Quality is a process of meeting the needs and expectations of the customers. Although quality has many perspectives, each customer has specific needs and expectations and the goal is for these expectations to be fulfilled by the provider organization. One method for the identification of customer needs and expectations is a satisfaction survey. Any system has three components: inputs, processes and outputs. Outputs and outcomes are the results of the processes and the activities of the system. One measure of this component is the rate of satisfaction of the users of the system. In healthcare, the ultimate user of the system is the patient and thus, the patient survey is the method most appropriate to measure satisfaction with outputs and outcomes of the system. The field of patient satisfaction surveying is growing. With most of the accrediting bodies such as JACHO, NCQA, AAHC and URAC requiring survey results to be reported on a regular basis, mechanisms for addressing them must be implemented and measured. This emphasis on patient satisfaction has created a new type of health care customer, one who is becoming increasingly intolerant of mediocre care and service. Several studies of patient satisfaction in both primary health care and inpatient settings have shown that patient satisfaction is directly correlated to patient’s expectation, but not necessarily to clinical outcomes.1-5 Two studies are worthy of note relating to Saudi Arabia (El-Shabrawy and Mahmoud, 19936 and Mansour and Al-Osimy, 19937). Both report on surveys conducted in Riyadh, Saudi Arabia with patients in primary health care (PHC) settings. Using interview methodology, both studies collected information from a randomly selected sample of patients regarding satisfaction with care and services received at the PHC centers. Both studies reported patients to be satisfied with their care in general, but they were less pleased with the waiting times and the thoroughness of their visits. This study was performed to assess patient satisfaction in Riyadh, Saudi Arabia. The analysis focused on assessing the relationships between patient characteristics and level of satisfaction and previous history with the facility from which they sought care. Patients were selected from public and private primary health care and inpatient care sectors. The objectives were to measure satisfaction by each variable identified in terms of service and care. The study also sought to measure the difference in satisfaction between these groups and find out if there were any correlations with the type of the facility and the satisfaction level of the patient.
The target population was patients attending two MOH and five private hospitals (the number of private hospitals was increased because they have fewer inpatients) and five MOH PHC centers in Riyadh, Saudi Arabia. A sample of patients representative of those attending the facilities were selected using stratified random sampling techniques. Only inpatients with at least a 3-day stay were included. A structured questionnaire was developed and 500 copies were distributed to hospitals and 500 to PHC centers. Of the 500 hospital questionnaires sent out, 392 (78.4%) were returned and used in the analysis. From the PHC centers 408 questionnaires (81.6%) were returned and validated. The study instrument consisted of questions on demographic information with one satisfaction question asking whether the patient would likely return to the facility a second time. Satisfaction was also assessed by the four-point Likert scale, ranging from 1 (strongly disagree) to 4 (strongly agree). The satisfaction measures assessed patients’ views about a variety of important hospital and PHC characteristics, including the availability of services, accessibility of the facilities to patients, the quality of the accommodation, affordability, the quality of facility personnel, including doctors, nurses and other staff, and the cleanliness and appearance of the facilities. The questionnaire had face validity based on health professional and patient comments, and was determined to be reliable, having an 88.2% coefficient alpha from pilot testing on 10 inpatients and 10 outpatients. We used logistic regression analysis to assess the volume and direction of the relationships between the independent and dependent (dichotomous variable) variables.

The source of payment for patients’ care, and patients’ level of education were the factors that most significantly impacted on satisfaction with the various aspects of care investigated in the study. These factors were independent of provider type (hospital or clinic), ownership (public or private), source of payment, and patient level of education. Patients attending primary care clinics were more likely than those attending hospitals to be satisfied with the availability of providers and services and their ease of access to the facility. In particular, clinic patients were significantly satisfied with the availability of specialists (odds ratio, 3.82; 95% CI, 2.22-6.57), felt the facility was sufficiently high tech (4.00; 2.30-6.93), appreciated the presence of Saudi doctors (1.96; 1.18-3.25), were satisfied with the quality of the non-physician and nurse staff (3.03; 1.71-5.39), had family living near by (1.75; 1.02-3.01), and had attended the facility because they had heard good things about it from others (12.62; 1.56-4.38) or a family member had a previous positive experience with the facility (1.66; 0.98-2.81). Specifically they did not think their facility was located sufficiently close to their residence (0.42; 0.25-0.70), were dissatisfied with the scheduling of appointments (0.50; 0.30-0.84), felt costs were too high (0.50; 029-0.87), and were not happy with the religious make-up of the staff (0.36; 0.21-0.60). Patients who attended private institutions were also dissatisfied with most of the factors in the survey. Items they were not significantly dissatisfied with included the availability of providers of the same sex, the ease to get to the facility, the length of waiting time, the ease of registration and scheduling of appointments, and the presence of Saudi doctors. For the most part, individuals who paid for care from personal resources or
those of the family (private pay) were most dissatisfied with the facilities they attended. Private-pay patients were significantly dissatisfied with the availability of specialists (0.56; 0.34-0.94), the ease of registering (0.58; 0.36-0.94), the quality of doctors available (0.64; 0.38-1.06), the quality of manners (0.54; 0.33-0.89), and the religion of facility staff (0.64; 0.39-1.05). They were satisfied with their ability to move around in their facility (0.64; 0.39-1.65), and the presence of Saudi doctors (1.53; 0.94-2.49).

The relationship between education level, and facets of patient satisfaction were consistently and significantly positive in direction. Patients with more years of education tended to be more satisfied with factors such as the availability of entertainment at their facility (2.24; 1.44-3.50), the facility’s proximity to their residence (1.71; 1.10-2.68), shorter waiting times (1.48; 0.94-2.33), cost of care (2.05; 1.24-3.40), quality of the doctors (1.57; 0.97-2.53), the cleanliness of the facility (1.72; 1.09-2.72), and the nationality (1.50; 0.93-2.40) and religion of the staff (1.48; 0.94-2.34). Patient age made a significant difference in reported satisfaction for only two items. Older patients tended to be more satisfied with the availability of entertainment in the facility they attended (1.02; 1.00-1.04), and the religion of the staff (1.02; 1.00-1.04). Living situation did not seem to make a difference with respect to patient satisfaction. Patients who were married as well as those who lived alone tended to be dissatisfied with the facilities they attended. Both married patients and those living alone tended to be dissatisfied with the availability of providers of the same sex, and the proximity of the facility to their residence. Patient family size was significantly related to only one satisfaction item. Patients coming from large families tended to be more satisfied with the appropriateness of appointments to the facility they attended (1.12; 1.04-1.20). The employment status of patients made a significant difference in reported satisfaction in six areas. Employed patients were more satisfied with how close their facility was to family living near by (2.02; 1.13-3.61), the technological sophistication of the facility (1.62; 0.92-2.85), the presence of Saudi doctors (3.16; 1.81-5.50), the quality of the nursing staff (2.27; 1.27-4.05), and felt the cost of care was appropriate (1.73; 0.96-3.10). They were, however, not satisfied with the religion of the staff at the facilities they visited (0.50; 0.29-0.88). The income level of patients as reflected by reported salary was significantly related to three items and all in a positive direction. Patients with higher salaries were more likely to be satisfied with the quality of the nursing staff (2.02; 1.27-3.21), and had a previous positive experience as a patient (1.56; 0.97-2.50) or knew of family member who had a previous positive experience at the facility they attended (1.94; 1.22-3.08). In contrast to the responses of patients with higher salaries, those who reported having a second source of income were more likely to be negative about their experiences. Patients with second incomes were significantly dissatisfied with the amount of time they had to wait for service (0.60; 0.33-1.10), the ease with registering (0.56; 0.31-1.00), and felt the cost of care was not appropriate (0.53; 0.28-1.03).
Patient health status was not significantly related to satisfaction with specific aspects of the facilities they attended. However, patients who had poor self-reported health status were significantly related to two ‘prior history’ factors i.e., more likely to have had a family relationship with a staff member (2.04; 1.23-3.40), and they felt the hospital had a good reputation (2.09; 1.27-3.46). On the other hand, patients with good self-reported health were significantly less satisfied with the nationality of the staff at the facility they attended (0.64; 0.39-1.07). Of all, the patient characteristics only sex did not significantly affect patient responses on any of the items on the satisfaction scale.

The most crucial challenge for all those who work in healthcare organizations, including those who manage them, was to ensure an exclusive standard of quality for their customers, particularly the patients. The importance of having continuous quality improvement principles must be embedded in the framework of an organization, in order to attain customer or patient satisfaction.

Healthcare organizations should focus on the importance of the care process from the patient’s viewpoint, by proclaiming patient satisfaction as their mission, with an underlying emphasis on providing the best possible care for their patients. To do so, the management team must rearrange their infrastructure to reflect patient needs and demands. Satisfaction surveys are a stepping-stone to evaluating customer needs and expectations, thus allowing for the formulation of a policy to accommodate their perspectives. To tackle dissatisfaction issues effectively, the management team needs to establish a strategic plan for evaluating performance. The plan should contain calculated guidelines for each department to follow, by which they can systematically measure their compliance levels. Subsequently, a regular reporting mechanism should be instituted, one that involves department heads, and in turn, the board of directors. Monitoring performance levels helps in understanding how the organization is performing, and how it can operate better in the future.

References