures in the health sector, the 'functional quality of care' measures how healthcare is delivered to patients. This analyst argues that the technical aspect of quality of care is difficult to rate or measure by patients as they have little knowledge of it.

As a result of this, patients attempt to classify all services under functional aspect of quality of care and therefore, whenever the service is not delivered well, they tend to

complain about the hospital care (Gronos, 1984). Soliman (1992) concludes in his study that technical interventions influence patients' ratings of the overall quality of healthcare and that these aspects of medical encounter were perhaps more important than the technical aspects. The identification and satisfaction of patients' needs and requirement has been the basis for many definitions of service quality (Cronin & Taylor, 1992).

Parasuraman *et al.* (1985) argue that service quality can be defined as the difference between predicted or expected service (customer expectations) and perceived service (customer perceptions). They indicate that if customers' expectations exceed performance, then perceived quality is considered less than satisfactory and a service quality gap materializes. This in effect, does not necessarily represent the fact that the service is of low quality, but rather customer expectations have not been met. Hence, customer dissatisfaction occurs and opportunities should be generated in order to meet customer expectations (Parasuraman *et al.*, 1985).

The central idea of providers' intervention can promote wellness, reduce the spread of illness and improve the health status of the individual (Parasuraman *et al.*, 1985). Hunt (2000) explains how quality of care could be achieved using nurses and observes that providers' practice is concerned with the general and comprehensive care of the community at large, with emphasis on primary, secondary, and tertiary prevention. This researcher indicates that nurses in these settings have traditionally focused on health promotion, maternal and child health. As nurses form majority of the providers in healthcare system, their focus is directed towards individuals and families (Hunt, 2000). Hunt (2000) suggests that these should also include home health care nursing, which would help relieve the patient from so many stress and also help to identify their needs.

Asubonteng *et al.* (1996) define service quality as the difference between consumer expectations of service performance before the service encounter; and their perceptions of the service actually received. Some researchers have reached the same conclusion that this concept has understandable implications for the measurement of service quality (Youseff *et al.*, 1996). This means that both perceptions and expectations need to be clearly measured in order to quantify service quality gaps (Youseff *et al.*, 1996). Myers *et al.* (2012) suggest that in order to improve quality of care, there should be a need to utilize health information technology that will facilitate the exchange of information among all providers involved in patients' care.

These researchers explain that this will help to disseminate information across clinical and non-clinical settings, which include: physicians, health educators, social workers, laboratory technicians, pharmacists, among others. These are people who in one way or the other contribute to the care of patients. Since they prevent the spread of patients' information, they can also share key information about the patient like: diagnosis, laboratory results, existing treatment modalities, missed visits and previous diagnoses. These could be done to ensure that decisions about a patient's care would be fully met (Myers *et al.*, 2012).

To ensure that health care providers provide quality health care to people in the communities, the Agency for Healthcare Research and Quality (AHRQ) has since 2003, been reporting on progress and opportunities for improving health care quality and how to reduce health care disparities (AHRQ, 2007). To ensure that healthcare providers adhere to quality of care standards, the National Healthcare Quality (NHQR) has been mandated by the U.S. Congress to focus on: 'national trends of quality in the health service delivery'

(NHQR, 2013). The reality is that the general public has become increasingly, interested and knowledgeable of health care and health promotion (Turcson, 2005). This awareness has been stimulated by television, newspapers, magazines and other communications media and by political debate. The public has become more health conscious and has in general begun to subscribe strongly to the belief that health and quality health care constitutes a basic right, rather than a privilege (Trkla, 2013).

The patient's assessment of quality of health care services could be viewed from how their conditions are diagnosed, including the kind of laboratory diagnosis made by health care providers (Kricka, Polsky, Park, & Fortina, 2014). However, it has been reported that most of the diagnoses have been proven to be wrong due to errors committed in the laboratory, which can bring mistrust between the patient and the hospital. When this happens, the patient may prefer to seek laboratory investigations outside the hospital (Kricka *et al.*, 2014). For this reason, some researchers suggest that the staff at the laboratory should try to reduce laboratory errors and eliminate unnecessary laboratory testing, wrong interpretations and to ensure accurate laboratory results, which will lead to accurate treatment that will also ensure quality of care (Favaloro *et al.*, 2014).

The barriers encountered by people when they try to access healthcare could cause their dissatisfaction with the services and as such quality of care (NHQD, 2013). These include: lack of regular provider, the provider is busy when patients want information; the provider has so many things to do at the same time and difficulty in contacting their usual source of care by telephone during regular hours to report of a health problem. The National Healthcare Quality and Disparities (NHQD) report suggests that all these contribute to patients' dissatisfaction (NHQD, 2013). The report suggests that for hospitals

to remain competitive there was the need to improve access to health care, reduce disparities and accelerate the pace of quality improvement (NHQD, 2013).

It is documented that many types of work require the engagement in relationships with other people as well as a great personal responsibility in fields such as: social services, health services and medical care, education and management (Biron, Brun, & Copper, 2006). Biron *et al.* (2006) argue that such work may cause the employee to feel unable to cope with the work tasks and could also lead to exhaustion and in effect affect quality of care. In addition, these researchers propose that conflicting relationships with colleagues and patients could be central factors, leading to lack of self-confidence, which could eventually lead to poor delivery of services (Biron *et al.*, 2006).

2.2 Conceptual Framework

This section presents the conceptual framework for the study, which is based on a modified model of quality of care as presented by Donabedian (1980). The various indicators in the framework have been examined in relation to existing literature.

2.2.1 Framework for Measuring Quality of Care using Relationship between Health Providers and Patients

The key elements of the conceptual framework, constituting factors that influence the long-term relationship among providers and patients, which consequently, influence patients' satisfaction (quality of care) forming the basis of the study are depicted in figure 1.1 below. These are shown as health provider factors and patient factors. For health provider factors, the following elements are considered: health providers' understanding of communication, long lasting relationship, confidentiality, availability of resources,

workloads and job stress, cost of healthcare, patronage in service provision and overall provision of service. For patient factors, the following elements are considered: patients' satisfaction with reception of staff, staff attitude, waiting time, competence and expertise of staff, hospital environment and overall hospital's services provision. These are shown on figure 1.1 below.

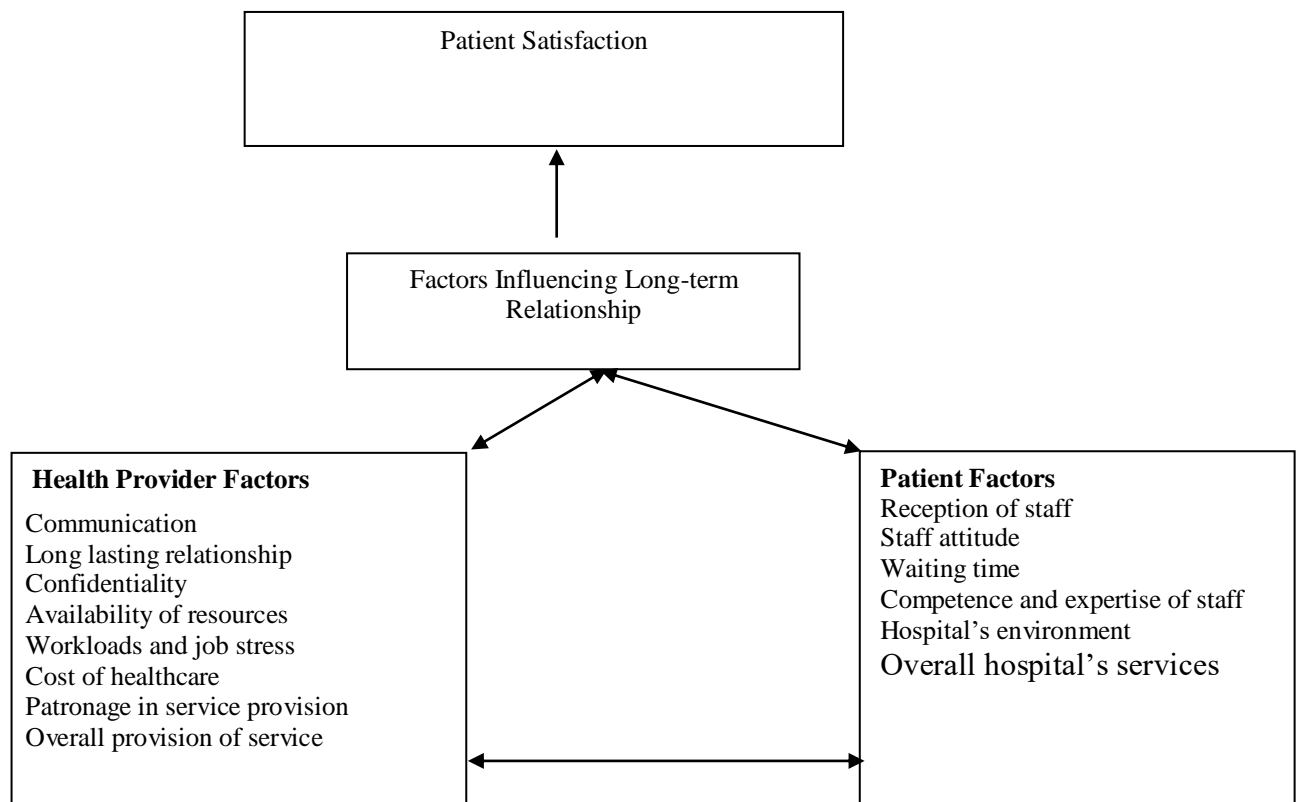


Figure 1.1: Framework of Relationship among Health Providers and Patients

This means that the cordial relationship between health providers and patients could influence and form the basis of long-term relationship between the providers and the patients. This will equally influence patient satisfaction.

2.2.2 Patient Satisfaction

Patients' satisfaction is defined as the result of a cognitive and affective assessment, where certain comparison standard is compared to the actually perceived performance (Kotler, 2003). What happens is that when the expectation of the patient is more than he or she perceived, then they (patients) become dissatisfied. Alternatively, if the expectation exceeds the perceived, then they (patients) tend to be satisfied. Otherwise, if the perceived is equal, then they (patients) keep quiet as if nothing had happened (Kotler, 2003). Patients' satisfaction is a highly desirable outcome of clinical care in the hospital and may even be an element of health status itself (Turcson, 2005).

A patient's expression of satisfaction or dissatisfaction is a judgmental tool on the quality of hospital care in all of its aspects. Whatever its strengths and limitations, patient satisfaction is an indicator that should be indispensable to the assessment of the quality of care in hospitals (Turcson, 2005). Gruen *et al.* (1997, 2000) report that previous studies had focused on the 'needs' and 'wants' of patients. However, in recent times, the concept of quality with its focus on customer satisfaction has been investigated (Gruen *et al.*, 1997, 2000).

A study on relationship between physicians' communication behavior and patients' overall satisfaction with hospital care shows that there was a considerable variation in patients' perception of their physician communication skills in the hospital (Turcson, 2005). Other studies established that physician communication behaviour such as lack of physician dominance, questions about psychosocial issues, information given to patients on how to take their drugs, discuss options and encouraging patients to ask questions were associated

with patients' satisfaction in the outpatient setting (Stewart, 1995; Williams, Weinman, & Dale, 1998).

It is viewed that practitioners regard customer satisfaction as the focal point for designing successful marketing strategies; and public policy officials / consumer agencies recognize satisfaction levels as barometers of consumer welfare (Dixon, 1989). Despite its importance, previous research in marketing had tended to focus mainly on satisfaction processes, paying little attention to its structure (Oliver & DeSarbo, 1988). As such, consumer researchers have advanced and tested the processes underlying satisfaction, placing less emphasis on its context (Oliver & DeSarbo, 1988).

Some analysts suggest that the authorities of the hospital could employ someone who is a Marketing Consultant to inculcate the importance of patient care in the providers, which it is believed would ensure that they know the skills used to retain customers (Naik *et al.*, 2010). Researchers Naik *et al.* (2010) observe that providers should be trained on etiquette and empathy. In most cases, health providers could identify expected satisfaction from previous experiences of patients, friends, relatives and comments in the press, which could help them to know how their clients were willing to either continue or stop using the facility (Naik *et al.*, 2010).

Keiningham and Vavras (2001) observe that satisfaction levels could influence customers' loyalty only when there were more extreme levels of satisfaction, which means that a small change in satisfaction would have less impact. These researchers show the view that

patients could dismiss future communications either because they doubt the competence of the hospital or the hospital does not care about their patients. In some instances, delighted patients could consider the facility as a better place even if things did go wrong because the providers could easily fix the problem (Keiningham, & Vavras, 2001).

2.2.3 Understanding Long-term Relationship among Health Providers and Patients

The word relationship has been defined in different disciplines (Berry, 1983; Lee, Chen, Chen, & Chen, 2010). For the purposes of this study, relationship is viewed from the perspective of a relationship that is related to marketing, which is a form of relationship that is established between the patients and the providers that encompasses ‘...activities directed toward establishing, developing, and maintaining successful relationships’ (Berry, 1983). Berry (1983) first proposed the concept of relationship related to relationship marketing in the service context, and defined it as ‘attracting, maintaining, and enhancing customer relationships’ (Berry, 1983: 25). It is believed that the private hospitals are already focusing on understanding the customer's needs and building a strategy around those needs. The belief is that this would help to evolve the best practice by relating well to the patients (Berry, 1983).

This definition of relation using the relationship marketing perspective is adopted because relationship marketing-related articles clearly broaden the domain in ways that are not restricted to the marketing area alone, but also in interpreting phenomenon in other areas like health delivery services and communication (Cummings & Frost, 1985). Cummings and Frost (1985) however, observe that a major question remains as to: ‘what do we know about relationship marketing that is ‘most important’ or ‘most influential’ to help us

determine the future of relationship marketing? Cummings and Frost (1985) suggest changes in a different component of the knowledge exchange process, and the need for more cross-disciplinary symposia at professional meetings. Hence, this seems an appropriate time to integrate the dispersion of all varieties of relationship marketing, in order to review its present state and discover future directions (Cummings & Frost, 1985).

Some researchers' note that dedicated providers serve the community in all its ethnic, religious, and economic diversity and ensure that the patients' healthcare needs are met (Oliver & DeSarbo, 1988). This means that the goal of providers should be to ensure that all patients have the same care and attention (Turcson, 2005). These researchers suggest that patients should be able to ask questions at any time, and all relevant questions should be answered by the provider. This is so because all unanswered questions could add to the stress of ill health. It is important for health providers to understand that the comfort and confidence the patients have in their care is very paramount (Vargheese & Prabhudesai, 2014). The suggestion is that the first priority of providers is to provide the patients' care needs, when they need it, with skill, compassion, and respect. Therefore, a good relationship with the patient will enable them to tell providers if they have concerns about their care or if they have pain (Vargheese & Prabhudesai, 2014). For instance, patients have the right to know the identity of doctors, nurses and others involved in their care (Hicks, 2004).

A study recognises that several different objects are usually present within a hospital-patient interaction, such as nurses, registration staff and technicians (Sheth & Ph, 2000). Indeed, some researchers recommend that provider-patient relationship in service delivery

is an important issue that hospital authorities should consider and make sure that both the provider and the patient are satisfied with the relationship and are ready to work together as a team: Caring for the patient is paramount to provider-patient relationship (Rose & Catherin, 2011). The argument is that this will create professionalism and the patient could go home partly, cured as most of the patient's condition could become worse due to the behaviour of the providers (Naik *et al.*, 2010).

There will always be a good relationship between patients and providers if there was commitment (Reichheld, 1996). It is argued that customer commitment is influenced by customers' ability to trust service quality (Reichheld, 1996). For instance, in the service marketing arena, customer commitment has been defined as a customer's conviction to maintain a relationship that might produce functional and emotional benefits, considering the customer's commitment as his or her wishes to maintain the relationship with the service provider. Reichheld (1996) further developed the importance of building customer commitment and focused on the cost of customer defection and set the stage for the problem by claiming many major corporations now lose and have to replace half their customers in five years.

In addition, trust is also important towards promoting a good relationship between the patient and the provider (Thaichon, Lobo, Prentice, & Quach, 2014). It is indicated that trust is known to be a foundation of a long-term relationship, possibly building an advanced exchange relationship between buyers and sellers (Thaichon *et al.*, 2014). This could be applied to the health care environment as a result of the current economic changes where health facilities are to be seen as business entities (Thaichon *et al.*, 2014).

In service marketing, customer trust is referred to as the customers' perceptions of attributes of service providers, including the ability, integrity, and benevolence of the providers.

Additionally, customer trust relates to the perception of customers persistence (Thaichon *et al.*, 2014). Lee *et al.* (2010) examined the correlation between customer orientation, medical service quality, service value and patient satisfaction in relation to providers located in southern Taiwan. Their findings show that patients have different perceptions of customer orientation in relation to service quality and satisfaction (Lee *et al.*, 2010).

Maibach *et al.* (2006) state that it is significant for public health to focus on health marketing strategies in order to cultivate opportunities to blend marketing and healthcare delivery, which will increase the number of patients who access the facility. They continue that the public health sectors should be involved and advocate for the advancement and proliferation of this discipline and perspective of long-term relationship (Maibach *et al.*, 2006).

Morgan and Hunt (1994) studied internal marketing and proposed that long-term relationship refers to all marketing activities directed toward establishing, developing, and maintaining successful relational exchanges. In addition, Buttle (1996) proposed that long-term relationship is concerned with the development and maintenance of mutually beneficial relationships with strategically significant marketing. Hibbard *et al.* (2001) in their study suggested that relationships should be built on trust and commitment, which

should be accompanied by an increased likelihood of constructive responses to relationship problems. This means that whenever there is cordial relationship between the provider and the patient, it could influence the patient's willingness to visit the facility anytime the need arises (Hibbard *et al.*, 2001).

Therefore, a long-term relationship based on a relationship marketing orientation is the latest need for the image upgrading of hospitals (Solayappan & Jayakrishnan, 2010). The main task of effective long-term relationship based on a marketing orientation is to determine the needs and wants of customers (patients) and to satisfy them through communication, pricing and delivery of appropriate and competitively viable products and services. The view is that a hospital should serve as a humanitarian organisation as well as a regulatory body that takes into account the patient's needs and wants. For instance, a patient needs only a quality and satisfactory care from the providers. They want smiling, empathetic nurses and staff, and a quick response to their calls (Solayappan & Jayakrishnan, 2010).

2.2.4 Health Provider Factors

Assessing quality of care using the long-term relationship concept could be viewed from health providers' perspective as well. Hughes (2014) observes that the culture is needed to support a quality infrastructure that has the resources and human capital required for successfully improving quality. To this end, it has been recommended that efforts to improve quality need to be measured to demonstrate whether improvement efforts: lead to change in the primary end point in the desired direction; contribute to unintended results in different parts of the system; and require additional efforts to bring a process back into

acceptable ranges (Varkey, Peller, & Resar, 2007; Hughes, 2014). For instance, Hughes (2014) observes that the rationale for measuring quality improvement is the belief that good performance reflects good-quality practice, and that comparing performance among providers and organizations will encourage better performance (Hughes, 2014).

Hughes (2014) concludes that the important component of quality improvement is a dynamic process that often employs more than one quality improvement tool. Thus, quality improvement requires five essential elements for success: fostering and sustaining a culture of change and safety, developing and clarifying an understanding of the problem, involving key stakeholders, testing change strategies, and continuous monitoring of performance and reporting of findings to sustain the change. Some health provider factors are explained below.

2.2.4.1 Understanding Communication

Woods *et al.* (2006) studied adolescent patients' satisfaction with care, perceptions of health care quality, and patient-provider communication. These researchers found that even as most of them seen in reproductive health settings constantly, reported that the concept was important to them, they felt reluctant to come for the service as they had little knowledge of the behaviour of the providers. The study, which used the Adolescent Patient-Provider Interaction Scale (APPIS) suggested that health providers' ability to communicate was an important tool, which providers should always use to communicate with the public to enhance the health care delivery (Woods *et al.*, 2006). This could help them to communicate effectively to their patients, which would go a long way to influence the relationship that patients have with their providers (Cho, 2014).

It was revealed in a study that the availability of information between the provider and management for patients increases their knowledge regarding their illness and treatment options, and being informed gives patients the opportunity to participate in shared decision making with clinicians and may help patients better articulate their individual views and preference (Reiling *et al.*, 2008). Reiling *et al.* (2008) report that most patients have expressed frustration with their inability to participate in decision making, to obtain information they need, to be received, and to partake in systems of care that are open to their needs, also when patient and providers are empowered it gives them the opportunity to participate in shared decision making with clinicians and may help patients better clear their individual opinions and favorites (Reiling *et al.*, 2008).

2.2.4.2 Understanding Long Lasting Relationship

A study revealed that market turbulence, competitive hostility and supplier power moderated the market orientation-performance relationship (Kumar, Subramanian, & Yauger, 1998). The growth in relationship as applicable to marketing was fueled by the writings of management consultants (Peppers, & Rogers, 1993). Peppers and Rogers (1993) note that mass customization of manufacturing technologies and applying them to marketing communications could encourage a one-to-one focus on 'share of customer' rather than the mass-marketer's 'share of market'. These researchers claim that this one-to-one interaction with customers could lead to improved life-time value (Peppers & Rogers, 1993).

Patient's satisfaction with a hospital's services is basically the patient's state of mind (Solayappan & Jayakrishnan, 2010). It is the ability of the providers to meet the

expectations of the patient that would enhance patients' satisfaction. Indeed, customer delight is all about exceeding the expectations of the patients to make them highly satisfied with the providers (Solayappan & Jayakrishnan, 2010). From the hospital's perspective, the customer/patient is any individual or institution who is an actual, potential or future user of the hospital and its various services. The patient in the hospital is very different from the regular customer, the difference being that they do not want to be patients in the first place. However, they are patients because their illness must be treated as such (Solayappan & Jayakrishnan, 2010).

The kind of relationship that is put in place between health providers and patients will require structures in order to assess the performance of the providers: this will help to measure standards in terms of capability and competency (O'driscoll, 2006). It is argued that having a strong interpersonal connection is believed to transfer knowledge easily between individuals and it will help the patient to ask for any clarification and also add his or her options during treatment modalities and does enhance quality of care, the more time and effort they are willing to put forth on behalf of each other, including effort in the form of knowledge transfer help to ease patient burden (Cummings & Teng, 200). These researchers also found that understanding of relationship influenced interpersonal relationships thereby generating good communication skills in order to investigate the influence that contextual network factors had on enhancing this relationship (Cummings & Teng, 200).

Inkpen and Tsang (2005) believe that as trust develops over a period of time, there could be an opportunity for knowledge to be generated and transferred to other members; and

trust could be built, which would depend only on the strength of a relationship. The presence of close interpersonal relationships in a business network will bring down the risks of opportunistic behaviour and mutual understanding would result, which could lead to open communication, sharing of information, ideas and knowledge (Wilkinson & Young, 2002).

The changes that occur during delivery of health service are been driven by formalizing marketing relationships between the patients and providers (Zolkiewski, 2004). Zolkiewski (2004) notes that managing these relationships is a critical and challenging task, which when performed well would improve the effectiveness and efficiency of service delivery. The researcher indicates that a hospital has to coordinate and adapt to the demands of the patients, which will help to build a long lasting relationship, and when that occurs it has the potential to become a powerful management tool. It is suggested that managers should pay particular attention to the process of adaptation because even as relationships develop and adaptations emerge, the ties between the organizations also grow (Zolkiewski, 2004).

2.2.4.3 Understanding Confidentiality

It could be argued that patients' consider issues of confidentiality when relating to health providers (Vargheese & Prabhudesai, 2014). This means that health providers should be very sensitive to how information about patients is being handled in the health sector as this will bring trust between the providers and the patients, leading to long lasting relationship (American Nurses Association, 1995). It is observed that for medicine to become real, there is the need to share information between providers and the patients

(Vargheese & Prabhudesai, 2014). Harrison-Cudjoe (2014) made a report that privacy during consultation in the healthcare delivery process would meet patients' satisfaction. A study by Nguyen (2014) revealed that patient satisfaction increased by 96.9%, when providers actually listened to the patients' problems and effectively discussed a care plan with them to ensure satisfaction.

However, the sharing of information across health care providers has no security as most of the patients hear the circulation of their condition all over the public sectors before they live the health facility (Vargheese & Prabhudesai, 2014). When it happens like that the patients access the service elsewhere. Therefore, understanding and ensuring confidentiality and integrity of the patient is very important as this could create a strong bond between providers and patients (Vargheese & Prabhudesai, 2014).

Vargheese and Prabhudesai (2014) observe that the healthcare information available to providers plays a crucial role in enabling better healthcare outcomes. The patient's willingness to share information is dependent on some level of guarantees that the patient expects. There should be trust between the patient and the provider and with the expectation that the provider will handle the information confidentially and responsibly. Therefore, the fundamental basis of a better outcome of health is to ensure trust, privacy and security (Vargheese & Prabhudesai, 2014). Viewing it from a different dimension, Manuel *et al.* (2006) argue that relational capabilities are steadily created as a result of a lasting relationship between two or more people. These researchers also state that a close relationship with a high level of trust and commitment between companies is necessary to develop relational capabilities.

2.2.4.4 Availability of Resources / Logistics

Globally, it has been argued that unavailability of resources / logistics in the hospital is one of the issues, which create confusion in health services delivery (Snow, 2009). Snow (2009) observes that the lack of appropriate logistics for providers to perform their duties could create stressful situation between the provider and the patient as the providers find it difficult to render the services. Snow (2009) reports that with the health commodity system in Nepal, the stock commodity for family planning was 8.2%, maternal and child health was 22.9% and the providers found it difficult to render the services as the patronage was high. This researcher suggests that the hospital should always ensure that there was enough logistics and there should be the availability of health commodity for health providers to work with at any point in time so as to produce quality healthcare (Snow, 2009).

Connett (2012) reports from a study conducted in Mozambique, that most of the health sectors did not have emergency drugs, vaccine and other material resources, which could be used to prevent some of their deaths. For instance, it was revealed that at the Kulula Health Centre in Mozambique, most of their clinic refrigerators were not functioning. Therefore, health care providers could not deliver any better services. This led to a situation where all the drugs, which required cool storage system, could not be stored. What happens is that almost all health providers at the Kulula Health Centre have to rely on providers who supply the surrounding communities with carrier bags. The researcher recommends that the government should make efforts to supply the community with refrigerators to enable health providers provide quality healthcare (Connett, 2012).

2.2.4.5 Workloads and Job Stress

Job-related stress is one of the factors, which has an influence on providers' relationship with patients and its consequential influence on quality of care in health care delivery (Better Health, 2014). This could be viewed from the perspectives of overwork, problems with immediate supervisor, uncertainty of work, lack of confidence, among others (Better health, 2014). These things could lead to fatigue, lack of interest, poor work done, laziness, low productivity and therefore, low internally generated fund (IGF). Job stress is a major issue these days and affects both health and productivity and happens when the individual capability is below expectation (Better health, 2014). According to National Health and Safety Commission in Australia (NHSC) a lot of money is paid to individuals who made claims to the government in Australia on work related issues, which in some way affected their health leading to morbidity (NHSC, 2005).

In identifying work-related stress, individuality also counts as people understand stressful situations differently: what one will claim to be stressful, another person will take it to be normal (NHSC, 2005). The commission states that lack of skills, uncondusive environment, lack of resources, delay or no promotion and poor relationship with co-workers or the supervisor could create stress in the workplace. The side effect is that a health provider who is stressed out might displace it on an innocent patient. Therefore, it is recommended that the hospital should ensure safe working environment, discuss bordering issues and take steps to solve them, organize periodic meetings and have recreational activities once in a while (NHSC, 2005).

2.2.4.6 Cost of Health Care

The costs of health care delivered or accessed are also taken into account by both providers and patients alike and as such should not be taken for granted (Steinberg *et al.* 1988). Steinberg *et al.* (1988) suggest that when costs are estimated from the perspective of Medicare, treatment strategies involving the use of either streptokinase or r&PA alone, even though they are more expensive than conventional treatment, result in additional lives being saved at a cost that is reasonably low and compares favourably with the increased cost per additional life saved associated with other common medical practices such as renal dialysis, which was \$54,000 per quality adjusted life year gained (Torrance, 1986; Steinberg *et al.* 1988).

On the other hand, treatment of a cholesterol level of 315 mg/dl in men ~50 years of age was \$56,000 to \$69,000 per year of life gained (Oster & Epstein, 1987; Steinberg *et al.* 1988). These researchers note that the costs to Medicare of alternative strategies for treatment of acute myocardial infarction are determined by the extent to which each treatment alternative shifts patients out of DRGs explicitly established for patients with myocardial infarction (DRGs 121, 122 and 123) and into higher paying DRGs associated with performance of bypass surgery (DRG 106) or angioplasty (DRG 112) [(Steinberg *et al.* 1988)].

Armour (2013) reports that it used to be a taboo to look like you were looking for money at a time when you were supposed to be focused on patient care. It also puts the employee or patient at risk of not getting the service because the deductible may be a barrier to care (Armour, 2013). Agbenorku (2012) found that some providers demand some form of

money before rendering services needed to patients. Some of the patients also think that it is the habit of the providers to take bribe: illegal money payment has become part of the healthcare delivery in Ghana. This researcher reports that patients complained that hospital staff demand unofficial monies from them before they could access quality care in the form of consultation fee, drug collection and other examinations in order to be attended to quickly.

2.2.4.7 Patronage of Patients in Health Facility

Patients' patronage in health care facilities could serve as a basis for health providers to be aware that they were providing quality of care and this could form the basis of a long-term relationship with them as well (Soliman, 1992; Morgan & Hunt, 1994). This explains why Morgan and Hunt (1994) propose that before marketing activities could achieve the ultimate goal, there was the need to establish and maintain a good customer and provider relationship, which could be applied in the health sector, especially the public hospitals in order to retain the patients.

A research on patients' evaluation of quality of care in general practice, and its cultural barriers among non-Western patients and Dutch-born patients revealed that the non-Western patients perceived that the quality of care was poor as they were not satisfied with the care rendered to them while the Dutch-born rated it as one of the best care (Harmsen *et al.*, 2008). The researchers concluded that patients' cultural values should be considered when caring for them because the non-Western patients' cultural values were not taken into consideration when caring for them and they preferred to visit a different facility next time (Harmsen *et al.*, 2008). A study revealed that providers were very arrogant

professionals, especially nurses, midwives, and generally female health providers as having a poor attitude towards pregnant women. With regards to maltreatment during delivery, ownership of the health facility emerged as a major determinant (Essendi, 2011).

2.2.5 Patient Factors

This section analyses factors that enhance patients' satisfaction (in other words, quality of care) with their relationship with health care providers. It is suggested that providers should understand the patient's perspectives and should appreciate their relationship orientation (Palmatier *et al.*, 2007). Palmatier *et al.* (2007) explain that patients' needs and desire for relationship could help them to enjoy significant benefits from the services being rendered to them. For instance, if the patient/customer has a low need, any investments in long-term relationship will not only generate poor output, but can actually damage the exchange by increasing customer perception of exchange inefficiencies (Palmatier *et al.*, 2007). Some elements are used to explain how patients measure their satisfaction (in other words, quality of care) with the health care they receive based on their relationship with health providers. These include: reception of staff, staff attitude, waiting time, competence and expertise of staff, hospital's environment and overall hospital's services as explained below.

2.2.5.1 Reception of Staff

A cordial reception accorded patients when they visit the health facility helps to improve their relationship and satisfaction with the health care they receive: this could happen if there was effective communication and information sharing (Woods *et al.*, 2006). Nwabueze *et al.* (2010) found that 8.7% of the patients said that providers were non-

discriminatory, friendly and helpful. Another study found that 35.1% of the respondents said that the nurses were always available at the OPD, while 50.2% also said the nurses were sometimes available (Aboagye, 2013). A report in health care disparities (NHCD, 2012) shows that providers are bias when it comes to the individuality of the patient and their expectation. Another study by Nguyen (2014) indicated that the providers actually listened to the patients' problems and effectively discussed a care plan for future follow-up visits and the providers were still passionate and dedicated in providing the best care possible which was greatly received by their patients.

Some analysts propose that in any inter-cultural organizational environments like health care facilities, one of the most critical issues that require attention is communication among employees of different linguistic and cultural backgrounds (Cho, 2014). Cho (2014) notes that in such intercultural contexts, information-seeking behaviours could be critically affected by the cultural backgrounds of both the information-seekers and providers. This researcher explains that this is mainly because such behaviours are influenced by the information-seekers' perceptions of the various characteristics like accessibility, expertise, affordability, among others, from the providers (Cho, 2014).

Namkoong *et al.* (2010) examined the effects of exchanging treatment information and suggest that attention had to be paid to psychological factors as these could worsen the condition and the effects of treatment. They suggest that one possible moderator of these effects may be self-efficacy, which has been considered to be positively associated with emotional well-being. It is believed that one's capability to produce desirable outcomes is to look into the self-efficacy of the patient, which forms an important cognitive

mechanism when dealing with ill health. The truth is that when patients seek information about their condition, and are able to ask right questions to get right answers, they get well early: this will prevent future complications (Namkoong *et al.*, 2010).

2.2.5.2 Staff Attitudes

It is anticipated that patients are aware of what to expect at any point in time. Therefore, a positive attitude from health providers would help influence the patient to create a long-term relationship with the health provider (Albers, Francke, Veer, Bilsen, & Onwuteaka-philipsen, 2014). Albers *et al.* (2014) reveal that patients described their physicians' reactions as nearly uniformly positive when they asked about a prescription drug. In addition, the study found that over 90% of respondents indicated that their doctor welcomed their questions, and 83% noted that the doctor responded as if their questions were a normal part of the visit (Albers *et al.*, 2014).

It would be remembered that most often, it is the nurses who are closer to the patients. This is why the findings of a study conducted in Flanders, suggest that nurses have an important role to play when it comes to the care of the patients (Albers *et al.*, 2014). However, nurses' work setting seems to be related to their attitudes as most of them do not want to involve themselves when the patients have to make a decision during the last days of their life. On the other hand, it was found that Dutch nursing staff displayed a good attitude and relationship towards their patients during the last days irrespective of their socioeconomic background (Albers *et al.*, 2014). However, a study at the University Hospital at Legon, Ghana, found that 18% of the patients expected the nurses to be polite to them in all their interaction, which was not so (Dzomeku *et al.*, 2013). Dzomeku *et al.*

(2013) report that nurses were scored very low: 14% for the type and amount of information given about patients' condition and treatment; and 73% of patients expected to be treated with love and dignity, which they did not receive.

2.2.5.3 Waiting Time

A study conducted in Nigeria, revealed that waiting time in the developing countries, has been demonstrated to be long and constitutes a major dissatisfaction with medical care delivery and a barrier to further use of health care facility by affected patients (Ajayi, 2002). Ajayi (2002) notes that long wait was prevalent in health care system where patients were not given a specific time. This researcher mentions some of the contributing factors to such long waiting time as: heavy workload in the hospital sectors, where a doctor has to see about 40-60 patients a day as compared to 16 patients a day by a doctor in developed countries. A related study carried out at a Saudi Arabian hospital's outpatient department revealed that patients preferred the provision of health education programmes during the waiting period (Ajayi, 2002). It was revealed however, that individual uniqueness had to come into play as some of the patients preferred other things due to their cultural values, socioeconomic status, literacy levels and religious background: these may differ from country to country (Ajayi, 2002).

Atinga *et al.* (2011) identified in their study that waiting time could be as a result of medical and administrative procedures and this could predict patients' satisfaction with quality of healthcare delivery. This means that service delivery with no or little waiting time is what most of the patients want, but when they do not get it that way, they tend to complain about their satisfaction. These call for the need for the hospital to consider and

re-engineer its operations to ensure that these factors were managed so as to meet the satisfaction of patients. When the number of staff is reduced, the workloads of those remaining become higher, and less likely to be accomplished successfully (Atinga *et al.*, 2011).

A study conducted in Ghana and Zimbabwe revealed that the workload of midwives increased, which led to poor quality of services rendered to patients: this in effect increased patients' waiting time, which made the patients unsatisfactory (Awases *et al.*, 2004). The emphasis on longer waiting time implies that it will raise opportunity costs of medical care and might delay medical intervention. A study in Zimbabwe, found that over a quarter of health workers believed that longer waiting time had resulted in unnecessary deaths: they also believed that prompt attention could have prevented them (Chikanda, 2004).

Chikanda (2004) reports that waiting time was a problem in most health centers in Africa: Ghana is not exempted. Meanwhile, most of the private hospitals have increased the number of their staff in order to reduce waiting time. However, it is indicated that public hospitals deal with the issue by rather sending some of the less serious cases (patients) home to return the next day (Chikanda, 2004). Conner-spady *et al.* (2005) suggest that to improve the fairness, timeliness, and waiting-time, the management of Western Canada hospital had to develop priority criteria scores and link them to maximum acceptable waiting times. These could be compared based on patients' and physicians' perspectives on maximum acceptable waiting time for different levels of urgency (Conner-spady *et al.*, 2005).

2.2.5.4 Competence and Expertise of Staff

Although it is difficult for patients to effectively rate the competencies and expertise of health providers due to lack of technical knowhow, their satisfaction with the relationship and services accessed could still be measured based on perception of the professional competence and expertise of the providers (American Nurses Association, 1995). A study by Nwabueze *et al.* (2010) revealed that only 12.7% of patients received effective treatments.

Researchers Ääri, Tarja and Helena (2008) explain that clinical and professional competence in intensive and critical care nursing can be defined as a specific knowledge base, skill base, attitude and value base and experience base of intensive and critical care nursing. Clinical competence can be divided into three and professional competence into four constituent domains. In clinical competence, these are the principles of nursing care; clinical guidelines; and nursing interventions. In professional competence, the domains are ethical activity; decision-making; development work; and collaboration (Ääri *et al.*, 2008).

Cescutti-Butler and Galvin (2003) studied parents' perceptions of staff competency in a neonatal intensive care unit and identified four key themes, which conceptualize competency as caring: parents are facilitated to integrate into the unit and do not feel a burden; parents feel in control whilst in the unit; parents have a choice to opt out from observing tasks and procedures on their baby; parents and the inter-professional team communicate well and provide appropriate information. These researchers conclude that parents' perceptions of competence in a professional are not based solely on skills and tasks but on many caring behaviours (Cescutti-Butler & Galvin, 2003).

2.2.5.5 Hospital's Environment

The environment within which health care is delivered must seek to contribute to patients' satisfaction since patients use the health care environment to assess quality of care (Lohr & Schroeder, 1990; Hughes, 2014). For example, the work environment in which nurses provide care to patients can determine the quality and safety of patient care (Hughes, 2014). Bogaert *et al.* (2014) suggest that for providers to achieve superior quality of care, the environmental factors like workload, burnout, respect of individual opinion and social factors, should be considered during the care of patients because they could affect the quality of care. The study by Nwabueze *et al* (2010) at Onitsha (Nigeria) found that 18.7% of respondents mentioned neatness of hospital, which increased their satisfaction level. Ofosu-Kwarteng (2012) reports that whilst 67% of the participants described the environment as clean and very clean, 64.6% described the washroom as dirty and very dirty, but 61% was willing to repeat visit to the same facility when they are sick.

Other researchers also look at it from the perspective of safety and note that the necessity for quality and safety improvement initiatives permeates health care (Hughes, 2014). Hughes (2014) explains that the importance of having strong leadership commitment and support cannot be overstated. This researcher notes that leadership needs to empower staff, be actively involved and continuously drive quality improvement. The idea is that without the commitment and support of senior-level leadership, even the best intended projects are at great risk of not being successful. The researcher recommends that champions of the quality initiative and quality improvement need to be throughout the organization, but especially in leadership positions and on the team (Hughes, 2014).

Hughes (2014) suggests that understanding the complexity of the work environment and engaging in strategies to improve its effects is paramount to higher-quality, safer care. This researcher observes that high-reliability organizations that have cultures of safety and capitalize on evidence-based practice offer favourable working conditions to nurses and are dedicated to improving the safety and quality of care. As to how the environment could affect the perception of patients with regards to their assessment of quality of care, it is noted that a culture of safety and improvement that rewards improvement and is driven to improve quality is important (Hughes, 2014).

2.2.5.6 Hospital's Provision of Service

Soliman (1992) concludes that technical interventions influence patients' ratings of the overall quality of healthcare. The kind of service delivered to patients constitutes one measure of patients' satisfaction or assessment of quality of care (Boscarino, 1992; Ayanian & Weissman, 2002). This indicates why hospitals, especially teaching hospitals are widely reputed to provide high-quality care (Boscarino 1992). A study observes that the provision of perceived quality of care was based on public and professional views, which might reflect features of teaching hospitals that are perceived to foster a higher quality of care, including the treatment of rare diseases and complex patients, the provision of specialized services and advanced technology and the conduct of biomedical research (Neely & McInturff, 1998; Ayanian & Weissman, 2002).

In order to avoid mistakes in the care of patients, it is expected that they (patients) are told what happens; and any resulting changes in their care should be discussed with them and appropriate measures taken to prevent future occurrence (Bogaert *et al.*, 2014). Heaney,

Black, O'Donnell, Stark and van Teijlingen (2006) observe that recent developments within the United Kingdom's (UK) health care system have re-awakened interest in community hospitals (CHs) and their role in the provision of health care and note that while lack of evidence on CHs does not imply lack of effect, there was an urgent need to develop a research agenda that could address the key issues of health care delivery in the CH setting.

In line with previous studies, this study considers long-term relationship orientation of health providers and patients in relation to organizational learning as intangible organizational resources that could enhance patients' satisfaction with health care services accessed. A study on this issue is currently, lacking in the literature.

2.3 Chapter Summary

The chapter has reviewed existing literature on the topic under study. The concepts informing the study have been explained as well. The gaps in the previous studies formed the basis of a study of this nature. The next chapter presents the research methods applied to gather primary data for subsequent analysis.

CHAPTER THREE

METHODS

3.0 Introduction

This chapter presents the methods and strategies that were applied to collect primary data for analysis. Section one presents the study type and design. Section two describes the study location. Section three presents the sampling strategy. Section four describes the study population. Section five explains the variables. Section six indicates the sample size determination. Section seven presents the data collection technique (administration of questionnaire). Section eight explains data analysis. Section nine explains the quality control issues, including the pretest / pilot study. Section ten presents how the ethical issues were addressed. Section eleven is the chapter summary.

3.1 Study Type and Design

The study was designed to throw empirical light on the structure of satisfaction constructs in the context of health care delivery. A cross sectional survey was conducted and anyone who met the criteria was selected for the study. Thus, the study adopted a quantitative research method so as to explore the relationship between providers and patients and how this could enhance patients' satisfaction or quality of care. Even though quantitative research is widely used in research, it is criticised for being good for quantification, but very weak in dealing with social complexities of phenomenon (Bryman, 2013).

Nevertheless, this strategy was adopted because the main assumption of this approach is that there is the presence of objective truth in the world that could be unraveled scientifically. Furthermore, quantitative research strategy was applied because it seeks to statistically and systematically measure the relationship between variables in order to

support or reject some pre-defined hypotheses (Bryman, 2013; Silverman, 2013). Thus, the study employed quantitative research methods using questionnaires to collect empirical data from health providers and patients at the Regional Hospital, Koforidua.

3.2 Study Location

The study was conducted at the Regional Hospital, Koforidua in the Eastern region. The Eastern region has 26 districts of which Koforidua is the capital. Koforidua Municipal is the smallest, but densely populated in the region. The square kilometre is about 1428 and covering a land area of 110.0 square with a projected population of 191,525 by 2013 (Regional statistical services).

The Regional Hospital is built in the centre of the Koforidua town and has staff number of 821, excluding National Service Personnel. The breakdown of the staff numbers is as follows: medical doctors (62), nurses (261), supporting staff (248) and non-mechanized staff (242). The hospital has a bed capacity of 340 and its average daily attendances were 646 as at 2012; and 586 in 2013 (Hospital records, 2013). However, this shows a decline, which the study will help to find if poor relationship could be one of the contributing factors. In addition, annual attendances were 185,952; and 168,763 in 2012 and 2013 respectively. The hospital has the following departments/units: two outpatient departments, a medical unit, a surgical unit, obstetrics and gynaecology unit, physiotherapy unit and a laboratory unit, among others. The Eastern region is depicted in figure 2.1 below.

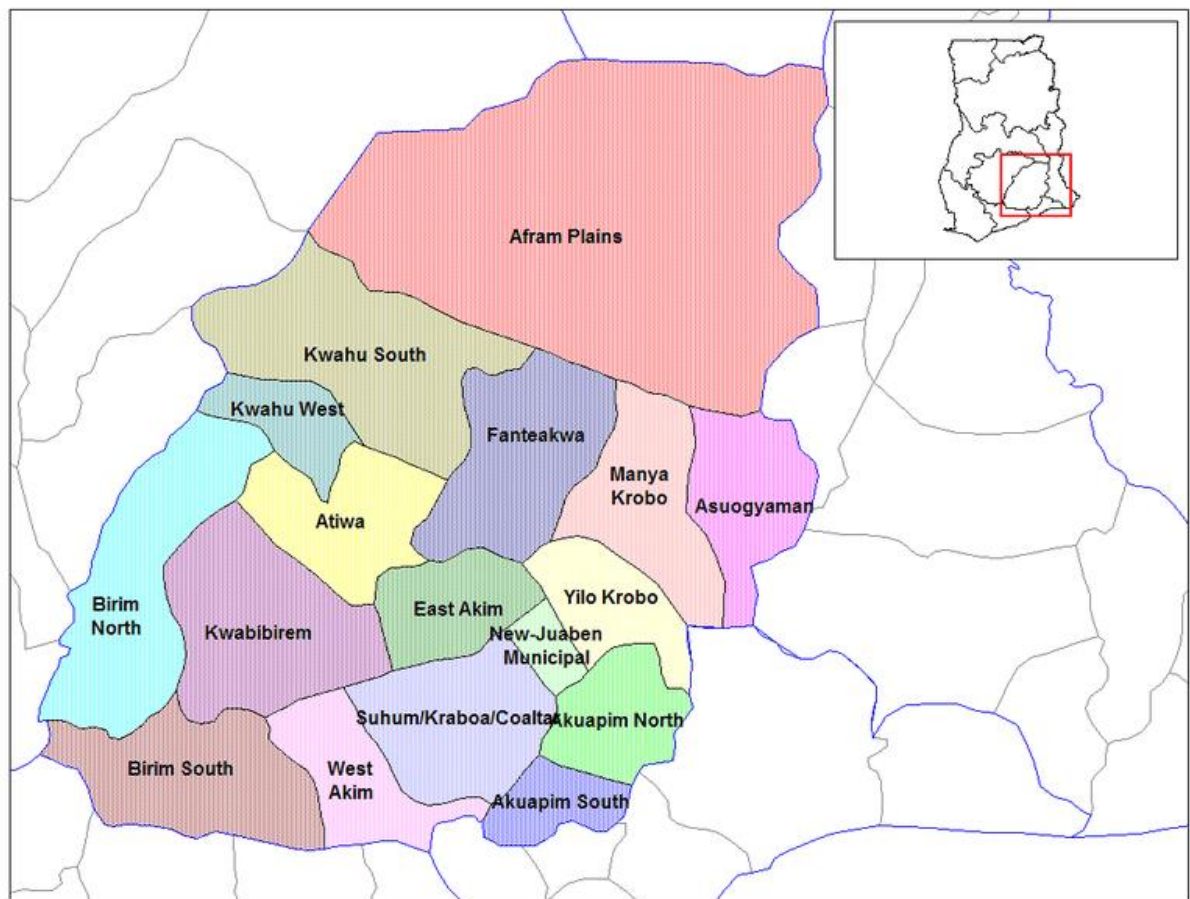


Figure 2.1: Map showing Eastern Region where Regional Hospital, New Juaben Municipality (Koforidua is located). Source: Wikipedia.org

3.3 Sampling Strategy

Simple random sampling technique was applied to select health workers and patients at the Regional Hospital, Koforidua as research participants. Pieces of paper with names of the participants in the register were put in a bowl and the research assistant randomly picked some for the study. It was done for both providers and patients at the hospital. This strategy assisted in a fair selection of research participants. Those who were available at the time of the study and were willing to participate were involved.

3.4 Study Population

The study population consists of mainly the health providers and patients of the Regional Hospital, Koforidua. The provider participants include: doctors, nurses, paramedics, and non-mechanized staff. All together, these staff constituted a total of 821, excluding national service personnel. The breakdown is as follows: medical doctors (62), Nurses (261), Supporting Staff (248) and non-mechanized staff (242). The patient participants include both in-patients and outpatients.

3.5 Variables

The dependent variable was patient satisfaction. In addition to the socio-demographic characteristics of both health providers and patients, the independent variables were based on both patient factors and health provider factors as presented below. Meanwhile:

Long term relationship: A bond or link between a provider and a patient where they understand each other.

Satisfaction: A patient is happy about the services rendered to him or her.

3.5.1 Dependent Variable

Patient Satisfaction

3.5.2 Independent Variables

1. *Patient Factors*

2. Reception of staff

3. Staff attitude

4. Waiting time
5. Competence and expertise of staff
6. Hospital's environment
7. Hospital's services

3.5.3 Independent Variables

Health Provider factors

1. Communication
2. Long lasting relationship
3. Confidentiality
4. Availability of resources / logistics
5. Workloads and job stress
6. Cost of healthcare
7. Patronage in service provision
8. Overall provision of service

iii

These were measured to find answers to respond to the research questions so that the objectives of the study could be addressed.

3.6 Sample Size Determination

Two different sample sizes are determined: providers and patients as presented below.

3.6.1 Sample size for Health Providers

The sample size was based on the population of the Eastern region as the Regional Hospital is the main referral centre. The regional population is: 191,525. Therefore, the formula for calculating the sample size is: $N = \frac{z^2 pq}{d^2}$, where:

N = Sample size.

$$q = (1 - p) = (1 - 0.084) = 0.916.$$

z = Reliability coefficient, which is 95% confidence level.

p = proportion of providers, which is 0.084.

$$pq = (0.084)(0.916).$$

d = Error tolerance, which is 0.05.

By substituting the values into the stated formula:

$$N = \frac{(1.96)(1.96)(0.084)(0.916)}{(0.05)(0.05)}$$

$$= \frac{(3.8416)(0.0769)}{0.0025}$$

$$= 118$$

Total sample size estimated = 118 providers.

3.6.2 Sample Size for Patients

The sample size was based on the population of the Eastern region as the Regional Hospital is the main referral centre. The regional population is: 191,525. Therefore, the formula for calculating the sample size is: $N = \frac{z^2 pq}{d^2}$, where:

N = Sample size.

$q = (1 - p)$.

z = Reliability coefficient, which is 95% confidence level.

p = attendance rate 88%.

$pq = (0.88)(0.12)$.

d = Error tolerance, which is 0.05.

By substituting the values into the stated formula:

$$N = \frac{(1.96)(1.96)(0.88)(0.12)}{(0.05)(0.05)}$$

$$= \frac{(3.8416)(0.1056)}{0.0025}$$

$$= 162$$

Then 5% was calculated on the 162 for margin of error. The result was 8, which was added to arrive at 170. Therefore, the total sample size estimated = 170 patients.

3.7 Data Collection Technique (Questionnaire Design and Administration)

The fieldwork took place between May and June, 2015. The questionnaire was designed in sections taking into account the independent variables indicated above (refer to 3.5. to 3.5.3). Two sets of questionnaires were developed for both the health providers and the patients and were close-ended questions using Likert Scale format (see appendices C and D). In addition to the independent variables, the following demographic characteristics were included. For patients: age, sex, educational level, occupation, religion, among others; and for health providers: age, sex, educational level, professional status, among others. Two research assistants were trained to help with the interviewer-administered questionnaires. Duration for each questionnaire was between 10 and 15 minutes at the hospital.

3.8 Data Analysis

The returned questionnaires were coded, cleaned and edited before analysis. Data analysis was done using statistical package for social sciences (SPSS) version 20. The data collected was sorted into themes and information checked for completeness and consistency. Descriptive statistics of participants are presented using cross tabulation to ensure easy understanding. Both univariate and bivariate analyses were performed for both the health provider and patient factors. Thus, Chi-square test was conducted to compute the proportions on understanding of long-term relationship between providers and patients and its effect on patients' satisfaction with health care delivery. This is to say that bivariate associations between health provider factors and patient satisfaction on one hand as well as patient factors and patient satisfaction were determined.

Statistically, logistic regression method was applied to estimate the levels of significance of the findings. Odds ratios were computed using Logistic regression analysis to determine the strength of association between patients' satisfaction and waiting time, providers' attitude, competency, and hospital environment. Logistic regression was used to investigate the overall effect of the independent variables on the outcome variable. This helped to unveil the true effects of each independent variable. The results are presented using tables to show diagrammatic representation of responses.

3.9 Pretest / Pilot Study

As part of ensuring quality control and validity and reliability, a pilot study was done at the Koforidua Polyclinic to know what to add or remove from the questionnaire and also the reaction of the respondents in order to verify acceptability and their collaboration with the study.

3.10 Ethical Consideration

Ethical issues involved in the study were addressed by doing the following:

1. A letter of introduction from SPH was sent to the Regional Director of Health Services, Eastern region, to seek permission to use the health facility for the data collection.
2. A similar letter was delivered to the Medical Director of the Regional Hospital, Koforidua who disseminated the information to the health providers for participation in the study.

3. Ethical clearance was sought from the Local Ethics Review Committee of the Ministry of Health / Ghana Health Service (MOH/GHS) as a requirement to conduct a research on a health facility.
4. The purpose of the study was provided to the research participants. A participants' consent form was designed and used for the participants (see appendices A and B).
5. Participants were assured of confidentiality and anonymity of the information provided.

3.10.1 Quality Control

To ensure reliability and validity of the data, a well-designed questionnaire containing all the details necessary to achieve the set objectives assisted in obtaining the right information from providers and patients. The research assistants were people who are knowledgeable and were trained for the data collection. However, daily checking and monitoring was done to ensure high quality.

3.10.2 Subjects of the Study

The study subjects include health providers working and patients attending the Regional Hospital, Koforidua, during the period of the study. Selection was based on participants' availability and willingness to be involved in the study.

3.10.3 Exclusion Criteria

The providers and patients below 20 years of age and those with special appointments at the facility.

3.10.4 Privacy and Confidentiality

Participants were informed that privacy and confidentiality would be ensured as no names would be mentioned. Participants were assured that all information provided would be kept confidential. They were assured that the outcome of the study would be very beneficial to individuals who access the facility as a whole and that most of their problems would be solved as this would ensure patient satisfaction at the hospital.

3.10.5 Data Storage and Usage

Participants were assured that the information gathered would be kept by the principal investigator and used to assess the facility and any amendment needed to be instituted to help provide better health care. The data was stored on devices such as CDs and memory sticks for reference purposes. The data would be discarded after a period of five years.

3.10.6 Compensation

The participants were informed that participation in this study would not lead to any harmful effect. Therefore, participation did not attract any compensation.

3.10.7 Conflict of interest

The principal investigator declares that there was no conflict of interest to disclose.

3.10.8 Risks and Benefits

Participants were informed that the information they provide would help the researcher to understand the state of long-term relationship and its effect on health service delivery. The information would be beneficial in the long run as it would arouse the interest of policy makers to pay more attention to patient satisfaction. Thus, their participation in the study did not involve any risk or cost.

3.10.9 Participation in the Research

Participants were informed that their participation in the study was voluntary and their decision not to volunteer would not influence the nature of the ongoing relationship they have with the investigator or the School of Public Health, either now or in the future.

3.11 Chapter summary

The chapter has presented the methods, especially quantitative research method used in collecting primary data for the study. The next chapter presents the results of the study.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the results of the study conducted with health personnel and patients at the Regional Hospital, Koforidua. The chapter is divided into seven sections. Section one presents the results of demographic characteristics of patient respondents. Section two presents factors influencing long term relationship among health providers and patients. Section three presents the results of the relationship between the devised long term relationship indicators and patient satisfaction. The results are also related to how these indicators influence long term relationship among health providers and patients at the Regional Hospital, Koforidua. Section four presents results of demographic characteristics of health provider respondents. Section five presents the results of health providers' perception of satisfaction with performance of healthcare delivery and how these influence patient satisfaction with healthcare accessed. Section six presents analysis of logistic regression. Section seven presents the chapter summary.

4.1 Socio-Demographic Characteristics of Patient Respondents

This section presents results of the analysis as related to the demographic characteristics of patient respondents. The results are presented according to the key variables used as shown in table 4.1.

The results in table 4.1 show that a total of 170 patients responded to the study giving a response/return rate of 100% (170/170). From this, 34 out of 170, representing 20.0% were in the age range 40-44 years as the highest. The rest were 15 (8.8%) fell in the age range 35-39 years, 20 (11.8%) in the age range 20-24 years, 20 (11.8%) in the age range

25-29 years and 20 (11.8%) in the age range 45-49 years. Moreover, the results show that 21 (12.3%) were in the age range 30-34 years, 19 (11.2%) were in the age range 50-54 years and 21 (12.3%) were in the age range 55 years and above. The mean age was 45.5years.

The results indicate that females constituted the highest respondents: 88 out of 170 (51.8%) while males were 82 (48.2%). This means that the females visit the facility frequently as they send their children and relatives to the hospital than the males.

The results revealed that most of the respondents: 90 out of 170 (52.9%) were married. The results also show that 29 (17.1%) were widowed, 26 (15.3%) were divorced and 25 (14.7%) were single, which formed the lowest group of respondents, indicating that the divorced are also encouraged to remarry. The highest number of respondents been married can be explained that it is in response to the expectations that each person is supposed to get married at a specific age in accordance with the traditions of the people (society) in the study area.

The results show that majority of respondents: 95 out of 170 (55.9%) were government workers, 48 (28.2%) were self-employed while the minimum number of respondents: 27 (15.9%) were unemployed.

The results show that 76 out of 170 (44.7%) been the highest number of respondents had attained secondary/technical level of education while the least number of respondents: 25 (14.7%) had obtained tertiary level. Then 36 (21.2%) had no-formal education, and 33 (19.4%) had achieved basic level of education.

The results as indicated in table 4.1 show that the study was participated mostly by Christians who were 122 out of 170 (71.8%), followed by Muslims who were 48 (26.5%) and traditionalist who were also 3 (1.8%).

Table 4. 1: Socio-demographic Characteristics of Patient Respondents

Category	Frequency	Percent (%)
Age		
20 -24 years	20	11.8
25-29 years	20	11.8
30-34 years	21	12.3
35-39 years	15	8.8
40-44 years	34	20.0
45-49 years	20	11.8
50-54 years	19	11.2
55 years and above	21	12.3
Total	170	100.0
Sex		
Male	82	48.2
Female	88	51.8
Total	170	100.0
Marital Status		
Single	25	14.7
Married	90	52.9
Divorced	26	15.3
Widowed	29	17.1
Total	170	100.0
Occupation		
Government employed	95	55.9
Self-employed	48	28.2
Unemployed	27	15.9
Total	170	100.0
Educational Level		
No-formal	36	21.2
Basic	33	19.4
Secondary/Technical	76	44.7
Tertiary	25	14.7
Total	170	100.0
Religious Status		
Christian	122	71.8
Muslims	45	26.5
Traditionalist	3	1.8
Total	170	100.0

4.2 Factors Influencing Long Term Relationship among Health Providers and Patients

This section presents results of the analysis related to factors influencing long term relationship among health providers and patients at the Regional Hospital, Koforidua. In other words, the analysis shows that the indicators used to assess patients' satisfaction with healthcare services delivery could also be used as a basis for measuring long term relationship between health providers and patients at the Regional Hospital, Koforidua. These are shown in table 4.2.

4.2.1 Patients' Satisfaction with Reception of Health Providers

This indicator analysed responses related to how patients' satisfaction with reception of staff in delivering healthcare could lead to establishing long term relationship between health providers and patients at the hospital. The results show that 79 out of 170 (46.5%) respondents indicated that they were 'satisfied', which constituted the highest number of responses. Then 56 (32.9%) answered 'very satisfied', 14 (8.2%) indicated 'not at all satisfied' and 21 (12.4%) indicated 'uncertain' to the question posed. This shows that patients' are satisfied with the reception they receive from the facility. The results are shown in table 4.2.

4.2.2 Patients' Satisfaction with Health Providers' Attitude

The results of patients' satisfaction with health providers' attitude at the hospital are detailed in table 4.2. A highest number of respondents: 58 out of 170 (34.1%) showed 'uncertain', followed by 57 (33.5%) who indicated 'not at all satisfied', 41 (24.1%) noted 'satisfied', and 14 (8.2%) said 'very satisfied' to the statement that their satisfaction with

health providers' attitude in delivering healthcare would encourage long term relationship with health providers at the hospital. It was deduced from the study that patients' were indifferent at the providers' attitude and its influence on long term relationship. Thus, patients' satisfaction with health providers' attitude **was** mixed.

4.2.3 Patients' Satisfaction with Waiting Time

The results of patients' satisfaction with waiting time and how it could ensure long term relationship with health providers in delivering healthcare at the hospital are provided in table 4.2. A highest number of patient respondents: 67 out of 170 (39.4%) noted 'not at all satisfied', which was followed by 60 (35.3%) been 'uncertain', 35 (20.6%) showed 'satisfied', and 8 (4.7%) said 'very satisfied'. This implies that while patients believe that waiting time may not influence long term relationship with health providers, they were also not satisfied with the waiting time at the facility.

4.2.4 Patients' Satisfaction with Competence and Expertise of Health Providers

The results of the analysis of the above indicator are contained in table 4.2. The results reveal that 87 out of 170 (51.2%) patient respondents showed 'satisfied', which was the highest of responses. This was followed by 43 (25.3%) who indicated 'very satisfied', 34 (20.0%) who showed 'uncertain', and 6 (3.5%) who also indicated 'not at all satisfied' to the observation that satisfaction with the competence and expertise of health providers in delivering healthcare will contribute to long term relationship with health providers at the hospital. This shows that patients' were satisfied with competence and expertise of providers.

4.2.5 Patients' Satisfaction with Hospital Environment

The results of analysis of the above indicator are included in table 4.2. The results portray that majority of the respondents: 138 out of 170 (81.2%) did indicate 'very satisfied' whilst 32 (18.8%) confirmed 'satisfied' to the fact that satisfaction with the hospital environment plays an important role towards improving long term relationship with health providers as well as affected their perception of satisfaction with healthcare delivery at the hospital. This implies that patients' were satisfied with the hospital environment.

4.2.6 Patients' Satisfaction with Overall Assessment of Hospital's Services

The above indicator helped assess how patient respondents' satisfaction with the overall services of the hospital could lead to forming long term relationship with health providers. The results reveal that a highest number of respondents: 128 out of 170 (75.3%) noted they were 'satisfied' with the services rendered to them at the facility whereas 42 (24.7%) indicated they were 'dissatisfied' with the provision of services at the hospital. This shows that patients are satisfied with the overall service provision. The results are captured in table 4.2.

Table 4. 2: Factors Influencing Long Term Relationship (Indicators) and Patient Satisfaction

Variable		Patient Satisfaction		Chi-square	df	Sig.
		N	%			
Reception of Health Providers	Not at all satisfied	14	8.2	11.932	3	0.008
	Uncertain	21	12.4			
	Satisfied	79	46.5			
	Very satisfied	56	32.9			
	Total	170	100.0			
Health providers' attitude	Not at all satisfied	57	33.5	10.99	4	0.027
	Uncertain	58	34.1			
	Satisfied	41	24.1			
	Very satisfied	14	8.2			
	Total	170	100.0			
Waiting time	Not at all satisfied	67	39.4	28.022	4	0.001
	Uncertain	60	35.3			
	Satisfied	35	20.6			
	Very satisfied	8	4.7			
	Total	170	100.0			
Competence and expertise of health providers	Not at all satisfied	6	3.5	1.358	2	0.507
	Uncertain	34	20.0			
	Satisfied	87	51.2			
	Very satisfied	43	25.3			
	Total	170	100.0			
Hospital's environment	Satisfied	32	18.8	4.953	2	0.084
	Very satisfied	138	81.2			
	Total	170	100.0			
	Dissatisfied	42	24.7	2.496	3	0.004
	Satisfied	128	75.3			
	Total	170	100.0			

4.3 Relationship between Long Term Relationship (Indicators) and Patient Satisfaction

This section presents the bivariate analysis as shown in table 4.2. Bivariate analysis was conducted to check the level of significance of the relationship between the independent variables: reception of health providers; health providers' attitude; waiting time; competence and expertise of health providers; hospital environment; and overall assessment of hospital's services and the dependent variable: patients' satisfaction. In other words, the analysis show the level of significance of the relationship between long term relationship and patients' satisfaction with health providers and healthcare provision at the Regional Hospital, Koforidua. The statistical test used was Chi Squared Test of Association. The level of significance was at 95% confidence interval (CI) with alpha level been: p -value should be less than 0.05 ($p < 0.05$).

4.3.1 Reception of Health Providers and Patient Satisfaction.

Results in table 4.2 show the level of significance of the relationship between the independent variable reception of health providers and the dependent variable patient satisfaction. In other words, reception of health providers has an influence on long term relationship at the facility. The p -value of 0.008 was significant at 95% CI. This means that there is a relationship between reception of health providers and patient satisfaction or long term relationship at the facility.

4.3.2 Health Providers' Attitude and Patient Satisfaction

Table 4.2 displays the results of the relationship between the health providers' attitude and its influence on patient satisfaction or long term relationship at the facility. The p -value was 0.027, which was significant at 95% CI. This means that there is relationship between the independent variable health providers' attitude and the dependent variable patient satisfaction. Therefore, health providers' attitude has influence on long term relationship.

4.3.3 Waiting Time and Patient Satisfaction

Table 4.2 shows results of the analysis of the relationship between the independent variable waiting time and the dependent variable patient satisfaction at the facility. The p -value was $p < 0.001$, which was very significant at 95% CI. This means that waiting time has a relationship with patient satisfaction or influences long term relationship at the facility.

4.3.4 Competence and Expertise of Health Providers and Patient Satisfaction

As seen from table 4.2, the results of the analysis of the relationship between competence and expertise of health providers and its influence on long term relationship are shown. The p -value was 0.507, which was not significant at 95% CI. Therefore, the argument is that patients' are not satisfied with the competence and expertise of providers' and therefore, it is not possible for competence and expertise of providers to influence long term relationship.

4.3.5 Hospital Environment and Patient Satisfaction

Analysis of the relationship between hospital environment and patient satisfaction as well as its associated influence on long term relationship was ranked. The results are shown in

table 4.2, which shows the p -value of 0.084, which was not significant at 95% CI. This could be explained that there was no relationship between hospital environment and patient satisfaction and its corresponding influence on long term relationship.

4.3.6 Overall Hospital's Services and Patient Satisfaction

Table 4.2, shows respondents' response to the relationship between overall hospital services and patient satisfaction as well as its related influence on long term relationship. The p -value was 0.004, which was significant indicating that there was a relationship between overall hospital services and patient satisfaction and its connected influence on long term relationship.

4.4 Socio Demography Characteristics of Health Provider Respondents

This section presents the analysis relating to socio-demographic characteristics of health providers of the Regional Hospital, Koforidua, who participated in the study. The results show that a total of 118 health providers participated in the study at the hospital. The response/return rate was 100% (118/118). The results are presented according to the key variables used in table 4.3 below.

The results show that 27 out of 118 (22.9%) health respondents fell between the age group 40-44 years and it constitutes the highest of all the groups. The rest were: 11 (9.3%) were in the age group 20-24 years, 20 (16.9%) in the age group 25-29 years, 24 (20.3%) in the age group 30-34 years, 19 (16.1%) in the age group 35-39 years, 9 (7.6%) in the age group 45-49 years, 5 (4.2%) in the age group 50-54 years and 3 (2.5%) in the age group above 55 years. This means that most of the respondents were relatively matured and had worked for a number of years with considerable experience. The mean age was 37.9 years.

The results show that most of the health provider respondents were females: 69 (58.5%) whilst males were 49 (41.5%). The results also indicate that more than half were married: 90 (76.3%). There were 24 (20.3%) who were single while 1 (0.8%) was divorced and 3 (2.5%) were widows. The greater number of respondents been married responded to the culture and traditions of the study location as the people believe in marriage than being single to the extent that even divorcees and widows/widowers are encouraged to remarry.

The results show that most of the health provider respondents were Christians: 108 (91.5%), Muslims were 10 (8.5%), but none was recorded for traditionalists. This can be explained to mean that the study location is dominated by Christians. The results show that 15 (13.4%) had no education with 5 (4.2%) who had basic education. The results show that 78 (65.5%) had tertiary education whilst 20 (16.9%) secondary/ technical level of education. The results show that 16 (13.6%) were medical doctors, 38 (32.2%) were in the nurse/midwife group, 17 (14.4%) were pharmacists and 47 (39.8%) were in the other categories, which included staff in the laboratory, x-ray and allied health workforce. The results are detailed in table 4.3.below.

Table 4. 3: Socio-demographic Characteristics of Health Provider Respondents

Variable	Frequency	Percent (%)
Age		
20 -24	11	9.3
25-29	20	16.9
30-34	24	20.3
35-39	19	16.1
40-44	27	22.9
45-49	9	7.6
50-54	5	4.2
above 55	3	2.5
Total	118	100.0
Sex		
Male	49	41.5
Female	69	58.5
Total	118	100.0
Marital Status		
Single	24	20.3
Married	90	76.3
Divorce	1	0.8
Widow	3	2.5
Total	118	100.0
Religion		
Christians	108	91.5
Muslim	10	8.5
Traditionalist	0	0.0
Educational level		
Non-formal	15	13.4
Basic	5	4.2
Secondary/Technical	20	16.9
Tertiary	78	65.5
Total	118	100.0
Professional Status		
Doctors	16	13.6
Nurse/Midwife	38	32.2
Pharmacist	17	14.4
Others	47	39.8
Total	118	100.0

4.5 Health Providers' Perception of Satisfaction with Performance of Healthcare

Delivery

This section presents results of the analysis relating to the health providers' perception of satisfaction with performance of healthcare delivery. It is believed that health providers' understanding and sense of internal relationship marketing strategy would translate into patient satisfaction as well as enhance their long term relationship with patients in healthcare provision at the Regional Hospital, Koforidua. The key indicators used to measure health providers' satisfaction with performance and their consequential influence on patient satisfaction are presented in table 4.4.

4.5.1 Health Providers' Satisfaction with Communication

The results as indicated in table 4.4 show that most of the respondents: 88 out of 118 (74.6%) were 'very satisfied' followed by 28 (23.7%) who were 'satisfied', and 2 (1.7%) who were 'uncertain' with how the communication flow between management and staff help to improve their perception of satisfaction with the performance of healthcare delivery at the hospital. Therefore, health providers were 'very satisfied' with communication within the organisation and by extension, among them and patients at the facility.

4.5.2 Health Providers' Satisfaction with Long Lasting Relationship

The results show that 52 out of 118 (44.1%) respondents were 'satisfied' with how long lasting relationship between management and staff was enhancing their perception of performance of healthcare delivery at the hospital. The rest were: 49 (41.5%) were 'very satisfied', 8 (6.8%) were 'not at all satisfied', 8 (6.8%) were 'dissatisfied' and only 1 (0.8%) was 'uncertain'. The results are indicated on table 4.4. Consequently, health

providers were 'satisfied' with long lasting relationship within the organisation and by extension, among them and patients at the facility.

4.5.3 Health Providers' Satisfaction with Confidentiality

The results show that 95 out of 118 (81.0%) of the respondents noted that they were 'very satisfied', while 23 (19.0%) confirmed that they were also 'satisfied' with the adherence to patients' confidentiality by management and staff, which was helping towards improving their perception of satisfaction with the performance of healthcare delivery at the hospital. Subsequently, health providers were 'very satisfied' with adherence to issues of confidentiality within the organisation and by extension, among them and patients at the facility.

4.5.4 Health Providers' Satisfaction with Availability of Resources/Logistics

The results reveal that 71 out of 118 (60.2%) showed that they were 'very satisfied', followed by 37 (31.4%) stating that they were 'satisfied', 8 (6.8%) were 'uncertain', and 2 (1.7%) noted that they were 'dissatisfied' with how the availability of resources / logistics to staff (by management) was improving their perception of satisfaction with the performance of healthcare delivery at the hospital. This means that health providers are 'very satisfied' with availability of resources / logistics to staff within the organisation. This will enable them perform to the satisfaction of patients at the facility. The results are shown in table 4.4.

4.5.5 Health Providers' Satisfaction with Workloads and Job Stress

As can be seen in table 4.4, most of the respondents: 66 out of 118 (55.9%) noted 'very satisfied', 39 (33.1%) showed 'satisfied', 9 (7.6%) showed 'uncertain', 2 (1.7%)

indicated 'dissatisfied', and another 2 (1.7%) indicated that they were 'not at all satisfied' with regards to the statement that the workloads and associated job stress among health providers had influence on their perception of satisfaction with the performance of healthcare delivery at the hospital. In effect, health providers were 'very satisfied' that they are able to manage workloads and job stress within the organisation.

4.5.6 Health Providers' Satisfaction with the Cost of Healthcare

The results show that 72 out of 118 (61.0%) health provider respondents indicated 'dissatisfied' with how the cost of health care contributes to their perception of performance of healthcare delivery at the hospital. The rest of the results were: 37 (31.4%) noted 'not at all satisfied', 7 (5.9%) indicated 'uncertain', while 2 (1.7%) noted 'satisfied'. Consequently, health providers are 'dissatisfied' with how the cost of healthcare is impacting on their performance within the organisation, which could translate to their relationship with patients at the facility. The results are displayed in table 4.4.

4.5.7 Health Providers' Satisfaction with Patronage in the Services Provision at the Facility

The results show that 54 out of 118 (45.7%) health provider respondents were 'dissatisfied', 29 (24.6%) noted 'not at all satisfied', 29 (24.6%) indicated 'neutral', 4 (3.4%) indicated 'very satisfied', and 2 (1.7%) noted 'satisfied' with regards to the assertion that satisfaction with the patronage in the services provision at the facility had effects on their perception of performance. It can be concluded that health providers were 'dissatisfied' with patients' patronage in the service provision at the facility. See the results in table 4.4.

4.5.8 Health Providers' Satisfaction with Overall Provision of Services

The results show that 72 out of 118 (61.0%) health provider respondents indicated 'very satisfied' to the observation that satisfaction with the overall provision of services influenced their perception of performance at the facility. The rest revealed that 34 (28.9%) were 'satisfied', 7 (5.9%) noted 'dissatisfied', 3 (2.5%) indicated 'uncertain', and 2 (1.7%) also said 'strongly disagree' to the statement. The observation was that health providers were 'very satisfied' with overall provision of services by the organisation. The results were displayed in table 4.4.

Table 4. 4: Relationship between Health Providers' Performance (Indicators) and Patient Satisfaction

Variable	Patient Satisfaction		Chi-square	df	Sig.	
	N	%				
Communication			4.269	3	0.234	
	Uncertain	2	1.7			
	Satisfied	28	23.7			
	Very satisfied	88	74.6			
	Total	118	100.0			
Long Lasting Relationship	Not at all satisfied	8	6.8	5.093	2	0.078
	Uncertain	1	0.8			
	Dissatisfied	8	6.8			
	Satisfied	52	44.1			
	Very satisfied	49	41.5			
	Total	118	100			
Confidentiality	Satisfied	23	19.5	5.577	3	0.134
	Very satisfied	95	80.5			
	Total	118	100			
Availability of Resources	Dissatisfied	2	1.7	14.109	3	0.003
	Uncertain	8	6.8			
	Satisfied	37	31.4			
	Very satisfied	71	60.2			
	Total	118	100.0			
Workloads and Job Stress	Not at all satisfied	2	1.7	12.62	3	0.738
	Uncertain	9	7.6			
	Dissatisfied	2	1.7			
	Satisfied	39	33.1			
	Very satisfied	66	55.9			
	Total	118	100.0			
Cost of Healthcare	Not at all satisfied	37	31.4	3.147	3	0.370
	Uncertain	7	5.9			
	Dissatisfied	72	61.0			
	satisfied	2	1.7			
	Very satisfied	0	0.0			
	Total	118	100			
Patronage in the Services Provision	Not at all satisfied	29	24.6	8.280	3	0.041
	Neutral	29	24.6			
	Dissatisfied	54	45.7			
	Satisfied	2	1.7			
	Very satisfied	4	3.4			
	Total	118	100.0			
Overall Provision of Services	Not at all satisfied	2	1.7	2.806	3	0.424
	Uncertain	3	2.5			
	Dissatisfied	7	5.9			
	Satisfied	34	28.9			
	Very satisfied	72	61.0			
	Total	118	100.0			

4.6 Relationship between Health Providers' Performance (Indicators) and Patient Satisfaction

This section presents the bivariate analysis for health provider respondents. Bivariate analysis was conducted to check the level of significance of the level of relationship between the independent variables: Communication, long lasting relationship, confidentiality, availability of resources / logistics, workloads and job stress, cost of health care, patronage and satisfaction with overall provision of services; and the dependent variable: patient satisfaction. It is believed that health providers' satisfaction with their own performance will automatically enhance patient satisfaction as well as encourage long term relationship at the Regional Hospital, Koforidua. The statistical test used was Chi Squared Test of Association. The level of significance was at 95% confidence interval (CI) with alpha level been p -value should be $p < 0.05$. The results are presented in table 4.4.

4.6.1 Communication and Patient Satisfaction

Table 4.4 shows analysis of relationship between health providers' communication and patient satisfaction and how it influences long term relationship. The p -value of 0.234 was not significant at 95% CI. It illustrates that health providers' communication has no relationship with patient satisfaction. In other words, communication has no influence on long term relationship among health providers and patients.

4.6.2 Long Lasting Relationship and Patient Satisfaction

The results in table 4.4 reveal that the p -value of 0.078 was not significant at 95% CI. This could be explained by the reason that providers' long lasting relationship has no

relationship with patient satisfaction. This also means that it has no influence on long term relationship.

4.6.3 Confidentiality and Patient Satisfaction.

The results show that confidentiality has no relationship with patient satisfaction as the p -value of 0.134 was not significant at 95% CI. It indicates that confidentiality has no influence on long term relationship. Therefore, the argument is that it is not possible for confidentiality to influence performance and enhance long term relationship among health providers and patients. The results are displayed in table 4.4.

4.6.4 Availability of Resources/Logistics and Patient Satisfaction

The results in table 4.4 show that availability of resources/logistics has a relationship with patient satisfaction and may influence long term relationship since the p -value of 0.003 was significant at 95% CI. This means that it is appropriate for availability of resources to influence health providers' performance and long term relationship.

4.6.5 Workloads and Job Stress and Patient Satisfaction

Results of the analysis of the relationship between workloads and jobs against patient satisfaction are displayed in table 4.4. The p -value of 0.738 is not significant at 95% CI. Thus, workloads and job stress has no relationship with patient satisfaction. This could also be explained that workloads and job stress cannot influence providers' performance and long term relationship with patients.

4.6.6 Cost of Health care and Patient Satisfaction

The results indicated in table 4.4 show a p -value of 0.370, which was not significant at 95% CI. This denotes that cost of healthcare has no relationship with patient satisfaction and does not influence health providers' performance and long term relationship.

4.6.7 Patronage and Patients Satisfaction

The results show that patronage has no relationship with patient satisfaction as the p -value was 0.041, which was not significant at 95% CI. This portrays the evidence that patronage has no influence on health providers' performance and long term relationship.

4.6.8 Overall Provision of Services and Patient Satisfaction

The results show a p -value of 0.424, which was not significant at 95% CI. This implies that overall provision of services has no relationship with patient satisfaction as well as influence on health providers' performance and long term relationship.

4.7 Logistic Regression

This section presents the evidence and statistical analysis using logistic regression. The results are presented in table 4.5 below.

Table 4. 5: Logistic Regression Analysis on Patient Satisfaction

Variables in the Equation	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B)	
							Lower	Upper
Reception of Staff	-.146	.170	.745	1	.388	.864	.619	1.205
Attitude of health providers	-.120	.159	.570	1	.450	.887	.649	1.211
Competence and Expertise	.430	.362	1.407	1	.235	1.537	.756	3.126
Hospital Environment	.172	.316	.296	1	.586	1.187	.640	2.204
Waiting Time	.580	.242	5.748	1	.017	1.787	1.112	2.872
Constant	-4.926	2.303	4.574	1	.032	.007		

4.7.1 Parameter Estimates for Patient Satisfaction

Table 4.5 stipulates the parameter estimates of patient satisfaction, which summarizes the effect of each explanatory variable on the response variable. The ratio of the coefficient to its standard error, squared, equals the Wald statistic. Once the Wald statistical significance level is small (less than 0.05) the parameter is different from 0. The results revealed that none of the predictor variables has its significance value of less than 0.05 with the exception of waiting time. This depicts that the parameters used in the model for predictions can be deceptive or the predictors' interpretation to patient satisfaction on services rendered to them at the facility are dependent on other factors, which were not taken into consideration in the model. The 'B' is convenient for testing the usefulness of predictors: Exp (B) makes it easier to interpret the odds ratios. The Exp (B) denotes the ratio - change in the odds of patient satisfaction for a one-unit change in the predictor.

It is essential to note that the model parameters with negative coefficients decrease the likelihood of services rendered to meet patient satisfaction. Parameters with positive coefficients increase the likelihood of services rendered to patients. It can be observed that the independent variables have both negative and positive coefficients with the positive being competence and expertise of providers, hospital environment and waiting time.

4.7.2 Explanation of the Predictor Variables in the Model

The predictor variables in the logistic regression model, which are reception of staff, attitude of providers, competence and expertise, and hospital environment in table 4.5 were found to have insignificant values with the exception of waiting time. The predictor variables showing insignificant values indicate that services rendered to meet patient satisfaction do not simultaneously predict patients' satisfaction. It was realized that all the explanatory variables indicated that the predictor variables are each not equal to zero at 95% confidence interval except waiting time. This indicates that the predictors' inclusion in the final model is very crucial. This also suggests that there is enough evidence to conclude that the explanatory variables are significant in predicting services rendered to meet patient satisfaction.

4.7.3 Interpretation of the Odds Ratios

It was observed (refer to table 4.5) that the strongest explanatory variables for predicting services rendered to meet patient satisfaction were waiting time, competence and expertise, and hospital environment whilst the least among the predictor variables were reception of staff and attitude of providers. It was realized that the strongest predictor is

waiting time, which recorded an odds ratio of 1.787 (95% C.I: 1.112 - 2.872), whereas the least predictor 'reception of staff', which also recorded an odds ratio of 0.864 (95% C.I: 0.619 - 1.204). The implication of this is that the strongest predictor 'waiting time' is 1.787 times most likely to influence patients' satisfaction whilst competence and expertise is 1.537 times more likely to make patients satisfied. Furthermore, it was established that reception of staff was 0.864 times less likely to make patients satisfied. Moreso, among the independent variables, waiting time and competence and expertise were found to be the most influential variables affecting patients' satisfaction.

4.8 Chapter Summary

The chapter sought to find out both patient and health provider factors, which influence long term relationship among health providers and patients and consequently, on quality of health care. It was noted that patient factors could be measured using patients' satisfaction with some factors like: reception of staff, attitude of providers, waiting time, competence and expertise of health providers, hospital environment, and assessment of overall hospital's services, among others. On the other hand, the chapter has shown that long term relationship among health providers and patients could also be assessed from providers' own perception of satisfaction with performance using provider factors such as: communication, long lasting relationship, confidentiality, availability of resources / logistics, workload and job stress, cost of health care, patronage, and overall provision of services. The next chapter presents discussion of results in relation to literature.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

This chapter presents the discussion of the results in relation to existing literature. There are four sections. Section one presents a summary of the demographic characteristics of the respondents. Section two presents factors influencing long term relationship among health providers and patients as related to existing literature. Section three presents the health providers' perception of satisfaction with performance of healthcare delivery in relation to present literature. Section four presents the chapter summary.

5.1 Demographic characteristics of patients

This section presents a summary of the findings on demographic characteristics of respondents and their relationship to existing literature. Majority of the patient respondents reside in the New Juaben Municipality and the rest came from nearby areas like Akwapim, Somanya, Tafo, Jumapo and Suhum. Majority of the patient respondents were in the age range of 40-44 years (20%), which means that most of the people who access the facility are matured and therefore, could make meaningful contribution to the study. Females constituted 51.8% of the study participants compared to males (48.2%). This supports the findings of the study by Ofosu-Kwarteng (2012) where females consisted 53.1% of the participants.

The current data with the patient respondents showed that 78.8% of the respondents could read and write, which gave an indication that they were capable of giving an independent assessment of the service delivered and accessed at the Regional Hospital, Koforidua. This contradicts the report by National Healthcare Disparities that patients with less than a

high school education are more likely to report poor satisfaction with both nurses and doctors (NHD, 2010).

The health providers' data also showed that 65.5% of the respondents had tertiary education and no-formal education formed only 13.4%. About 52% of the patient respondents and 76.3% of the health provider respondents were married because in most Traditional African societies and more particularly the study area where social cohesion is strong, the traditional beliefs are suggest that everybody should marry at the right age. However, if people are not married at a certain age, they tend to lose respect in the eyes of community residents accordingly. This finding is in line with Ofosu-Kwarteng's (2012) findings that 52% of the participants had married.

The religious affiliation of participants in the study that 71.8% of the patient respondents and 91.5% of health provider respondents were Christians. The higher percentage of Christians is due to the fact the study institution, the Regional Hospital, Koforidua, is located in Koforidua town, which is a predominantly Christian area. This is contrary to the findings of the study by Hussen *et al.* (2012) that Muslims constituted 90% of their study participants.

5.2 Factors Influencing Long Term Relationship among Health Providers and Patients

This section presents the discussion of findings on the factors influencing long term relationship among health providers and patients in relation to literature.

5.2.1 Patients' Satisfaction with Reception of Health Providers

The study found that 46.5% of patient respondents was 'satisfied' with the reception of staff in delivering healthcare and how this could lead to establishing long term relationship among health providers and patients at the hospital. Correspondingly, there was a significant relationship between reception of health providers and patient satisfaction with consequential influence on long term relationship between health providers and patients at the facility as the p -value of ($p < 0.008$) was significant at 95% CI.

This supports Solayappan and Jayakrishanan's (2010) finding that patients want smiling, empathetic nurses and staff, and a quick response to their calls. However, this contradicts the findings by Dzomeku *et al.* (2013) that even as 18% of patients expected the nurses to be polite to them in all their interactions, this was not so. Moreover, it deviates from the report that there is lack of regular provider-patient interaction: the provider is busy when patients want information, the provider has so many things to do at the same time and difficulty in contacting their usual source of care (NHQD, 2013).

5.2.2 Patients' Satisfaction with Health Providers' Attitude

The study observed that 34.1% of patients showed 'uncertain / neutral' or indifferent to the fact that health providers' attitude in delivering healthcare leads to patients' satisfaction with and could encourage long term relationship among health providers and patients at the hospital. This may contradict the findings that 8.7% of patients saw providers as non-discriminatory, friendly and helpful (Nwabueze *et al.*, 2010). In addition, it may support the study by Essendi *et al.* (2011) which revealed that most participants cited health professionals, especially nurses, midwives, and generally female health providers as having a poor attitude towards pregnant women. Furthermore, this supports a study in Ghana, which found that although 73% of patients expected to be treated with love and dignity, they did not receive it (Dzomeku *et al.* 2011).

Nonetheless, the bivariate analysis showed a p -value of ($p < 0.027$), which was significant at 95% CI. Thus, health providers' attitude had significant relationship with patients' satisfaction and could influence long term relationship among health providers and patients at the hospital. This supports the findings that good attitude created professionalism and the patient could go home partly cured, otherwise, most of the patients' condition could become worse due to the behaviour of the providers (Naik *et al.*, 2010).

5.2.3 Patients' satisfaction with waiting time

The study found that 39.4% of patients was 'not at all satisfied' in respect of the suggestion that waiting time has an influence on patients' satisfaction and could ensure long term relationship among health providers and patients in the delivery of healthcare at

the hospital. This is in line with the finding that most patients waste time in outpatients department (Arnesen, Erikssen & Stavem, 2002). This is also in line with the findings by Hussen *et al.* (2012) that 47% of total delay was contributed by health providers, which could be associated with the type of condition the patient had.

However, the bivariate analysis showed a significant relationship between waiting time and patient satisfaction as the p -value of ($p=0.001$) was significant at 95% CI. Although the reason for the strong disagreement were not assessed, the significant influence could be considered against the background that a doctor had to see about 40-60 patients a day, which contributes to the delay at the consulting room in a developing country context as compared to 16 patients a day by a doctor in developed countries (Ajayi, 2002).

5.2.4 Patients' satisfaction with competence and expertise of health providers

The study found that 51.2% of patient respondents was 'satisfied' that health providers' competence and expertise influence patients' satisfaction. However, the p -value of ($p<0.507$) was not significant at 95% CI. Thus, the argument is that it is not possible for competence and expertise of health providers to influence both patient satisfaction and long term relationship. This is why a report by the National Health Care Disparities (NHCD) suggests that patients consider their providers' interpersonal characteristics essential to competent care and take them into consideration when determining the quality of the care they receive (NHCD, 2014). Furthermore, it supports the study that provision of specialized services and advanced technology and the conduct of biomedical research are aspects of health providers' skill (Neely & McInturff, 1998; Ayanian & Weissman, 2002).

5.2.5 Patients' satisfaction with hospital environment

The study observed that 81.2% of patients was 'very satisfied' that hospital's environment has a relationship with patients' satisfaction as well as could influence long term relationship among health providers and patients. This is why 67% of the participants described environment as clean and very clean (Ofosu-Kwarteng, 2012). However, a p -value of ($p < 0.084$) was not significant at 95% CI. This contradicts the observation where 18.7% of respondents at Onitsha, Nigeria, mentioned neatness of hospital as a factor, which increases their satisfaction level (Nwabueze *et al.* 2010). This explains the need for the suggestion that the environment within which health care is delivered must seek to contribute to patients' satisfaction since patients use the health care environment to assess quality of care (Lohr & Schroeder, 1990; Hughes, 2014).

5.2.6 Patients' satisfaction with overall assessment of hospital's services

It was found that 75.3% of patients was 'satisfied' in respect of the fact that the overall hospital's service has a relationship with patient satisfaction. This corresponds with the fact that there was a significant relationship as the p -value was equal ($p = 0.004$), which was very significant at 95% CI. This supports the assertion that patients' satisfaction with the overall hospital's services had a significant influence on long term relationship among health providers and patients. This is contrary to the findings of the study by Jiang *et al.* (2014) that most providers show unprofessional behaviour. Additionally, it contradicts the findings that health workers in government facilities abused patients, a practice that discouraged women from seeking health facility services when in need (Essendi *et al.*, 2011).

5.3 Health Providers' Perception of Satisfaction with Performance of Healthcare

Delivery

This section presents analysis of health providers' perception of satisfaction with performance and its relationship with patient satisfaction as well as influence on long term relationship among health providers and patients based on existing literature.

5.3.1 Health providers' satisfaction with communication

The analysis revealed that 74.6% of health providers showed 'very satisfied' with how the communication flow between management and staff help to improve their perception of satisfaction with performance and its influence on patient satisfaction as well as long term relationship among health providers and patients at the hospital. However, the p -value of ($p < 0.234$) was not significant at 95% CI. Thus, health providers' communication has no significant relationship with patient satisfaction as well as influence on long term relationship among them and patients. This is why it is argued that the availability of information between the provider and management for patients increases their knowledge regarding their illness and treatment options and being informed gives patients the opportunity to participate in shared decision making with clinicians and may help patients better articulate their individual views and preference (Reiling *et al.*, 2008).

5.3.2 Health providers' satisfaction with long lasting relationship

It was observed that 44.1% of respondents indicated 'satisfied' with how long lasting relationship between management and staff was enhancing their perception of performance and its influence on patient satisfaction as well as long term relationship with patients at the hospital. However, a p -value of ($p < 0.178$) was not significant at 95% CI.

Thus, it is important to look at the assertion that whenever there is cordial relationship between the provider and the patient, it can influence the patient's willingness to visit the facility anytime the need arises (Hibbard *et al.*, 2001).

5.3.3 Health providers' satisfaction with confidentiality

The study revealed that 80.5% of respondents showed 'very satisfied' with the adherence to patients' confidentiality by management and staff, which was helping towards improving their perception of performance and its influence on patient satisfaction and long term relationship among them and patients at the hospital. However, a p -value of ($p < 0.134$) was not significant at 95% CI. This is not in line with the suggestion that health providers should be very sensitive to how information about patients is handled in the health sector, since this will bring about trust between the providers and the patients, which could also lead to long lasting relationship (American Nurses Association, 1995). This is also not in line with the study by Vargheese and Prabhudesai (2014) which indicated that patients dislike the sharing of information across health care providers, which has no security as most of the patients hear the circulation of their condition all over the public sectors before they leave the health facility.

5.3.4 Health providers' satisfaction with availability of resources / logistics

The study found that 60.2% of health providers showed 'very satisfied' with how the availability of resources / logistics (by management) was improving their perception of performance and its influence on patient satisfaction and long term relationship among them and patients at the hospital. Correspondingly, the p -value of ($p < 0.003$) was significant at 95% CI. This may contradict the findings of a study from Mozambique,

which reported that most of the health sectors did not have emergency drugs, vaccine and other material resources, therefore, health care providers could not deliver any better services (Connett, 2012).

5.3.5 Health providers' satisfaction with workloads and job stress

It was noted that 55.9% of health providers 'strongly agree' to the statement that the workloads and associated job stress among health providers had influence on their perception of satisfaction with performance and its influence on patient satisfaction and long term relationship among them and patients at the hospital. This did not correspond with a p -value of ($p < 0.738$), which was not significant at 95% CI. This is not in line with the report that job stress is a major issue these days and affects both health and productivity and happens when the individual capability is below expectation (Better Health, 2014). This also contradicts the argument that a health provider who is stressed might displace it on an innocent patient (NHSC, 2005). Therefore, it is optional to consider the recommendation that the hospital should ensure safe working environment, discuss bordering issues and take steps to solve them, organize periodic meetings and have recreational activities once in a while for staff (NHSC, 2005).

5.3.6 Health providers' satisfaction with the cost of healthcare

The study observed that 61.0% of health provider respondents noted 'dissatisfied' with how the cost of health care contributed to their perception of performance and its influence on both patient satisfaction and long term relationship among them and patients at the hospital. As expected, a p -value of ($p < 0.370$) was not significant at 95% CI. This is contrary to the report that some providers demand some form of money before rendering

services needed to patients (Agbenorku, 2012). However, it is important to consider the finding that costs of health care delivered or accessed are also taken into account by both providers and patients alike and as such should not be taken for granted (Steinberg *et al.* 1988).

5.3.7 Health providers' satisfaction with patronage in the services provision at the facility

The study revealed that 45.7% of health provider respondents showed 'disagree' to the assertion that satisfaction with the patronage in the services provision at the facility had effects on their perception of performance and its influence on both patient satisfaction and long term relationship among them and patients at the hospital. However, a p -value of ($p < 0.004$) was significant at 95% CI. This is why it is explained that the importance of having strong leadership commitment and support cannot be overstated; and leadership needs to empower staff to be actively involved and continuously drive quality improvement (Hughes, 2014).

5.3.8 Health providers' satisfaction with overall provision of services

The analysis indicated that 61.0% of health providers noted 'strongly agree' to the observation that health providers' perception of satisfaction with the overall provision of services could influence their perception of performance and its influence on both patient satisfaction and long term relationship among them and patients at the hospital. Contrarily, a p -value of ($p < 0.424$) was not significant at 95% CI. This is why it is observed that the rationale for measuring quality improvement is the belief that good performance

reflects good-quality practice, and that comparing performance among providers and organizations will encourage better performance (Hughes, 2014).

5.4 Chapter Summary

The chapter has analysed the findings of the study and related them to existing literature. It has demonstrated that while some of the patients' satisfaction indicators were significant in influencing long term relationship with health providers, others were not significant. On the other hand, whilst some of the health providers' satisfaction indicators had significant influence on their perception of performance with associated influence on both patient satisfaction and long term relationship among them and patients, there were other indicators, which were not significant. The next chapter presents the conclusions and recommendations of the study.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary, conclusions and recommendations of the study. There are five sections. Section one presents the summary of the study. Section two presents the conclusions of the study. Section three presents the contribution to knowledge / recommendations. Section four presents the limitations. Section five presents the suggestions for future research.

6.1 Summary of the Study

This section presents the summary of the study. The study was set out to determine how long-term relationship among health providers and patients enhances patients' satisfaction with health care delivery at the Regional Hospital, Koforidua. This was achieved by determining factors that influence long-term relationship among health providers and patients; and health providers' perception of satisfaction with performance and its influence on patient satisfaction as well as long-term relationship among them and patients using a quantitative research method to collect data between May and June, 2015. The data were analysed using appropriate statistical techniques, including SPSS version 20 / Stata.

Generally, the study concludes that patients' satisfaction with healthcare provision (based on the patient factors/indicators used) is enhanced by long-term relationship among health providers and patients at the Regional Hospital, Koforidua. Crucially, the study also concludes that health providers' perception of satisfaction with performance (based on the

provider factors/indicators used) is enhanced with consequential influence on patient satisfaction as well as long-term relationship among them and patients. Therefore, the hypothesis is true that long term relationship enhances patient satisfaction with healthcare accessed. This is based on the following discussed conclusions presented on the basis of the specific objectives of the study.

6.2 Conclusions of the Study

This section presents the conclusions of the study. These are drawn based on the objectives of the study spelt out in chapter one.

6.2.1 Factors Influencing Long Term Relationship among Health Providers and

Patients

This section presents the conclusions on how long term relationship among health providers and patients enhances patient satisfaction. This was achieved by assessing factors influencing long term relationship among health providers and patients using indicators that measured patients' satisfaction with healthcare provision; and health providers' own assessment of satisfaction with performance of healthcare delivery. These are related to literature in this section. The underlying assumption is that customer perceptions of service encounters are important elements of customer satisfaction since perceptions of quality and long term loyalty are reasons why service encounter research focuses on the interactions between customers and employees in service firms (Czepiel *et al.*, 1985; Brown *et al.*, 1994).

6.2.1.1 Patients' satisfaction with reception of staff

The study concludes that there was a significant influence of reception of health providers on patient satisfaction as well as long term relationship among them and patients as the p -value of ($p=0.008$) was very significant at 95% CI. Generally, the study recognises that patient satisfaction is not solely based on professional and technical treatment of patients alone, but rather goes in tandem with mutual trust and good interpersonal relationship. This is why there should be long term relationship between health providers and patients in order to understand their needs and wants.

It would be recalled from chapter two that if the patient/customer has a low need, any investments in long-term relationship will not only generate poor output, but can actually damage the exchange by increasing customer perception of exchange inefficiencies (Palmatier *et al.*, 2007). This can be rectified by assessing the opinions of patients and providers and the relationship that exists and whether it has influence on the satisfaction of the patients. This supports the literature that when patients seek information about their condition, and are able to ask right questions to get right answers, they get well early: this will prevent future complications (Namkoong *et al.*, 2010).

6.2.1.2 Patients' satisfaction with health providers' attitude

The study concludes that health providers' attitude in delivering healthcare has a relationship with patient satisfaction and associated long term relationship among health providers and patients at the hospital as the p -value of ($p<0.027$) was very significant at 95% CI. However, the study argues that the negative attitude of health providers in government facilities and the way they receive patients is one of the causes of patients'

inability to access the facilities for treatment and prefer either herbal or other alternative to health care.

Through personal interactions, it was revealed that while some patients indicated that the providers at the hospital were polite and friendly, others were also not happy with the providers regarding their attitude towards them. They emphasised the need for long term relationship to address the concerns of patients: this will create room for good relationship among patients and providers. This will ensure quality healthcare as patients will understand providers' behaviour better. It is for this reason that the literature reports that Dutch nursing staff displayed a good attitude and relationship towards their patients irrespective of their socioeconomic background (Albers *et al.*, 2014).

6.2.1.3 Patients' Satisfaction with Waiting Time

The study concludes that waiting time has a significant influence on patient satisfaction with extended impact on long term relationship among health providers and patients as the p -value of ($p=0.001$) was very significant at 95% CI. The study argues based on personal interactions that one of the challenging issues is the waiting time, which the patients find it difficult to understand as the delay is very common in the facility. Even though the hospital has been providing patients with information about what they should do and also the providers talk nicely to them, some of the patients were not happy with the process they go through before they receive healthcare. This supports researcher Ajayi's (2002) observation that waiting time in developing countries, has been demonstrated to be long and constitutes a major dissatisfaction with medical care delivery and a barrier to further use of health care facility by affected patients..

6.2.1.4 Patients' Satisfaction with Competence and Expertise of Health Providers

The study concludes that health providers' competence and expertise has no significant influence on patient satisfaction as well as long term relationship among health providers and patients since the p -value of ($p < 0.507$) was not very significant at 95% CI. Despite this revelation, the study observes that the quality issues in healthcare delivery from the viewpoint of the consumer is given little attention as health professionals are only satisfied in measuring quality from the number of clients who visit the facility and not the perception of the patients about their satisfaction with the competence and expertise of providers. This is the reason why the literature suggests that even though it is difficult for patients to effectively rate the competencies and expertise of health providers due to lack of technical knowhow, their satisfaction with the relationship and services accessed could still be measured based on perception of the professional competence and expertise of the providers (American Nurses Association, 1995).

6.2.1.5 Patients' Satisfaction with Hospital Environment

The conclusion of the study is that hospital's environment has no significant influence on patient satisfaction and corresponding long term relationship among health providers and patients because the p -value of ($p < 0.084$) was not significant at 95% CI. However, the study revealed through personal interactions that most of the patients were happy about the cleanliness of the hospital environment with only few who were not happy. Thus, the literature suggests that for providers to achieve superior quality of care, the environmental factors like workload, burnout, respect of individual opinion and social factors, should be considered during the care of patients (Bogaert *et al.*, 2014).

6.2.1.6 Patients' Satisfaction with Overall Assessment of Hospital's Services

The study concludes on the assertion that overall hospital's services has a significant relationship with patient satisfaction as well as long term relationship among health providers and patients with a corresponding p -value of ($p=0.004$) at 95% CI. This is why the literature argues that hospitals, especially teaching hospitals (in this case a Regional Hospital) are widely reputed to provide high-quality care since the kind of service delivered to patients constitutes one measure of patients' satisfaction or assessment of quality of care (Boscarino, 1992).

6.2.2 Health Providers' Perception of Satisfaction with Performance of Healthcare Delivery

This section presents analysis of conclusions related to health providers' perception of satisfaction with performance and its influence on patient satisfaction as well as long term relationship among health providers and patients in relation to prevailing literature. The basic premise of internal marketing is that satisfied employees (or well served internal customers) will lead to satisfied customers (or well-served external customers) [(George, 1990; Brown *et al.*, 1994)].

6.2.2.1 Health Providers' Satisfaction with Communication

The study concludes that communication flow between management and staff to improve their perception of satisfaction with the performance has no significant influence on patient satisfaction and long term relationship among health providers and patients due to the fact that the p -value of ($p<0.234$) was not very significant at 95% CI. This notwithstanding, the literature in chapter two is clear that in any inter-cultural

organizational environments like health care facilities, one of the most critical issues that require attention is communication among employees of different linguistic and cultural backgrounds (Cho, 2014).

6.2.2.2 Health Providers' Satisfaction with Long Lasting Relationship

The literature in chapter two explains that the concept of relationship used is the one between the patients and the providers that encompasses activities directed toward establishing, developing, and maintaining successful relationships (Berry, 1983). The study concludes that long lasting relationship between management and staff and their perception of satisfaction with performance has no significant influence on patient satisfaction and related long term relationship among health providers and patients because the p -value of ($p < 0.178$) was not significant at 95% CI. In spite of this, it is very relevant to look at Cummings and Frost's (1985) suggestion on the need for changes in a different component of the knowledge exchange process, and more cross-disciplinary symposia at professional meetings.

6.2.2.3 Health Providers' Satisfaction with Confidentiality

It could be recalled from chapter two that for medicine to become real, there was the need to share information between providers and the patients (Vargheese & Prabhudesai, 2014). The study concludes that adherence to patients' confidentiality by management and staff and their perception of satisfaction with performance has no significant relationship with patient satisfaction and by extension long term relationship among health providers and patients since the p -value of ($p < 0.134$) was not significant at 95% CI. However, it is imperative to consider the observation that the healthcare information available to

providers plays a crucial role in enabling better healthcare outcomes as the patient's willingness to share information is dependent on some level of guarantees that the patient expects. There should be trust between the patient and the provider and with the expectation that the provider will handle the information confidentially and responsibly (Vargheese & Prabhudesai, 2014).

6.2.2.4 Health Providers' Satisfaction with Availability of Resources/Logistics

It is argued that availability of resources/ logistics (by management) leading to improvement in health providers' perception of satisfaction with performance has a very significant relationship with patient satisfaction and associated influence on long term relationship among health providers and patients due to the reason that the p -value of ($p < 0.003$) was significant at 95% CI. This corresponds with Snow's (2009) observation that the lack of appropriate logistics for providers to perform their duties could create stressful situation between the provider and the patient as the providers find it difficult to render the services.

6.2.2.5 Health Providers' Satisfaction with Workloads and Job Stress

The literature argues that job stress could be viewed from the perspectives of overwork, problems with immediate supervisor, uncertainty of work, lack of confidence, which could lead to fatigue, lack of interest, poor work done, laziness, low productivity and therefore, low internally generated fund (IGF) [(Better Health, 2014)]. On the other hand, the study concludes that workloads and associated job stress among health providers has no significant influence on health providers' perception of satisfaction with performance and interrelated long term relationship among health providers and patients as the p -value of

($p < 0.738$) was not significant at 95% CI. Although this was the case, it is important to note the recommendation that the hospital should ensure safe working environment, discuss bordering issues and take steps to solve them, organize periodic meetings and have recreational activities once in a while for staff (NHSC, 2005).

6.2.2.6 Health Providers' Perception of Satisfaction with the Cost of Healthcare

The study concludes that the cost of healthcare contributing to health providers' perception of satisfaction with performance has no significant influence on long term relationship among health providers and patients simply because the p -value of ($p < 0.370$) was not significant at 95% CI. This may be contrary to the suggestion that the costs of health care are also taken into account by both providers and patients (Steinberg *et al.* 1988). However, this fact was not assessed from the patients' perspective in this study so as to make a decisive conclusion.

6.2.2.7 Health Providers' Satisfaction with Patronage in the Services Provision at the Facility

The study confirms that patronage in the services provision at the facility and its effects on health providers' perception of satisfaction with performance has no significant relationship with patient satisfaction or influence on long term relationship among health providers and patients since the p -value of ($p < 0.041$) was not very significant at 95% CI. Despite this conclusion, it is noteworthy to recall from chapter two that patients' patronage in health care facilities could serve as a basis for health providers to be aware that they were providing quality of care and this could form the basis of a long-term relationship with them as well (Soliman, 1992; Morgan & Hunt, 1994).

6.2.2.8 Health Providers' Satisfaction with Overall Provision of Services

The study concludes that overall provision of services and its influence on health providers' perception of satisfaction with performance has no significant relationship with patient satisfaction as well as influence on long term relationship among health providers and patients as the p -value of ($p < 0.424$) was not significant at 95% CI. Nonetheless, it is still relevant to adhere to the literature when it suggests that health providers should be trained on etiquette and empathy so that they could identify expected satisfaction from previous experiences of patients, friends, relatives and comments in the press, to help them to know how their clients were willing to either continue or stop using the facility (Naik *et al.*, 2010).

6.3 Contribution to Knowledge

This section presents the study's contribution to knowledge in the following areas as explained.

6.3.1 Contribution to Policy and Practice

The study observes that although quality of health care programmes have been implemented in the health sector of the country for some time now, they have still not been able to resolve the perceived problems of quality of care or patients' dissatisfaction with healthcare provision at the facilities (Lavy, Strauss, Thomas, & De Vreyer, (1996). The study on the influence of long term relationship between health providers and patients on patients' satisfaction can contribute to the drive of ensuring that quality of care is upheld in all health facilities. Policy makers and healthcare providers can consider how to embrace it to ensure optimum satisfaction of patients at the health institutions.

6.3.2 Contribution to Theory

Different concepts have been applied to explain the findings of the study and have indicated that a study of this nature can be explained from different perspectives. However, no particular theoretical framework was applied to explain the findings since it was a quantitative study (Figgis, & Hitchman, 2000). Thus, future qualitative study could apply a particular theory accordingly.

6.3.3 Contribution to Methodology

The application of quantitative research method in the data collection has enabled the quantification of health providers' and patients' perception of long term relationship and its relative influence on patient satisfaction with healthcare delivered and accessed, which can be generalised to the population of the study area (Amaratunga, Baldry, Sarshar, & Newton, 2002). However, as this was a quantitative study, the reasons behind the responses could not be explored on one-on-one basis with the respondents. Hence, future qualitative study could consider this for indepth analysis accordingly.

6.4 Recommendations

This section presents the recommendations for consideration by health policy makers and practitioners. The study makes the following recommendations on the basis of the findings for consideration by health policy makers and practitioners towards improving long term relationship so as to enhance patient satisfaction with healthcare accessed in health institutions:

1. There is the need for management to ensure availability of resources/logistics to improve healthcare delivery in the facility. This will help address health providers'

- complaint on heavy workload as a factor, which contributes to patient dissatisfaction.
2. There is the need for health providers to discuss issues with patients to relieve them of anxiety.
 3. There is the need for health providers to constantly examine their perception of satisfaction with their own performance. This will ensure that long term relationship is established between them and patients so as to affect patient satisfaction or quality of healthcare delivery in the hospital.
 4. There is the need for health providers to seek the opinion of the patients on matters regarding their confidential information. This is likely to enhance patient satisfaction with healthcare since most of them are enlightened. This will have influence on long term relationship because disclosing patients' information to relatives without their consent is a big issue in health facilities.
 5. There is the need for health providers to explain patients' conditions to them in simple terms for them to understand. Provider-patient long term relationship in service delivery is an important issue that hospital authorities should consider and make sure that both the provider and the patient are ready to work together as partners.

6. There is the need for the hospital to have a section where patients' complaints could be channeled through to enable them air their dissatisfaction and also commend some providers at the hospital. This section should be known to the patients and the general public and the process for expressing grievances should not be burdensome. Thus, the hospital authorities should advertise and make operational the complaints unit for patients' complaints and suggestions to be considered for improved services.
7. There is the need for hospital administrators to work hard to improve efficiency and reduce waiting time, work on providers' attitude, ensure availability of resources / logistics and long lasting relationship between providers and patients to enhance health care delivery services at the Regional Hospital, Koforidua.
8. There is the need for the hospital to have sufficient health providers at all times to relieve them from heavy workloads.

6.5 Limitations to the Study

The study was faced with few limitations as explained below:

1. The researcher encountered few problems during data collection as the providers were very busy at the time of the study and hardly got the time to read the questionnaire thoroughly before answering. Following up on distributed questionnaires was very difficult.

2. The sample size of the study was small for both patients and health providers. The study focused on only the patients and health providers at the Regional Hospital, Koforidua. Since this does not give a true picture of what really goes on at other health facilities, it is difficult to draw concrete generalisation of the findings of the study to the population outside of this hospital.
3. Since the study adopted a quantitative approach using structured questionnaire(s), it was difficult to examine the issues from the perspectives of both health providers and patients themselves through researcher-researched interactions. Nevertheless, the responses might not confirm any biases of the researcher.

6.6 Future Research

Future researchers should seek to address the challenges faced by the researcher, including the following:

1. The application of qualitative research method in future studies will help explore the perspectives of research participants to understand why they gave the responses to the questions posed through the questionnaires.
2. There should be an increment in the sample size of study participants in future research to ensure wider coverage. That is to say that other health facilities outside of the Regional Hospital, Koforidua, should be included in future studies to know their views on the issues raised in the study. This will also require that adequate logistics are provided to ensure more patients' and health providers' views are solicited.

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APPENDICES

Appendix A: Participant Consent Form – Health Providers

**School of Public Health
College of Health Sciences**

University of Ghana+

Project Title

Assessment of Factors Influencing Long-Term Relationship among Providers and Patients: Effects on Patients' Satisfaction at the Regional Hospital, Koforidua

Background

Dear Participant,

I wish to invite you to take part in this study. My name is Doris Darkoa Mantey. I am a student of the Department of Health Policy Planning and Management, School of Public Health, University of Ghana. I am conducting a study on the topic: Assessment of Long-term Relationship among Providers and Patients on Patients' Satisfaction at the Regional Hospital, Koforidua. The objective of this study is to determine how long-term relationship among health providers and patients enhances patients' satisfaction with health care delivery at the Regional Hospital, Koforidua.

Procedures

The study seeks to interview health providers and patients in order to ascertain long-term relationship among providers and patients and how it enhances quality of care provided in health facilities. Questionnaire would be administered. This is purely an academic research, which forms part of my work for the award of Masters Degree in Public Health.

Risks and Benefits

The information you provide will help me understand the current relationship among providers and patients in the health facilities. The information, I believe, would benefit you in the long run as it would arouse the interest of policy makers to pay more attention to long-term relationship in health facilities. Your participation in this study does not involve any risk or cost. Be assured that the information you will provide shall be treated with uttermost confidentiality and anonymity.

Health Providers' Consent

I,declare that the purpose, procedures as well as risks and benefits of the study have been thoroughly explained to me and I have understood them. I hereby agree to take part in this study.

Signature of participant / thumbprint.....

Date..... / /

Interviewer's Statement

I, the undersigned, have explained this consent form to the subject in simple language that she/he understands, clarified the purpose of the study, procedures to be followed as well as the risks and benefits involved. The subject has freely agreed to participate in the study.

Signature of interviewerDate / /

Address

Doris M Darkoa
Regional Hospital
P O Box 201
Koforidua

In case of any concern you can contact the Ethics Administrator, Miss Hannah Frimpong, GHS/ERC on: 0243235225 / 0507041223.

Appendix B: Participant Consent Form – Patients

School of Public Health

College of Health Sciences

University of Ghana

Project Title

Assessment of Factors Influencing Long-Term Relationship among Providers and Patients: Effects on Patients' Satisfaction at the Regional Hospital, Koforidua

Background

Dear Participant,

I wish to invite you to take part in this study. My name is Doris Darkoa Mantey. I am a student of the Department of Health Policy Planning and Management, School of Public Health, University of Ghana. I am conducting a study on the topic: Assessment of Long-term Relationship among Providers and Patients on Patients' Satisfaction at the Regional Hospital, Koforidua. The objective of this study is to determine how long-term relationship among health providers and patients enhances patients' satisfaction with health care delivery at the Regional Hospital, Koforidua.

Procedures

The study seeks to interview health providers and patients in order to ascertain long-term relationship among providers and patients and how it enhances quality of care provided in health facilities. Questionnaire would be administered. This is purely an academic research, which forms part of my work for the award of Masters Degree in Public Health.

Risks and Benefits

The information you provide will help me understand the current relationship among providers and patients in the health facilities. The information, I believe, would benefit you in the long run as it would arouse the interest of policy makers to pay more attention to long-term relationship in health facilities. Your participation in this study does not involve any risk or cost. Be assured that the information you will provide shall be treated with uttermost confidentiality and anonymity.

Patients' Consent

I,declare that the purpose, procedures as well as risks and benefits of the study have been thoroughly explained to me and I have understood them. I hereby agree to take part in this study.

Signature of participant./ thumbprint.....Date...../..... /

Interviewer's Statement

I, the undersigned, have explained this consent form to the subject in simple language that she/he understands, clarified the purpose of the study, procedures to be followed as well as the risks and benefits involved. The subject has freely agreed to participate in the study.

Signature of interviewerDate / /

Address
Doris M Darkoa
Regional Hospital
P O Box 201
Koforidua

In case of any concern you can contact the Ethics Administrator, Miss Hannah Frimpong,
GHS/ERC on: 0243235225 / 0507041223.

Appendix C: Questionnaire for Patients

School of Public Health
College of Health Sciences
University of Ghana

The purpose of this study is to assess long-term relationship among health providers and patients on patients' satisfaction at the Regional Hospital, Koforidua in the Eastern region. The findings will help to improve service delivery. Your response and contribution will be used for academic purposes and no disclosure will be made to any third party. However, you are allowed to discontinue this interview at any stage. Thank you.

Directions: Choose the corresponding answer against each question with a tick ():
 Rating: Very Satisfied () Satisfied () Uncertain () Dissatisfied () Not at all Satisfied ()

Name of interviewer.....

Name of hospital.....

Section A: Socio-Demographic Characteristics

1. Age

- a. 20-24 () b. 25-29 () c. 30-34 () d. 35-39 () e. 40-44 () f. 45-49 () g. 50-54 ()
 h. 55+ ()

2. Sex

- a. Male () b. Female ()

3. Marital status

- a. Single () b. Married () c. Divorce () d. Widower ()

4. Occupation

- a. Government-employed () b. Self-employed () c. unemployed ()

5. Religion

- a. Christian () b. Moslem () c. Traditionalist ()

d. other (specify).....

6. Educational level

- a. Non-formal () b. Basic () c. Secondary/Technical () d. Tertiary ()

Section B: Factors Influencing Long Term Relationship between Health Providers and Patients

7. Reception of Staff

Patients are satisfied with reception of health providers and it influence on long term relationship

Very Satisfied	Satisfied	Uncertain	Dissatisfied	Not at all Satisfied

8. Providers Attitude

Patients are satisfied with health providers' attitude and it influence on long term relationship

Very Satisfied	Satisfied	Uncertain	Dissatisfied	Not at all Satisfied

9. Waiting time

Patients are satisfied with waiting time at the hospital and it influence on long term relationship with health providers?

Very Satisfied	Satisfied	Uncertain	Dissatisfied	Not at all Satisfied

10. Competency and Expertise

Patients are satisfied with the competency and expertise of health providers and it influence on long term relationship

Very Satisfied	Satisfied	Uncertain	Dissatisfied	Not at all Satisfied

11. Hospital Environment

Patients are satisfied with the hospital environment and it influence on long term relationship with health providers

Very satisfied	Satisfied	Uncertain	Dissatisfied	Not at all satisfied

12. Overall Assessment of Hospital's Services

Patients are satisfied with overall services rendered at the health facility and it influence on long term relationship?

Very satisfied	Satisfied	uncertain	Dissatisfied	Very dissatisfied

Section B: Patients' Satisfaction with Healthcare Provision at the Health Facility

13. How satisfied are you with the reception of health providers at the health facility?

Very satisfied	Satisfied	uncertain	Dissatisfied	Very dissatisfied

14. How satisfied are you with the attitude of health providers at the health facility?

Very satisfied	Satisfied	uncertain	Dissatisfied	Very dissatisfied

15. How satisfied are you with waiting time at the health facility?

Very satisfied	Satisfied	uncertain	Dissatisfied	Very dissatisfied

16. How satisfied are you with the competency and expertise of the health providers at the health facility?

Very satisfied	Satisfied	uncertain	Dissatisfied	Very dissatisfied

17. How satisfied are you with the health facility's environment?

Very satisfied	Satisfied	uncertain	Dissatisfied	Very dissatisfied

18. Overall Hospital's Services

How satisfied are you with the overall hospital's services provision?

Very satisfied	Satisfied	uncertain	Dissatisfied	Very dissatisfied

Appendix D: Questionnaire for Health Providers

**School of Public Health
College of Health Sciences
University of Ghana**

The purpose of this study is to assess factors influencing long-term relationship among health providers and patients on patients' satisfaction at the Regional Hospital, Koforidua in the Eastern region. The findings will help to improve service delivery. Your response and contribution will be used for academic purposes and no disclosure will be made to any third party. However, you are allowed to discontinue this interview at any stage. Thank you.

Directions: Choose the corresponding answer against each question with a tick ():

Rating: Very satisfied () Satisfied () Uncertain () Dissatisfied () Not at all satisfied ()

Name of interviewer.....

Name of hospital.....

Section A: Socio-Demographic Characteristics

1. Age

- a. 20-24 () b. 25-29 () c. 30-34 () d. 35-39 () e. 40-44 () f. 45-49 () g. 50-54 ()
h. 55+ ()

2. Sex

- a. Male () b. Female ()

3. Marital status

- a. Single () b. Married () c. Divorce () d. Widower ()

4. Religious Status

- a. Christian () b. Moslem () c. Traditional () d. other (specify).....

5. Educational level

- a. Non-formal () b. Basic () c. Secondary/Technical () d. Tertiary ()

6. Professional status

- a. Doctor () b. Nurse/midwife () c. Pharmacist () d. Others (specify).....

Section B: Health Providers' Perception of Satisfaction with Performance of Healthcare Delivery

Directions: choose the corresponding answer against each question in the table below.

7. Communication

How satisfied are you with the communication flow between management and staff towards improving performance?

Very satisfied	satisfied	uncertain	Dissatisfied	Very dissatisfied

8. Long Lasting Relationship

How satisfied are you with the long lasting relationship between management and staff towards improving performance?

Very satisfied	satisfied	uncertain	Dissatisfied	Very dissatisfied

9. Confidentiality

How satisfied are you with the adherence to patients' confidentiality by management and staff towards improving performance?

Very satisfied	satisfied	uncertain	Dissatisfied	Very dissatisfied

10. Availability of Logistics

How satisfied are you with the availability of logistics to staff (by management) to work towards improving performance?

Very satisfied	satisfied	uncertain	Dissatisfied	Very dissatisfied

11. Workload and Job Stress

How satisfied are you with the workloads and associated job stress among health providers and its influence on performance?

Very satisfied	satisfied	uncertain	Dissatisfied	Very dissatisfied

12. Cost of Health care

How satisfied are you with how the cost of healthcare contributes to patients' satisfaction and its influence on improving performance?

Very satisfied	satisfied	uncertain	Dissatisfied	Not at all satisfied

13. Patronage

How satisfied are you with how poor attitude of providers discouraging patients from patronising the services provided at the facility and its effects on performance?

Very satisfied	satisfied	uncertain	Dissatisfied	Not at all satisfied

14. Satisfaction Service Provision

How satisfied are you with the overall provision of services to the patients at the facility and its influence on performance?

Very satisfied	satisfied	uncertain	Dissatisfied	Not at all satisfied