UNIVERSITY FOR DEVELOPMENT STUDIES

ASSESSING CLIENTS SATISFACTION WITH MEDICAL SERVICES IN THE TAMALE TEACHING HOSPITAL

RABIATU MUHAMMAD

2016

UNIVERSITY FOR DEVELOPMENT STUDIES

ASSESSING CLIENTS SATISFACTION WITH MEDICAL SERVICES IN THE TAMALE TEACHING HOSPITAL

BY

RABIATU MUHAMMAD (MSc. COMMUNITY HEALTH AND DEVELOPMENT)

UDS/CHID/0033/11

A THESIS SUBMITTED TO THE DEPARTMENT OF PUBLIC HEALTH, SCHOOL OF ALLIED HEALTH SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF SCIENCE DEGREE IN COMMUNITY HEALTH AND DEVELOPMENT

2016

DECLARATION

Student

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

Rabiatu Muhammad

Candidate's Signature:……Date:……

Supervisor

I hereby declare that preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies.

Name of Supervisor: Dr. Abdulai Abubakari

Signature:……Date:……

ABSTRACT

Access to quality health service in recent times is an influencing factor in clients' satisfaction with health service in contemporary Ghana. This study assessed the satisfaction of clients who seek medical health care at the Out Patient Department (OPD) in Tamale Teaching Hospital (TTH). Through convenience and random sampling techniques, 120 respondents were involved with the help of questionnaires at the OPD in TTH. The study revealed that there were many children and teenagers (36.68%) visiting the OPD for medical health care than the adults whose ages were between 18 – 30 years. The least among them were those above 50 years (8.33%). About 24.2% were satisfied with the attitude of health workers whiles 11.7% were very dissatisfied with their attitudes. However the overall assessment of patients' satisfaction revealed that 55% of patients were satisfied with the medial health service from TTH, whiles 5% were very dissatisfied. There was a significant statistical difference in the age of patients and attitude of health workers with 70.9% of clients between 18 – 30 years being satisfied with the attitude of health workers whiles 29% were dissatisfied. About 57.1% of patients who were attended to by NHIS staff in less than 30 minutes were satisfied with service rendered in receiving NHIS folder whiles 42.9% were dissatisfied, 73.1% of patients who were attended to within 1 – 2 hours were dissatisfied with their services while 26.92% were satisfied. This explains the importance patients attached to quick access to medical care with little time spent at the OPD. The study results show that many patients were not educated on the patients' charter regarding health service delivery at TTH, very few of them were aware of their rights and responsibility with Ghana Health Service prescribed ethics of the patients' charter. The study recommend management of TTH to put the interest and satisfaction of clients first in the delivery of health service since many of the respondents were influenced to seek health care at the facility based on the quality of health care given to them and the good relationship between doctor-patient at TTH than other health facilities.

ACKNOWLEDGEMENT

All praise is to Allah for the good health, strength and wisdom granted me to bring this work to a successful end. Many individuals lend a hand in my success story hence they are worth mentioning. My special thanks goes to my supervisor Dr. Abdulai Abubakari, despite his busy schedule guided and supervised this work to a successful completion.

My Head of Department also deserves a tap on the back for his assistance in the review and submission of this work. My heartfelt thanks also goes to Mr. Boakye Yiadom (my lecturer and 'father') at the School of Allied Health Science (SAHS) from UDS Tamale campus. Finally my special thanks also goes to Mr. Adam Iddrisu and Mr. Musa Salifu for their assistance in the data collection and analyses of the study.

DEDICATION

I dedicate this work to my late mum Hajia Jummai Muhammad who left no stone unturned to see me through my education. Finally I also dedicate it to my dear husband, the children and the entire Inua family.

TABLE OF CONTENT

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

NHIS	National Health Insurance Scheme
OPD	Out Patient Department
TTH	Tamale Teaching Hospital
UDS	University for Development Studies
WHO	World Health Organisation

CHAPTER ONE

1.0 Introduction

This chapter discusses the background and the general conceptualization of this study. Other sub-sections discussed under this chapter include; objective of the study, research questions, problem statement, the scope of the study and its significance and the organization of the study.

1.2 Background of the Study

Good health for the people in countries is essential to the human development and improvement of their economies (Brundtland, 2001). Health service delivery has been explained as one of the services that demand high consumer involvement in the consumption process (Peprah, 2014). The whole process of the service delivery involves the client. A bad service delivery harms the client and to some extent could even lead to the loss of life. For this reason, checking and assessing client satisfaction with health care is an essential effort to improving the quality of the health system (Bara et al, 2002). Client satisfaction is the level of satisfaction that clients experience having used a service. This reflects the gap between the expected service and the experience of the service**,** from the client's point of view. Measuring client or patient satisfaction has become an integral part of hospital/clinic management strategies across the globe (Fekadu et al, 2011).

In the past, there was not much direct pressure to improve health service quality in Ghana, but now public health services face increased competition from the private sector (Atinga et al, 2011), along with rising expectations from patients who are more aware of what they need and what is available in terms of medical care. In the prior years, when hospitals were symbols of humanitarian efforts for community welfare, accountability for performance was of little concern.

Today however, people are increasingly concerned about hospital's performance because they are using increasing proportion of scarce community resources and there are increasing questions about quality and effectiveness. Moreover, client satisfaction of service healthcare basically refers to addressing what clients most readily appreciate, such as access, provider relationship, availability of information and opportunity for participation influences health care quality outcomes (Atinga et al, 2011).

The health sector in Ghana is undertaking quite a lot of transformation, and there is a remarkable scope for the application of quality concepts to healthcare (Peprah, 2014). Patients now have access to good quality healthcare, which comes with the readiness and ability to pay for medical care (Augustine, 2014). The main beneficiaries of a good healthcare system are clearly the patients, making them the focus of the healthcare delivery system. Health, which is mainly the relief or cure of ill health, is universally vital and this results in the imperative to provide high-quality services in response to developments in medicine and the desire of the caring professions to aspire to clinical excellence (Sewell, 1997).

According to Duggirala et al (2008), a healthy population, characterized by balanced birth and death rates, and a low incidence of disease, is considered critical to the development and prosperity of a nation. This can be attained when the quality of healthcare provided to the people is successful in appropriate management of the disease, and is accessible to the large widely held of the population at an affordable cost (Augustine, 2014). Patients have become more aware of quality issues and want health care to become safer and of higher quality where the providers have a moral obligation to provide high-quality and safe care.

In many countries, studies of patient satisfaction and experiences with health care are carried out regularly, and the results are made available to the public together with other indicators of health care quality. This means that the fundamental principle of a nation's health system should be quality patient-care. A healthcare service has been described as one that requires high consumer involvement in the consumption process.

Consumers especially in the developing countries are gradually becoming aware of their right to quality service delivery as far as their health is concerned (Abuosi & Atinga, 2013). As a result, the provision of quality services in the health sector is gaining strength and has made many stakeholders in the health industry, governmental institutions and consumers, to place much premium on unprecedented quality service delivery as means to eradicate hostile treatment effects and to meet consumer's numerous demands while fostering real value for money (Smith et al, 2006; Nketiah-Amponsah & Hiemenz, 2009). Abuosi & Atinga (2013), reveal that Ghana's health system has undergone several developments over the years with the utmost target of creating outstanding improvements in healthcare delivery. They further added that one of the major developments was the implementation of medium term health strategy from 1997 to 2001 by the Ministry of Health that stressed two important healthcare quality dimensions that is improving access to basic health services geographically and strengthening service delivery in health facilities. Health workers in Ghana are charge to maintain good attitudes and relation with patient for the reason that patients are more assertive now and are demanding value for money (Seth et al, 2015).

Client satisfaction is of prime importance as a measure of the quality of medical services because it gives information on the provider's success at meeting those client values and expectations, which are matters on which the client is the ultimate authority (Youssef, 2011).

The measurement of satisfaction is, therefore, an important tool for research, administration, and planning. The informal assessment of satisfaction has an even more important role in the course of each practitioner-client interaction, since it can be used continuously by the practitioner to monitor and guide that interaction and, at the end, to obtain a judgment on how successful the interaction has been (Donabedian, 1988). Clients generally have only a very incomplete understanding of the science and technology of care, so that their judgments concerning these aspects of care can be faulty. Moreover, clients sometimes expect and demand things that it would be wrong for the practitioner to provide because they are professionally or socially forbidden, or because they are not in the client's best interest.

Healthcare is the fastest growing service in both developed and developing countries (Dey et al, 2006). Patients are now regarded as healthcare customers, recognizing that individuals consciously make the choice to purchase the services and providers that best meet their healthcare needs (Wadhwa, 2002). Related to this, healthcare quality and patient satisfaction are two important health outcome and quality measure (Ygge and Arnetz, 2001; Jackson and Kroenke, 1997, Zineldin, 2006). Some literatures identified the satisfaction as a super-ordinate construct and considered perceived service quality as an antecedent of satisfaction (Cronin and Taylor, 1992; Cronin and Taylor, 1994). Some studies on health care service observed a causal relationship between perceived service quality and patient satisfaction (Woodside et.al, 1989, Choi et al, 2004). This finding implies that meeting the needs of the patient and creating healthcare standards are imperative to achieve high quality (Ramachandran and Cram, 2005). Therefore, the patient is the center of healthcare's quality agenda and satisfaction. This study will identify the factors that are associated with satisfaction in the Tamale Teaching Hospital and again find out the clients' knowledge of their rights to demand and expect service quality or satisfaction from the health care facilities.

1.3 Problem Statement

The provision of satisfactory health services is a product of a range of factors reflecting patients' expectations, values and experiences (Baker and Streatfield, 1995). In the face of heightening competition and customer sophistication, scholars and practitioners are laying more emphasis on quality service delivery as an important driving force to clients' satisfaction of service delivery and organizational excellence. These days, customers have become more knowledgeable and sophisticated in demanding for their rights partly due to technological upsurge and industrial interplay (Anthony, 2014). As a result, their expectations of service quality delivery have risen considerably. Customer satisfaction has become a subject of great concern to organizations and researchers alike in recent years where issues of quality service and customer satisfaction are concerned (Blumberg et al, 2005). These days there are a high number of complaints reported by the people who visit the hospitals due to the hostile attitudes and unpleasant satisfaction of services rendered to health personnel in the various facilities in Ghana.

Many customer satisfaction studies have concluded that there is a significant relationship between customer satisfaction and loyalty (Anthony, 2014). Hence, the primary objective of health service providers is to develop and provide services that satisfy patients' needs and expectations.

Assessing the factors associated with patient's satisfaction is an important issue for a healthcare provider to understand what is cherished by patients, and to know where, when and how service can be altered or possible improvement can be made as well as how the scarce resources of the healthcare service would be channelled. Customer needs and expectations are changing when it comes to governmental services and their quality requirements. However, service quality practices in public sector organizations is slow and is further exacerbated by difficulties in measuring outcomes, lack of supervision by management and the poor relation of health workers with clients.

The provision of service quality is of great importance to the management of all service organizations and hospitals should particularly be interested to providing excellent clinical care, also focus on providing quality service to their patients (Anthony, 2014). Furthermore, several studies (historic and recent) have indicated that a high level of service quality is related to an increase in profits, cost savings, and market share (Woodside et.al, 1989, Baker and Streatfield, 1995). This study show that it has and remains vitally important in the current health service providers to deliver patient satisfaction, quality service and effective medical treatment through the better understanding of service quality as defined by the customer and how to deliver this type of service.

The Ministry of Health (MOH) in Ghana has been concerned about quality of care, but improvements in quality have been slow partly because quality improvement activities have received inadequate priority (Doyle and Haran, 2008). There have been efforts to research into quality of healthcare and institutionalisation of quality assurance in Ghanaian health facilities (Turkson, 2009). Perhaps they continue to be complaints about the quality of care given by health workers or received by clients. Poor quality of healthcare results in loss of customers, lives, revenue, material resources, time, morale, staff, recognition, trust and respect and in individual and communities' apathy towards health services, all of which contribute to lowered effectiveness and efficiency (Bannerman et al, 2002). The MOH has identified improving the quality of healthcare as one its five key objectives of health sector reforms in Ghana (Turkson, 2009). It envisages that quality of care might be improved through paying more attention to the perspectives of clients, improving the competencies and skills of providers and improving working environment by better management, provision of medical equipment and supplies and motivation of staff (MOH, 2006).

It has been suggested that if health programmes are to succeed in resource-poor countries, it is important to get the opinions of the local people in addition to their degree of satisfaction with available services (Turkson, 2009). The patient's perception of quality of care is critical to understanding the relationship between quality of care and utilisation of health services and is now considered an outcome of healthcare delivery (Augustine, 2014). In view of the above mentioned and also the fact that little empirical studies have been conduction on clients' satisfaction, especially at TTH, this particular study is very crucial to fill this lacunar. The study therefore, examined customer or clients' level of satisfaction with services at TTH. A better understanding of the determinants of client satisfaction should help policy- and decision makers to implement programmes tailored to patients' needs as perceived by patients and service providers.

1.4 Research questions

The following research questions are set to guide the studies:

1. What are the categories of patients frequently using the OPD?
2. What is the level of patient satisfaction at the OPD of Tamale Teaching Hospital?
3. What are the enabling factors that influence patient's satisfaction?
4. What is the level of knowledge of patients regarding their rights?

1.5 Objectives of the Study

The general objective of the study is to assess the level of client/patients' satisfaction, and identify factors that influence their choice of health facility at the Tamale Teaching Hospital.

1.6 Specific Objectives

1. To determine the categories of patient who frequently use the OPD.
2. To examine the level of satisfaction of patients generally in the hospital
3. To evaluate and analyse the enabling factors that influences patient satisfaction.
4. To determine the level of patients knowledge regarding the patients charter.

1.7 Rationale of the Study

One significant trend in the health sector has been the emergence of client participation in determining the quality of health due them. This study therefore seeks to assess clients'/patients' satisfaction in the OPD of Tamale Teaching Hospital. The study will provide information on determinants of client satisfaction at TTH, and would inform management of TTH to develop and implement programmes that meet the need of clients to improve quality. In Ghana, many of the studies on clients' medical services satisfaction have often focused on the quality award dimensions (GHS, 2003; Osei et al., 2005; MOH, 2007b; Atinga et al, 2011).

Studies conducted in public hospitals over the years provide substantive evidence that, the quality of health services enjoyed by clients' is inadequate based on the opinion of patients (GHS, 2008; MOH, 2007). Moreover, research on quality healthcare has generally reported poor service delivery with respect to long waiting time, frequent shortage of drugs and the poor attitude of health providers as factors militating against patients' satisfaction with quality healthcare in Ghana (Turkson, 2009; Atinga et al, 2011). The study find it necessary to unravel the challenges that create room for dissatisfied services by clients, and provide further information for effective management that focus on patients satisfaction in health service delivery at the Tamale Teaching Hospital.

1.8 Significance of the Study

The quality of medical service has a very strong significant influence on the patients' overall perception of quality service delivery (Barker et al, 2008). Service quality offers a healing environment where the patient is more likely to continue utilizing services provided by the provider (Fottler et al, 2002; Atinga et al, 2011). Many studies on patient satisfaction with quality of care often place emphasis on communication, provider courtesy, support/care, environment of the facility and waiting time as important tools in measuring quality care. The study reveals to the stakeholder and public health institutions the view of patients' on the what influences their satisfaction with medical services they receives from services providers. This is important because even the best technical competence is worthless if it does not satisfy patients (Bielen & Demoulin, 2007). By understanding and documenting the patents' views, providers will be more aware of what is required of them.

The study also identifies the dimensions of medical services that are rated worst by the patients, thus indicating areas in which the service providers have weaknesses and the need to improve dimensions that are more highly rated. The study also contributes to health policy-making by documenting good practices to help hospital policy-makers pick out and apply lessons learned, to ensure a successful strategy of patients' satisfaction in all form of health service delivery.

Finally, it also adds to existing literature on patients' satisfaction and quality healthcare as well as the pool of knowledge on the clients' satisfaction with medical services literature in Ghana.

1.9 Scope of the Study

The study assessed clients'/patients' satisfaction with the medical service rendered to them in the Tamale Teaching Hospital (TTH). TTH is the largest health facility that receives many patient in the Northern region, due to its status as the only teaching hospital in the northern part of Ghana.

Patients who visit the facility were interviewed with survey questionnaire and sought their response in relationship to the study objectives. Respondents were selected using the appropriate sampling methods at the OPD in order to capture diverse views of all categories of clients who visit the facility. Understanding the factors that promote clients' satisfaction would aid management not only to identify its strengths and limitations but also on how to adequately channel its efforts in improving service delivery. The selected respondents were allowed to give their own assessment of the attitudes of health workers in the facility. However clients' satisfaction was aimed to basically measure clients' perception on the quality and value of medical health care they receive at the TTH.

1.10 Definition of Key Concepts

Patient

Refers to people waiting at Out-patient-Department of the various units in the hospitals.

Quality Medical Service

This study adopts the definition of quality medical service by Steffen (1988) who defined quality of medical services as the capacity of the elements of that service to achieve legitimate medical and nonmedical goals set by the patient with the assistance of the physician. This implies that medical goals are determined by the nature of the patient's illness and nonmedical goals are determined by the needs of the physician and the patient to maintain autonomy.

Clients' Expectation

Expectations here are the desires or wants of the client. It is the expectations the customer expects from the organisation and its range of products or services, i.e. what customers feel the organization should offer them.

These expectations are, in most instances, different from what the customer gets in real-life situations from the organization.

Clients' Perception

Client's perceptions in this study refers to the process of receiving, organising and assigning meaning to information that it gives meaning to the world that surrounds the customer. Perceived service quality is a client's judgment (a form of attitude) that has an outcome based on comparisons consumers make between their expectations and their perceptions of the actual service performance.

1.11 Organisation of the Study

This study is organized into six chapters. Chapter One spelled out the background of the study, problem statement, objectives of the study, research questions, the scope and organization of the study.

Chapter Two dealt with literature review. The issues discussed in the literature review included the specific research objectives of the study. Chapter Three outlined the methodology of the study, giving a clear explanation of how it was conducted: the study area, study population, sampling procedure and sample size, sources of data, instruments of data collection, data processing and analysis.

Chapter Four dealt with the presentation of the results of the study and provided detailed qualitative and quantitative analysis of the results for a clear presentation of the findings from the study. Chapter Five, also discussed into details the thematic areas on the results presented by the study. Finally chapter six provided a summary of findings, conclusions and relevant recommendations based on the findings of the study.

CHAPTERTWO

LITERATURE REVIEW

2.0 Introduction

This section presents a review of literature on client's satisfaction when they visit a health care providing institution. The review specifically covers customer satisfaction and its determinants, quality of customer care and patients' knowledge on their charter and its importance. This was to enable the researcher to meaningfully connect findings in the empirical literature to the findings from the field, in order to draw conclusions for the study. The overarching themes of the literature review are: the concept of service quality, the dimension of the service quality in relation to patient satisfaction and the factors that influences clients' satisfaction of medical care.

2.1 Patients satisfaction and quality healthcare in the context of Ghana

Ghanaians perceive the quality of health services as sub-standard and therefore choose alternative sources of treatment (Turker et al, 2001). The trust and confidence is undermined by frequent shortages of drugs and medical supplies, long queues, the absence of emergency services and poor staff behaviour. This has resulted in low utilization of health services despite the substantial investment aimed at improving access to health services in Ghana (Gyapong et al, 1996).

However, others perceive the quality of healthcare in Ghana to be high. Turker et al, (2001) looked at the quality of healthcare delivery in a rural district of Ghana and found that generally the quality of healthcare delivery was perceived to be high for most of the indicators used. That is ninety percent of the respondents were satisfied or very satisfied with the care given during their visit to the health facility. The participants however perceived poor attitude of some health workers, long waiting times, high cost of services, inadequate staff, and policy of payment for health as some of the dissatisfaction with health care in the facility

According to Newman (2001, page 126), "patients' satisfaction has become very serious consideration in health delivery to such an extent that, not only do a majority of a senior health care executives have compensation tied to patient satisfaction scores, but hospitals reimbursement is also being affected by patient satisfaction ratings".

The satisfaction of clients has now grown into international health care consideration since many governments have contributed financially and through other means to improve clients satisfaction. There is a lot of inconvenience on the part of patients who are given referrals to other hospitals due to lack of resource to cater for them in the facilities as being detrimental to effective delivery of quality healthcare. Furthermore, another study by Atinga et al (2011), examined how communication, provider courtesy, support/care, environment of the facility and waiting time significantly predict patients' satisfaction with the quality of healthcare in two hospitals located in northern Ghana. They observed that the five-factor model, support/care, environment of the facility and waiting time determine patients' satisfaction with quality of healthcare delivery.

Much of the literature on client views of the good doctor or clinic pertains to the relative importance of the technical management of illness as compared to the management of the relationship between the client and the practitioner (Youssef, 2011). Johnson (1995) interviewed patients about their reasons for liking and disliking certain doctors, and for continuing to receive care from one but not from another. Johnson (1995) concluded that patients assume that all doctors possess a minimal competence and they are concerned only with degrees of competence.

The patients' defined quality in terms of certain behaviors on the part of the physician, or attributes of his care, which they felt denoted personal interest or competence (Youssef, 2011). In addition, these two traits were, themselves, interrelated, since they were necessary conditions to a highly individualized application of medical knowledge to each patient condition, in a manner that took account of the patient's needs, expectations, and preferences.

2.2 Customer Care and Satisfaction

One of the desired outcomes of health care is client satisfaction which is directly link with health service utilization. According to Fekadu et al (2011) client satisfaction can be explained as the level of satisfaction that client experience having use a service. Client satisfaction is also frequently used in marketing services to measure how products and services meet or surpass client expectations. Also, satisfaction may be a person feeling of happiness or disappointment in a result for comparing a product perceived performance or outcome with its expectation (Kotler and Keller, 2009). Generally it is very difficult to satisfy all persons, this is because people have different aspirations, angle of imaginations and expectations. The word satisfaction may share a similar meaning as happiness, acceptance and coming to being what was expected.

However satisfaction is a judgment of peoples from over a period of time as they reflect from their experiences and it is not a phenomenon that has been waiting to be measured by people (Youssef, 2011). In addition, satisfaction is also seen as positive response of peoples to specific focus which is determined at a particular time (Willging, 2004). Patient's satisfaction is the main focus of health service delivery, therefore in planning development or improving quality of health service delivery, quality of service should be investigated to its maximum thus, quality of health service delivery includes investigating factors that brings out patient satisfaction with several factors.

Hospitals or health delivery institutions are known to be social units, due to their complex nature consisting of different professionals, customs and norms, for that matter patient satisfaction in health delivery is influenced greatly by different professionals, norms and customs.

Primarily, satisfaction derived by patient is a subjective judgment that results from appraisal of health delivery experiences, it involves the explicit and implicit relationship of the actual event with the expectation of the person involved .The degree or level to which a person or patient actual aspiration or expectation corresponds to the preferences regarding their experience.

It is now clear that different professionals' present different definitions to clients' satisfaction in terms of health delivery, however going with the said definitions, Tam (2004) suggested the definition of patience satisfaction by the use of content analysis of the satisfaction studies whereby five psychological variables were proposed to be possible determinants of individual's satisfaction in health care services. These include the following: occurrence (where the clients are able to have access to the service delivered due it availability or existence). The value judgment of the quality perceived as good or bad or a feature of health care encounter is considered by the customer as value. The expectation where a patient belief that certain attitude might be attracted to an object and judging importance of those attributes are the building blocks of satisfaction. In addition the interpersonal comparison which comprises the evaluation of individual's experience of current health care encounter with what he has already experienced. Finally the entitlement**,** which involves the individual thinking that he/she, has a solid and sound basis for claiming particular results.

Furthermore, Tarintino (2004) also named the following as the basic factors that impact on patients' satisfaction that is behaviour of doctors, behaviour of medical assistants, quality of atmosphere and quality of administration.

According to Tam (2004) there are evidences that show positive effect on customers' perception about service providers, such patients having little or some level of experience with the service they provide, positive information about even a single employee could lead to a perception that the firm provide positive services. However negative perceptions also go a long way to affect the health care delivery institution. Also patients, for that matter customers who benefited from services should tell others from their positive experiences, therefore indirectly turn to advertise that service provider (Chunulaka, 2010). According Tarintino (2004) customers that are not satisfied or happy most often change brands and engage in negative word of advertising. In the words of Levesque et al (1996) the idea of unsatisfied customer services could lead to a drop in customer satisfaction and willingness to advice friend to seek services from such institutions. Based on these facts, Taylor et al (1994) reported the five factors that contribute to customer satisfaction. Firstly there should be a clear understanding of customer needs and expectations, a perceived value of the product, the service quality which the client enjoys, an internal satisfaction which suit the preferences of the client and finally how best client complaints managed to maintain their loyalty with the service provider.

These therefore show that quality of service provided is also very important factor in consumer satisfaction. Taylor et al (1994) stated that among other things, doctors and nurses' service orientation and tangible evidence of facilities were the main factors considered by patients to be satisfied with health delivery services in Bangladesh

However Carman (1990) reported nursing care was the most important issue considered by patients in terms of satisfaction also, it was followed by the outcome of hospitalization and finally physical care at the third most important factor. In addition, Caman (1990) also stated that nursing care was the most determinant of patients' satisfaction and quality, followed by environment, nutrition, pain relief and transit time. This therefore indicates that nursing care is very important determinant in quality health delivery and patient's satisfaction.

However, Willging (2004)stated that waiting time and amount of caring were the most important determinants of patients satisfaction, also on waiting time, Saila et al (2002) reported that important reasons behind patients dissatisfaction with quality of outpatient care were, waiting time for appointment, length of waiting time, communication and information received, duration of consultation, lack of reachability, lack of continuity and not being able to participate in and contribute to decision making. Contrary to the waiting time as the most important determinant of patient satisfaction; Tam (2004) stated that even though waiting time is important, it is not the most important but rather identified nine key aspects of medical services providers' interaction with patients as: doctors' technical ability, doctors' interpersonal skills, quality of nurses, quality of support staff, efficiency of appointment system, waiting time., duration of consultation, physical environment and respect for patients privacy.

Baruch (1999) confirmed that satisfaction born from waiting time is important because it is not only a service satisfaction determinant but it also moderates the satisfaction sought for.
Moreover patient waiting time include perceived waiting time, the satisfaction with information provided in the case of the delays and the satisfaction of the waiting environment.

In terms of communication, Caman (1990) reported that patients' satisfaction level was highly influenced by communication and follow up care. Core qualities of communication were also important, such as communication access, interpersonal skills, care co-ordinations and follow ups. Client satisfaction is very important in health delivery because it helps policy and decision makers to implement programs that suit patient's expectation and that of the services.

There are also a lot of factors that come readily when client satisfaction is mentioned. Such as opening and closing time of service, behaviour of providers and drug prescribed. Since more democracy is needed in health service delivery, emphases are being laid on users' assessment of health care services.

According to Aldana et al (2001, page 512) "efficiency of medical treatment is enhanced by greater patient satisfactions" which at the end become a useful measure and to the extent that it is based on patient accurate assessment which may provide direct indicator of quality care.

The issue of closing and opening time of health services have much effect on the patients' satisfaction. According to Baruch (1999) the physical presence of health services also does not guarantee the ability to access it. In some cases, indigenous people in deprive areas might not have transport to attend hospitals or clinics across town or several suburbs away, also some general practitioners may not provide the types of services required by many indigenous clients with complex needs. The result can be that those clients need to travel some distances for appropriate alternative services (Soliman, 1992).

Sometimes the unavailability or insufficient numbers of medical officers delay accessibility of the service delivery. Since a huge number of OPD attendance is most popular in developing countries, which therefore calls for early start of work and prolonged working time, to enable the patient attending health centres to be seen by a Professional however this also put pressure on service deliverers.

According to Synay (2012) physical availability of health service begins with the existence of those services, but the distribution of services and the medical workforce is not uniform throughout Australia. Same is the problem in Ghana, where medical officers turn to concentrate in capital and regional capitals sometimes rendering accessibility of health services difficult. In addition, patients get frustrated after waiting for hours to see doctor and he or she is later told to report the next day since the doctor or the institution is closing the day's work, these sometimes discourages patients from visiting health institution to seek health care when ill, also even, if they do, they visit another health institution based on their previous experiences.

According to Anthony (2014) a study conducted in Bangladesh indicated that around half of community clinics were closed, some were providing little or no services, and in that case it was clear that the services available falls very short of what was planned. Also, in some cases patient end up spending the whole day at the health facilities whiles their intention was to come back early as possible to continue on their important duties, this also scare or discourages patients from visiting hospitals or health institution when they are sick.

2.3 Causes of Poor Quality Healthcare Delivery

2.3.1 Poor Customer Service

Inadequate provision of care in hospitals leads to lack of funds, interest, respect, belief among others (Iren et al, 2014). It is envisaged that clients receive good customer care by health facilities given much focus so far as patient's expectation is concerned. In the healthcare facility, for every 100 clients that experienced poor services, about 70 patients would be unlikely to patronize the same health facility again (Irene et al, 2014). Moreover, for the same 100 patients who have experienced deficient services, about 75 of them will tell average 9 relatives members and colleagues about their experiences; 75 dissatisfied patients who might have been potential patients will probably not patronize the health facility (Anthony, 2014).

2.3.2 Inadequate Health Professionals

Irene et al (2014) report on a study conducted in 2006 by WHO propounded that African accounts for 24% of the world sickness, meanwhile, 3% of the whole health employees are to take care of them and the movement of health professionals from developing countries to develop areas. This showed worldwide worry which is called "brain drain". According to the study diseases that affect the lungs also recorded 79,000 whilst 3.5 million recorded yearly (WHO, 2006). According to a study conducted by Turkson (2009) the researcher's focus on a community sectors above their understanding on prevention and treatment of diseases in Ghana. The research found out that inadequate health professionals, lack of ambulance at the hospital and payment policy were some of the factors that affect poor quality health care in Ghana.

2.3.3 Inadequate Resources/Materials

Anthony (2014) report that inadequate resource like human resources, equipment, consumable supplies and some essential medicine undermines health facility functioning, damages reputation, increased out-of-pocket costs to patients and brings a spiral of mistrust and alienation to the said facility and hence affect their clients satisfaction with the services delivered.

2.3.4 Untrained Staff

The low staff strength available to take care of patient in the facility are some of the factors that affect quality and accessible health care in Ghana. There are no enough staff training available in Ghana in order to take care of the available diseases, hence the need for continuous in-service training to build up the capacities of health personnel's. This can go a long way to bridge up the gap of inadequate health staff professionals in the various hospitals in Ghana (Donkor and Andrews, 2011).

2.3.5 Inadequate Funds

Ghana is one of the few African countries that started the National Health Insurance (NHI) law (Act 650). This was possible due to the small population size. Inadequate fund is a major challenge faced by most health facilities (Iren et al, 2014). The delay in the reimbursement of the NHIS consequently affects quality of healthcare delivery due to lack of enough fund to purchase medical equipment and supplies. Some of the challenges faced by the NHIS in Ghana include the institutional framework as provided for in the NHIS Act. The application of the framework has led to governance, operational administrative and financial challenges (Anthony, 2014).

2.3.6 Refusal of Postings

Chunulaka (2010) is of the view that movement factors by employees of hospital facilities are as result of priorities given to material items. Donko and Andrews (2011) in the research study indicated that health care professionals are ready to migrate from developing country to developed nation as a result of differential salaries between the two countries. The researchers caution adequate treatment will be given to clients of the developed nation due to higher salary.

2.4 Improving Patients Satisfaction

Sentimental analysis of comments gives room for an interpretation to gain deeper insight into patients' evaluation of a health facility. This measures how strongly patients feel using "natural language processing" (interactions between computers and human languages and it enables computers to derive meaning from human or natural language input) to complement the numerical ratings source. Higher levels of communication and explanation from the clinical and non-clinical staff, rank interactions with health care providers as paramount in how they evaluate their health care experiences, therefore if nurses and doctors communicate well and maintains a cordial cooperation between patients, they will react positively towards it source. Also, Dhand (2014) reported the following as straight forward ways to improve patients' satisfaction in hospitals: time with doctors and nurses, better hospital food, precise and clear about waiting time, privacy and trust and multidisciplinary rounding.

According to Gullapali (2002) patients' satisfaction with the medical care received can categorised into non-medical and medicals factors. Health care facilities especially in developing countries in their quest to improve patient's satisfaction should introduce of management systems that emphasis cost recovery (Gullapalli, 2002).

The system should first be developed to attract patients who can afford to pay for high quality services and should be extended to non-paying patients. Non-medical factors that need to be addressed to improve patient care include the following (Gullapalli, 2002):

Access: accessibility and availability of both the hospital and the physician should be assured to all those who require health care.

Waiting: waiting times for all services should be minimised. This can be addressed effectively through continual review of patient responses and other data and using this feedback to make the necessary changes in systems.

Information: patient information and instruction about all procedures, both medical and administrative, should be made very clear. Well trained patient counsellors form an effective link between the patient and the hospital staff and make the patient's experience better and the physicians' task much easier.

Administration: check-in and checkout procedures should be 'patient friendly'. For example, for in-patients, the facility should institute a system of discharging patients in their rooms, eliminating the need for the patient or the family to go to another office or counter in the hospital and waiting there for a long time.

Communication: communicating with the patient and the family about possible delays is a factor that can avoid a lot of frustration and anxiety. The system should create a special 'patient care department' with a full time this will go a long way to enhance interactions with patients and their families effectively.

The medical aspects of patient care are much better understood by most health care providers and are dependent on the quality of medical and technical expertise, and the equipment and quality assurance systems in practice (Gullapalli, 2002). According to Gullapalli (2002) factors that contribute to improvement of patient's care include the following.

Trained Personnel. A well-trained 'eye care team' is critical to providing high quality care with desirable outcomes. Lack of adequate personnel and lack of adequate training facilities for the available personnel are major problems. The temptation to recruit untrained or poorly trained people should be resisted. The number of training programmes must be increased, and the existing programmes must be improved. Making a uniform basic curriculum available for all training institutions/programmes should help bring about standardisation.

Quality Eye Care. There is significant concern about the outcomes of cataract surgery, and other common surgical procedures. Incorporation of quality assurance systems in every aspect of patient care is critical. For example, adherence to asepsis in the operating rooms will help reduce post-operative morbidity and proper training of ophthalmologists in diagnostic techniques will help achieve better control of sight threatening diseases.

Equipment. All the necessary equipment must be in place and properly maintained. This is vital to the performance of the medical system and contributes significantly to better results.

Use of Newer Technologies. It is important to continually employ newer technologies that improve the quality of care. Of course, this must be done with reference to cost-efficiencies. Improvement of patient care is a dynamic process and should be uppermost in the minds of medical care personnel. Development and sustenance of a patient-sensitive system is most critical to achieving this objective.

2.5 Privacy and Trust

Trust in some cases refers to being able to predict what other people will do and what situation will occur. Whiles privacy deals with being personal and not public. According to Mayer et al (1995) trust is when one party willingly put itself vulnerable to the other party and first one expects that the other party will do better in his part. These factors are truly considered by patients, when they visit health institutions for health care service, and therefore determines patient's satisfaction for health care delivery. In addition, Nimako and Azumah (2009) explained further that trust cannot be separated from vulnerability because in the absence of vulnerability there is no need for trust. Distrust or trust may avail itself more in case of greater vulnerability or risk, it is therefore very important to think of trust in case of vulnerable situations.

Furthermore, in health delivery, trust put the patient in a greater position to access a help from physician because vulnerability increases or call for more level of trust. According to Saynay (2002) trust develops between two parties under several conditions. Firstly, interdependency must exist between the seeker and provider, that is ones action must have an effect on the other, also there should be an alternative which must be chosen by any of the party and finally they must be a risk or uncertainty attached to those alternatives. These help one or two parties to place trust on each other and select one that the other party will act in best interest of them.

In other words, a trust for another person usually must be based on experience and knowledge of the other party, meaning the competences and willingness to act on behalf of one another.

According to Robinson (2003) trust is of different types and is multi-dimensional whereby one party focuses on a particular act, the others stress on personal attributes or characteristics.

Credibility and reputation are well understood by consumers, whether to believe or consult an institution is based on a reputation achieved by a health institution and its workers, meaning reputation plays very large role in the patients choice of a particular institution for health care and it goes a long way to promote patients satisfaction and the performance of the health institution involved. According to Herbig and Milewics (1993) reputation is a precious and valuable commodity; it takes time to build and needs continuous improvement to maintain. Reputation in health delivery is affected by experience, therefore an institution needs a consistency in their operation to build the needed experience therefore leading to building of positive reputation because health matters are serious since it involves life and therefore patients regard institutional reputation very importantly. Also as patients get treatment from health centres of their preference, it is important to measure the reputation depending on patients' perceptions (Irene et al, 2014).

Ramez (2012) states that the importance of a positive reputation to a hospital, since patients now have more choices in the health care providers they can choose and that hospitals need to continue to enhance the clinical and experimental quality of the patients care and effectively communicates their performances in the communities they serve.

2.6 Quality of Customer Care

The level of quality services provided at a particular health institution creates a bond between the patient and the institution. Customer care should seek to make available higher customer satisfaction, create customer loyalty which will therefore bring more customers to the health delivery institution involved (GHS, 2009).

It is believed that customer care is the surest way to increase acceptance of the health institution, thereby allowing patients to trust the institution for proper health care delivery in the time of need, based on this Shama and Chahal (2003) reported that patients satisfaction has become very important for all health delivery points due to the increase awareness created among patients and for that matter consumers. Patients are mostly attracted to services by focusing on quality (Solomon, 2009). Others also define service by a means of delivering value to customer by facilitating on quality. In other words services area means of delivering value to customer by facilitating outcomes. Zineldin (2006) also reports that service is the art of doing the right nothing, at the right time, in the right way, for the right person and having the best possible results. Institutions main focus nowadays is providing quality service, with the aim of satisfying and maintaining customers that will create a level of trust and build experience between them.

Hayford (2013) looks at three elements in service delivery and it include the following: the overall technical facilities, process and procedures of an organization, the staff behaviour and responses towards their serving and the staff effort and professionals judgments to improve quality of service. He continued that appropriate play of this three elements in a balanced manner for quality to be achieved and the appropriate and balance mix of these elements is determined by the relative degrees of service process customization, labour intensity, contact and interaction between the customer and the service process (Haywood,1988). The gap model, thus the most popular and strong tool is mostly used in measuring service quality dimensions. This can measure the customer satisfaction level regarding the quality of service.

Shama and Chahal (2003) concluded that the earlier ten dimension of the gap model were streamline into five dimensions as: tangibility which explains the physical facilities, equipment and appearance of personal of institution. Reliability is the ability to perform the promised service and responsiveness, is the willingness to help customers and provide prompt service. Assurance, thus how knowledgeable and courtesy of employees and their ability to inspired trust and confidence and Empathy which measures how much of an individual is given attention by the firm in the provision of service to its customers. Since there are now many health care facilities available, most of them turn to compete among themselves mostly in the field of patient satisfaction, this satisfaction is achieved by patients through various means such as responsiveness towards patients' needs and views, the continuous improvement of health care services and doctor patient relationship and also nurse patient relationship.

According to Zineldin (2006) health care providers are also interested in understanding the value of patients which help them to determine how patients perceive quality care and also know where, when and how service improvement can be made. Zineldin (2006) designed a comprehensive model on patients' satisfaction from health care providers and it is known as 5Q model. This includes the following:

Q1 is Quality of object: this refers to the technical quality that relates to technical accuracy of medical diagnosis and procedures.Q2 is Quality of process and it refers to the functional quality, how the health care organization provides the core services, thus how well activities are implemented practically.

Q3 is Quality of infrastructure measures the level of essential and basic resources that are needed to perform the health care services efficiently.

Q4 is Quality of interactions and it measures the quality of information exchange and Q5 is Quality of atmosphere and it refers to the relationship and interaction between two parties and how it is influenced by the atmosphere.

2.7 The Patients Charter

By definition, a charter is the grant of authority of rights, stating that the granter formally recognises the prerogative of the recipient to exercise the right specified. In addition, the Business Dictionary (2015) defined charter as a formal document or instrument that creates a legal entity, expectation, immunity, privilege or right, organisations mandates, functions and lay down rules and regulations. Furthermore Free Dictionary (2016) defined charter as a document issued by a sovereign, legislature, or other authority, creating a public or private corporation, and defining its privileges and purpose. Based on the various definitions, it emerges that patient's service health care and delivery have some privileges. It could be right to be told what is wrong with the patient or right for the patient to ask question or ask for clarification of something which might not be clear to him or her. However, for patients to be in position to exercise this privileges or rights both service provider and the patients must be well aware of the charter and what it constitutes. Being knowledgeable of a right or privilege encourages you to practise it. But the question is, are patients aware of their right when they visit the hospital. According to Buabeng (2014) staffs of Kasua Polyclinic in Ghana are aware of the existence of patients' charter and are very conversant with its content, meaning they help patients to benefit from their privileges and purpose when they visit the clinic. However, the visiting patients rather seem not to be aware of the existence of the patience charter and they have no knowledge of its content.

Therefore as medical staff work according to the charter to allow patients benefit from their rights to medical care it is assumed that health workers were being generous to them. For the successive and active operationalization of the patients charter, Drain (2001) suggested that at the health facilities, visiting patients should be informed about their rights and responsibilities, rights and responsibilities should be dramatized and air on television and radios in major Ghanaian languages which will go a long way to create awareness to the public for that matter visiting hospitals about their rights. Among the reasons of increasing legislations on patient rights is the improvement on quality of health care service delivery (Taylor, 1994). Furthermore, patients' rights are ways of ensuring the ethical treatment of all patients, since it forms the bases of patient satisfaction with treatment process, confidentiality, informed consent and privacy (Humayun et al, 2008). It is said that since patient have more physical, mental and social needs than other individuals due to their specific situation and vulnerability that may prevent them from meeting all necessary requirements, therefore it is very necessary to consider patients right and privileges as important.

Many countries all over the world ensured that their health care organisations have established regulations for patients and are announced and implement them in aid to enhance patients satisfaction (Manbari, 2000).When patients attending hospitals or the public as whole is made aware of their health seeking rights it increases quality of health care service, reduce cost and increases quick service delivery, decrease length of stay in the hospital, lower risks of irreversible physical damages and spiritual damages and also increases dignity of patients through informing them about their rights to participate in decision making.

However, if patients' rights are not respected, negative outcomes such as hazard to security and health situation of the health care seeker which can lead to negative relationship between staff and patients who will at the end affect the efficiency and effectiveness of the care provides.

Patients' awareness of the right also depends on some factors which differ from place to place. According to Fotaki (2012) patients knew more about some rights compared to others, thus patients awareness of their rights differs greatly from various regions of Russia. He suggested that all health care actors should provide adequate information in all regions (Fotaki, 2012).

Also reasons of patients being aware of some rights compare to others might be because some rights are embedded in treatment processes so patients are fully aware of them. What patients normally are aware of in term of right are trust and assurance to confidentiality of treatment team, providing sufficient information about treatment options and their complications. Medical professionals are very well aware of the right of providing information sufficiently on patients sickness and progress. However they withhold information from patients because they believe it could limit their authority (Kuzu et al, 2006).

It has been identified that age, gender and place of residency could affect patient ability to be aware of their rights; however, Zahra and Mouseli (2013) stated that there is no significant relationship between age and awareness of patients. However, the case for educational level and the place of residency was converse. Patients from urban areas were identified to have higher awareness about their rights compare to those from rural areas and promoting educational level of patients lead to patients awareness of their rights.

The Ghana Health Service (GHS) in aid to increase patients satisfaction and protection when they seek health care put a charter that treat every other person as equal irrespective of their age, sex, ethnicity and religious background. According to GHS, attainment of optimal health care is

a team work; it therefore requires collaboration between health workers, patients and society. In addition, health facilities should therefore provide for and respect the right and responsibilities of patients, families, health workers and other health care providers. The GHS, charter urged providers to be sensitive to patient's socio-cultural and religious background, age, gender and other differences as well as needs of patients with disabilities it therefore addresses the following:

1. The right of an individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the country.
2. Respect for patients as an individual with a right of choice in the decision of higher healthcare.
3. The responsibility of the patience/ client for personal and communal health through preventive, promote and simple curative strategies.

A study by the World Health Organisation (2007) shows that modern health care practise can only function when health care providers and patients behave as partners. However, Anku (2014) reported that, it was not the case when a nurse yelled at an old man who was rushed to hospital in a critical condition for reporting late to hospital. Over the years it has been proved that patients who are informed, involved in the process of their treatment and whose rights rare respected by health care practitioners, recover more quickly and have shorter stay in hospitals. The question then arises, is the rights or charter implemented and is the majority of public aware of them. According to Donkor and Andrews (2011) formulating the rights was not enough without regulating and implementing them; the two needs to move and complement each other.

The concern of health authority should be how possible the rights would massively be enforced in the nation's health facilities and practitioners will put them in practise in their day to day health care delivery systems (Donkor and Andrews, 2011). Care givers often cite the large number of patients waiting for them to attend to as an excuse to deny patients most of their rights, they normally complain there is just not enough time to explain everything to the patient. A patient may be thrown off or given cheeky answers or even abused by the care-giver to a patient who really wants to know what is wrong with him or her.

2.8 Factors that influences clients satisfaction of medical services

Patient satisfaction is defined as an evaluation of distinct healthcare dimensions (Linder-Pelz, 1982). It may be considered as one of the desired outcomes of care and so patient satisfaction information should be indispensable to quality assessments for designing and managing healthcare (Turner and Pol, 1995; Naidu, 2009). Patient satisfaction with health care has been argued as a subjective and dynamic perception of the extent to which expected health care is received (Senarath, et al, 2014). Jenkinson et al (2001) suggests that immediately after the visit, patient satisfaction is strongly influenced by patient-doctor communication variables and at all-time points, satisfaction is influenced by both patient age and functional status. According to them, patient satisfaction is used for four purposes: (1) to compare different health care programs or systems, (2) to evaluate the quality of care, (3) to identify which aspects of a service need to be changed to improve patient satisfaction, and (4) to assist organizations in identifying consumers' likely to disenroll.

The physical setting in which services are delivered has been found to influence customer service performance evaluations, including customer satisfaction (Bitner, 1990, 1992; Parasuraman et al, 1985, 1988). In the healthcare literature, a common finding is that physical facilities are a component of patient healthcare evaluations (Woodside et al, 1989). Swan et al, (2003) recent study showed that room appearance affects patient perceptions and satisfaction. Their study compared patients' evaluations of rooms that ranged in quality. Healthcare dimensions affected by room appearance are: physician skill and expertise, physician and nurse courtesy (answering questions, listening to concerns), food (overall satisfaction, receiving what was ordered, temperature), general hospital evaluations, the intentions to use the hospital again and recommending the hospital to others. On all these dimensions, patients staying in appealing rooms gave more positive evaluations than those in typical rooms. However, regarding nurse behavior (answering calls, explaining illness, treatment and home care) no significant differences were found between room types. Patient satisfactions of the health care delivered are also influenced by the quality of services.

According to Tucker and Adams (2001) quality is positively correlated with satisfaction; however, the direction and strength of the predictive relationship between quality and satisfaction remains unclear. Some authors believe that complex healthcare services and the patient's lack of technical knowledge to assess them should incorporate broader healthcare quality measures, including financial performance, logistics, professional and technical competence (Niadu, 2009). Quality is a judgmental concept (Turner and Pol, 1995) and operational quality definitions, as we have seen, are based on values, perceptions and attitudes (Taylor and Cronin, 1994). The implication thus is to develop quality measures based on expert judgment, specifically insightful customers and respected practitioners (Turner and Pol, 1995).

Consequently, healthcare quality can be categorized in three ways (Donabedian, 1986) which include; the technical aspects (how well clinicians diagnose and treat problems), the interpersonal component (provider responsiveness, friendliness and attentiveness) and the amenities (health care facility appeal and comfort).

Individual healthcare quality measures include (Donabedian, 1986):

1. Structure – the medical delivery system's fixed characteristics such as staff number, types, qualifications and facilities.
2. Process – what is done for the patient such as treatment,
3. Outcomes – changes in the patients' current and future health attributed to antecedent medical care.

Drain (2001) integrative patient evaluation model shows how caring, empathy, reliability, responsiveness, access, communication and outcome dimensions predict satisfaction and quality as moderated by the patients' socio-demographic characteristics. Also Conway and Willcocks (1997) integrated model applies service quality to healthcare settings. It incorporates influencing factors such as: the patient knowledge and experience, the perceived risk/pain/distress level, the affiliated parties' experience, the provider information, the provider's image, the affiliated parties' information, the patient preference, the patient personality; and socio-economic factors with measurement issues (reliability, responsiveness, tangibles, assurance, empathy, information, access, redress and representation).

For each, the degree of confirmation/disconfirmation is incorporated with expectations and service-quality gaps (Parasuraman et al, 1985) to arrive at patient satisfaction levels.

Baruch (1999) found patients in large multi-specialty organizations were more satisfied with physicians who fit an expected demographic norm (middle-aged, Whiteman from higher socio-economic groups). Also, a greater match between role expectations and physician behaviour meant more satisfied respondents (Ditto et al, 1998). There is a clear relationship between medical care satisfaction and patient compliance; when patients are dissatisfied with medical advice they are less likely to cooperate. Ditto et al (1998) argue that it is healthcare's socio-emotional component rather than the physician's perceived competence or intelligence that seems to be most important in determining patient satisfaction with their physician, and consequently their adherence to treatment regimens. According to the authors, patients encounter two physician types – authoritarian and egalitarian. The former is defined as one where the physician assumes the role of an expert and primary decision maker.

The patient expecting such a role places great faith in the physician's abilities, anticipating the physician will provide clear-cut treatment. The egalitarian belief, on the other hand, is defined as one where the patient expects the physician to make treatment recommendations, discuss options and allow the patient to participate in treatment decisions (Ditto et al, 1995). Subjects expressing authoritarian beliefs about physician roles tend to show greater healthcare utilization by visiting medical professionals more often (Naidu, 2009). Beliefs about physicians were unrelated to age, gender, marital status, race or education. Authoritarian role expectations were also found to be significantly associated with longer physician-patient relationships. Authoritarian expectation subjects reported poorer health status than egalitarian ones.

Physicians presenting treatment in an egalitarian style were perceived as significantly more competent and inspired greater confidence in both themselves and their prescriptions than did authoritarian physicians (Naidu, 2009).

2.9 Conceptual Framework for the Study

Various instruments have been developed over the years for the measurement of consumer satisfaction in the medical care sector with no defined consensus among the instruments (Onyeka, 2014). Challenges plaguing the determination of consumer satisfaction through research include ascertaining how to best fashion the research strategy and approach. Hayford (2013) developed the satisfaction with physician and primary care scale; Ware & Irene et al (2014) noted that consumer satisfaction is largely subjective and based on individual's perception. If that is the case the measurement of consumer satisfaction in medical care will be better achieved using qualitative means. For instance Onyeka (2014) noted that interviews (telephone and face-to-face) generate higher responses than mail survey.

Quantitative approach will only permit consumers to give answers to fixed questions or simply choose from a list of answers as provided in the questionnaire. This may be strongly limiting, as the respondents will be compelled to stay within the confines of the provided questions. By using qualitative approach the researcher is better positioned to understand the body languages of the respondents including their attitude, behavior, value system, culture, life style, concerns, aspirations and emotions (Onyeka, 2014). The model specified for the study is developed from SERVQUAL for measuring customers' perceptions of service quality (Parasuraman et al1988). Parasuraman, Zeithaml and Berry (1985) propose that service quality is a key function of the

differences between expectation and perception along the quality dimension. This model was developed based on a gap analysis (Parasuraman, Zeithaml, & Berry, 1985). The model developed from SERVQUAL was designed to measure components of customer satisfaction by using five dimensions of real or potential gaps in service quality of a hotel (Saleh & Ryan, 1991). The various gaps in the model are visualized as:

i. Gap1: Difference between consumers' expectation and management's perceptions of those expectations, thus not knowing what consumers expect (Parasuraman et al, 1985; Nitin et al, 2005; Gunawardane, 2011).
ii. Gap2: Difference between management's perceptions of consumer's expectations and service quality specifications, thus improper service-quality standards (Dabholkeret 2000, Drain, 2001).
iii. Gap3: Difference between service quality specifications and service actually delivered, that is the service performance gap (Groonroos 1984; Matterson, 1992; Nitin et al, 2005).
iv. Gap4: Difference between service delivery and the communications to consumers about service delivery, thus whether promises match delivery (Parasuraman et al, 1988; Groonroos, 1984; Nitin et al, 2005).
v. Gap5: Difference between consumer's expectation and perceived service. This gap depends on the size and direction of the four gaps associated with the delivery of service quality on the marketer's side (Parasuraman et al, 1988; Nitin et al, 2005).

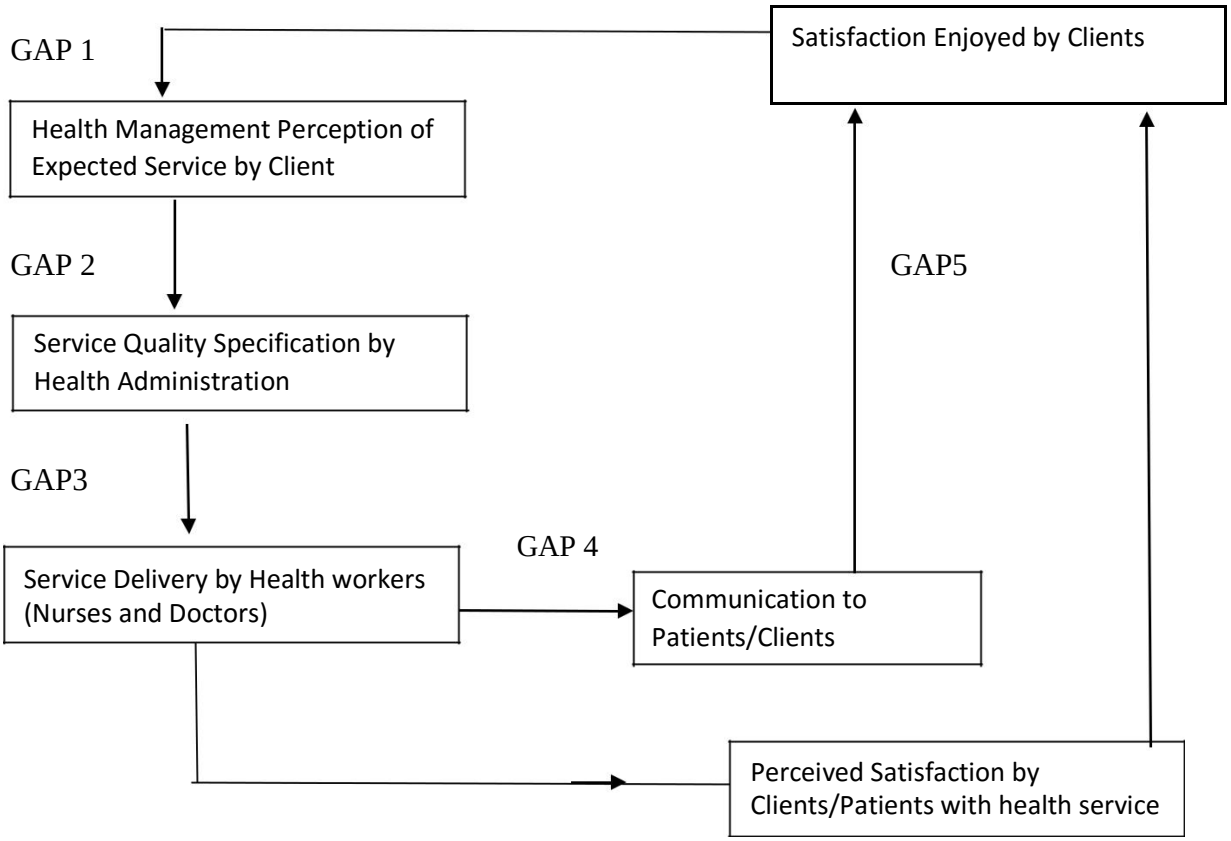


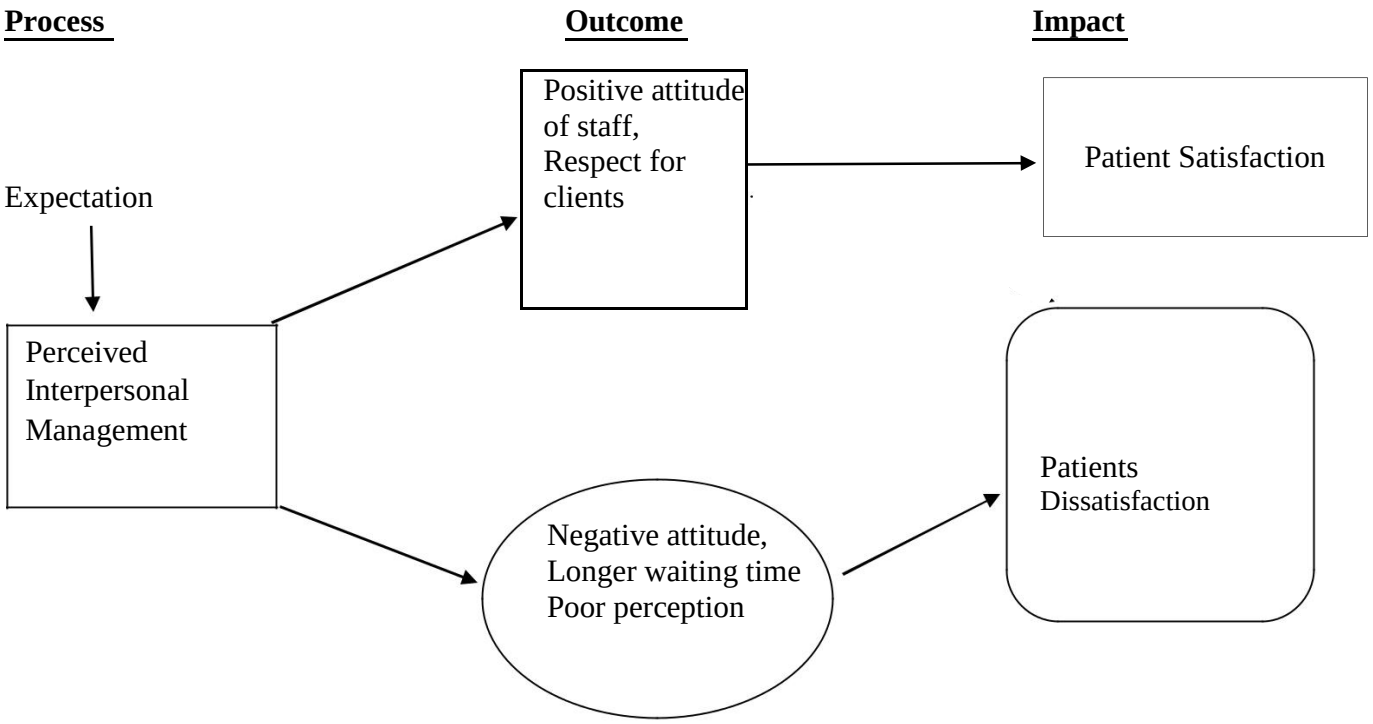
Figure 2.1: Conceptual Framework for Measuring Clients Satisfaction of Healthcare. Adapted from Parasuraman et al, 1988).

2.10 Proposed conceptual model of the study on Clients' Satisfaction with Medical Service

The model as shown in Figure 2.2 explains the flow of client satisfaction with healthcare from the facility based on his/her expectation which in the long run maintains his continuity of care and loyalty as a result of the personal satisfaction received from health personnel. Patients who visit the health facility have their perception of how better healthcare based on their experience or advise from a friend or relative, hence make the choice of going to the facility to seek medical health care.

The outcome which measures how best his satisfaction is met based on the expectation influences the client to either chose to stay with it or not. Patients becomes dissatisfied with service based on indicators such as poor attitude of health workers, long waiting time to access health care and might discontinue seeking medical healthcare from the facility.

Figure 2.2: Conceptual Model of Clients' Satisfaction with Medical Service



Source: Author's Design, 2016

2.11 Summary of Literature Review

The literature covers a review of the specific objectives that forms the overall objectives of the study. First and foremost it highlighted more review of patient satisfaction in the Ghanaian context. Many people in Ghana are not able to express their displeasure of the seeking health care in public hospitals and some considers it as sub-standard and hence resort to other alternative of health care. Patients' satisfaction of health care is a major factor which people consider and hence ensure their comfort and satisfaction in selecting their choice of health facility in Ghana

However much of the literature on client views of attitude and relation of health personnel is more on the relative importance of the technical management of illness as compared to the management of the relationship between the client and the practitioner (Youssef, 2011).

Secondly one of the desired outcomes of health care is client satisfaction which is directly link with health service utilization. Generally it is very difficult to satisfy all persons, this is because people have different aspirations, angle of imaginations and expectations. Satisfaction is seen as positive response to services rendered at the medical facility and hence maintain their loyalty if they are satisfied with the care given to them.

According to Linder (1982) the determinants of individual satisfaction in health care depends on five psychological variables. These include it occurrence for them to have access to health care, value judgment of the quality perceived, expectation which builds on their satisfaction, interpersonal comparison and entitlement which gives room for them to claim particular results.

Taylor (1994) also reported the five factors contributing to customer satisfaction in the medical health care; patients' clear understanding of customer needs and expectations, perceived value of the product, service quality, internal satisfaction, and complaint management. However Irene et al (2014) stated that among other things, doctor's service orientation, nurse's service orientation and tangible evidence of facilities are the main factors considered by patients to be or their satisfaction with health service delivery. Communication between patients and health personnel also plays and important roles in ensuring their satisfaction. Therefore if nurses and doctors communicate well by explaining patient responses to treatment they will also react positively and becomes satisfied with their output.

Naidu (2009) reported factors which improve patients' satisfaction in hospitals; time with doctors and nurses, a good night sleep by patients in the facility especially when on admission, better hospital food provided, be clear about waiting time to avoid frustrations and a multidisciplinary rounding thus patient access to doctor at random time and nurses with minimum efforts or inconvenient.

The trust between patients and health personnel also plays a key role in ensuring their satisfaction of health care given. Furthermore, in health delivery, trust put the patient in a greater position to access a help from physician because vulnerability increases or call for more level of trust. According to Drain (2001) trust develops between two parties under several conditions such as; interdependency must exist between the seeker and provider, and there should be an alternative which must be chosen by any of the party and finally they must be a risk or uncertainty attached to those alternatives. In other words, a trust for another person usually is based on experience and knowledge of the other party, meaning the competences and willingness to act on behalf of one another. The patient charter is another important factor health personnel must forestall in the delivery of transparent services to their clients. It is defined as a formal document or instrument that creates a legal entity, expectation, immunity, privilege or right, organisations mandates, functions and lay downs rules and regulations. However, for patients to be in position to exercise this privileges or rights both service provider and the patients must be well aware of the charter and being knowledgeable of a right or privilege encourages the satisfaction of the patients.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter discusses the study area and the methodology that was used to carry out the research. It provides an explanation of how this study was conducted. Specifically these include the sampling procedure and size, data collection and sources, instruments for data collection, field work, data processing and analyses.

3.1 Study Area

3.1.1 Tamale Teaching Hospital

The Tamale Teaching Hospital is the only teaching hospital in the Northern part of Ghana. It was formerly known as the Tamale Regional Hospital. It was commissioned on 2nd February, 1974 by Lt. Col. I.K Acheampong, the then Head of State of Ghana. TTH is located in the Eastern part of Tamale Metropolis with a total land surface area of 490,000 square meters. The hospital is currently undergoing major rehabilitation and expansion works and it serves as a clinical institution for the ; School of Medicine and Health Sciences (SMHS), Ghana College of Physicians and Surgeons, Nursing and Midwifery Training College, Tamale, Health Assistants Training School (HATS), Northern region and the Health Module of the National Youth Employment Programme (NYEP). In 2005 the Northern Regional Coordinating Council decided to partner the Ghana Health Service to upgrade the hospital to the status of a Teaching Hospital. The upgrade made the hospital the third teaching hospital in the country. The upgrade was to help with the training of health professionals from the University of Development Studies.

TTH serves as a referral hospital for the three northern regions of Ghana**.** It cooperates with the University for Development Studies in Northern Ghana to offer undergraduate and graduate programs in medicine, nursing and other health sciences. It is the third teaching hospital in Ghana after the Korle Bu Teaching Hospital and the Komfo Anokye Teaching Hospital.

The Tamale Teaching Hospital management is headed by the Chief Executive Officer and is assisted by five (5) directors as prescribed by law. The Chief Executive officer is responsible for the execution of the policies and decisions of the Board and the day-to-day administration of the Teaching Hospital. The five administrative directorate of the TTH include; administration, finance, pharmacy, medical affairs and nursing. Their activities coordinate together and ensure a smooth running of the teaching hospital and hence able to deliver on the mission of providing quality and affordable healthcare; delivered by well trained, highly motivated and client-friendly professional health staff.

3.1 Research Design

The study adopted the case study design and gathered data from clients who visit the facility at the OPD level, through observations and interviews. The case study approach was adopted to achieve the results of the study objectives with a limited enquiry in the Tamale Teaching Hospital of the Northern region. This design was adopted because it is a method used to narrow down a very broad field of research into easily researchable study (Bastram, 2000). The adopted design allows the researcher to limit all enquiries on clients' satisfaction with medical services at TTH, and proposed further information and recommendations to address these challenges of patients' satisfaction with health services provision in the Northern region.

3.2 Sampling Technique and Size

The study adopted convenient and simple random sampling to select respondent for the study. Convenience sampling was employed due to the accessibility and proximity to conduct the study by the researcher. The region have other health facilities but based on the convenience and limited resource of the researcher, TTH was chosen to carry out the study. Simple random sampling was used at the OPD to select respondent at random who walk in to access medical health care. Thus participants were randomly selected with equal chance for both gender to avoid bias of skewed response to respond to the study.

3.3 Sample Size Determination

The sample size for the study was determined by the intuitive method. The intuitive method is defined as sample determined based on the researcher's own judgment. Thus sample required was determined based on the resources of the researcher to carry out the study at the specified time period. Again the total sample was arrived based on the number of questionnaire administered within the six days period of the data collection exercise. In all the study covered 120 individuals who came to access medical care from the facility. Again the researcher was constrained by financial resources to interview all patients at the TTH, hence it was more appropriate to consider the total sample of 120 at the end of the six day period of data collection exercise in the facility.

3.4 Data Collection

The study used primary data which was collected through questionnaire assisted interviews at the OPD in TTH. Data was collected through direct interviews to respondent who were willing to answer the study questions. The researcher was assisted by 9 data enumerators making up 10 interviewers together with the researcher. Respondents were interviewed in the local dialogue

(illiterate) whiles those who were literate were interviewed in English language. In all the data collection was done in six days at the OPD level.

3.5 Data collection instruments

This study employed questionnaire, structured interviews and observation as the valid and reliable instruments to collect relevant information for the data analyses. Questionnaires were the main tool that was used to interview respondents selected for the study. This enabled the researcher to collect information with a face-to-face interview with respondents with large sample of the given population contacted at relatively low cost. The purpose of the structured interview was to explore the responses of the people to gather more and deeper information on the subject under study. Observations were also employed to provide extra information that was added to the verbal answers of the interviewees and hence ensured reliable information gathered from respondents.

3.6 Quality Assurance in Data Collection

3.6.1 Pretest

A pretest is a test that involves an interview setting where respondents are asked to respond and react to predefined questions to validate and measure the outcome variable or objective of a survey. The questionnaire for the survey was pre-tested in the Tamale Central Hospital with five (5) research assistants who were trained and schooled on how to administer the questionnaire. The pretest was done in a day with 12 respondents comprising 7 patients at the OPD who participated in the exercise. The essence was to test the survey questionnaire before using it to collect data. In addition this was to identify questions that were ambiguous to participants, or problems with the questionnaire that might lead irrelevant answers. More so asking the respondents to answer the questions gave provisions to comment on the wording and clarity of

the structured questionnaire for the main questionnaire administration. The first draft of the questionnaire was then revised and prepared for the main questionnaire administration based on the experience and comments from the pretest conducted.

3.6.2 Questionnaire Administration

The questionnaire administration was done with 10 research assistants including the researcher at the OPD in the Tamale Teaching Hospital. The consent of the TTH administration was sought with the objective of the survey made known to the authority and the respondents before beginning any interview. Participants in the survey were interviewed upon expressing their willingness at a scheduled period when they are less busy or free to respond to the questions. A total of 120 respondents were interviewed in 6 days in the study area.

3.6.3 Data Processing

The raw data was processed with the help of Statistical Package for the Social Science (SPSS). Quantitative variables such as age, marital status, number years of experience and educational status among others were coded into forms that can be used to conduct statistical data analysis in SPSS.

3.7 Data Analyses

Both quantitative and qualitative data analysis techniques were used. Quantitative data was analyzed using descriptive statistics while qualitative data was also analyzed with central tendencies and dispersions. With the help of Statistical Package for Social Sciences (SPSS) inferential statistics such as probability value (test of significance) was also used to test the relationship between the variables of the study. The results of data processing and analyses were generated in the form of percentages, tables and graphs with the help of Microsoft Excel

spreadsheet. Percentages, graphs, chart and cross tabulation were used to present the data to make the results clear for understanding and interpretation of the findings of the study.

3.8 Ethical Consideration

Before the study was carried out, the researchers sought the consent of respondents by explaining the purpose of the study to them and assuring them of their confidentiality. In addition to this, the researcher administered the questionnaires to respondents who were willing and have agreed to share their experience about the medical care they receive from TTH. Thus the consent of patients was sought about the study solely for academic purpose. In addition permission was also obtained from TTH authority before carrying out the study. This was to ensure that the study is guided by the ethics of an academic research in the area of study.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter of the study presents the main results on the thematic areas of the study, based on the stated objectives. The main objective of the study was to assess clients' satisfaction of medical services in the Tamale Teaching Hospital. In addition the key socio demographic variables that affect the findings of this study are also presented followed by the results of the specific objectives.

4.1 Socio Demographic Characteristics

The key socio demographic variables of respondents presented under this section include; gender, age, occupation, educational background, age of patient who uses the OPD and place of resident. The gender variable was measured by the proportion of males and females who visit TTH to seek medical care at the OPD level. Majority of respondents were females representing 52.5% and 47.5% males. The ages was categorised into 18 – 30 years, 31 – 40 years, 41 – 50 years and Above 50. Majority of the respondents were within the age group 18 - 30, representing 77.5% followed by 31 – 40 years representing 10.8% of the sample, however only 5% were between 41 - 50 years.

The levels of education of respondents were group into people with no formal education, basic education/JHS, Secondary education/vocational and tertiary. The study revealed that majority of the respondents obtained senior high school certificate representing 40%, this was followed by those with no formal education (30%). The least among them were tertiary level which constituted 8.3% of the total sample.

The place of residence of respondents were from urban areas of the Tamale metropolis representing 62.5% of the total sample whiles the others were from the rural areas of the Northern region, which also were about 37.5%, who were largely made up of farmers and traders who resides in communities within and the rural areas of the Northern region. The occupation of respondents comprises of students, traders, public servants, business men/entrepreneurs, farmers, private sector workers. The survey revealed that majority of the respondent were traders representing 25.8%, this was followed by public servant (20%) and business men/entrepreneurs (16.7%). However the least among them were private sector workers.

The survey revealed that majority of the patients were between 18 – 30 years, representing 65%. This was followed by people within 31 – 40 years (15.8%) and 41- 50 years (10.83%). The least among them were those above 50 years (8.3%). The results are illustrated in Table 4.1.

Table 4.1 Socio-demographic Characteristics of Respondents

Demographic Variable	Categories	Frequency	Percentage (%)
Gender	Males	57	47.5
	Females	63	52.5
	Total	**120**	**100**
Age	18 - 30	93	77.5
	31 - 40	13	10.8
	41 - 50	6	5
	Above 50	8	6.67
	Total	**120**	**100**
Level of Education	No formal Education	36	30
	Basic/Junior High School	26	21.7
	Secondary/Vocational	48	40
	Tertiary	10	8.3
	Total	**120**	**100**
Place of Residence	Urban	75	62.5
	Rural	45	37.5
	Total	**120**	**100**
Occupation of Respondents	Students	17	14.16
	Farmers	15	12.5
	Traders	30	25.8
	Public Servants	24	20
	Business/Entrepreneurs	20	16.7
	Private Sector Workers	14	10.8
	Total	**120**	**100**
Age group of patient who use OPD frequently	18 - 30	77	65
	31 - 40	19	15.8
	41 - 50	13	10.8
	Above 50	11	8.3
	Total	**120**	**100**

Source: Field Survey, 2016

4.2 Level of Satisfaction of Patients in TTH

The level of satisfaction of patients' medical care was measured by their own assessment of how best it meets their expectation in terms of quality of treatment, attitudes of health personnel and fairness devoid of favors and special care to a particular group of people. The study revealed that 35.8% of patients who were mostly illiterate or had basic educational status were satisfied with the time spent to process NHIS folder before seeing a doctor, and 8.3% (tertiary educational status) were very dissatisfied with the time spent to process NHIS folder.

In addition about 33.3% of patients (senior high school educational status) were neutral with the duration of waiting time before seeing a doctor, whiles 20.8% were satisfied with it. The attitude of health workers at the OPD revealed that 24.2% were satisfied with their attitude and 11.7% were very dissatisfied with their attitudes and 10% were also very satisfied as shown in Table 4.2.

The availability of drugs after patients has seen a doctor also revealed that 23.3% were satisfied with health care given, whiles 13.3% were dissatisfied with the availability of drugs in the hospital. More so 23.3% of people who attained senior high school and basic education were satisfied with access to information whiles 13.3% of the tertiary and diploma educational status were very dissatisfied with access to information from health workers.

Table 4.2 Clients Satisfaction Level of Medical Service in TTH

Characteristics	V. Sat (%)	Sat. (%)	Neut. (%)	Disst. (%)	V. Disst(%)
Time spent to process NHIS folder	17.5	35.8	23.3	15	8.33
Duration of waiting time before seeing a doctor	8.3	20.8	33.3	22.5	15
Attitudes of Health workers at OPD	10	24.2	29.2	25	11.67
Consulting service	15	32.5	10	16.7	13.3
Confidentiality	33.3	29.2	10	16.7	12.5
Availability of drugs	20	23.3	25.8	17.5	13.33
Access to information from Health workers	17.5	25	26.67	15.8	15
Food provided on admission	18.3	21.7	25	21.7	13.3
Ways questions and queries are Dealt by staff	15	22.5	26.7	24.2	13.3

v.sat= very satisfied sat= satisfied Neut.= neutral disst.= dissatisfied v.disst.= very dissatisfied

Source: Authors own calculation, 2016

4.3 Clients' Satisfaction with the Attitudes of Health Workers in TTH

The study conducted a chi square test to assess the relationship between health workers attitude with patient's and clients overall satisfaction with the socio-demographic characters of the respondents. (Table 4.3). The results revealed that male were satisfied with the attitudes of the health workers in the TTH. About 50.88% of the respondents were satisfied with their attitude whiles 49.12% were dissatisfied with the overall attitude of health workers in TTH. However the chi square test revealed no significant statistical relation (0.341) with the gender of the respondents and the attitude of health workers in TTH. However there was significant level (0.031) in the age of patients and attitude of health workers in the facility. About 70.97% of clients whose ages are between 18

– 30 years were satisfied with the attitude of health workers whiles 29.03% were not. More so 66.67% of patients within 41 – 50 years were also satisfied and 33.33% were not satisfied. The place of residence of a patient also revealed that about 60% of patients who were from both urban and rural residence were satisfied with the attitude of health workers whiles 40% were not. The chi square test revealed a significant statistical difference (0.002) in the place of residents and the attitude of health workers. The Marital status of respondents also revealed a significant level (0.000) with the attitude of health workers in TTH. About 66.18% of married patients were satisfied with health workers attitude in TTH whiles 33.82% were not. While 55.77% of single patient were satisfied with health workers in TTH and 19.17% were not. The rest of results are further illustrated in Table 4.3.

Table 4.3 Patients' Satisfaction with Health Workers Attitude in TTH

Characteristics		**Satisfied Freq(%)**	**Dissatisfied Freq(%)**	**p-value**
Gender	Male	29 (50.9%)	28 (49.1)	0.341
	Female	49 (77.8%)	14 (22.2%)	
Age	18 - 30	66 (70.9%)	27 (29%)	
	31 – 40	6 (46.2%)	7 (53.9%)	
	41 - 50	4 (66.7%)	2 (33.3%)	0.031
	51 – 60	3 (60%)	2 (40%)	
	Above 60	2 (66.7%)	1 (33.3%)	
Level of Education	No formal Education	23 (63.9%)	13 (36.1%)	0.367
	Basic/JHS	16 (61.5%)	10 (38.5%)	
	Secondary/Vocational	29 (60.4%)	19 (39.6%)	
	Tertiary	4 (40%)	6 (60%)	
Place of Residence	Urban	45 (60%)	30 (40%)	0.002
	Rural	15 (60%)	10 (40%)	
Marital Status	Married	45 (66.2%)	20 (33.9%)	0.000
	Single	29 (55.8%)	23 (19.2%)	

Source: Authors Calculation, 2016

4.4 Client Satisfaction with OPD waiting time

The satisfaction patients enjoy at TTH was measured by the waiting time taken by patients to undergo procedures or stages from acquiring a folder to receiving medical drugs on a treatment plan. Patients own assessment of satisfaction was measured by the limited duration it took him/her to receive medication. The study revealed that 57.1% of patient who were attended to by NHIS staff in less than 30 minutes were satisfied service rendered in receiving NHIS folder whiles 42.9% were dissatisfied. Again 57.6% of patients who were attended to by NHIS staff within 31 – 1 hour were satisfied with services whiles 42.4% were dissatisfied. In variably 73.1% of patient who were attended to within 1 – 2 hours were dissatisfied with their services. However there was a significant statistical difference which determines their overall satisfaction of medical services in TTH.

For the time taken to see a doctor after receiving a NHIS folder, 60.9% of clients were satisfied with the services rendered in less than 30 minutes, whiles 39.1% were dissatisfied. However 37.5% of clients who were attended to by a doctor within 1 -2 hours were dissatisfied with their services, whiles 62.5% were dissatisfied with their services. The results also revealed a significant statistical relation in the time taken to see a doctor in less than 30 minutes by clients in TTH. The time it took a patient to receive a lab specimen also revealed an equal proportion of 50% patient who were attended to in less than 30 minutes were satisfied with the services whiles 50% were also dissatisfied with their output.

The study revealed that 64.6% of patient received their drugs in less than 30 minutes and were satisfied with their services whiles 35.4% were dissatisfied with their output. Invariably 61.1% of clients who received their drugs within 1 – 2 hours were dissatisfied with their services whiles 38.9% of patient were satisfied. However there was no significant statistical relation with client satisfaction and the time taken by patients to receive drugs. This implies that an average of 48.3% of patient who receive medical care in TTH were overall dissatisfied with the services due to inconvenience and delays in receiving drugs from their pharmacy. Table 4.5 further shows the rest of the results.

Table 4.4 Client Satisfaction with duration of outpatient service by socio demographic characteristics

Characteristics		Satisfied Freq(%)	Dissatisfied Freq(%)	p-value
Waiting time for receiving NHIS folder	< 30 min	20 (57.1%)	15 (42.9%)	0.001
	31 – 1 hour	19 (57.6%)	14(42.4%)	
	1- 2 hours	14 (26.9%)	38 (73.1%)	
Waiting time to see a doctor	< 30 min	14 (60.9%)	9 (39.1%)	0.003
	31 – 1 hour	18 (54.5%)	15 (45.5%)	
	1 – 2 hours	24 (37.5%)	40 (62.5%)	
Given lab specimen	< 30 min	9 (50%)	9 (50%)	0.012
	31 – 1 hour	29 (52.7%)	26 (47.3%)	
	1 – 2 hours	18 (30.3%)	29 (61.7%)	
Waiting time to receive drugs	< 30 min	31 (64.6%)	17(35.4%)	0.120
	31 – 1 hour	21 (58.3%)	15 (41.7%)	
	1 – 2 hours	14 (38.9%)	22 (61.1%)	

Source: Authors Own Calculation, 2016

4.5 Factors that Influence Client Satisfaction of Medical Services in TTH

There are many variables that come into play with the factors that influences patient satisfaction and their loyalty to a medical facility. The study revealed that majority of the respondent were influenced by the satisfaction of treatment received by patients in TTH which makes it their number one choice of medical facility in Tamale this was represented by 25.8% of the total sample. This was followed by medical care given on admission representing 19.2% and patient - doctor relationship (16.7%). More so the attitude of health workers in the facility was also influenced by 15.8% of the respondents as shown in Table 4.6. However the least factor that influenced clients' satisfaction was the availability of equipment represented by 9.2% of the total sample.

Table 4.5 Factors that Influence Client Satisfaction of Medical Care in TTH

Factors	Frequency	Percentage
Patient-Doctor relationship	20	16.7
Satisfaction of treatment received by patient	31	25.8
Quality of service rendered	16	13.3
Availability of medical equipment	11	9.2
Attitude of Health workers	19	15.8
Medical care given on admission	23	19.2
Total	**120**	**100**

Source: Field Survey, 2016

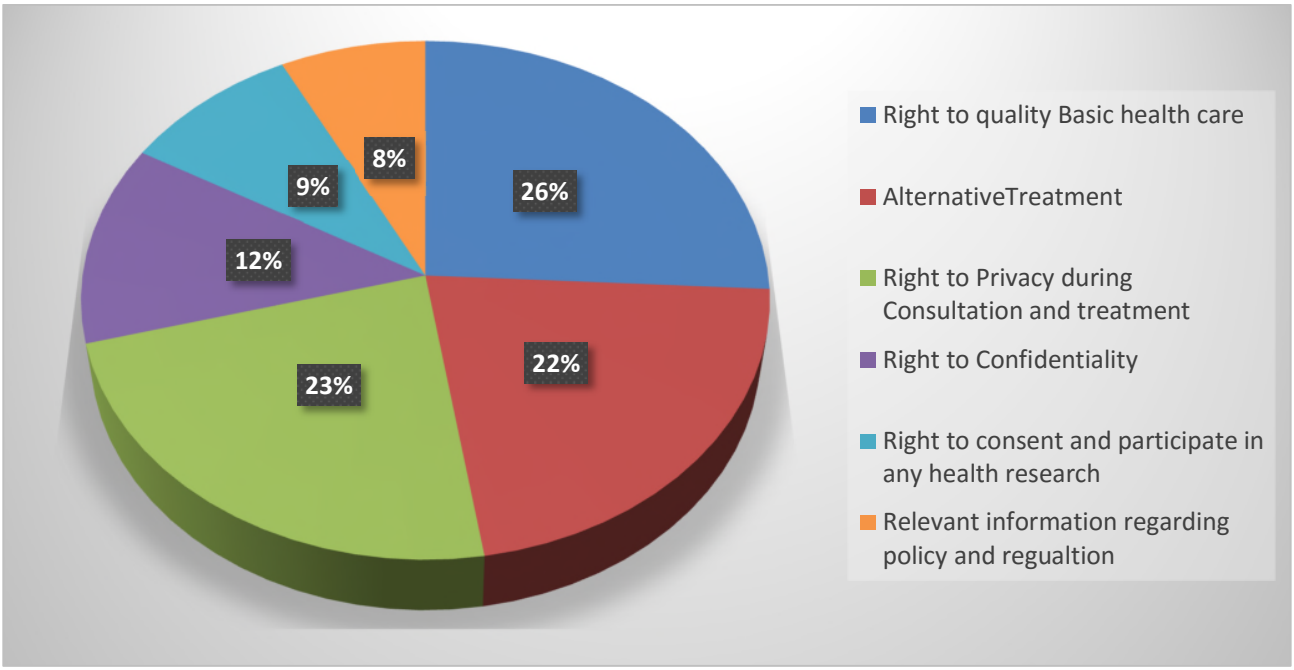
4.6 Level of Knowledge of Patients Regarding Their Medical Health Care Rights

The level of knowledge of respondents in the study was assessed to ascertain how best patient who uses TTH medical facility are well informed with their right in medical care. The criteria used to assess the level of patients knowledge regarding the patients charter was adopted from the Ghana Health Service model of patient charter. The model is based on the rights and responsibilities of patients on a number of indicators.

The Ghana Health Service expects health care institutions to adopt the patient's charter to ensure that service personnel as well as patients/clients and their families understand their rights and responsibilities. On clients' rights regarding the charter, the following indicators were administered to examine their knowledge based on their rights seeking medical health service from the facility (see figure 2.3). The study revealed that many clients were more aware of their right to quality basic health care representing 26%, while 22% were also aware of their right to seek alternative health care. Again 23% of clients indicated their right to privacy during consultation and treatment. However very few clients were aware of their right to relevant

information regarding policy and regulation, and right to consent and participate in any health research, representing 8% and 9% respectively. The results are further shown in Figure 2.3.

Figure 2.3 Knowledge Level of Patients' Rights



Source: Field Survey, 2016

The responsibility of clients was rather inadvertently complied by clients at the facility when seeking medical health care. And was rather interesting to them when asked on their responsibilities during the study. The study revealed that 29.2% of clients were of their right to provide full and accurate medical history for diagnosis, whiles 25.8% were aware of their responsibility to comply with prescribed treatment and report adverse effects. However very few of them were aware of their responsibility to request relevant information regarding their health from a health service provider, and obtaining necessary information which have bearing on their treatment, representing 7.5% and 19% respectively. This is further highlighted in Table 4.6.

Table 4.6 Knowledge Level of Patients' Responsibilities

Responsibilities	Frequency	Percentage
Comply with prescribed treatment and report adverse effects	31	25.8
Respect right of other patients	19	15.8
obtaining necessary information which have bearing on treatment	14	11.7
Provide full and accurate medical history for diagnosis	35	29.3
obtaining necessary information which have bearing on treatment	12	10
Requesting relevant information regarding his health	9	7.5
Total	**120**	**100**

Source: Field Survey, 2016

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

This chapter discusses the results of the study. The discussion takes into consideration the objectives of the study and its relation to literature that was reviewed on the thematic areas of the study. Again, the discussion was presented in the order of the following areas: demographic characteristics of respondents, level of satisfaction of patients with medical service in TTH, clients' satisfaction with the attitudes of health workers in TTH, client satisfaction with the overall time to get outpatient service by socio-demographic characteristics, factors that influences client satisfaction with medical services in TTH and the level of knowledge of patients regarding their medical health care rights.

5.1 Socio-demographic Characteristics of Respondents

The study revealed there were more females visiting TTH to seek medical care than males. In addition women are the most vulnerable in nature in terms of health fitness therefore will have more probable conditions of unfit health conditions than men (WHO, 2006). This findings is consistent with the studies by (GLSS, 2008; Abane & Adu-Gyamfi, 2013) who also observed that healthcare utilization is influenced by several factors all over the world and predominant among these factors are gender, educational level, economic status and age. Again the study revealed that patients below the age of 30 years (who are the most active age group) usually visit the facility to seek health care either for themselves or their patients. In addition young children get sick more than adults mainly because they have not yet built up the necessary immunity to defend their bodies from ailments as compared to adults (WHO, 2006). This finding also reveals the dominant

population of people within the economic and active age group in the Northern region who visit TTH for medical care. This was also consistent with the study by Abane & Adu-Gyamfi (2013) with the age category among the factors that influences utilization of medical health care.

The study was also not different with that of GLSS (2008) and Abane & Adu-Gyamfi (2013) with the level of education influencing the utilization of medical care in the hospital. Majority of the respondent who frequently visit TTH were Secondary/Vocational school leavers with least been tertiary education leavers.

However majority of the respondents were from the urban areas of the Tamale metropolis while the rest were from the rural areas of the Northern region. This reveals that urban dwellers have the high probability of accessing health care from the hospital. In addition the proximity of the facility within the Tamale town might have determined their utilization of the facility. More so majority of the respondent were traders representing, followed by public servant and business men/entrepreneurs with the least among been private sector workers. This finding shows the domination of traders on employment status and income levels of respondents within the Tamale metropolis and the communities within the Northern region as these categories of people often visit TTH.

5.2 Level of Satisfaction of Patents in TTH

The assessment of patient satisfaction is a useful parameter to predict the quality and availability of health care services (Illana, 2003). These parameters can help identify the deficiencies in the delivery of healthcare services and intervene to enhance patient satisfaction with medical care.

However, the satisfaction patients enjoy in TTH was measured by their own assessment of how best it meets their expectation. The findings explains how important NHIS card plays in accessing healthcare in the hospital, this is illustrated by the high majority of respondent (68%) who uses the NHIS card to access health care in TTH. Hence NHIS has enhanced medical health care access by patients within the Tamale metropolis. More so the duration of waiting time before consulting to a doctor was more dissatisfied by people who attained high educational background (tertiary level). The educational background influences patient to make inform choices of health facility to patronize, hence might not be bordered much by illiterate or basic educational level attainders as 35.85% of them were satisfied with the time spend before consulting a doctor. However respondents who attained senior high school/vocational level were rather neutral with their satisfaction of duration of time spent before consulting a doctor.

Access to information also plays an integral part of patients' satisfaction with medical health care in TTH. Majority of the respondents who attained above senior high school/vocational education were dissatisfied with time spent to access information on getting a NHISS folder, where to locate consulting room, laboratory and pharmacy units in the TTH. This explains the more enlightened respondents were on their right to free access and assistance by health workers in accessing medical health care in the facility. In addition the attitudes of health workers at the OPD also affect the image and expectation with the medical health care in TTH. This is so because the efficiency of services which determines patients' satisfaction with medical health care in a facility is measured by the promptness of the care given to patients, quick response to emergencies, quick dispensation of drugs, fast and accurate laboratory tests (Oji, 2015). The outpatient department in any hospital is considered the shop window of the hospital; hence patients' perception of services obtained there reflects the overall view of the hospital service.

5.3 Clients' Satisfaction with the Attitudes of Health Workers in TTH

The overall outcome of clients' satisfaction with the attitude of health workers also significantly determines clients' willingness to stay loyal with a health facility in seeking medical health care. Dissatisfied attitudes of clients' assessment have the likelihood to scare patients from using the facility as reported by Fekadu et al (2011). The result on the relation between the age and attitude of health workers implies that the satisfaction enjoyed by clients due to the attitude of health workers in TTH is determined by age group which was dominated by people below the age of 30 years.

The place of residence of a patient also revealed that patients who were from both urban and rural residence were satisfied with the attitude of health workers. The significant chi square test with the place of residents and the attitude of health workers implies that urban dwellers in Tamale were not satisfied with the poor attitudes of health workers in TTH since they enjoy the privilege of accessing health care from different facilities including private health care providers in the metropolis. This predisposes them to more experiences of the quality medical health care they expect as available in other facilities. The Marital status of respondents also revealed a significant relation with the attitude of health workers in TTH. This implies that the married respondent who enjoys good relationship and attitudes from their spouses expected health workers to relate cordially with them in the delivery of medical health care in the facility that equally serves as regional and an academic health institution in the Northern part of the country.

5.4 Client Satisfaction with the overall time to get outpatient service by socio-demographic characteristics

The study revealed patients who were attended to by NHIS staff in less than 30 minutes were satisfied service rendered in receiving NHIS folder. This finding explains the difficulty patients' encounters with the processing of NHIS folder for medical care, hence a quick response by NHIS staff enhances their satisfaction. Invariably patients' dissatisfaction increases beyond one hour waiting time, and discourages most people from choosing TTH as their first priority of health care access in the Tamale Metropolis. The significant chi square with the overall satisfaction of medical services in TTH implies despite all the challenges of dissatisfaction with the waiting time to receive drugs and laboratory specimen they still prefer TTH as their choice of accessing health care in the region.

However the equal proportion of clients' satisfaction and dissatisfaction with time (30 minutes) taken to receive a lab specimen implies the laboratory unit in TTH are able to deliver fairly quick service delivery to patients. More so the high majority of respondents who were satisfied with the services delivered in the pharmacy unit implies that access to drugs after consulting a doctor faces minimal challenges in the facility as compared to other units which recorded a high dissatisfaction by clients. This is consistent with Birna (2006) who stated that the higher dissatisfaction rate with waiting time could be attributed to the increased number of clients' dissatisfaction of a health facility and hence dent their image.

5.5 Factors that Influence Client Satisfaction of Medical Services in TTH

The study revealed that majority of the respondent preference of TTH in accessing health care were influenced by factors such as good patient-doctor relationship, quality of service rendered by health workers, availability of medical equipment and attitude of health workers among others.

Among the factors that influences the satisfaction clients were as result of improved infrastructure and equipment in the various units in the facility hence contributes to better health care by patients. This finding is also consistent with Oji (2015) who states that efficiency of services in health facility is based on the infrastructure; cleanliness and hygiene of the environment, convenience in waiting room, waiting time before consultation. However the outpatient department in any hospital is considered the shop window of the facility hence, patients' satisfaction of services obtained reflects the overall view of the service rendered in the facility.

5.7 Level of Knowledge of Patients Regarding Their Medical Health Care Rights

Awareness of patients from their rights can bring about a lot of advantages such as increased quality of health care services, decreased costs, decreased length of stay in hospitals and increased dignity of patients through informing them about their rights to participate in decision making (Peprah, 2014). According to Ghana Health Service (2017), it is the duty of health service institutions and patients to know the patients charter for quality health service delivery. The study results show that many patients were not educated on the patients' charter regarding health service delivery at TTH. That notwithstanding some of the patients agreed that, they were merely told that it is a requirement for them in accessing health care, but rather saw it appropriate to submit themselves and behave accordingly for treatments. This was not surprising with the results that, very few patients representing 8% and 9% were aware of their right to relevant

information regarding policy and regulation, and right to consent and participate in any health research respectively.

However there was no difference on the knowledge level patients on their responsibility with that of their rights. The results rather agreed with many of the indicators seem to be the common ethics of them seeking medical care in a health facility. For example very few of them were aware of their responsibility to request relevant information regarding their health from a health service provider, and obtaining necessary information which have bearing on their treatment, representing 7.5% and 19% respectively. And more of them were aware were of their responsibility to provide full and accurate medical history for diagnosis (29.2%) and their responsibility to comply with prescribed treatment and report adverse effect (25.8%).

CHAPTER SIX

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

6.0 Introduction

This chapter presents the summary and proposed recommendations based on the findings of the study objectives. The main objective of the study was to assess clients' satisfaction of medical services in the Tamale Teaching Hospital. The study employed accidental and simple random sampling techniques to select 120 people at the OPD of TTH. A summary of the key findings on the specific objectives is provided and the conclusions and recommendations that arise are also presented in the context of their implications for policy as well as future research.

6.1 Summary of Findings

The study objective was to assess the satisfaction of clients who seeks medical health care at the OPD in TTH. The study came out with the following findings. There were many patients who seek medical health service with the National Health Insurance (NHIS) representing 68%, whiles 32% were non-card bearers of NHIS. The study also revealed that 35.83% of patients were satisfied with the time spent to process NHIS folder before seeing a doctor, and 8.33% were very dissatisfied with the time spent to process NHIS folder. The attitude of health workers at the OPD revealed that 24.17% were satisfied with their attitude and 11.67% were very dissatisfied with their attitudes. The availability of drugs after patients has seen a doctor also revealed that 23.33% were satisfied with it whiles 13.33% were dissatisfied with the availability of drugs in the hospital However the overall assessment of patients' satisfaction revealed that 55% of patients were satisfied with the medial health service from TTH, whiles 5% were very dissatisfied with the medical services and 11% were neutral with their assessment of medical services at TTH. The results on the comparison of the relationship between health workers

attitude with patient's and clients overall satisfaction with the socio-demographic characters of the respondents revealed that 50.88% male were satisfied with the attitudes of the health workers in the TTH whiles 49.12% were dissatisfied with the overall attitude of health workers in TTH. There was no significant statistical relation with the gender of the respondents and the attitude of health workers in TTH. However there was significant statistical difference in the age of patients and attitude of health workers in the facility. About 70.97% of clients whose ages are between 18 – 30 years were satisfied with the attitude of health workers whiles 29.03% were dissatisfied. More so people who came from both urban and rural areas irrespective of the distance were satisfied with health workers attitude in TTH hence they are more willing to patronage their health services in the facility.

The result on the comparison of client satisfaction with the time taken to get outpatient service by selected socio-demographic characteristics revealed that 57.14% of patient who were attended by NHIS staff in less than 30 minutes were satisfied with time taken to receive NHIS folder whiles 42.86% were dissatisfied. Again 57.58% of patients who were attended within 31 – 1 hour were satisfied with health care services whiles 42.42% were dissatisfied. In variably 73.08% of patient who were attended by NHIS staff within 1 – 2 hours were dissatisfied with their services and 26.92% were satisfied. About 60.87% of clients who were attended to in less than 30 minutes were satisfied with the health care services rendered whiles 39.14% were dissatisfied. The results also revealed a significant statistical relation in the time taken to see a doctor and the overall client satisfaction of clients in TTH. More so the time taken by patient to receive drugs for medication plays a key significant determinant of client satisfaction since patient who are on admission or critical condition are more worried for delay in receiving a treatment plan. The study revealed that 64.58% of patient who received their drugs in less than 30 minutes were satisfied with their services whiles 35.42% were dissatisfied with their output.

Invariably 61.11% of clients who received their drugs within 1 – 2 hours were dissatisfied with their services whiles 38.89% of patient were satisfied.

The study also revealed 25.83% of the respondents were influenced by the satisfaction of treatment received from health care service given and hence makes TTH as their number one choice of medical facility in Tamale. More so the attitude of health workers in the facility was also influenced by 15.83% of the respondents, but the least factor that influenced clients' satisfaction was availability of equipment represented by 9.17% of the total sample.

The study results show that many patients were not educated on the patients' charter regarding health service delivery at TTH; very few patients representing 8% and 9% were aware of their right to relevant information regarding policy and regulation, and right to consent and participate in any health research respectively.

However very few of them were aware of their responsibility to request relevant information regarding their health from a health service provider, and obtaining necessary information which have bearing on their treatment, representing 7.5% and 19% respectively. But were rather aware of their responsibility to provide full and accurate medical history for diagnosis (29.2%) and comply with prescribed treatment and report adverse effect (25.8%).

6.2 Conclusion

The study assessed the clients' satisfaction of medical health care services in TTH. It is concluded that many patients (20% very satisfied and 55% satisfied) were satisfied with the health service delivery at the OPD in the Tamale Teaching Hospital. The factors that led to clients' satisfaction were the minimum time spent to undergo health care, especially processing NHIS folder and seeing a doctor. However the quality of health service satisfaction enjoyed in

TTH been the premier and one stop health facility were among other reason that encourage their satisfaction with health care services.

The study indicated a significant relation between variables (attitude of health workers, access to easy information for health care, waiting time and quality of health service) and the overall satisfaction of health care services in the facility. There are still little knowledge and education of patient right on medical health services. Many patients indicated that there have not been educated on their rights and responsibility to comply with in accessing health care. However they were not informed with rights such as seeking relevant information regarding policy and regulation, and right to consent and participate in any health research respectively. And their responsibility to provide full and accurate medical history for diagnosis and comply with prescribed treatment and report adverse effect, which were seen as strange to their knowledge.

6.3 Recommendations

The following recommendations are proposed based on the findings of the study objectives.

1. Even though many patients were satisfied with health services delivery, the facility has little structures in placed to ensure that patient have easy access to information on seeking medical services in the facility.
2. The study also recommends management of TTH to put the interest and satisfaction of clients first in the delivery of health service since many of the respondents were influenced to seek health service at the facility based on the quality of health service given to them and the good relationship between doctor-patient hence should improve upon these factors for more patronage from the public.
3. That notwithstanding there is still low level of clients knowledge of medical health service right in the public, hence TTH management should implement mechanisms and

forum that will ensure that people who seek medical health services are better informed on their right and will go a long way to increase the dignity of patients through informing them about their rights and their satisfaction of health service delivery in the facility.

4. Finally the study was limited to TTTH therefore it recommended that future researcher should examine the factors that enhance clients' satisfaction and choice of health facility in both public and private to ascertain the significant difference that exist in their choice of health facility in the Tamale metropolis.

REFERENCES

Abuosi, A.A., & Atinga, R.A. (2013). Service quality in healthcare institutions: Establishing the gaps for policy action. *International Journal of Health Care Quality Assurance, 26*(5), 481-492.

Adu-Gyamfi, A.B., & Abane A.M. (2013). Utilization of health care facilities among residents of Lake Bosomtwe basin of Ghana. *European International Journal of Science and Technology*, 2(4),131-142.

Aldana J.M., Piechulek, H., & Al-Sabir, A. (2001). Client satisfaction and quality of health care in rural Bangladesh. *Bulletin of the World Health Organization*, 279: 512–517.

Almoajel A.M. (2012). Hospitalized patients' awareness of their rights in Saudi governmental hospital. Middle East journal of scientific research 2012.11:329-36.

Anderson, E. and Zwelling, L. (1996), Measuring service quality at the University of Texas M.D. Anderson Cancer Center, International Journal of Health Care Quality Assurance, Vol. 9, n. 7, pp. 9-22.

Anthony S., K. (2014). Service Quality and Customer Satisfaction: Empirical Evidence from the Ghanaian Public Service. Faculty of Management (Department of Business Administration), University of Professional Studies,Accra-Ghana. *European Journal of Business and Management*Vol.6, No.6. ISSN 2222-1905.

Atinga, R. A., Abekah-Nkrumah, G and Domfeh, K. A. (2011). "Managing healthcare quality in Ghana: a necessity of patient Satisfaction" International Journal of Healthcare Quality Assurance Vol. 24 No. 7, pp. 548-563.

Augustine A. P. (2014). Determinants of Patients' Satisfaction at Sunyani Regional Hospital, Ghana.

Bannerman C, Offei A, Acquah S. D & Tweneboa N. A. (2002). Health Care Quality Assurance Manual, Ghana Health Services, 84p.

Baker, R. and Streatfield, J. (1995). What type of general practice do patients prefer? Exploration of practice characteristics influencing patient satisfaction. *British Journal of General Practice*, Vol. 45, pp. 654-9.

Bara A. C., van den Heuvel, W.J.A., Maarse, J.A.M., & van Dijk, J.P. (2002). Users' satisfaction with the Romanian health care system: and evaluation of recent health care reforms. *European Journal of Public Health (Supplement),*12(4), 39-40.

Bartram, D. (2000). Internet Recruitment and Selection: Kissing Frogs to Find Princes, *International Journal of Selection and Assessment,* 8 (4), 261-274.

Baruch, Y. (1999), Response rate in academic studies; A comparative analysis. *Human Relations*, 52, 421- 38.

Bielen, F., & Demoulin, N. (2007). Waiting time influence on the satisfaction-loyalty relationship in services. Managing Service Quality: An International Journal, 17(2), 174 193.

Birna A. (2006). The quality of hospital services in eastern Ethiopia: Patient's perspective. *Ethiopian Journal of Health Development.* ;20(3):199–200.

Bitner, M.J. (1990). Evaluating service encounters: the effect of physical surroundings and employee responses. *Journal of Marketing*, 54, April, 69-82.

Blumberg, B., Donald, R. C. & Pamela S. (2005). *Business Research Methods*. UK, McGraw-HillEducation.

Brundtland G. H. (2001). *Improving health systems' performance*, OECD.

Buabeng T.B. (2014).) Operationalization of Ghana's patients charter in public hospitals; a case study of Kasoa poly clinic in Awutusenya East Municipal Assembly.

Business Dictionary. Com. (2016). Definition of Patients Charter.*Care Management Review*, *28*(3), 254-264.

Carman, J. (1990). Consumer perceptions of service quality: an assessment of the SERVQUAL dimensions. *Journalof Retailing, 66*(1), 33-55.

Choi. K.S., Cho. W.H., Lee S.H., Lee. H., Kim.C. (2004).The Relationship among Quality, Value, Satisfaction and Behavioural Intention in Health Care Provider Choice: A South Korean Study, *Journal of Business Research*, 57,913-921.

Chunulaka, P. (2010). International Patients' Satisfaction towards Nurses Service Quality at SamtivejSrinakarin Hospital, Masters' Project cited by Srinakharinwirot University.

Conway, T. and Willcocks, S. (1997). The role of expectations in the perception of health care quality: developing a conceptual model. *International Journal of Health Care Quality*, 10(3), 131-140.

Cronin Jr, J. J., & Taylor, S. A. (1994). SERVPERF versus SERVQUAL: reconciling performance-based and perceptions-minus-expectations measurement of service quality.*The Journal of Marketing*, 125-131.

Cronin, J., & Taylor, S. (1992). Measuring service quality: a re-examination and extension. *Journal of Marketing*,*56*(3), 55-68. http://dx.doi.org/10.2307/1252296

Dabholker, P.A., Shephered, C.D. & Thorpe, D.L. (2000). A conceptual framework for service quality: an investigation of critical conceptual and measurement issues through a longitudinal study. *Journal of Retailing*, 76 (2), 139-173.

Dey, P.; Hariharan, S. Brookes, N. (2006), Managing healthcare quality using logical framework analysis. *Managing Service Quality*. 16 (2): 203-222.

Ditto P.H, Scepansky J.A, Munro G.D, Apanovitch A.M, Lockhart L.K. (1998). Motivated sensitivity to preference-inconsistent information. *Journal of Personal Sociology Psychology*, 75:53-69.

Donabedian A. (1988). The quality of care. How can it be assessed? *Journal of American Medical Association*, 260:1743-48.

Donkor, N.T & Andrews, L.D (2011).21st century nursing practice in Ghana: challenges and opportunities**,** *International Nursing Review*, 58(2):218-24.

Doyle V and Haran D. (2000). Quality Assurance in healthcare. Policy Briefings for Health Sector Reform. Health Sector Reform Research Work Programme (Liverpool School of Tropical Medicine). Paper number 1.

Drain, M. (2001). Quality improvement in primary care and the importance of patient perceptions. *Journal of Ambulatory Care Management*, 14 (2), 30-46.

Duggirala, M. Rajendran, C. and Anantharaman, R.N. (2008). "Patient-perceived dimensions of total quality service in healthcare" Benchmarking: An International Journal Vol. 15 No. 5, pp. 560-583.

Fekadu A. Andualem M. Yohannes M. (2011). Assessment of Clients' Satisfaction with Health Service Deliveries at Jimma University Specialized Hospital. Department of health services management, College of Public Health and Medical Sciences, Jimma University.

Folkes. V.S. Patrick V.M. (2003). The positivity effect in perception of services, seen one, seen them all. *Journal of consumer resources* vol.30pp125.137.

Fotaki M. (2012). User's perceptions of health care reforms; quality of care and patient right in four regions in the Russian Federation Social Science Medi. 2006; 63; 1637- 47.

Fottler, M. D., & Blair, J.D. (2002). Introduction: New concepts in health care stakeholder management theory and practice. Health Care Management Review, 27(2), 40– 51.

Ghana Health Service (2003). Annual Report. Accra: Ghana Health Service.

Ghana Health Service (2014). Performance report.

Ghana Statistical Service (2008). Ghana Living Standards Survey Report of the Fifth Round

Ghana Statistical Service (2010). Population and Housing Census. Accessed from: http://www.statsghana.gov.gh/docfiles/2010phc/Census2010_Summary_report_of_final results.pdf. (30th November, 2016).

Gray, B. (2004). The relationships between service quality, customer satisfaction and buying intentions in the private hospital industry. *South African Journal of Business Management*, 35(4), 27–37.

Groonroos, C. (1984). A service quality model and its market implication. *European Journal of Marketing*, 18(4), 36-44.

Gunawardane G. (2011). Reliability of the internal service encounter. *International Journal of Quality & Reliability Management*, 28(9), 1003-1018.

Gyapong M., John 0. G., Joseph A., James A., & Elias S. (1996). Introducing insecticide impregnated bed nets in an area of low bed net usage: an exploratory study in north-east Ghana. *Tropical Medicine and International Health*, 1:328-333.

Hawthorne, G. (2006). *Review of Patient Satisfaction Measures*, Australian.

Hayford, S. K. (2013). *Special Educational Need and Quality Education for All*. Winneba: Department of Special Education Books

Haywood-Farmer, J. (1988). A conceptual model of service quality. *International Journal of Operations and Production Management* 8 (6), 19 – 29.

Herbig, P. & Milewicz, J.(1993). The Relationship of Reputation and Credibility to Brand Success. *Journal of Consumer Marketing* 10, 18-24.

Hofitede, G. (1970). Cultures consequences; International Differences in work related values, Newbury Park C.A; Sage Publications.

Humayun A., Fatimah N. N., Naqqash H. Rasheed A.,Imtiaz H. (2008). Patient's perception and actual practice of informed consent, privacy and confident in general medical outpatient department of two tertiary care hospitals of Lahore.

Illana F. (2003). Patients' satisfaction with health care in public facilities. . *Journal of Consumer Marketing*. 18(5):259–260.

Irene A., Mariam A., & Emelia D. A., (2014). Assessing the Role of Quality Service Delivery in Client Choice for Healthcare: A Case Study ofBechem Government Hospital and Green Hill Hospital. *European Centre for Research Training and Development*, Vol.2, No.3, pp.1 23.

Jackson, L.; Kroenke, K. (1997). Patient satisfaction and quality of care. *Military Medicine*; 162: 273- 277.

James M. Carman, (2000). Patient perceptions of service quality: combining the dimensions", Journal of Services Marketing, Vol. 14 Iss: 4, pp.337 – 352.

Jenkinson C., Coulter A., Bruster S, Richards N., Chandola T. (2002). Patients' Experiences and Satisfaction with Health Care: Results of a Questionnaire Study of Specific Aspects of Care. *Quality and Safety in Health Care*,11(4):335-9.

Johnston, R. (1995). The determinants of service quality: satisfiers and dissatisfiers. *International Journal of Service Industry Management*, Vol. 6 No.5, pp. 53-571.

Kotler, P., & Keller, K. L. (2009). *Marketing management*. Upper Saddle River, N.J: Pearson Prentice Hall.

Kuzu N. Ergin A. Zencis M. Rokhafrooz D. (2006). Patient's awareness of their rights in a developing country. Public Health; 1206.

Levesque, T., & McDougall, G. (1996). Determinants of customer satisfaction in retail banking. *International Journal of Bank Marketing*, 14(7), 12-20.

Lewis, B.R. (1989). Quality in the Service Sector; A Review. *International Journal of Bank Marketing, 7(*5).

Linder-Pelz S. (1982). Toward a theory of patient satisfaction. *Social Science and Medicine*,16;577-82.

Lovelock, C. & Wright, R. (2002). *Principles of Service Marketing and Management*. 2nd ed. New Jersey:Pearson Education Inc.

Manbari S. (2000). Patient Right Charter in Iranian and world's hospitals. Congress of the Role of Management in Health Care Services; Tehran, Iran

Marjolein D. & Jan W. H. (2006). Improving health worker performance: in search of promising practices. Retrieved from: http://www.who.int/hrh/resources/improving_hw_performance.pdf. (Date: 23rd January, 2016).

Mastaneh, Z., &Mouseli, L. (2013). Patients' Awareness of Their Rights: Insight from a Developing Country .*International Journal of Health Policy and Management*, 1(2), 143-146. http://doi.org/10.15171/ijhpm.2013.26.

Matterson J., (1992). A service quality model based on an ideal value standard. *International Journal of Service Industry Management*, 3(3), 18-33.

Mayer, R. C., Davis, J. H., &Schoorman, F. D. (1995). An integrative model of organizational trust. *Academy of Management Review*, 20, 709-734.

Ministry of Health, Ghana. (2006). The second health sector 5 year programme of work 2002-2006. Partnerships for health: Bridging the inequalities gap. MOH/PD/005/03/02/GD.

Ministry of Health (2007b). Quality Healthcare Delivery Assessment Report. Accra. Ministry of Health.

Naidu. A. (2009). Factors affecting patient satisfaction and healthcare quality. *International Journal of Health Care Quality Assurance*, Vol. 22 Iss: 4, pp.366 – 381.

Newman, K. (2001), "Interrogating SERVQUAL: a critical assessment of service quality measurement in a high street retail bank.*International Journal of Bank Marketing*, Vol. 19 No.3, pp. 126-39.

Nimako, G., & Azumah, F., (2009). An Assessment and Analysis of Customer Satisfaction with Service Delivery of Mobile Telecommunication Networks in Ghana. Unpublished MBA thesis, Lulea University of Technology, Sweden.

Nitin S. and Deshmukh, S.G. (2005). Service quality models: a review. *International Journal of Quality & Reliability Management*, 22(9), 913-949.

Oji K. (2015). Assessment of Patients` Satisfaction with Health Services at the General out Patient Department of the University Of Port Harcourt Teaching Hospital. Dissertation Submitted to the Department of Preventive and Social Medicine as Partial fulfillment For the Award of Bachelor of Medicine, Bachelor of Surgery. The College Of Health Sciences, University Of Port Harcourt, Rivers State, Nigeria.

Oliver, R. L. (1997). Satisfaction: A behavioural Perspective on the Consumer, New York: McGraw-Hill.

Oliver, R.L. (1980). A cognitive model of the antecedents and consequences of satisfaction decisions. *Journal of Marketing Research, 17*, 460 - 469.

Oliver, R.L. (1980). A Cognitive Model of the Antecedents and Consequences of Satisfaction Decisions. *Journal of Marketing Research*, Vol. 17, No, 4, pp. 460-469.

Onyeka U., O. (2014). Patient Satisfaction in Healthcare Delivery; a review of current approaches and methods. European Scientific *Journal*, vol.10, No.25 ISSN: 1857 7881 (Print) e - ISSN 1857- 7431.

Osei, I., Garshong, B., Owusu Banahene, G., Gyapong, J., Tapsoba, P., Askew, I., Ahiadeke, C., Killian, R. & Bonku, E. (2005), The Ghanaian Safe Motherhood Programme: Evaluating the Effectiveness of Alternative Training Models and Other Performance Improvement Factors on the Quality of Maternal Care and Client Outcomes, Health Research Unit, Ghana Health Service, 23-38.

Panneerselvam, R. (2004).*Research Methodology*. Prentice Hall, New Delhi India.

Parasuraman, A., Berry, L. L., &Zeithaml, V. A., (1991). Refinement and reassessment of the SERVQUAL scale. *Journal of Retailing*, 67(4), 420–450.

Parasuraman, A., Zeithaml, V. A., & Berry, L. L. (1985). A conceptual model of service quality and its implications for future research. *Journal of Marketing*, 49(4), 41-50.

Parasuraman, A., Zeithaml, V. A., & Berry, L. L. (1988). SERVQUAL: A multiple-item scale for measuring customer perceptions of service quality. *Journal of Retailing*, 64,12 -40.

Peprah, A. A. (2014). Determinant of Patients' Satisfaction at Sunyani regional Hospital, Ghana. *International Journal Business and Social Research* (IJBR), Vol 4, No 1. Pp. 96 108.*Assurance*, Vol. 19 Iss: 1, pp.8 - 31.

Ramachandran; A. Cram, N. (2005), Standards and Customer Satisfaction in the Healthcare industry. *Journal of Clinical Engineering*. October/December: 219-228.

Ramez, W.S., (2012). Patient's perception of healthcare quality, Satisfaction and behavioural intention: An empirical study in Bahrain. International Journal of Business and Social Science, 3(18), 131-141.

Robinson, L., (2003). Committed to quality: the use of quality schemes in UK public leisure services. *Managing Service Quality*, *13*(3), 247-55.

Rust, R. T., & Oliver, R. L. (1994). *Service quality: New directions in theory and practice*. Thousand, CA: Sage Publication, Inc.

Saila S.B, Nixon S.W, Oviatt C.A .(2002). Does lobster trap bait influence the Maine inshore trap fishery? *North American Journal of Fish Management* 22:602- 605.

Senarath, U., Wickramage, K. &Peiris, S. L. (2014). Prevalence of depression and its associated factors among patients attending primary care settings in the post-conflict northern province in Sri Lanka: A cross-sectional study. *BMC Psychiatry*, 14(1), 85 96.

Seth N., Francis B. Y.,& Ernest A. (2015). Client Satisfaction with Service Delivery in the Health Sector: The Case of Agogo Presbyterian Hospital. *International Journal of Business Administration,* Vol. 6, No. 4.

Sewell, N. (1997). Continuous quality improvement in acute healthcare: creating a holistic and integrated approach", International Journal of Healthcare Quality Assurance, Vol. 10 No. 1, pp. 20-6.

Sharma R.D. &Chahal H. (2003). Patient satisfaction in government outpatient services in India. *Decision* 30: 109-28.

Smith et al. (1989), Living with the Dying-Dying at home, Toronto Publisher, Canada.

Soliman, A. (1992).Assessing the quality of healthcare: a consumerist approach. *Health Marketing Quarterly,* Vol. 10, pp. 121-41.

Solomon J. (1990). Trying to Be Nice Is No Labor of Love. *The Wall Street Journal*, 29 (122 140).

Steffen, G., (1988), "Quality of Medical Care: A Definition", *JAMA*, Vol.260, N0.1 pp. Strydom, J. W., Jooste, C. J. & Cant, M.C. (2000). *Marketing Management*, 4th ed. Cape Town: Juta.

Swan, J. E., Richardson, L. D. and Hutton, J. D. (2003). Do Appealing Hospital Rooms Increase Patient Evaluations of Physicians, Nurses, and Hospital Services? *Health Care Management Review*, *28*(3), 254-264.

Synay, T., (2002). Access to Quality Health Services: Determinants of Access. *Journal of Health Care Finance,* Vol. 28, N0.4 pp.58-68.

Tam, J.L. (2004). Customer Satisfaction, Service Quality and Perceived Value: An integrated Model", *Journal of Marketing Management*, Iss. 7,8 September, pg.897.

Tarantino, D. (2004). How should we measure patient satisfaction? *Physician executive*, Vol.30, N0. 4 pg. 60-61.

Taylor, S.A. (1994). Distinguishing Service Quality from patient Satisfaction in developing Health Care Marketing strategies, *Hospital and health service Administration*, 39, p.221.36.

Tucker, J.L. and Adams, S.R. (2001). Incorporating patients' assessments of satisfaction and quality: an integrative model of patients' evaluations of their care. *Managing Service Quality*, *Vol.* 11 No.4, pp. 272-87.

Turkson P. K. (2009). Perceived Quality of Healthcare Delivery in a Rural District Of Ghana. Ghana Medical Journal. Volume 43, Number 2.

Turner, P., & Pol, L. (1995). Beyond patient satisfaction. *Journal of Health Care Marketing*, 15(3), pp. 45-53.

USC Libraries (2016). Research Guide. Retrieved from: http://libguides.usc.edu/writingguide/casestudy (11th March, 2016).

Wadwha, S. S. (2002). Customer satisfaction and health care delivery systems: Commentary with Australian bias. *The Internet Journal of Nuclear Medicine*.1 (1):1539-4638.

WHO (2007). The International classification for patient safety: Version 1.0 for use in field testing 2007-2008 (ICPS). Geneva, WHO World Alliance for Patient Safety.

WHO (2006).The World Health Report 2006. Working together for health. Retrieved from: http//.ncbi.nlm.nih.gov/pubmed/17178522. (Date: 12th September, 2016).

Willging, P., (2004), "Customer Satisfaction Surveys are more than just Paper", *Nursing Home*, Vol. 53, N0.8 pg.20.

Woodside, A.G., Frey, L.L. and Daly, R.T. (1989). Linking service quality, customer satisfaction, and behavioural intention. Journal of Healthcare Marketing, Vol. 9 No. 4, pp. 5-17.

Wright G, Causey S, Dienemann J, Guiton P, Coleman F. S, & Nussbaum M (2013). Patient Satisfaction With Nursing Care in an Urban and Suburban Emergency Department. Journal of Nurses Administration. 2013;43(10):502-508.Retreived from: http://dx.doi.org/10.1097/NNA.0b013e3182a3e821 (Date: 5th June, 2016).

Ygge, B.; Arnetz, J. (2001). Quality of paediatric care: application and validation of an instrument for measuring parent satisfaction with hospital care. *International Journal for Quality in Health Care*; 13(1): 33-43.

Yin, R. K. (1984). *Case study research: Design and methods*. Newbury Park, CA: Sage Publications.

Youssef H. (2011). Determining Patient's Satisfaction with Medical Care. American University of Science and Technology, Beirut, Lebanon.

Zineldin M (2006). The quality of health care and patient satisfaction. *International Journal of Health Care Quality, (12)*56-61.http://dx.doi.org/10.1108/IJHCQA-12-2011-0077.

APPENDIX

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF ALLIED HEALTH SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

INTRODUCTION

Assessing clients satisfaction of medical services: The case of Tamale Teaching Hospital

Questionnaire for Clients

Hello My name is..... a research student from UDS-Tamale. I am conducting a scientific survey on the above topic. I kindly seek your permission to answer these questions to the best of your knowledge and ability on your satisfaction of medical services in the Tamale Teaching Hospital. I wish to assure you that this is an academic study and all information provided shall strictly be used for academic purposes. You are also assured of absolute confidentiality and anonymity. There is thus no right or wrong answer. Please respond to the questions by ticking [√] the answer that reflects your opinion.

You will be contributing significantly to the development and delivery of better services to patients at the hospital if you answer frankly to the following questions. The purpose for the study is purely academic and your views will be treated as confidential. Thank you. Please are you willing to participate in this exercise? Yes [ ] No [ ].

Section A: Socio-economic background of Respondents

1. Sex of Respondents Male [ ] Female [ ]
2. Age of Respondents 18 – 30 [ ] 31 – 40 [ ] 41– 50 [ ] 51 – 60 [ ] Above 60 [ ]
3. Age of Patient 0 – 5 [ ] 6 – 10 [ ] 11 – 17[ ] 18 – 30 [ ] 31 – 40 [ ] 41 – 50 [ ] Above 60 [ ]

4. Level of education of respondent No formal education [ ] Basic education [ ] Secondary/Vocational Education [ ] Tertiary [ ]
5. Occupation of respondents Farmer [ ] Public Servant [ ] Private Sector Worker [ ] House wife [ ] Others Specify .....
6. Residential location Rural [ ] Urban [ ]

Section B: Categories of Patients who frequently use of the OPD

7. What calibre of people frequently come to the hospital? Children [ ] Women [ ] Men [ ] All kinds of respondents [ ]
8. What do you think is their level of education? No formal education [ ] basic education [ ] Secondary/Vocational [ ] Tertiary [ ]
9. What is their economic status? Low economic status [ ]middle income [ ] Rich people [ ]
10. Do most OPD users use Health Insurance? Yes [ ] No [ ]

Section C: Level of Satisfaction of patients generally

11. How long do you wait before you get your card?.....
12. How long do you wait before seeing the doctor?.....
13. What is the attitude of workers at the OPD? Very bad [ ] Bad [ ] Fair [ ] Good [ ] very good [ ]
14. Give reasons your above.....
    .....
15. Do you think people bribe before they are attended to? Yes [ ] No [ ] Don't know [ ]
16. Do people of certain class jump the queue? Yes [ ] No [ ]

17. Do you think the doctors have time for you? Yes [ ] No [ ]

18. Are you always satisfied with the consultation services? Yes [ ] No [ ]

19. What do you think is the cause of this?.....

.....

.....

20. Are you satisfied with drugs given to you? Yes [ ] No [ ]

21. Are always asked to buy drugs outside the hospital? Yes [ ] No [ ]

22. If no why.....

.....

.....

23. What do you like about the hospital?.....

.....

24. What do you hate about the hospital? .....

.....

Section D: Level of patient knowledge regarding the patient charter

25. Have you heard about the patient charter before? Yes [ ] No [ ]

26. If yes from what source?

27. What is it about?.....

28. What is good about it?.....

29. Do you think health workers go by the charter? Yes [ ] No [ ]

30. What do you think are the reasons?.....

.....

Section E : Factors that influences Patient Satisfaction

31. Do you think the facilities are good/sufficient to cater for the volume of OPD? Yes [ ] No [ ]
32. Do you think they are enough workers at the card development? Yes [ ] No [ ]
33. Are there enough doctors to take care of patients? Yes [ ] No [ ]

Section F: Recommendations

34. What other challenges do patients face in the hospital?.....

    .....

35. What do you think can be done to solve these problems?.....

    .....

36. Who (institutions, individual, organisation, government etc) can solve the problem?...

    .....

    .....

    .....