SERVICE DELIVERY IN THE HEALTH SECTOR: CONSUMER PROTECTION, AWARENESS AND SATISFACTION

A STUDY OF KORLE BU POLYCLINIC

by

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DECLARATION

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

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ABSTRACT

Service delivery in the health sector has come under the spotlight in recent times. This study was designed to find out the level of protection, awareness and satisfaction of service delivery at the Korle Bu Polyclinic.

The objectives of the study was to identify the level of satisfaction of Ghanaian patients as regards health delivery, the level of protection available for patients in Ghana, the awareness level of patients with regards to that protection and what the Government, Ghana Health Service and patients collectively need to do to improve patients satisfaction and protection.

The design for the study was non-experimental and exploratory in nature. The instrument of data gathering was a questionnaire. One hundred and forty five respondents between the ages of eighteen and seventy five of both sexes were selected using the non-probability convenient sampling method.

The results of the study showed that Doctors, Nurses and other allied staff like X-ray and Laboratory staff generally treat patients with courtesy and respect. However, patients are not provided with adequate information on medications. Doctors and nurses do not explain to patients when they are being discharged or after treatment what to expect as they recover and what to do when they experience some adverse symptoms. On the whole, the Polyclinic was rated highly on cleanliness. Delays and favoritism were major causes of dissatisfaction for patients at the Polyclinic. As majority of the patients do not know of the existence of a Patients Charter they did not know what to expect from health care workers with regards to their rights as patients.

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CHAPTER 1

INTRODUCTION

1.1 Background

A country's constitution spells out the rights of citizens and the state policy defines the remedies. These are then reflected in legislation enforcement mechanisms and other administrative structures.

In 1962, President John F. Kennedy moved the consumers' bill of rights in the US Congress by saying,……"if a consumer is offered inferior goods, if prices are exorbitant, if drugs are unsafe or worthless, if the consumer is unable to choose on an informed basis, then his dollar is wasted, his health and safety may be threatened and national interests suffers" This speech delivered on 15th March, 1962 is what generated the global consumer rights. The day is now observed as World Consumer Rights Day in several countries by the global consumer protection movement. (www.cuts.international.org/consumer-rights.htm)

The UN Guidelines for consumer Protection adopted by the UN General Assembly of April 1985 call upon governments to develop, strengthen and maintain a consumer policy, and provide for enhanced protection of consumers by communicating it through various means on seven major themes:

- Physical Safety
- Economic Interests
- Standards
- Essential Goods & Services
- Redress

- Education & Information
- Health

Every welfare state seeks to provide protection of the Right to Basic Needs of consumers especially for the vulnerable citizens like the under-privileged and the sick. The right to these basic needs is not just a consumer right but a human right too. Article 25 of the UN Declaration of Human Rights says among other things "…. Every one has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services". (www.un.org/en/documents)

Governments are urged in the UN Guidelines to give special attention to the needs of disadvantaged consumers, in both rural and urban areas, including low-income consumers, and those with very low levels of literacy. In most developing countries, problems of consumers are more related to the provision of essential services such as drinking water, sanitation, education and health care than market related ones. (www.un.org/en/documents)

The right of access to quality health services is firmly enshrined in the Universal Human Rights Charter to which Ghana is a signatory. Therefore, the government has a responsibility in assuring the fulfillment of the Charter. The rights relating to health – health as defined by the WHO being " a state of complete physical, mental and social well being and not merely the absence of disease or infirmity". (www.un.org/en/documents).

This can be translated to mean equitable access to quality health services and respect for individual patients' rights including the non-disclosure of confidential information acquired in the process of service delivery.

1.2 Problem Statement

Since 1989, the Ministry of Health's Policy thrust has been on the improvement of health institutions and the health delivery system as a whole. Over the years, there has been a lot of changes – from the Cash and Carry System to the National Health Insurance Scheme. Whilst there is a focus on improving health status of the citizens thereby leading to economic well being, a question needing to be addressed is whether the population on whose behalf strategies are designed and implemented are aware of the rights and responsibilities enshrined in documents meant for their protection and whether they are generally satisfied with services delivered by the health sector? Another point worth thinking about is what impact these documents have on consumer/provider behaviour especially where a significant part of the population cannot be described as literate?

1.3 Objectives of the Study

Because consumers are the intended beneficiaries of health care, their needs should be of utmost importance to the government and the health service providers. A healthy citizenry means a healthy economy. Government will also spend less on importing drugs into the country if the general population is healthy. This means there will be enough savings to be redirected to other areas of the economy like education, infrastructural amenities, etc. Health is priceless, so the general objective of this study is to assess the

performance and quality of service of the health service in Ghana. The specific objectives are:

1. To examine the quality of service available for patients at the Korle Bu Polyclinic in terms of environmental cleanliness and the general ambience.
2. To find out how the patients charter, which contains the rights and liberties of patients in Ghana, is being adhered to by health workers and their health institutions.
3. To assess patients' awareness of their rights under the Charter and whether they feel satisfied with protection offered by the Charter.
4. To provide lessons to the Government, health institutions and patients as to what to do – both individually and collectively – to improve health service provision in the country for the benefit of all stakeholders.

1.4 Research Questions

Every country institutes a health care system not only to ameliorate the burden and impact of illness, injury and disability but more importantly to improve the health and functioning of the people. While many current quality improvement efforts of the Government of Ghana such as the provision of health infrastructure, equipment, the introduction of the health insurance scheme and the adjustments of the salaries of health workers are commendable and show great promise, they seem to relegate the need for constant monitoring to examine the quality of service being provided to the background. This study intends to find answers to the following questions:

- What level of quality care are consumers (patients) receiving now that health care is very accessible?

- Are Ghanaian consumers satisfied with the services of the Korle-Bu Polyclinic?
- What is the level of awareness of Ghanaian patients of the "Patients Charter" promulgated to protect them?
- Will Consumers be more demanding if they were aware of their rights?

1.5 Methodology and Scope of the Study

Being essentially a social research, the study was basically non-experimental and exploratory/qualitative in design. The study covered the Korle Bu Polyclinic and included doctors, nurses, other allied health workers and patients. In the case of the patients, random sampling was employed.

Data for this study was collected from both primary and secondary sources. Primary data was sourced from administering questionnaire, observation and interview. Three sets of questionnaire were administered - one each for Nurses and Doctors, another for the Hospital Administrator and a third set for the patients.

Secondary Data were from books, journals, magazines, articles from the web, newspapers etc. related to this study. Some examples of laws/decrees from other countries on the protection of patients' rights were also examined. The results of the study were presented in both tabular and narrative form.

1.6 Relevance of the Study

Globally, governments have seen the need for patients protection and satisfaction and have therefore taken steps to improve health delivery services in their individual

countries. The USA under President Bill Clinton commissioned a committee to formulate patients' bill of rights for the protection of American patients and other stakeholders. (www.govinfo.library.unt.edu/qhealth). The European Union also met in Amsterdam to do same. These two instances show that patients' rights is gradually gaining centre stage in every state. "Assuring that the rights of patients are protected requires educating citizens about what they should expect from their governments and their health care providers – about the kind of treatment and respect they are owed. Citizens, then can have an important part to play in elevating the standard of care when their own expectations of that care are raised" (WHO, 2002) Thus any research that seeks to assess the performance of the health sector also find out the level of awareness of the patients on their rights under the law is very significant to all stakeholders:

1. It is significant to the patients because they stand to gain if it leads to better services after revealing the pitfalls of the health sector for remedies.
2. It is significant to the government because it will enable it assess the performance of a very key sector of the economy that is very important to the development of the nation.
3. It will benefit the health sector too as it will make them improve on their services and satisfy their consumers (patients).

1.7 The Ghana Health Sector

The health, nutrition, and environmental sanitation of any people are linked to the general state of development in the country. The Government of Ghana, for that matter, seeks to improve the health of all people living in Ghana regardless of age, sex, race,

ethnic origin, religious conviction, political affiliation, or socio-economic standing. This it is believed, can only be achieved through strengthening the health system by improvement in its access, quality, efficiency and financing.

The Health Services in Ghana is organised at five levels namely community, sub-district, district, regional and national levels. Services provided at the community, sub-district and district levels constitute primary health services delivered in the context of a district health system. Services to communities are delivered through outreach programmes from the sub-districts and through the Community Based Health Planning and Services Programme. Other services available to the communities are those offered by traditional birth attendants, chemical sellers and itinerant herbalists.

The sub-district level provides clinical, public health and maternity services through the sub-district management team. This team is required to forge a close partnership with the communities through community institutions, community based health workers and other health related institutions in their catchment area. The Sub-district health team is responsible for the overall planning, monitoring and evaluation of services as well as ensuring quality of services within the sub-district. The planning responsibility of the sub-district health team requires that they have access to information on health needs, service delivery, coverage and resource availability.

The district level is responsible for operational planning and programme implementation and is organised under clinical, public health and administrative units. Clinical services are provided by the hospitals in the district while public health activities

are managed by the district health management team which is also responsible for planning, organising, monitoring and evaluation of the package of services at the district level.

The Region is responsible for strategic planning and it monitors performance of district and regional hospitals. Its main role is that of advisory and the provision of technical support. The current structure of the regional health administration includes the Public Health Unit, Clinical Care Unit and the Regional Health Administration Unit. Some regions have additional structures including training and diagnostic facilities. (www.ghanahealthservice.org)

1.8 Organization of the Study

The study was organized into five chapters. Chapter one included the general introduction, comprising background to the study, statement of the problem, objectives of the study, research questions, methodology and scope of the study, significance of the study, overview of the Ghana Health sector and organization of the study. Chapter two tries to put the study in context by reviewing relevant literature on consumer rights, protection, awareness and satisfaction. Chapter three examines the methodology employed by the researcher. Chapter four presents and analyses data collected and Chapter five is a summary with conclusions and recommendations for the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 HEALTH DELIVERY AS A SERVICE

All over the world, companies are competing strategically through service quality for greater differentiation in today's competitive marketplace. Successful companies focus on the services dominant paradigm with investment in people, technology, human resource policies, and compensation linked to service performance of employees. This is important because contact employees' attitudes and behaviours significantly influence the quality of service. In the health sector, they present the "face and voice" of the care centers to the patients/consumers.

McCarthy J. (1981) proposed the 4 factor (also known as the 4Ps) of the marketing mix which represents Product, Process, Pricing and Promotion, have been widely employed as a model for product marketing. It shows the company preparing an offer which combines the mix of product and price, with an integrated promotion mix to reach the target consumers through the selected distribution channels. The 4Ps of marketing have been key areas where marketing managers allocate scare corporate resources to achieve the business objectives of satisfying consumers. Services on the other hand, have unique characteristics: intangibility, heterogeneity, inseparability and perishability. To discern the differences between services and physical goods, Booms and Bitner (1981) suggested the extension of the 4Ps framework to include three additional factors: People, Physical evidence and Process as marketing mix variables for services marketing.

People – refer to all people directly or indirectly involved in the consumption of a service, e.g. employees or other consumers.

Physical Evidence – relates to the environment in which the service is delivered, and the tangibles that help to communicate and perform the service, and

Process – is the delivery and operating systems of procedures, mechanism and flow of activities which services are consumed.

The additional 3Ps has gained widespread acceptance in the services marketing literature. The 3Ps together represent the service and provide the evidence that makes services more tangible.

2.1.1 People

People are all directly and indirectly involved in the service encounter – namely the firm's contact employees, personnel and other customers. Due to the inseparability of production and consumption, service firms depend heavily on the ability of contact employees to deliver the service. Contact employees contribute to service quality by creating a favourable image for the firm, and by providing better service than the competition. Service providers such as doctors and nurses are involved in real time production of the service. They are the "service". Much of what makes a service special derives from the fact that it is a lived-through event. (Booms & Bitner 1981)

Service firms must find ways in which they can effectively manage the contact employees to ensure that their attitudes and behaviours are conducive to the delivery of service quality. This is especially important in services because employees tend to be

variable in their performance, which can lead to variable quality i.e. heterogeneity in the performance of services. The quality of a service (a visit to a hospital for medical check-up) can vary from service providers and customers among many other factors. This lack of homogeneity creates difficulty for service firms. As delivery of services occurs during interaction between contact employees and customers, attitudes and behaviours of the service providers can significantly affect customers' perceptions of the service. This is important because customers' perceptions of service quality and its value can influence customer satisfaction. (Booms & Bitner, 1981)

2.1.2 Physical Evidence

Physical evidence refers to the environment in which the service is assembled and in which the seller and customer interact, combined with tangible commodities that facilitate performance or communication of the service. The physical evidence of service includes all the tangible representations of service such as brochures, letterhead, business cards, furnishing, lightning, layout and decoration as well as the appearance and attitudes of its employees. Because of the simultaneous production and consumption of most services, the physical facility can play an important role in the service experience. As services are intangible, customers/consumers increasingly search for cues to help them understand the nature of the service experience. (Booms & Bitner, 1981)

2.1.3 Process

Process refers to the procedures, mechanisms and flow of activities by which the service is delivered i.e. the service delivery and operating systems. Because services are performances or actions done for or with the customers, they typically involve a sequence

of steps and activities. The combination of these steps constitute a service process which is evaluated by the customers. It helps if consumers understand the process of acquiring a service and the acceptable delivery times. Creating and managing effective service processes are essential tasks for most service firms.

Managing the process factor is essential due to the perishability of services which means that services cannot be inventoried, stored for reuse or returned. Another distinctive characteristic of the service process that provide evidence to the customer is the standardized or customized approach based on customer's needs and expectations. Since services are created as they are consumed, and because the customer is often involved in the process, there are more opportunities for customizing the service to meet the needs of the customers. (Booms & Bitner, 1981)

2.2 Consumer Rights As A Human Right

Patients' rights is not just a consumer right, but a human right as well. Article 25 of the UN Declaration of Human Rights adopted in 1948 says: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services". In addressing the basic needs of consumers, governments are urged to cover pharmaceuticals, food standards and drinking water, and also food, clothing, shelter, education, health care and sanitation. This has resulted in many countries now adopting a number of legislations to protect consumers including patients and making public services more accountable to their users. A consumer Ombudsman in the form of a central body oversees all consumer protection issues with the support of consumer protection laws in many countries.

2.3 Patients Rights in Ghana

In our part of the developing world, the problems of consumers are more related to the provision of essential services such as drinking water, sanitation, education and health care than market-related ones. In Ghana there are some institutions that work to protect the consumer. In the area of health, we have the Patients Charter. (Ghana Health Service Patients' Charter 2002) This Charter addresses:

- The right of the individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the country.
- Respect for the patient as an individual with the right choice in the decision of his/her health care plans.
- The Right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability.
- The responsibility of the patient/client for personal and communal health through preventive, promotive and simple curative strategies.

Carved out of these, are 14 Patients' Rights among which are:

- "The Patient has the right to quality basic health care irrespective of his/her geographical location",
- "The Patient is entitled to know of alternative treatment(s) and other health care providers within the service if these may contribute to improved outcomes",
- The Patient is entitled to full information on his/her condition and management…"
- The Patient is entitiled to confidentiality of information obtained about him/her…".

(Full list can be found in appendix2)

2.4 Patients' Rights in The Global Arena

In 1948, with the Universal Declaration of Human Rights, the "inherent dignity" and the "equal and unalienable rights of all members of the human family" was given recognition. (www.unhcr.ch/udhr/). It is on the basis of this concept i.e. the fundamental dignity and equality of all human beings, that the notion of patient rights was developed. In other words, what is owed to the patient as a human being, by physicians, and the by the state, took shape in large part due to this understanding of the basic rights of the person.

Patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms. Different models of the patient-physician relationship have been developed and these have informed the particular rights to which patients are entitled. In North America and Europe there are at least 4 models which depict this relationship – the Paternalistic Model, the Informative Model, the Interpretive Model and the Deliberative Model. Each of these suggests different professional obligations of the physician toward the patient. In the Paternalistic model, the best interests of the patient, judged by the clinical expert, are valued above the provision of comprehensive medical information and decision-making power to the patient. The informative model, in contrast, sees the patient as a consumer who is in the best position to judge what is in her own interest, and thus views the doctor as chiefly a provider of information. (Emanuel & Emanuel, 1992).

There continues to be enormous debate about how best to conceive of this relationship. However, there seems to be an international consensus that all patients have a fundamental right to privacy and dignity, to the confidentiality of their medical

information, to consent or to refuse treatment and to be informed concerning risks related to medical procedures.

On the strength of the above, most countries have legislations which govern the relationship between the health workers and the patients. A look at some of these charters from the various countries reflect a general consensus on privacy, confidentiality of medical information, consent to treatment, information about relevant risk of medical procedures etc. Below are some of the salient points of some selected countries.

2.4.1 Information Disclosure and Right to Medical Care

In the USA, one has the right to receive accurate and easily understood information about his or her health plan, health care professionals, and health care facilities. This view is also shared by the EU – "Information about health services and how best to use them is to be made available to the public in order to benefit all those concerned". Patients have the right to be fully informed about their health status, including the medical facts about their health condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment" The California patients' Bill of Rights states among other things that "you have the right to know all the risks, benefits and treatment alternatives before consenting to any treatment" (www.who.int/genomics/public/patientrights). Ghana's Charter states "The Right of the individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the individual". (Ghana Health Service Patients' Charter 2002).

2.4.2 Choice of Providers

The USA Patients' Charter on the above enables one to have the right to a choice of health care provider that is sufficient to provide you with access to appropriate high quality health care. The Israeli Charter states, "A patient shall be entitled to proper medical care, having regard both to its professionalism and quality, and to the personal relations incorporated in it". In the EU Charter, "Everyone has the right to receive such health care as is appropriate to his or her health needs, including preventive care and activities aimed at health promotion. Services should be continuously available and accessible to all equitably, without discrimination and according to the financial, human and material resources which can be made available in a given society". The Ghana Charter states, "Respect for the patient as an individual with a right of choice in the decision of his/her health care plans." (www.who.int/genomics/public/patientrights).

2.4.3 Respect & Non-Discrimination

The EU Charter aims to promote human dignity, equity and solidarity, and professional ethics, acknowledging differences in the needs, values and cultures of different population groups. Ghana's Charter puts it this way "the right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability".

2.4.4 Confidentiality of Health Information

Almost all the countries' charters agree on the above. USA Charter states that "one has the right to talk in confidence with health care providers and to have your health care information protected. You also have the right to review and copy your own medical

record and request that your physician amend your record it is not accurate, relevant, or complete". In the EU, "all information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death".(www.who.int/genomics/public/patientrights) The patient in Ghana is entitled to confidentiality of information obtained about him/her.

2.4.5 Complaints and Appeals

In most countries, patients have the right to fair, fast, and objective review of any complaint they have against their health plans, doctors, hospitals or other health care personnel. In California for instance, patients have the right to sue any person who unlawfully releases their medical information without their consent. They can also submit grievances to the Department of Managed Health Care.

2.4.6 Consent

In the EU, an informed consent of the patient is a prerequisite for any medical intervention. In the USA State of California, patients have the right of consent to treatment after knowing all the risks, benefits and treatment alternatives of any treatment.

2.5 The Role of Stakeholders

Hall, (2004) in reviewing the patient bills/laws of rights of various countries made the following observation "that most of the patient protection laws are dominated by provisions that are directed primarily at patients' rights. Laws that are directed primarily to providers' interests are less frequent and are not very strong. The laws targeted most directly to protecting providers are not especially prominent in the overall package of state

patient protection laws". He also noted that most of the laws do not advance the agendas of the providers more than they protect consumers. Have these bills enough guarantee for health providers, the implementers of the patients bills and if so what role are they expected to play?

2.5.1 Rights and Obligations of Health Care Workers

While health care workers are obliged to implement all bills that has to do with patients rights such as the provision of emergency health care services irrespective of time and place, examine all patients requesting to be seen and depending on the findings of the examination, treat the patient or, in the absence of proper objective and personnel conditions, refer the patient to a physician or healthcare provider with the proper conditions, be within reach, or be in stand-by in a specific place or provide on-duty services, provide information to the patient carefully considering the patient's condition and circumstances, etc. The question to ask is what kinds of freedom are guaranteed under the law for caregivers? This is very important because as internal customers, if they are not cared for adequately, how can they guarantee adequate care and satisfaction for their clients?

The Szószóló (Spokesperson) Foundation for Patients' Rights was founded in 1994 at Budapest, Hungary. The Foundation's members are lawyers, physicians, advisors on medical ethics and sociologists.

The main goals of the Szószóló Foundation are as follows:

- to analyse the rules and practices related to patients' rights and, if necessary, to make proposals for their alteration. The members of the Szószóló Foundation took part in constructing the statue of the Health Care Act
- to co-operate with other Hungarian and foreign patients' rights organizations
- to inform the public about main issues and other questions of significance related to patients' rights.

Act CLIV (1997) on health, the Hungarian Health Act is very categorical on the issue of a physician having the right to deny care or refuse to examine a patient seeking care as captured below in Section 131 of the Act that states:

1. A physician directly involved in patient care may refuse to examine a patient seeking care

a) if prevented from doing so because of the immediate need to care for another patient or,

b) because of a personal relationship with the patient on condition that he refers the patient to another physician.

2. A physician may refuse to examine and provide further treatment for a patient if his own health or some other obstacle renders him physically unfit to do so.

3. A physician may refuse to provide care for a patient only following an examination, if in the course of the examination he determines that:

a) the patients's health status does not require medical care,

b) the treatment requested by the referring physician or the patient is not justified professionally,

c) the healthcare provider does not have the personnel or objective conditions needed to provide the care and he refers the patient to a professionally responsible healthcare provider, or

d) the condition of the patient does not require immediate intervention and the physician completing the examination can order the patient to return at a later time, or the physician acts in accordance with paragraph (b).

4. If, during the course of examining the patient, it is concluded that the treatment recommended by the referring physician or the patient is in conflict with the statutes or with professional rules, the physician may deny care.

5. A physician also may refuse to treat a patient if

a) said treatment is in conflict with the physician's moral outlook, conscience, or religious convictions,

b) the patient seriously violates his obligation to cooperate

c) patient behaves in a manner that insults or threatens the physician, unless this behaviour can be attributed to the disorder,

d) patient behaviour puts the life or physical well-being of the physician at risk.

6. In the cases set forth under Paragraphs a) and c) of subsection (5), the physician only may refuse care if

a) said refusal will not damage patient health, and

b) he refers patient to another physician or recommends that the patient see another physician in his own interests. (www.szoszolo.hu)

Apart from the right to deny treatment, the physician also has the right to choose freely among the scientifically accepted methods of examination and therapy within the

framework of valid statutes, that are to be applied, are known to and practiced by him though the patient has to consent to it.

2.5.2 Code of Ethics – Ghana Health Service

It is impossible in today's world to function as health personnel without an awareness of the impact of ethics on health care. Ethics play a huge role in the health delivery service. Ethics calls for honesty, trustworthiness, integrity, confidentiality and fairness. Traditionally, ethics has been defined in terms of what is right or wrong.

For healthcare Professionals, ethics is often defined by a code or creed as seen in the code of ethics. Unlike laws which seldom change, unless challenged and examined in courts, Code Of Ethics constantly change and evolve just as personal values and morals change and evolve. Below is the Code of Ethics of the Ghana Health Service:

1. All Service personnel shall be competent, dedicated, honest, client-focused and operate within the laws of the land

2. All Health Professionals shall be registered and remain registered with their Professional Regulatory Bodies

3. All Service personnel shall respect the Rights of patients/clients, colleagues and other persons and shall safeguard patients'/client' confidence.

4. All Service personnel shall work together as a team to best serve patients'/clients' interest, recognizing and respecting the contributions of others within the team.

5. All Service personnel shall co-operate with the patients/clients and their families at all times.

6. No service personnel shall discriminate against patients/clients on the grounds of the nature of illness, political affiliation, occupation, disability, culture, ethnicity, language, race, age, gender religion, etc. in the course of performing their duties.

7. All Service personnel shall respect confidential information obtained in the course of their duties. They shall not disclose such information without the consent of the patient/client, or person(s) entitled to act on their behalf except where the disclosure of information is required by law or is necessary in the public interest.

8. All Service personnel shall treat official discussions, correspondence or reports obtained during official duties as confidential except where disclosure is required by law.

9. All information obtained from patients/clients shall only be used for the prime purpose of their management. Any other use of such information shall only be done with the prior consent of the patient or person(s) entitled to act on his/her behalf.

10. All Service personnel shall provide information regarding patient's condition and management to patients or their accredited representatives humanely and in the manner they can understand.

11. All Service personnel shall protect the properties of the Service including properties entrusted in their care.

12. All Service personnel shall respect the rights and abilities of disabled persons and the aged and work together to serve or safeguard their interest

13. All Service personnel shall keep their professional knowledge and skills up to date.

14. No Service personnel shall demand unauthorized fees from patients/clients.

15. No Service personnel shall accept any gift, favour or hospitality from the patient/public which might be interpreted as seeking to exert undue influence to obtain preferential consideration in the course of their duty

16. All Service personnel shall refrain from all acts of indiscipline including drunkenness, smoking, immorality, abuse of drugs and pilfering in the course of performing their duties.

17. All Service personnel shall avoid the use of their professional qualifications in the promotion of commercial products.

18. All Service personnel shall not act in collusion with any other person for financial gain.

19. Service facilities and resources shall not be used for unauthorized private practice. (www.ghanahealthservice.org)

2.5.3 The Role of Consumers/Patients

What role should the consumers play in the service delivery to see to it that that they are not only protected, but derive satisfaction as well? In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost conscious environment. According to the World Health Organisation, "assuring that the rights of patients are protected requires more than educating policy makers and health providers; it requires educating citizens about what they should expect from the Governments and their health care providers – about the kind of treatment and respect they are owed. Citizens, then can have an important part to play in elevating the standard of care when their own expectations of that care are raised". The responsibilities of consumers include:

- Taking responsibility for maximizing health habits, such as exercising, not smoking, and eating a healthy diet.
- Becoming involved in specific health care decisions.
- Working collaboratively with health care providers in developing and carrying out agreed upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Using the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoiding knowingly spreading disease.
- Recognizing the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.

- Being aware of the health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Becoming knowledgeable about his or her health plan coverage and health plan options (when available) including all covered benefits, limitations and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and process to secure additional information, and the process to appeal coverage decisions.
- Showing respect for other patients and health workers.
- Making a good effort to meet financial obligations.
- Abiding by administrative and operational procedures of health plans, health care providers, and Government health benefit programs.
- Reporting wrongdoing and fraud to appropriate resources or legal authorities.

(www.who.int/genomics/public/patientrights).

2.6 Health Service Quality

A system of continuous quality improvement committed to preventing errors and correcting them when they do occur is a vital step in improving the quality of care in any health delivery system. Modern scientific development and technological advancement has made it possible for patients to receive first class services from hospitals and other health care givers. All over the world, people receive health care services of high quality that is delivered in timely fashion these days because of advanced technology. However, even in the best systems, mistakes are made leading to injuries during the course of treatment. Such injuries can result in additional health expenses, increased disability, lost wages, lost productivity and a host more. These costs are borne by individuals, families,

and society as a whole. Even in a developed country like the United States of America, studies conducted estimating the number of people who got injured in the course of treatment yielded the following statistics:

- Adverse drug events in hospitalized patients lead to excess length of stay, extra costs, and mortality (Classes et al, 1997). Such costs totaled USD8.4 million in one year alone for a 700-bed teaching hospital (Bates et al., 1977).
- From 1983 to 1993, deaths due to medication errors rose more than twofold, with 7,391 deaths attributed to medication errors (Phillips, Christenfeld, and McGlynn, 1998).
- A 1991 study of medical records from acute care hospitals in New York State found that adverse events occurred in 3.7 percent of hospitalizations and that 27.6 percent of those errors were due to negligence (Brennan et al., 1991).
- A study of errors in a medical intensive care unit revealed an average of 1.7 errors per day per patient, of which 29 percent had the potential for serious or fatal injury (Gropher et al., 1989).

It is therefore no wonder that states, international organizations, corporate bodies and even individuals are working tirelessly to promote quality health care and patients protection and safety these days. Irrespective of where one is coming from however, quality service standards can be judged by the following:

Equality/Diversity -Ensure the rights to equal treatment by all with regards to gender, marital status, family status, sexual orientation, religious belief, age, disability, race and social standing.

Physical Access -Provide clean and accessible offices to facilitate access for people with disabilities and other with specific needs.

Information-Take a proactive approach in providing information that is clear, timely and accurate, is available at all points of contact, and meets the requirements of people with specific needs.

Timeliness and Courtesy -Deliver quality services with courtesy, sensitivity and minimum delay, fostering a climate of mutual respect between provider and customer/consumer.

Complaints -Maintain a well publicized, accessible, transparent and simple to use system of dealing with complaints about the quality of service provided.

Internal Customer -Ensure staff are recognized as internal customers and that they are properly supported and consulted with regard to service delivery issues.

2.6.1 History of Quality Health Care

Health professionals, service managers and patients alike have come to expect the health care they provide or receive to be of a high quality. A lot of innovations have been developed to improve quality. A review of the history of quality provides valuable insights into issues affecting quality assurance today.

As early as the 19th Century, Florence Nightingale developed a system using hospital statistics for assessing the quality of care among patients admitted during the Crimean War (Maxwell, 1984). The outcome of medical care for the individual patient was the basis for measuring quality and this became the accepted approach for most health professions.

During the 1940s there was a new worldwide emphasis on health care interventions for control of major communicable diseases such as malaria and tuberculosis. In these programs, quality care was not just what was good for the individual patient but what was effective in reducing the burden of the disease in the whole population.

By the 1950's the emphasis began to shift from end results to the process of care. In one of the first major evaluative studies of quality in primary care, Collings (1950) investigated general practitioners at work. His qualitative assessment included the performance of the doctors and the conditions in which they worked. His conclusions highlighted the lack of objective performance standards and absence of recognized criteria for establishing them.

Achieving a fair outcome of care remains the ultimate determinant of quality care. Also, the inputs used to deliver services and the processes by which they are actually delivered must also be examined if quality is to be improved.

Donabedian, (1966) describe 3 approaches to the measurement of quality care. These entail evaluating quality of care using data collected on structural characteristics, the process of care and the outcome of care. This comprehensive approach gained popularity with the development of Primary Health Care during the 1970's. Major influences on health care quality during the 1980s included development in quality management, the rise in consumerism, and economic constraints in the health sector. These led to the

widespread introduction of health sector reforms which influenced health care delivery in the 1990s.

The whole definition of quality has shifted from the characteristics of the product to "meeting the customers requirements" (Oakland, 1989). This is more so with services which has to be more responsive to client expectation and demands.

2.6.2 Quality Perspectives

Ovretveit, (1990) distinguishes between Client Quality (what client wants), Professional Quality (whether techniques and procedures are carried out according to standards and whether service meets needs as defined by professionals), and Management Quality (the most efficient and productive use of resources to meet client needs).

There may be conflict of standards between service providers and the users. Patients may relate quality to overall satisfaction with treatment, thus a medically appropriate treatment may be perceived to be of poor quality (Weakliam, 1992). On the other hand, health practitioners may well see quality in terms of accuracy of diagnosis and efficacy of treatment, even though cost to achieve this level of accuracy may be high and the need for it, questionable (Clark and Forbes, 1979).

There is no consensus on what the correct balance is though in practice, appraisal has usually focused on the side of the provider rather than the patient. The client perspective is considered especially important in developing countries where utilization of

government rather than traditional health care is related to perceived quality (Martinez, 1992).

2.7 Satisfaction as a Measure of Quality

There is no consensus on how to define consumer satisfaction. Satisfaction is one way in which patients determines quality of care and its assessment may be used to measure outcome of care and the process (Lohr, 1988). It is argued that this approach ensures that services become more responsive to the views and needs of the community (Cibulskis and Haran, 1991). Despite extensive research in the years since Cardozo's (1965) classic article, researchers have yet to develop a consensual definition of consumer satisfaction. Oliver (1997) addresses this definitional issue by paraphrasing that "everyone knows what [satisfaction] is until asked to give a definition. Then it seems, nobody knows". Based on the perception that satisfaction has been defined, most research focuses on testing models of consumer satisfaction (e.g., Mano and Oliver 1993; Oliver 1993; Oliver and DeSarbo (1988). As Peterson and Wilson (1992) suggest, "Studies of customer satisfaction are perhaps best characterized by their lack of definitional and methodological standardization" (p. 62). A basic definitional inconsistency is evident by the debate of whether satisfaction is a process or an outcome (Yi 1990). More precisely, consumer satisfaction definitions have either emphasized an evaluation process (e.g., Fornell 1992; Hunt 1977; Oliver 1981) or a response to an evaluation process.

A final discrepancy occurs in the terms used as a designation for this concept. Researchers have used discrepant terms to mean satisfaction as determined by the final user: consumer satisfaction (e.g., Cronin and Taylor 1992; Oliver 1993; Spreng,

MacKenzie, and Olshavsky 1996; Tse and Wilton 1988; Westbrook 1980), customer satisfaction (e.g., Churchill and Surprenant 1982; Fornell 1992; Halstead, Hartman, and Schmidt 1994; Smith, Bolton, and Wagner 1999), or simply, satisfaction (e.g., Kourilsky and Murray 1981; Mittal, Kumar, and Tsiros 1999; Oliver 1992; Oliver and Swan 1989). These terms are used somewhat interchangeably, with limited, if any, justification for the use of any particular term. The lack of a consensus definition for satisfaction creates three serious problems for consumer satisfaction research:

(a)selecting an appropriate definition for a given study;

(b) operationalizing the definition; and

(c) interpreting and comparing empirical results.

These three problems affect the basic structure and outcomes of marketing research and theory testing. In some cases, satisfaction is not defined at all. Even if a researcher attempts to define satisfaction, there are no clear guidelines for selecting an appropriate definition for a given context. Cote J.L., Joseph A, (2000) Academy of Marketing Science Review; Defining Consumer Satisfaction.

The most common method of assessing quality is to conduct patient satisfaction surveys using unstructured questionnaires. Ware et al (1978) summarized several reasons for surveys of patient satisfaction. First, along with health status, patient satisfaction is an ultimate outcome of the delivery of personal medical care services. Patient satisfaction ratings contain useful information about the structure, process and outcome of care and has a unique evaluative component. Secondly, satisfaction is predictive of how patients will

behave in the future, that is, with regard to continuity of care, return visits to specific providers and compliance to therapy.

Vuori (1987) presents one of the most compelling arguments for utilising patient perceptions (satisfaction) in the assessment of quality of care. He states that health care providers and consumer perceptions are changing from purely biological concept of disease to an experiential concept of disease. This means that the patient's perceptions of the hospital experience, constitutes reality for them. He goes on to ask how then, can care be considered of high quality if the patient is not satisfied?

Bull (1994) in a study to determine patients and professionals perception of quality in discharge planning, identified that patient satisfaction was mentioned by all the health care professionals as an indicator of quality. They also stated the importance of family satisfaction and their willingness to accept a discharge plan. When patients or family were dissatisfied, professionals received complaints from patients or family members. Bull (1994) also identified that from the patients perspectives, satisfaction with care was implied and referred to not only to the plan but also the outcome of the plan.

In a five year study by Fisk et al (1990) they noted that the "classic model of satisfaction is that it results when service experience meets consumer expectations". Thus they appear to suggest that patient satisfaction is classically defined in health services by the confirmation of expectations paradigm (Oliver, 1980) or by achieving a level of perceived service performance that exceeds customer expectations.

A study by Koos (1954) which focused on issues of quality of care and delivery of services, satisfaction was viewed as an aspect of quality. Frequent reasons given for

dissatisfaction were cost, ineffectiveness of treatment, lack of physician interest and concern, and unnecessary treatment and diagnostic procedures.

The prominence given to satisfaction has its roots in the premises that, it is meaningfully and functionally related to specific health behaviours and other attributes. Hulka et al (1975) in their study to find out correlates of satisfaction and dissatisfaction of medical care, found that satisfaction varied with certain demographic characteristics such as race, age, sex, social class, family size, and having a regular source of care. Persons with fewer illnesses and complaints tend to be more satisfied. Income, age, education and being female were found to be positively related to satisfaction.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The research is non-experimental and exploratory in nature designed to find the factors influencing patient's satisfaction, awareness and protection at the Korle Bu Polyclinic.

3.2 Population

The Korle Bu Teaching Hospital is the primary health care facility in Ghana. It is the only tertiary hospital in the southern part of Ghana and it is also a teaching hospital affiliated with the medical school of the University of Ghana. The hospital was founded in 1923 as the Gold Coast Hospital. The then Governor, Gordon Guggisberg laid the foundation for Korle Bu Hospital in 1921, and it was finally opened on 9 October 1923. The hospital has expanded in phases and now has 1600 beds.

Being one of the leading tertiary hospitals in the sub-region, it receives referrals from the various regions and also neighbouring countries such as La Cote d'Ivoire, Burkina Faso, Togo, Niger etc.

The Korle Bu Polyclinic is the starting point for the assessment and treatment/discharge or referral to Consultants in the various units of the Hospital for people living around Korle Gonno, Mamprobi, and beyond. The Polyclinic provides 24-hour

general service including a specialist sickle-cell clinic. The polyclinic has a 30-bed capacity and attends to an average of 200 patients daily.

The study was embarked upon due to the interest of the researcher on stories from the media and comments made by individuals on the quality of care and the level of satisfaction with health delivery in the country with specific emphasis on Korle Bu Polyclinic.

3.3 Sampling Size and Sampling Method

To determine the correct sample size for any study, according to Miaoulis and Michener (1976) these criteria should be taken into consideration: the level of precision, the level of confidence or risk and the degree of variability in the attributes being measured.

3.3.1 Level of Precision

This is sometimes called sampling error or allowable error. This is the amount of error researchers are willing to tolerate. This range often falls between ± 5 percent. For example, if 60% of doctors in a sample have adopted a certain procedure with a precision rate of ±5 percent, then the research can conclude that between 55% and 65% of the doctors in the population have adopted the procedure.

3.3.2 The Confidence Level

Also known as risk level, this is based on Central Limit Theorem. The key idea in this theorem is that when a population is repeatedly sampled, the average value of the

attribute obtained by those sampled is equal to the true population value. Furthermore, the values obtained by these samples are distributed normally about the true value, with some samples having a higher and some obtained a lower score than the true population value.

3.3.3 The Degree of Variability

The degree of variability refers to the distribution of attributes in the population. The more dispersed a population, the larger the sample size required to obtain a given level of precision. On the other hand, if the population is concentrated, the smaller the sample size required.

3.4 Probability and Non-Probability Samples

Two general approaches to sampling are used in social science research – probability and non-probability sampling. With probability sampling, all elements (e.g., persons, households) in the population have some opportunity of being included in the sample, and the mathematical probability that any one of them will be selected can be calculated.

With non-probability sampling, in contrast, population elements are selected on the basis of their availability (e.g., because they volunteered) or because of the researcher's personal judgment that they are representative. The consequence is that an unknown portion of the population is excluded (e.g., those who did not volunteer). One of the most common types of non-probability sample is called a convenience sample – not because such samples are necessarily easy to recruit, but because the researcher uses whatever individuals are available rather than selecting from the entire population.

Because some members of the population have no chance of being sampled, the extent to which a convenience sample – regardless of its size – actually represents the entire population cannot be known.

3.5 Sample Size and Sampling Method Adopted

For this study, the convenient sampling method was adopted in selecting the sample. The target population used for the research were patients who had visited the polyclinic on more than one occasion. One hundred and forty-five patients (145) of both sexes were selected from the target population over a four-day period.

The researcher went to the field and distributed structured questionnaires to patients willing to take part in the study. The aims and objectives of the study were explained to the participants and those who could read and understand the questions were given pens to respond. Those who could not read or write however, were assisted by the researcher to answer the questions. Each question was read/and translated to the patients and the responses recorded.

In addition to the patients who were the main focus of this research, some key staff of the polyclinic whose job descriptions brought them into close touch with the consumers (patients) were also given some questionnaires specifically designed for them to answer. These were the administrator, some doctors and nurses and a few health workers like the radiologist and pharmacists. The main focus of the study was not to judge the hospital on technical grounds but rather on social and psychological factors.

Out of the one hundred and forty-five respondents 57(39.3%) were males and 88(60.7%) were females.

3.6 Tool of Data Collection

The tool used to gather data for this study was a structured questionnaire. Structured questionnaires helps control response bias and thus increase reliability. The questionnaire had both open-ended and forced choice questions.(Appendix 3). The researcher also made a conscious effort to allow those who had visited the polyclinic on more than one occasion to respond to the question because of the nature of the questions where one had to answer between a choice of "never' and "always".

Approval was sought and support was given by the Polyclinic authorities for this research. A letter was formally presented to the Polyclinic for permission to conduct the study. (Appendix 1). The relevance and objectives of the study which acted as an introduction to the questionnaire were explained to each patient/respondent.

3.7 Reliability and Validity

Data is said to be valid when the tool used in collection measures what it aims at measuring and can be said to be reliable when the same results are obtainable anytime the research is duplicated. The questionnaire was shown to the research supervisor who suggested some corrections before administering. The questionnaire was administered individually so as to avoid biases.

3.8 Limitation of The Study

The main limitation of the study was the sample size which small. 145 respondents selected through convenient sampling cannot be said to be representative of the whole population of patients who use the Polyclinic. Consequently, the findings cannot be generalised. Another limitation is the fact that the researcher had to translate for those who could not read or write. This posed a little bit of challenge as extreme responses as "Always" or "Never" were easily understood in vernacular but median responses like "Usually" and "Sometimes" came across as almost the same in meaning when translated. The researcher tried as best as she could to surmount this challenge under the circumstances. The small sample size was used because of time constraints.

Despite the above limitations, the findings brings to the fore some important issues worth considering in our health delivery. As the study is basically exploratory, it may also form the basis for future studies.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF DATA

4.1 Introduction

The Korle Bu Polyclinic on the average attends to over 1000 patients per week. The polyclinic has 20 doctors and 51 nurses and other health personnel such as Radiographers, Pharmacists, Dispensing Technicians and Laboratory Technicians. The Administrator, 8 Doctors, 18 Nurses and 7 other health staff made up of Radiographers, Laboratory Technicians, Pharmacist and Dispensing Technicians were also given questionnaires designed specifically for them to answer as they interacted closely with patients during the course of their work. The questionnaire for the Doctors, Nurses and other Health Workers centered around questions about their familiarity with the Patients' Charter and whether any patient had ever reported them to any authority. The Administrator's questionnaire sought to find whether any staff had ever been reported to her unit by a patient and what action was taken to seek redress for that patient.

4.2 Research Findings

The questionnaire administered to the patients was categorised under 10 main headings with sub questions under each category. The 10 categories were as below:

- Interaction with Nurses
- Interaction with Doctors
- Interaction with Other Health Personnel
- Communication about Medications
- Responsiveness of Polyclinic Staff
- Discharge Information

- Pain Management
- Cleanliness of Polyclinic Environment
- Patients' Protection
- General Perception

The data was analysed using frequencies and percentages presented in the form of tables, bar graphs and pie charts. The pie charts can be found in appendix 4.

4.3 Demographic Characteristics of Respondents

4.3.1 Age of Respondents

The respondents were aged between 18 and 75

Table 4.3.1: Age of Respondents

Age (Years)	Number	Percentage (%)
Below 21	24	16.5
21 – 40	72	49.7
41 – 60	31	21.4
Above 61	18	12.4
	145	**100**

Source: Field Data

Table 4.3.1 shows that 16.5% of the respondents were below 21 and 12.4% were aged above 61.

4.3.2 Educational Background of Respondents

A substantial number of respondents had some level of education – with the majority having basic education (55.9%). Secondary education covered vocational, technical as well as other forms of education beyond basic education but below tertiary education. Tertiary education refers to Teacher Training, Nursing Training, Polytechnics and University level.

Table 4.3. 2: Education Background of Respondents

Educational Level	Number	Percentage
Tertiary Education	6	4.1
Secondary Education	37	25.5
Basic/Primary Education	81	55.9
No Education	21	14.5
TOTAL	**145**	**100**

Source: Field Data

4.3.3 Religion of Respondents

The three major religions were represented by the respondents e following table.

Table 4.3.3: Religion of Respondents

Religion	Number	Percentage
Christian	131	90.3
Moslem	9	6.2
Traditional Worship	5	3.5
TOTAL	**145**	**100**

Source: Field Data

4.3.4 Marital Status of Respondents

Table 4.3.4: Marital Status of Respondents

Marital Status	Number	Percentage
Single	22	15.2
Married	95	65.5
Divorced	17	11.7
Widowed	11	7.6
TOTAL	**145**	**100**

Source: Field Data

4.4 Responses of Patients

Table 4.4 captures the various responses given by the patients in answer to the questions relating to the foregoing:

Table 4.4: Responses of Patients

	Never	Sometimes	Usually	Always
Nurses treating patients with Courtesy and Respect		34 (23.5%)	50 (34.5%)	61 (42%)
Nurses listening carefully to patients	1 (0.7%)	33 (22.8%)	57 (39.3%)	54 37.2%
Nurses explaining carefully to patients	6 (4.2%)	42 (28.9%)	53 (36.5%)	44 (30.4%)
Doctors treating patients with courtesy and respect	1 (0.7%)	24 (16.5%)	50 (34.5%)	70 (48.2%)
Doctors listening carefully to patients	2 (1.4%)	49 (33.9)	37 (25.3%)	57 (39.4%)
Doctors explaining carefully to patients.	2 (1.5%)	44 (30.3%)	45 (31%)	54 (37.2%)
Doctors informing patients about treatment options	112 (77.2%)	29 (20.%)	4 (2.8%)	

	Never	Sometimes	Usually	Always
Lab/X-Ray Staff treating patients with courtesy and respect		25 (17.2%)	50 (34.5%)	70 (48.3%)
Pharmacy Staff treating patients with courtesy and respect		25 (17.2%)	50 (34.5%)	70 (48.3%)
Polyclinic staff informing patients about what medicine is for	62 (42.7%)	43 (29.7%)	20 (13.8%)	20 (13.8%)
Informing patients about possible side effects of drugs/medication	86 (59.3%)	30 (20.7%)	18 (12.4%)	11 (7.6%)
How often patients had help when they needed it.	1 (0.7%)	75 (51.8%)	36 (24.8%)	33 (22.7%)
How often Polyclinic Staff inform in word or writing about symptoms to look out for on discharge	**Yes** 28 (19.3%)		**No** 117 (80.7%)	
	Never	**Sometimes**	**Usually**	**Always**
How often patients were helped with pain management	1 (0.7%)	90 (62.1%	37 (25.5%)	17 (11.7%)
How often hospital was kept clean		2 1.4%)	71 (48.9%)	72 (49.7%)
Health workers mistreating patients on any occasion	**Yes** 33 (22.7%)		**No** 112 (77.3%)	

Source: Field Data

Out of the 145 respondents, 22.7% indicated that they had been mistreated before by Polyclinic staff. Of those who answered yes, 51.5% believed it was due to their financial status and 48.5 were of the opinion is was due to other status. 100% of those who reported that they had been mistreated by health personnel did nothing about it. 15.1% did nothing because they were afraid. (84.9%) did not know where to direct their complaint.

In answer to the question regarding how many patients know that patients have rights protected by law, 29% said Yes and 71% said No. Only 9 out of the 42 who answered yes could name any of the patient rights.

What the patients liked about the polyclinic were: - cleanliness, good health personnel, friendly staff. Some of the things they did not like were favoritism with 78% of the total respondents citing delays as a factor they disliked most about the polyclinic.

About 9.6% of the patients rated the overall service delivery as Excellent, 53.8% rated it as Very Good, 27.6% rated the service as Good, 8.3% said it was Fair and 0.7% said poor. 90.4% will visit the polyclinic again even if they had other facilities to go to and 9.6% will not want to come again.

4.5 Discussions of Findings

Satisfying consumers by offering quality service is a must for all service providers. The service industry has been finding ways not only to satisfy the consumer but also delight him as well. Can this be said for our health delivery service in Ghana. It is therefore imperative that health providers narrow the gap between what the patient expects and what they are offering in order to fully satisfy their patients.

The study conducted at the Korle-Bu Polyclinic brought to fore a lot of significant lessons that will help the Polyclinic administration to strive towards customer satisfaction or consumer satisfaction in their dealings with the patients.

4.5.1 Staff Courtesy to Patients

The study revealed that staff generally treated patients with courtesy and respect. Of the 145 respondents, 42.6% said Nurses at the Polyclinic Always treated them with respect while 34.5% said they usually do. These together form 76.5% of the respondents who said they were satisfied when it comes to the question of courtesy and respect to patients. On the part of the Doctors, 48.2% said they were always treated with respect and 34.5% said usually bringing the total to 82.3%. This suggests that Doctors at the Polyclinic perform better on that issue than the Nurses.

The study also revealed that X-Ray and Laboratory staff also treated patients with courtesy and respect with a significant number, 82.8% indicating that they are always or usually treated with courtesy and respect by the staff.

4.5.2 Staff Listening Carefully to Patients

The study revealed that 37.2% of the total respondents said Nurses always listened to them while 39.3% said they usually did which means though not always, this is a frequent occurrence. This implies that over 76% of the patients were of the opinion that Nurses listened carefully to them. Less than 1% said they have never been listened to carefully. With regard to the Doctors, 39.4% said they are listened to always and 25.3% said sometimes. This result shows that Nurses did better on that score than the Doctors. This could be attributed to the Paternalistic approach adopted by most of our Doctors or to the Doctor-Patient ratio – which makes it impossible for Doctors to give much time to their patients due to time constraints.

4.5.3 Staff Explaining Issues Carefully to Patients

On this issue, it came to light that Doctors and Nurses at the Korle-Bu Polyclinic performed a little above average. The results showed that 66.9% of the patients answered that Nurses do so either always or usually – i.e. most of the time while the Doctors scored 68.2%. Though this is above average performance, there still is room for improvement. The onus also lies on the patients to seek clarification and more information when the need arises since they have the right to do so.

4.5.4 Communication about Medication

The two issues that came under this topic were: (a) Before giving any new medicine, how often did Polyclinic staff inform patients on what the medicine was for and (b) how often polyclinic staff described possible side effects of medicines given in a way patients could understand. On both questions, the staff did not perform very well. 42.7% of respondents answered that staff never took time to explain adequately to them on medications while 29.7 said they sometimes did. This represents over 70% of the total respondents. In our kind of environment, this is a serious issue considering the educational background of most people. On the issue of explaining side effects to patients, about 60% said this is never done. The question to ask is how many people take their time to read manufacturers manual usually packed in medicine boxes? When side effects are not explained to patients, they might erroneously think the medicine "is not good for them" when unpleasant reactions develop which could lead them to stop their medication midway. This could lead to drug resistance and more powerful medication will need to be developed to fight the disease. In the long term, monies that could be channeled elsewhere will have to be used to buy or develop costly medications.

4.5.5 Responsiveness of Polyclinic staff.

On the question of staff responsiveness to calls from patients who are in pain, 51.8% said staff answer calls only sometimes. About 47.8% said they either get help always or majority of the times. This all shows that some improvement is needed that area.

4.5.6 Discharge Information

Just as like the question on what side effects to look out for when patients are given medication, the polyclinic staff did poorly when it came to information given to patients on discharge on symptoms to look out for. A discouraging 80.7 of the respondents said they did not receive information either in the form of writing or even verbally. As some symptoms are natural to the treatment being offered, it is incumbent on the polyclinic staff to make this known to the patients. Article 2 of the patients rights says that " the patient is entitled to full information on his/her condition and management and the possible risk involved…."

4.5.7 Cleanliness of Polyclinic Environment

Patients were very happy with the cleanliness of the Polyclinic area. An overwhelming 98.5% responded that the polyclinic area was always or majority of the times kept clean. The Staff of the Polyclinic are to be commended for this for this very positive performance.

4.5.8 General Perception of Patients about the Polyclinic

Approximately 9.6% of the patients rated the overall service delivery as Excellent, 53.8% rated it as Very Good, 27.6% rated the service as Good, 8.3% said it was Fair and less than 1% said poor. This suggests that on the average people's perception of the polyclinic is Very Good. 90.4% will visit the polyclinic again even if they had other facilities to go to and 9.6% will not want to come again.

Figure below depicts the responses patients gave about what they liked most about the Polyclinic.

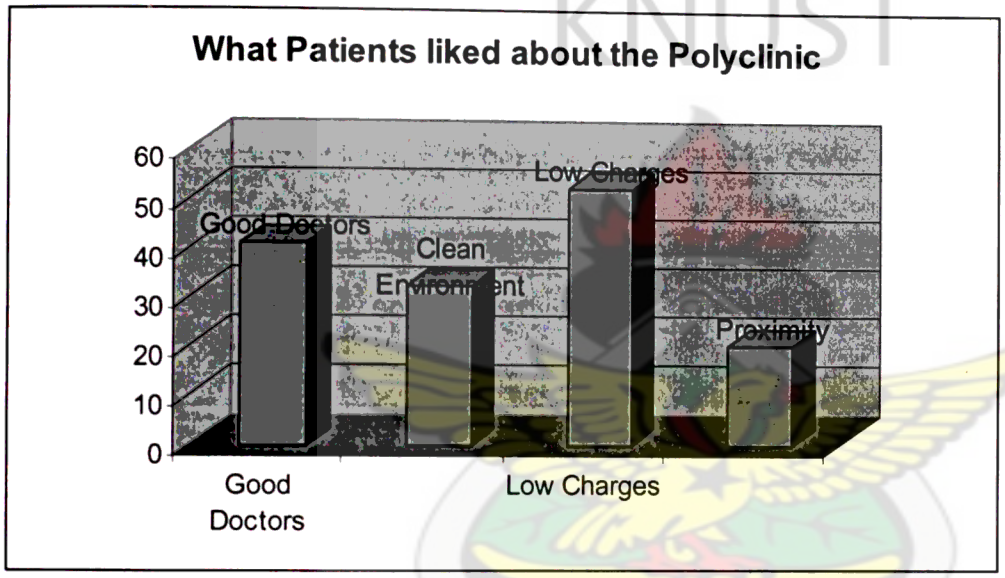

Figure 4.5.8: What Patients liked about KorleBu Polyclinic

From the Figure above, it is clear that though good doctors and clean environment scored very high on what they liked about the clinic, cost of service played the major part in consumer/patient satisfaction.

4.5.9 What Patients disliked about the Polyclinic

Overwhelmingly, almost every patient attributed what they disliked most about the Polyclinic to delays. They sited instances of spending more than 6 hours sometimes just to

see a doctor. They suggested that if for one reason or the other Doctors cannot attend to them immediately, the courteous thing under those circumstances will be that they be informed rather than just left sitting with no explanation as to the delay. They were of the view that if more staff could be deployed at the Polyclinic and also when staff desisted from the practice of favouritism, a lot more people will be very satisfied with the service.

4.5.10 Patients Protection and Awareness of Their Rights

The study brought out some interesting findings. Of the 145 respondents who were specifically asked whether they had ever being mistreated by a health worker, 22.7% answered Yes and 77.3% said No. This is a rather surprising find considering the number of unsavoury stories one hears sometimes from people who purport to have suffered mistreatment at the hands of health workers. Out of the 33 who answered Yes, 51.5% attributed that to their financial status. The other 48.5% could not be more specific and intimated that it could be as a result of other reasons. Out of the number who said they had suffered some form of mistreatment at the hands of health workers, none of them did anything about it - no complaints were lodged by any of them! This confirmed the responses received from the Health Workers in their answers to the questionnaire. None of them indicated that they had ever been the subject of a patient's formal complaint. The Administrator indicated in her response to her questionnaire that there was no complaints unit and no patient had ever lodged any complaint with her as regards the conduct of the Polyclinic staff.

In answer to the question why they did nothing, 15.1% of the 33 who claimed they had suffered some mistreatment at the hands of health workers responded that they did

nothing because they were afraid of further mistreatment and 84.9% did not know whom or where to direct their complaint to.

On the issue of Patients Awareness of their rights, out of the total number of respondents (145) 42 representing 29% said they knew that patients had rights. 71% did not know anything about Patients' Rights. Even those who claimed they knew that patients had rights, only 9 could mention any one of the rights. Interestingly, apart from the Doctors and Nurses sampled, the rest of the other Polyclinic staff knew nothing about Patient Rights.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

The aim of the study was to find the level of satisfaction of Ghanaian patients with regards to health delivery taking the Korle Bu Polyclinic as a case study and the level of awareness of the patients viz a viz their rights and protection.

5.1 Summary of Findings

- Doctors, Nurses and other allied staff like X-Ray and Laboratory staff generally treat patients with courtesy and respect.
- Patients are not provided with adequate information on medications. Medicines prescribed are not fully explained to patients as to the use and side effects. This should be addressed as quickly as possible.
- Doctors and Nurses do not explain to patients when they are being discharged or after treatment what to expect as they recover and what to do when they experience some symptoms.
- Polyclinic was rated highly on cleanliness
- Delays and favoritism was a major cause of dissatisfaction for patients at the Polyclinic.
- Majority of the patients do not know of the existence of a Patients Charter much more know what to expect from health care workers in relation to the charter.

We can see from the study that most of the things that patients did not know was their right for example - Doctors explaining treatment options to patients - had a very high

score of "Never". However, since they did not even know that this was their right, they would not rate that as a cause of dissatisfaction.

The return of clients to a facility and the recommendation of the facility to others, are highly related to the client's level of satisfaction. Return of clients is a marketing principle that is becoming increasingly important for health care providers today. As Marquis et al (1983) indicated, satisfied patients are likely to maintain a consistent relationship with a specific provider. This relationship will encourage the client to recommend the facility to others who need health care. 131 out of the 145 respondents indicated that even if they had other facilities to go to, they would still patronize the Korle Bu Polyclinic. This is a major indication of their satisfaction with the services provided. As indicated in the Bar Graph, this satisfaction derives from the fact that the cost of services is less. That study revealed that cost of service plays a major role in patient satisfaction. There are good doctors and nurses available and proximity of the Polyclinic to their residences also was a factor to their satisfaction.

Notwithstanding the overall rate of satisfaction, there was some level of dissatisfaction expressed in the study. The study found that patients were very dissatisfied with the length of time they had to wait to receive a service – right from the records office, nurses and doctors consulting rooms.

5.2 Conclusion

According to Crow et al (2003) "Something that satisfies, will adequately fulfill expectations, needs or desires, and by giving what is required, leaves no room for

complaint". This statement aptly shows that satisfaction depends mostly upon the knowledge base of the respondent and therefore feeling "satisfied" with a service does not necessarily indicate it is of a high quality. A consumer with limited knowledge and low expectations may express high levels of satisfaction even when standards are poor.

One can conclude from the study that generally, clients were satisfied with the level of courtesy and respect showed them by health workers at Korle Bu Polyclinic, the area was highly rated as clean, they were satisfied with the skill of doctors at the polyclinic and would return to the Polyclinic again even when there were other facilities available. This does not however mean that service delivery at the Polyclinic is above board. As indicated in the literature by Crow et al above, satisfaction goes hand in hand with expectations. If you do not expect a certain level of service, when it is absent, you have no basis for complaint. From the findings it was obvious that patients' awareness of their rights and responsibilities was woefully poor and even when they had a grievance, they did not know whom or where to direct their complaints to.

5.3 Recommendations

The patient is the hub around whom all activities in the health center revolves. Provision of quality health service is a teamwork between the state, the individual and the health care providers. For this reason, the views and opinions of clients should be incorporated into quality assurance programs to help increase client satisfaction.

Patients should also be educated on their rights and responsibilities as this will lead them to demand better services from health workers and ultimately lead to quality service.

The WHO captures this point by the following statement ***"..assuring that the rights of patients are protected requires more than educating policy makers and health care providers; it requires educating citizens about what they should expect from their governments and their health care providers – about the kind of treatment and respect they are owed. Citizens, then, can have an important part to play in elevating the standard of care when their own expectations of that care are raised"*** Thus it is incumbent on the Ghana Government and all other institutions charged with information dissemination to the citizenry to educate every citizen on patient rights and responsibilities.

The Polyclinic should aim at continuous quality improvement of the processes to meet the needs of the patients. This could be done by constantly adjusting and improving the system and getting rid of processes/persons that cause delays or lapses in the delivery of service.

Patients should be informed if there are bound to be delays. Waiting for hours on end without any explanation from the Polyclinic staff should be a thing of the past. Being a patient does not mean one should be patient with undue delays!!

Favouritism/jumping the queue by friends and relatives of health personnel should be avoided and clients should be served on first come, first served basis.

A complaints unit could be set up by the administration to rectify the situation where people do not know where/whom to direct their grievances. Posters informing patients about this unit should be at all vantage points of the Polyclinic. So also is the Patients Charter - this should also be displayed at vantage points for all to see.

It is hoped that the implementation of the above recommendations will go a long way in improving quality of care at the KorleBu Polyclinic and make patients more aware of their rights thereby making them more discerning of the kind of care they should expect from the health delivery sector in Ghana and the Korle Bu Polyclinic in particular.

REFERENCES

Bitner, J. en Booms, B (1981), "Marketing Strategies and Organizational Structures for Service firms" *American Marketing Association*, Chicago

Bull M. S. (1994), "Patients and Professionals Perception of Quality in Discharge Planning; Journal of Nursing Care Quality" *Lippincott Williams & Wilkins Ltd.*.

Bursch B, Beezy J. and Shaw R. (1993), "Emergency Department Satisfaction: What Matters Most:" Annals of Emergency Medicine 22

Cassels A and Janovsky K (1991, " A Time of Change: Health Policy, Planning and Organisation in Ghana, WHO/SHS/CC91.2

Cilbuskis R and Haran D. (1991), "Implementing Quality Assurance in the Peripheral Health Units of Sierra Leone, Liverpool School of Tropical Medicine, UK."

Clark E. and Forbes J. (1979), "Evaluation of Medical Care in Evaluating Primary Health Care" Billing and Sons Ltd.

Collings J. (1950), "General Practice in England Today: A Reconnaissance" Lancet I

Cote J.L., Joseph A, (2000) "Defining Consumer Satisfaction" Academy of Marketing Science Review

Donabedian A. (1989), "The End Results of Care: Ernest Codman's Contribution to Assessment and Beyond" The Milbank Quarterly 67

Fisk T. A., Brown C.J. Cannizaro and Naftal B. (1990), "Creating Patient Satisfaction and Loyalty" Journal of Healthcare Marketing 10

Fornell, Claes (1992), " A National Customer Satisfaction Barometer" Journal of Marketing 56 (January): 6 - 21

Hall M.A., (2004) "State Managed Care Patients Protection Laws Dataset"

Halstead Diane, David Hartman, Sandra L. Schmidt (1994), "Multisource Effects on the Satisfaction Formation Process" Journal of the Academy of Marketing Science 22 (Spring) 114-129

Howard, John A and J.N. Sheth (1969), - "The Theory of Buyer Behaviour", John Wiley and Sons.

Hulka B.S., Kupper L., Cassel J.C., Daly M. and Schoen F. (1975), "Correlates of Satisfaction and Dissatisfaction with Medical Care: A Community Perspective"

Koos E.L., (1954), "The Health of Regionsville" Columbia University Press 1954

Kwansah J. (1998), "Patient Satisfaction with HealthCare Services At The Trust Hospital" Dissertation for MBA, School of Administration, University of Ghana

Lohr K.N. (1988), "Outcome Measurement: Concepts and Questions" Inquiry 25

Martinez C. (1992), "Utilization of the Out-Patient Department Services in the Health Facilities of Tolon/Kumbungu District, Ghana" Dissertation for Masters in Community Health, Liverpool School of Tropical Medicine

Maxwell R. (1984) "Quality Assessment in Health" British Medical Journal: 288

McCarthy J. (1981) "Basic Marketing: A Meaningful Approach"

Miaoulis G. and Mitchner R.D. (1976). "An Introduction to Sampling" Kendal/Hunt Publishing Company

MOH (1993), " Health Sector Brief" Ministry of Health, Accra, Ghana

Oakland J.S. (1989), "Total Quality Management" MCB UP Ltd

Oliver R. (1980), " A Cognitive Model of the Antecedents and Consequences of Satisfaction Decisions" Journal of Marketing Research – Nov. 17: 460-469

Oliver, Richard L. (1981) " Measurement and Evaluation of Satisfaction Process in Retail Setting" Journal of Retailing 57

Ovretveit J. (1994), "A Comparison of Approaches to Health Service Quality in the UK, USA and Sweden and the use of Organisational Audit Frameworks" European Journal of Public Health 4: 46-54

Owusu F.Y.(2007) "Health Delivery Service in Ghana: Consumer Protection and Satisfaction: Assessment at Komfo Anokye Teaching Hospital" Dissertation for MBA , BleKinge Teknisa Hogskola/Sektionen For Management, Sweden

Peterson, Robert A. and William R. Wilson (1992), "Measuring Customer Satisfaction: Fact and Artifact" Journal of the Academy of Marketing Science: (Winter) 61-71

Tse, David K. and Peter C. Wilton (1988), "Models of Consumer Satisfaction: An Extension" Journal of the Academy of Marketing Science 25 (May): 204 - 212

Vuori H (1987), "Patient Satisfaction: An attribute or Indicator of the Quality Care" Qualtity Care Review Bulletin 13 (13): 106 - 108

Ware J. E., Wright W. R., Snyder M.K., Chu G.C. (1975), "Consumer Perception of Health Care Services: Implications for Academic Medicine" Journal of Medical Education 50: 839

Ware J.E., Davis-Avey A., Stewart A.L. (1978), "The Measurement and Meaning of Patient Satisfaction: A Review of Literature, Health Medical Care Services Review 1: 1

Weakliam D. (1992), "Quality of Care in a Tuberculosis Control Programme - Evaluative Study of Integrated Tuberculosis Activities at Health Posts in Surkhet District, Nepal," Liverpool School of Tropical Medicine

Yi, Youjae (1990), "A Critical Review of Consumer Satisfaction" Review of Marketing; American Marketing Association, 68-123

INTERNET WEBSITES

American Nurses Association Code of Ethics (USA)
www.med.howard.edu/ethics/handouts [accessed 24/01/09]

Jean Y. T. Lukaz – Towards A Consumer Protection Policy in Ghana
www.ghanaweb.com/publicagenda/index.php [accessed 7/02/09]

Legal & Policy Framework for Health Information & Health Data Reporting (2007)
www.moh-ghana.org/moh/docs/hmn [accessed 28/01/09]

Patients' Charter & Ghana Code of Ethics
www.ghanahealthservice/org [accessed 23/01/09]

Rights And Obligations of Healthcare Workers
www.szoszolo.hu/53/rights [accessed 11/02/09]

Universal Declaration of Human Rights
www.unhcr.ch/udhr/ [accessed 24/01/09]

Consumer Bill of Rights : Business Study Guide – Bookgras.com
www.cuts.international.org/consumer-rights.htm [accessed 25/01/09]

Patients Bill of Rights
(www.govinfo.library.unt.edu/hquality) [accessed 24/01/09]

Patients Rights
(www.who.int./genomics/public/patientrights) [accessed 21/02/09]

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9TH Febraury, 2009
DATE.....

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION
MRS. CYNTHIA GARSHONG-OWUSU

This is to confirm that the above-named student is pursuing an Executive Masters in Business Administration (EMBA) Programme at the KNUST – Institute of Distance Learning. As part of the requirements for the Postgraduate Programme, she would need to complete a project.

The Institute would be very grateful if you could avail to her any information she would need from your organization to enable her complete her project successfully. We assure you that the information given will be kept confidentially.

Thanks for your co-operation.

Yours faithfully,

Kofi Adu
Head, KNUST Accra Office
For: Dean: IDL

APPENDIX 2

The Patients Charter

The Ghana Health Service is for all people living in Ghana irrespective of age, sex, ethnic background and religion.

The service requires collaboration between health workers, patients/clients and society. Thus the attainment of optimal health care is dependent on Team Work.

Health facilities must therefore provide for and respect the rights and responsibilities of patients/clients, families, health workers and other health care providers. They must be sensitive to patient's socio-cultural and religious backgrounds, age, gender and other differences as well as the needs of patients with disabilities.

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.

This Charter is made to protect the Rights of the patient in the Ghana Health Service. It addresses:

a. The Right of the individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the country.

b. Respect for the patient as an individual with a right of choice in the decision of his/her health care plans.

c. The Right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability.

d. The responsibility of the patient/client for personal and communal health through preventive, promotive and simple. curative strategies.

THE PATIENT'S RIGHTS

1. The patient has the right to quality basic health care irrespective of his/her geographical location.
2. The patient is entitled to full information on his/her condition and management and the possible risks involved except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent.
3. The patient is entitled to know of alternative treatment(s) and other health care providers within the Service if these may contribute to improved outcomes.
4. The patient has the right to know the identity of all his/her caregivers and other persons who

may handle him/her including students, trainees and ancillary workers.

5. The patient has the right to consent or decline to participate in a proposed research study involving him or her after a full explanation has been given. The patient may withdraw at any stage of the research project.
6. A patient who declines to participate in or withdraws from a research project is entitled to the most effective care available.
7. The patient has the right to privacy during consultation, examination and treatment. In cases where it is necessary to use the patient or his/her case notes for teaching and conferences, the consent of the patient must be sought.
8. The patient is entitled to confidentiality of information obtained about him or her and such information shall not be disclosed to a third party without his/her consent or the person entitled to act on his/her behalf except where such information is required by law or is in the public interest.
9. The patient is entitled to all relevant information regarding policies and regulation of the health facilities that he/she attends.
10. Procedures for complaints, disputes and conflict resolution shall be explained to patients or their accredited representatives.
11. Hospital charges, mode of payments and all forms of anticipated expenditure shall be explained to the patient prior to treatment.
12. Exemption facilities, if any, shall be made known to the patient.
13. The patient is entitled to personal safety and reasonable security of property within the confines of the Institution.
14. The patient has the right to a second medical opinion if he/she so desires.

THE PATIENT'S RESPONSIBILITIES

The patient should understand that he/she is responsible for his/her own health and should therefore co-operate fully with healthcare providers. The patient is responsible for:

1. Providing full and accurate medical history for his/her diagnosis, treatment, counseling and rehabilitation purposes.
2. Requesting additional information and or clarification regarding his/her health or treatment, which may not have been well understood.
3. Complying with prescribed treatment, reporting adverse effects and adhering, to follow up requests.
4. Informing his/her healthcare providers of any anticipated problems in following prescribed treatment or advice.
5. Obtaining all necessary information, which have a bearing on his/her management and treatment including all financial implications.
6. Acquiring knowledge, on preventive, promotive and simple curative practices and where

necessary to seeking early professional help.

7. Maintaining safe and hygienic environment in order to promote good health.
8. Respecting the rights of other patients/clients and Health Service personnel.
9. Protecting the property of the Health facility.

NB:

These rights and responsibilities shall be exercised by accredited and recognized representatives on behalf of minors and patients who are unable for whatever reasons to make informed decisions by themselves;

In all healthcare activities the patient's dignity and interest must be paramount.

APPENDIX 3

SERVICE DELIVERY IN THE HEALTH SECTOR – CONSUMER PROCTECTION, AWARENESS & SATISFACTION

Research Objectives: - This research aims at finding

1. the level of satisfaction of Ghanaian patients as regards health delivery
2. the level of protection available for patients in Ghana
3. what the government, Ghana Health Service and Patients need to do to improve patients satisfaction and security.

Significance of the Research

4. It is relevant to the patients because it will examine one of their most important need-satisfying service
5. It will be relevant to the government, because it will measure the performance of one of the key sectors in the development of the nation
6. It will be beneficial to the health sector since it will enable them know patients expectations and thereby aim at continuous quality improvement for patient satisfaction.

Directions

a. For each of the following statements below, please check/tick one of the options that describe your situation or experience.

b. There are no right or wrong answers, however honest answers are needed for the findings to be useful.

c. Your responses will be kept **confidential**. Please do not write your name.

1. **Gender** ☐ Male ☐ Female

2. **Age**
   - ☐ Below 23
   - ☐ Between 23 - 41
   - ☐ Between 41 – 51
   - ☐ Above 51

3. **Education**
   - ☐ Doctoral Degree
   - ☐ Master's Degree
   - ☐ Bachelor's Degree
   - ☐ Secondary Level
   - ☐ Primary Level
   - ☐ No Education

3. **Religion**
   - ☐ Islam
   - ☐ Christian
   - ☐ Traditionalists
   - ☐ Other

4. **Marital Status**
   - ☐ Single
   - ☐ Married
   - ☐ Divorced
   - ☐ Widowed

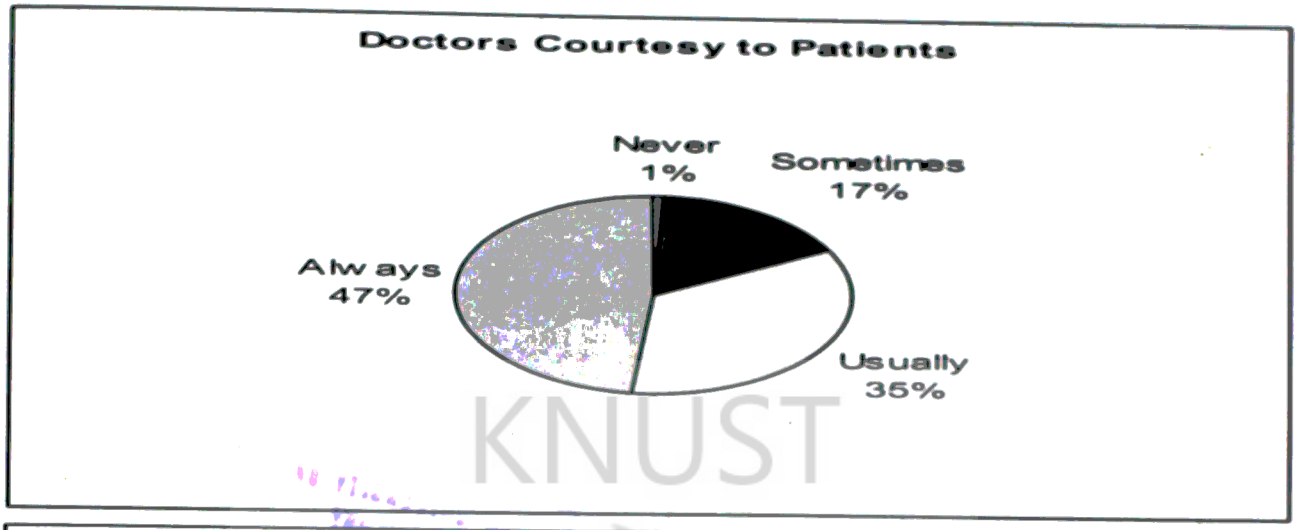
	INTERACTION WITH NURSES	
1.	During your Polyclinic stay/visit(s), how often did nurses treat you with courtesy and respect?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
2.	During your Polyclinic stay/visit(s), how often did nurses listen carefully to you?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
3.	During your Polyclinic stay/visit(s), how often did nurses explain things in a way you could understand?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
	INTERACTION WITH DOCTORS	
4.	During your Polyclinic stay/visit(s), how often did Doctors treat you with courtesy and respect?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
5.	During your Polyclinic stay/visit(s), how often did Doctors listen carefully to you?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
6.	During your Polyclinic stay/visit(s), how often did doctors explain things in a way you could understand?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
7.	During your Polyclinic stay/visit(s), how often were you informed about treatment options?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
	INTERACTION WITH OTHER HEALTH PERSONNEL	
8.	How often have did Laboratory/X-Ray staff treat you with courtesy and respect	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
9.	How often did you Pharmacy Staff treat you with respect?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
	COMMUNICATION ABOUT MEDICATIONS	
10.	Before giving you any new medicine, how often did Polyclinic staff tell you what the medicine was for?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
11.	Before giving you any new medicine, how often did Polyclinic staff describe possible side effects in a way you could understand?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
	RESPONSIVENESS OF POLYCLINIC STAFF	
12.	During your Polyclinic visit/stay, after you called for help, how often did you get help as soon as you wanted it?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐

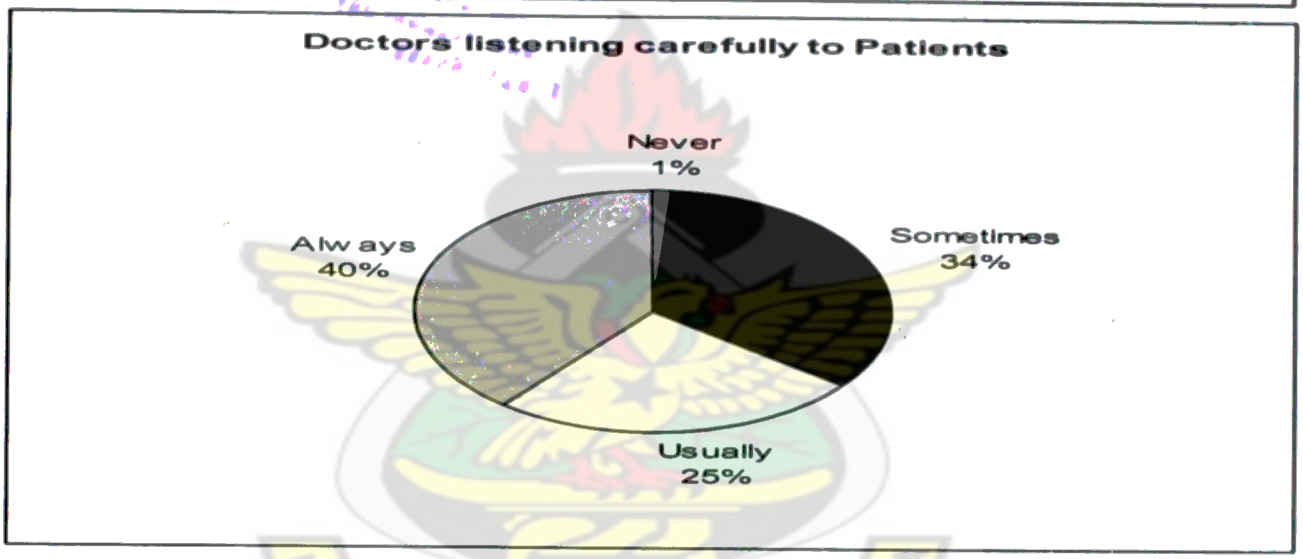
	DISCHARGE INFORMATION	
13.	During your Polyclinic stay/visit, did you get information in word/ in writing about what symptoms or health problems to look out for after you left the Polyclinic?	Yes ☐ No ☐
	PAIN MANAGEMENT	
14.	During your Polyclinic stay/visit, how often did the Polyclinic staff do everything they could to help with your pain?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
	CLEANLINESS OF CLINIC ENVIRONMENT	
15.	During your Polyclinic stay/visit, how often were your rooms and general area kept clean?	Never ☐ Sometimes ☐ Usually, ☐ Always ☐
	PATIENTS' PROTECTION	
16.	Have you ever been mistreated by a health worker (Doctors, Nurses, etc)	Yes ☐ No ☐
17.	If you answered "Yes" to 14, what do think caused the health personnel to treat you the way they did?	Education Backgound ☐ NHIS (Financial) ☐ Other Status ☐
18.	If you answered 'Yes' to 14, what did you do?	Nothing ☐ Reported ☐
19.	What informed your decision in 15?	Fear ☐ Didn't know I can complain ☐ Have no time ☐ Would not know where to direct my complaint ☐ Other:-
20.	Do you know that patients have rights protected by law?	Yes ☐ No ☐
21.	If Yes to " 20" Mention one of them	
	GENERAL PERCEPTION	
22.	What do you like about this polyclinic	
23.	Is there something you do not like about the clinic?	
24.	In general how would you rate the overall service provided to patients at this polyclinic?	Excellent, Very Good, Good, Fair, Poor ☐ ☐ ☐ ☐ ☐
25.	If you have any other health facility to go to, will you come here again?	Yes ☐ No ☐
26.	What improvement(s) will you recommend to the health sector?	

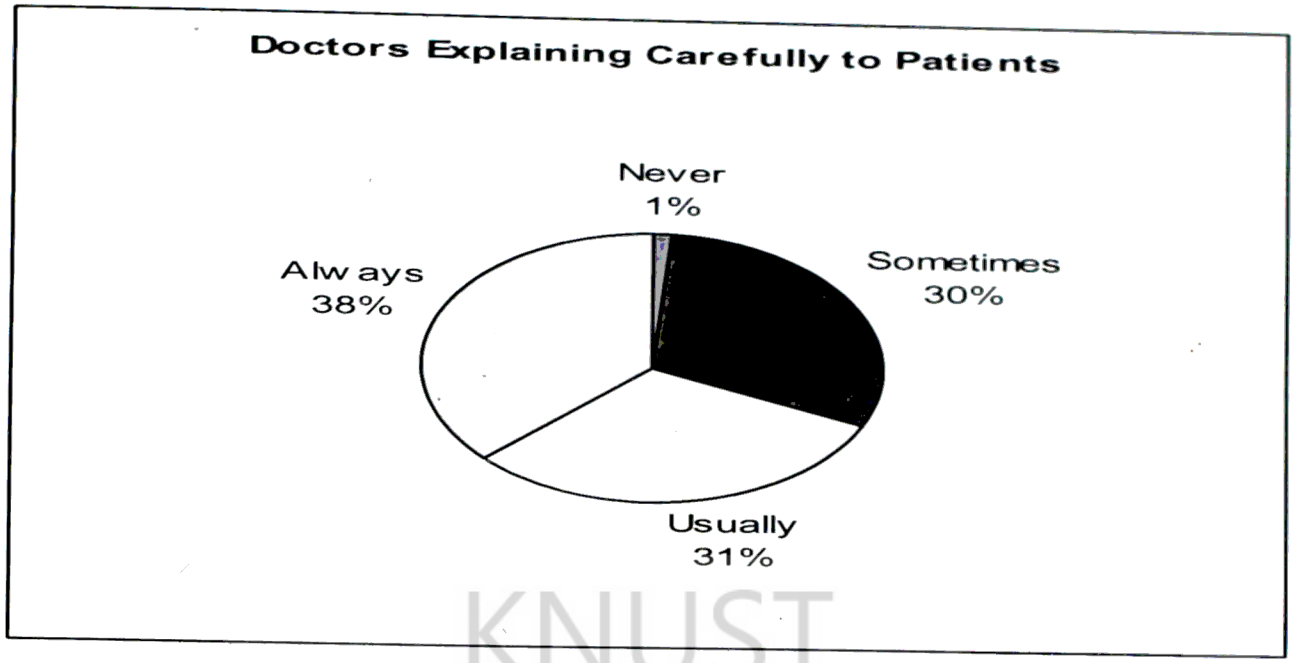
	QUESTIONS FOR DOCTORS, NURSES/OTHER HEALTH WORKERS	
1	Area of Practice	General ☐ Specialist ☐
2.	How long have you been a Doctor or Nurse	1-5 ☐ 6-10 ☐ 11-15 ☐ 15+ ☐
3.	On average, how many patients do you attend to a day?	1-20 ☐ 21-40 ☐ 41-60 ☐ 60+ ☐
4.	How many minutes (on average) do you spend on each patient?	(In Minutes) -5 5-10 11-20 21-30 30+
5.	Is this time enough for you to treat the patient the way you would have wished?	Yes ☐ No ☐
6.	In your own personal assessment, how will you rate the level of satisfaction of your patients before they leave your consulting room?	Very Satisfied ☐ Satisfied ☐ Not Satisfied ☐ Confused ☐ Don't Know ☐
7.	Have you ever been reported by a patient?	Yes ☐ No ☐
8.	If yes to 7, where and to whom were you reported to?	Administration, ☐ Court ☐ Medical Association ☐ Other.....
9.	What happened?	Was queried ☐ Punished ☐ Warned ☐ Nothing ☐
10.	Are you familiar with the tenets of the Patients' Charter	Yes ☐ No ☐
11.	If Yes, are you measuring up to its requirements	Very Well ☐ Somehow ☐ No ☐
12.	Is something hindering you from measuring up?	Yes ☐ No ☐
13.	If yes, what is it?	
14.	In your opinion, is the charter enough to protect patients rights from abuse	Yes ☐ No ☐
15.	Your final Comment (if any)	

	QUESTIONS FOR ADMINISTRATORS	
1.	How many Doctors and Nurses work at this Polyclinic	
2.	How many patients are treated in a day?	
3.	Do you have a complaints unit?	
4.	How many complaints do you receive in a week? (average)	
5.	What do you do about them.	
6.	Do you have a way informing the Complainants of the actions you take?	
7.	How are patients rights protected at this Polyclinic?	
8.	Are the workers of this Polyclinic familiar with the tenets of the Patients Charter?	
9.	Are the workers measuring up to the standards of the Patients Charter? How?	
10.	What in your opinion needs to be done to improve full protection of patients rights at this polyclinic?	
11.	How will you grade the Polyclinic in relation to the satisfaction and protection of patients?	Excellent ☐ Very Good ☐ Fair ☐ Poor ☐
12.	Has the Polyclinic or any of your workers being sued for negligence or patients rights abuse?	Yes ☐ No ☐
13.	What is the reason for your answer in 12	

APPENDIX 4







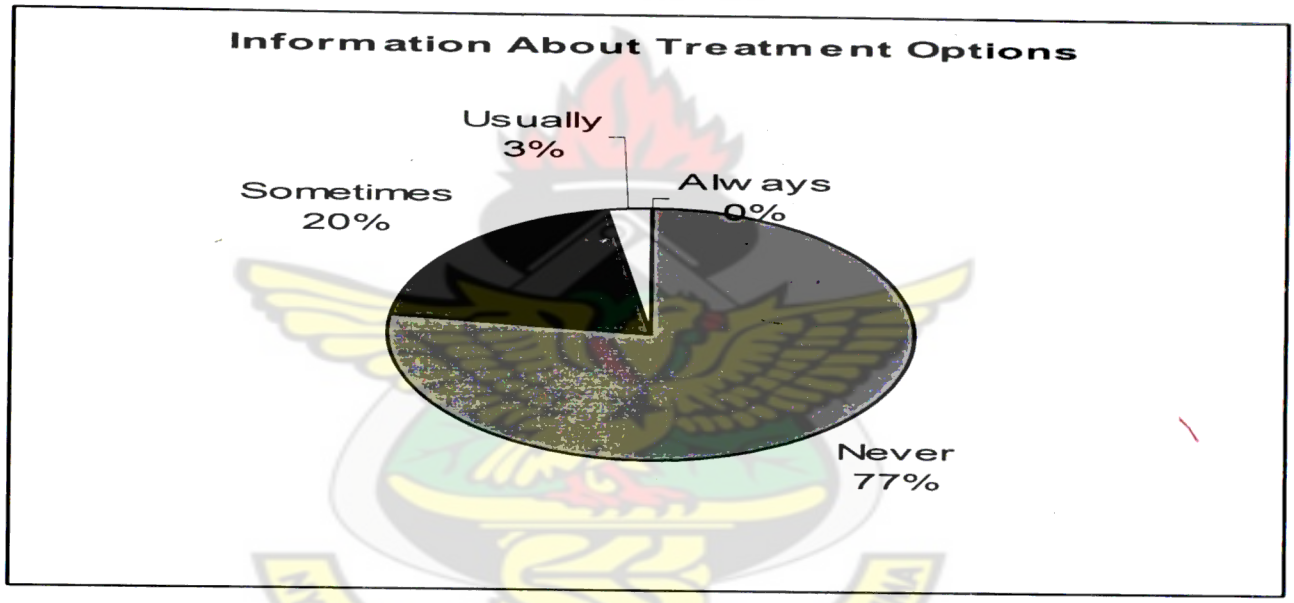


Figure 4.4: Interaction with Health Personnel