The Effects of Health Care Financing Reform on Quality of Health Service:

A Case of Private Wing Service in Addis Ababa Public Hospitals

By

Tirunesh Bazezew Kassa

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Abstract

Back ground: Health care financing reform is the main strategy designed to solve both the accessibility and the quality issues of the health care system of Ethiopia. Assessment the effect of this reform on the quality of health provided in the private wings of public hospital was the main objective of this study. The three aspects of quality, structural, process and the outcome of care were then assessed.

Methods: A descriptive cross-sectional quantitative study was conducted at the outpatient private wing service. Quality of service was assessed using a structured questionnaire through clients exit interview. The data collection period was between the month of April and May/2013. Data was coded and analysis using SPSS version 16. 0. was done using Univariate, bivariate and multivariate logistic regression analysis method.

Result: Better satisfaction rate of clients were reported on the professionals characteristics of courtesy and respect of clients, listening, explanation, advice and information sharing, which on average was 78.2 %. But a relatively low performance was observed in the service characteristics. Only 59 % of the clients were satisfied with the general cleanliness of the physical environment, 73.1 % had got the ordered laboratory service and only 22.8% of them had the prescribed medication.

Conclusion and Recommendation: Implementation of the health care financing reforms has brought some improvements of quality and a rise in patient satisfaction in the private wings of public hospitals. Howe ever, much has to be done for full implementation of the health sector reforms to further improve the quality of service provided to community.

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Acronyms

BPR	Business Process Re-engineering
EHRIG	Ethiopian Hospital Reform Implementation Guide
EMOH	Ethiopian Ministry of Health
HCFR	Health Care Financing Reform
HMIS	Health Management Information System
HSDP	Health Sector Development Program
I-PAHC	Inpatient Assessment of Health Care survey
MDG	Millennium Development Goal
NASW	National Association of Social Workers
O-PAHC	Out Patient Assessment of Health Care survey
OPD	Outpatient Department
SPSS	Statistical Package for Social Science
WHO	World Health Organization

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CHAPTER ONE: INTRODUCTION

Back ground

According to the Federal Democratic Republic of Ethiopia Ministry of Health (EMOH), "health care is one of the crucial components of basic social services that have a direct linkage to the growth and development of the country as well as to the welfare of a society". Accessibility and quality of health care by all population is among others that the health policy of Ethiopia outlines (Federal Democratic Republic of Ethiopia Ministry of Health (EMOH, 2010, p.30).

In order to strengthen and improve the accessibility and quality of health service in the country and better achieve public health goals, the federal ministry of health has currently implemented various health sector reforms. Such reforms include Health Care Finance Reform (HCFR), Business Process Re-engineering (BPR), Health Management Information System (HMIS), and the Ethiopian Hospital Reform Implementation Guidelines (EMOH, 2011).

Health Care Finance Reform (HCFR), among other health sector reforms is a recognized strategy that health care should be financed through multiple financing mechanisms to ensure long-range sustainability. The strategies introduced in the HCFRs include revenue retention and use at health facility level, systematizing a fee-waiver system for the poor, standardizing exemption services, introducing private wing in public hospitals, and outsourcing of nonclinical service (Hailu Zelelew, 2012)

Currently all hospitals under Addis Ababa city administration health bureau have implemented almost all the principal components of HCFRs. Among the components of HCFR, private wing service is a lately practiced initiative by many public hospitals of Addis Ababa. According to proclamation 26/2001of Addis Ababa city Cabinet, Private wing service is a program planned: "To provide better quality service for those who can afford to pay for it; to retain highly qualified specialists; to generate more revenue and to cross-subsidize the general service of the hospital."

Providing quality of health service entails focus on the process of service delivery such as communication and information sharing, respect, medication availability and cost. These are also a valuable indicators of quality of health service and satisfaction of patients by the service is measured (Gremigni , Sommaruga & Peltenburg ,2008). The main purpose of this study is to assess the provision of quality of health service in the private wing of three public hospitals of Addis Ababa. Zewditu Memorial hospital,Yekatit 12 and Ras Desta Damtew are selected for the study since private wing service is fully implemented and well functioning .

Statement of the problem

The quality of health service in Ethiopia has been compromised by inadequate and poorly maintained infrastructure and equipment, scarcity of trained health personnel, and the unavailability of drugs and pharmaceutical supplies which mainly was associated with inadequate financing which was caused by poor budget allocation and utilization. To solve this problem, the government has focused on improving the organization and structure of the health delivery system (HSDP- IV,2010) .

Health Care Financing Reform is the key strategy designed to improve the financial and organizational issue of the public health institutions. Private wing service as one component of health care financing reform is implemented in public hospitals to provide better quality of service for those who can afford for it on the way to build the financial capacity of the institutions. The private wing service is expected to be provided with a higher level of amenities and customer service, more comfortable and cleaner environment, more convenient opportunity times and personal choice of doctors. These are necessary conditions for satisfaction of patients in a health service as well as the process aspect of quality of service is realized.

Better quality of health service is said to be achieved when all the three aspects quality are ensured which are, structural, process and outcome aspects. Major indicator of this are availability of necessary medical supplies and materials , waiting time, cleanliness of facilities and equipment, courtesy and competence of providers and the effectiveness of the services provided and cost (EMOH,2011)& (Gremigni , Sommaruga & Peltenburg ,2008) .

The services provided by public hospitals of Ethiopia as stated by many service users is often failed to meet most of this quality standards. It is commonly said that, the approaches and skill in which health care providers are communicating and sharing information to patients and their families is often unpleasing, necessary materials and supplies are usually not fulfilled. Generally patients who get services at public hospitals of Ethiopia are observed to be dissatisfied.

This study is therefore, planned to assess the service provided at the private wings has met those quality measures , whether it is provided as stated in the private wing policy and how patients are satisfied with the service. Patient satisfaction survey is the method used for the assessment of those aspects.

Significance of the study

From social policy and community service perspective: According to the current health policy of Ethiopia not only those who can afford for, but also the poor has the right to have equitable and quality of health service. Private wing service is implemented to provide better quality of service for those who can afford and fees from better-off clients to be used to help pay for services for those who cannot afford. Assessment of the quality of service and identifying gaps is there for important for the service to be sustained. From community service perspective, assessment of the quality of service provided to the community is also important to improve the quality of service provided to the community.

Significance of the study for Social Work education: The study is planned to assess the quality of service provided through patient satisfaction survey which entails good communication, effective patient provider relationship and information sharing of clients. In the social work practice as well these are requirements have to be maintained in the helping process. According to (Pamela, 2005), quality of the relationship between those who delivers the service and who receives it and good communication are social work skills that have to be practiced well in helping of clients (Pamela, 2005)

Finally, since the study is the first of its kind which will be conducted at the private wing service, it may contribute to current knowledge of the quality of service provided at the private wings of public hospitals.

Objectives of the study

General objective of the study

To assess the quality of health service provided at the private wing of public hospitals.

Specific objectives of the study

1) To do an assessment of the satisfaction of patients by the private wing service
2) To know that the cost of the private wing service is affordable by service users
3) To determine the private wing service is provided as stated in its guiding Principle

Research questions

1. Does the private wing service provide quality of health care?
2. Does private wing service add to the satisfaction rate of patients?
3. Is the cost of the service satisfying to patients?

CHAPTER TWO: LITERATURE REVIEW

In the first part of the literature review, the current health situation of Ethiopia in the implementation of health sector reforms will be assessed, literatures that can explain the quality of health service will be referred and reviewed, the relationship between quality of health service and patient satisfaction will be discussed. Important variables and concepts of patient satisfaction and quality of health service together with their conceptual definitions will be reviewed. In the second part of the literature review, theories and models that could support the central idea of the study will be reviewed.

The Current Health Situation of Ethiopia

In1993 the government published the country's first health policy in 50 years setting with the vision for the healthcare sector development for the next two decades. The policy tried to reorganize the health services delivery system with the objective of contributing positively to the overall socio-economic development effort of the country. Major aspects of this policy focus on fiscal and political decentralization, expanding the primary health care system, and encouraging partnerships and the participation of nongovernmental actors. (Health Sector Development Program IV, 2010/11 -2014/15)

To implement the policy, the Health Sector Development Program (HSDP) was developed in1997/98, and a healthcare financing strategy in 1998. The program under HSDP-I covered the first five years (1997/98–2001/02) and prioritized disease prevention and decentralizing health services delivery. The new strategy, HSDP-II (2002/03–

2004/05), was developed with an added aim of including NGOs in the implementation of a basic health package.

In pursuant of the health policy goals of improving the health status of the Ethiopian population using the cycle of the five year term health strategy framework, HSDP-III was developed in 2005 to run through 2005/06 2009/10. This latest strategy stresses the need to increase national health spending, the strategic role of NGOs as partners in achieving universal primary healthcare coverage not only in planning but also implementing healthcare delivery particularly at the woreda level and also emphasizes the need to strengthen government-NGOs collaboration (Health Sector Development program (HSDP) IV, 2010).

After the successive implementation of the health sector development plan, especially of HSDP III, some improvements have been observed in the health care system of Ethiopia. A mid-term review of HSDP-III shows a near 100% in health coverage as indicated by the availability of primary health services (health posts, health extension workers and kits for essential health services) but outpatient utilization rate per person per year is only 0.32, far short of the target of 0.66 with only about a year left to 2010.21 This shows that the increase in availability of services does not guarantee utilization. At the same time, increase in antenatal coverage has not resulted in equal levels of supervised deliveries.

Hence, improving health will require increasing health service utilization, particularly the critical maternal and child health services, as a matter of priority, and this

cannot be done by merely increasing services availability but by providing quality and reliable services.

Health sector reforms in Ethiopia

As part of the national efforts to improve accessibility and quality of health service in Ethiopia, various reforms have been implemented. Health Care Finance Reform (HCFR), Business Process Re-engineering (BPR), Health Management Information System (HMIS), and the Ethiopian Hospital Reform Implementation Guidelines (EHRIG) are some of the reforms (Federal Hospital Performance Monitoring and Improvement Manual, 2011).

Business process Reengineering (BPR) BPR has been used as a tool for comprehensive analysis, redesign and revamping of the health sector in Ethiopia. As a process itself forms a fundamental rethinking and requires a purpose full and radical redesign of health business process to achieve dramatic improvements in critical contemporary measures of performance such as cost, quality, service and speed. The purpose of BPR in the context of health sector is establish customer focused institutions, rapid scaling up of health services and enhancing the quality of care in order to improve the health status of the Ethiopian people as indicated in the mission of the health sector (HSDP IV, 2010).

Health Management Information System and Monitoring and Evaluation (HMIS and M&E) are one of the priorities of the third Health Sector Development Program (HSDP III) 2005/06-2009/10). The purpose of HMIS is to routinely generate quality health information that provides specific information support to the decision-making

process at each level of the health system for improving the performance of health system and thereby the health status of the population (HMIS Reform Team, 2008)

Health Care Financing Reform (HCFR)

Ethiopia had endorsed a health care financing strategy in 1998 that envisioned a wide range of reform initiatives. It is a very important policy document for introduction of health financing reforms. The government recognized that health cannot be financed only by government and underscored the importance of promoting cost sharing in provision of health services.

The main objective of the implementation of health care financing reform is to address the overall infrastructural as well the general dysfunctional health care system of the country .This will be done through:

- Identifying and obtain resources that can be dedicated to preventive, promotive, curative, and rehabilitative health services
- Increasing absolute resources to the health sector
- Increasing efficiency in the use of available resources
- Promote sustainability of health care financing and improve the quality and coverage of health services (Hailu, 2012)

Physical access to health service providers was beyond the reach of the majority of the Ethiopian population, and even more difficult for the poorest segments of the population. The overall country budget was limited, resulting in inadequate financing of health care. In addition, health service delivery was inefficient and inequitable, and quality of health care was generally poor (USAID, 2011)

The key health financing issues of the country were associated with limited availability of health resources, overreliance on direct payments at the time people need care, and inefficient and inequitable use of resources (WHO 2010).

The limited availability of resources for health in Ethiopia is very clear. The total health spending in Ethiopia increased from about uS$522 million in2004/05 to about uS$1.2 billion in 2007/08. However, overall health is under-financed, both in absolute terms and when compared to the sub-Saharan Africa average, as evidenced by per capita health spending of uS$4.5 in 1995/96 that reached only 16.10 in2007/08 (FMOH 2011).

The implementation of these reform initiatives was legalized through regional legislations. The strategy recognized that health care should be financed through multiple financing mechanisms to ensure long-range sustainability. The reforms introduced include implementing revenue retention and use at health facility level, systematizing a fee-waiver system for the poor, standardizing exemption services, setting and revising user fees, introducing a private wing in public hospitals, outsourcing nonclinical services, and promoting health facility autonomy through the introduction of a governance system (Hailu, 2012).

Health care financing reforms generally address questions about how funds are to be raised and allocated to pay for health care for the population. Many health systems are plagued by overall resource constraints as well as poor allocation of funds; some relatively well-off households consume more than their share of scarce public resources. Increasingly, policymakers in developing countries are basing decisions about financing

and resource allocation on evidence about how much is spent on health, who pays, and who benefits from health spending. (Hailu, 2012).

Alternative financing approaches some long-term measures try to mobilize additional funds for health care and channel funds to the most effective uses, allowing more citizens to benefit from services and improving the quality of services. In order for such approaches to work well, however, systems must be strengthened and be able to identify and support those individuals most in need of public subsidies and support. Cost-sharing and risk-sharing arrangements are two types of alternative approaches.

Cost sharing or cost recovery involves imposing user fees for some or all health services as a way to get clients to share the expense of services. One premise behind cost sharing is that clients who pay for services will demand better quality and that funds will be used to improve it. Another possibility is that fees from better-off clients could be used to help pay for services for those who cannot afford to pay. Achieving this objective involves establishing waiver systems to exempt the poorest clients from payment, but putting such systems into practice has proven difficult. In some cases, imposing fees has led to a decline in the use of health services, and improvements in quality have been questionable. http://www.prob.org/bookstoreaspx

The principal components of Health Care Financing Reform include development of the legal and regulatory provisions related to: local retention and use of facility user fee revenue, fee waiver and exemption systems, establishing and operation of hospital management boards and related steps toward hospital autonomy, out sourcing of non-clinical services management and operation of private wings in public hospitals

Revenue retention and utilization is the autonomy given to hospitals in the proclamation 10/95 for the collection of revenue from various hospital services and utilization of it. The revenue is used under the principles and law of finance administration and its main objective is to fulfill the gaps of human resource, medication and medical equipments in order to provide better and quality service (Hailu, 2012).

Private wing service:

Private wing service as one of the major component of health care financing reform is implemented in public hospitals is to generate additional incomes to the health professionals and health facilities while providing better quality of service for those who can afford for it.

As described by (EMOH), "private wing" commonly refers to an official arrangement according to which medical services are provided, on a fee-for-service basis, to inpatients and/ or outpatients in an acute -care public hospitals. The rationale for the implementation of private wing is to generate additional income for health professionals and health facilities (EMOH, 2009)

Principles of Private Wing service: According to the private wing service, the service is expected to be provided with a higher level of amenities and customer service, more comfortable and cleaner environment, more convenient opportunity times and personal choice of doctors (EMOH, 2009).

The private wings offer alternatives and choices to private health service users while also addressing improvements in health worker retention and income generation for the health institutions. Its general objective is therefore, to offer better quality service for those who can afford to pay for it, to retain highly qualified specialists ,to generate more revenue and to cross-subsidize the general services (social functions of) the hospital (EMOH).

Based on the Patient-Centered culture aspects of private wing, of all the stake holder groups, patients are the ones it is most crucial to pleas. Quality of care and medical outcomes are the most important influences on patient perceptions and on the reputation of health care facility in general. Three aspects of a patient-centered culture are a patient service character, patient –centered procedures and patient –sensitive medical and administrative staff (FMOH, 2009, p.44)

According to (Laura, 2007), "an important dimension of patient-centeredness is respect for patient's values, preferences, and expressed needs. One way to improve patient centeredness is to consider justice in the patient-provider interaction and the importance of the patient-provider relationship. Using the concept of fair process to bring the environment into the patient-provider interaction, encourages a shift from a professional-patient relationship founded on one-way communication to one founded on engagement, exploration, explanation, and mutual learning. Fair process brings a different expertise—the patient's expertise—into the health care interaction".

Quality of health care service

"There is no single, universally accepted definition of health care quality. This is because health care quality involves descriptions of many different, complex aspects of care from several different perspectives. Quality may be measured in terms of outcomes, the end results of care and treatment, or it may be evaluated in terms of process, the way in which the care is delivered. The definition also depends on who is describing quality. Researchers, health care providers, government, and consumers may all assess health care quality differently" (Barbara, 2002).

Though each group has its own specific and different interests and opinions, the definition, measurement and improvement of health care quality have been a primary issue for health care providers, health service managers and those who commission the service for patients for centuries .However, in both developing and developed countries, there has been an implicit acknowledgment that many health services do not meet minimum standards for clinical effectiveness or client satisfaction (Tatek,2012).

According to (EMOH, 2008), quality of health care is the degree to which health services to individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

(Palmer ,1991), defined quality of health care as "the production of improved health and satisfaction of a population within the constraints of existing technology, resources, and consumer circumstances."

According to (Jeanmarie, 2005), quality as it relates to healthcare, represents the overall satisfaction with life during and following an individual's encounter with the

healthcare system its organizations and providers. Quality acts an indicator of satisfaction based upon an individual's experience while receiving medical care. As cited in (Jeanmarie, 2005) "comfort factors, dignity, privacy, security, degree of independence, decision-making autonomy, and attention to personal preferences" (Shi & Singh, 2005, p.27) are all significant attributes of healthcare that are important to most people. These essential factors influence healthcare consumers in making decisions about specific providers and facilities.

Generally quality has been defined at a clinical level, and it involves offering technically competent, effective, safe care that can be described and measured differently (WHO, 2004).

There are about three categories of quality. The first one is client quality, what consumers want from the service, individually and as population; this can be ensured by consumer, satisfaction. The second one is professional quality, which deals to meet consumers need, focus on about service delivery system ensured by standard setting and the process of clinical professional or organizational audit. The third one is management quality; focuses on efficient and productive use of resources to meet consumer need (J. mark, 1994)

Importance of Quality Assessment in a Health Care system

Measuring quality of care requires relating disease-specific outcome measures to assessments of general, physiological, mental, physical, and social health along with patient preferences and level of satisfaction. Effective measurement of quality enables researchers, practitioners, payers (health plans, insurance companies, government,

employers, and health care coalitions) and other stakeholders to identify aspects of quality care and medical practice. It also enables comparisons to be made between institutions, health plans and providers. (Barbara, 2002)

As an important component of effective health care services, the measurement of Patient satisfaction assists in the evaluation of health care services from the patients' point of view. It also facilitates the identification of problem areas and generates ideas for resolving these problems. Monitoring patient satisfaction is also an important and useful quality improvement tool for the over all aspects of clinical activities (East African J of Public Health, 2008)

Measurement of Quality of Health Care Service

To get the entire picture of quality care being delivered by a provider, it is important to know the results of both recommended care/process of care and outcome of care measures in addition to other information. Recommended care /process of care measures refer to the actions taken to care for the patient. Using the correct process, such as diagnosing, treating, or educating patients, is likely to lead to better outcomes. Outcome of care measures refer to the results of the specific treatment on a patient's health. Each measure is based on national standards developed by different federal agencies looking at different parts of quality. Data gathered from different sources show different aspects of care and treatment (http://web.doh.state.nj.us)

Donabedian has developed a model based on structure, process, and outcome for evaluating the quality of health care. Structure refers to the attributes of organizations delivering care and the conditions under which care is provided, process relates to the

professional activities associated with providing care, and outcome denotes the effects of care. Outcome includes health status improvements in knowledge, change in behavior, and patient satisfaction with care (Donabedian, 1988)

Quality assessment studies usually measure one of the three aspects of quality-structure, process and outcome. Asking for and understanding users' views and measuring patient expectations are seen as key components of both process and outcome evaluation and the effectiveness of health care to some degree is determined by consumer satisfaction with the services provided. Moreover, patient satisfaction is also directly related with utilization rate and hence meeting patient satisfaction improves the utilization of health services (Sitizia & Wood ,2002).

In general process measure reflect the quality of activities (preparations, interactions, and interventions) that occur prior to and during care. The process of care thus includes the infrastructure as well as the direct delivery of care to patients. Outcome measures on the other hand reflect the result of care (whether intended or unintended). This result could manifest any time during or after the patient's stay. Outcome measures are categorized into, adverse events or negative results of the technical process; the desired (intended), documentable result of care; and Patient reports of healing (Bekele, 2005).

Standard measurement techniques to measure health care quality are patient interviewing, healthcare worker interviewing, testing personnel, individual audit of patient data and some others. Out of all healthcare performance measurement methods, the best way to measure quality of health service is to observe the actual service delivery (and/or

record it), and have it reviewed by many professionals (a reasonable number of 10-20). Those observers must be independent experts, so that their feedback is genuine and not distorted. They should review the service more than once, and assess the performance in any sufficient way (http://www.consumer.gov/qualityhealth)

The Three Aspects of Quality of Health Care:

The three aspects of care are Structure, Process and Outcome

- **Structure**: environmental, management aspect, organizational structure, Philosophy and value of available resource .In other words , structure includes care provider competency, availability of basic & necessary materials and equipments, and physical setting of the health institution
- **Process:** process of care is connected to interpersonal and technical skills of providers which include treating client, respectfully, confidentiality, treat clients timely, providing adequate and accurate information provide care according to client choice.
- **Outcome:** is associated with the end results of quality of care provided to the client which includes client satisfaction, decrease morbidity and mortality.

Quality in the Perception of Providers and Patients

Traditionally, researchers, health care professionals, and practitioners tend to view quality in technical terms, such as the skills of the practitioners, the appropriateness of care, and the outcomes (results) of treatment.

Health care consumers are more likely to focus on process measures such as waiting time for a scheduled appointment, whether they are treated courteously, the extent to which they feel health care practitioners have answered their questions, and the nature of the interpersonal relationships they have with their providers. Respect, understanding, complete and accurate information, technical competence, access, fairness and result are what clients usually want.

It is generally accepted that when patients are satisfied with the quality of care they have received, they are more likely to adhere to prescribed treatment, return for necessary follow-up, and recover more quickly and completely. (Jeanmarie, 2005) in his study has described quality of health service as perceived by the patient and health worker. With regards to patient satisfaction, quality from the perspective of a physician, administrator, or clinician is generally judged by clinical outcomes. However, evidence shows that quality from the perspective of the health care consumer is rarely judged on the basis of which organization has the best clinical quality. As (Jeanmarie) cited from (Lee, 2004, p.10). In the healthcare industry, most patients view potential clinical outcomes as the "purview of their physician who would not put them in the hands of incompetent people or an unsafe environment".

As cited in (Laura, 2007), "from a patient perspective, quality is not a simple concept but is best understood in terms of five dimensions: technical outcomes in terms of quality of life; decision-making efficiency in terms of efficient routes to health; amenities and convenience; information and emotional support (relationships); and overall patient

satisfaction Failure to include these five aspects of quality from the patient's perspective can be considered a justice issue (van den Bos , 1998)."

For the patient, quality is experienced at the micro-level of the organization, in the patient-provider interaction. It is at this micro level that we must consider justice in health care and conceptualize and apply learning about the patients' perspectives to cross the quality and health care chasm. One way to improve patient-centeredness is to consider justice in the patient-provider interaction, which enlighten the importance of the patient provider relationship and leads us to re conceptualize both outcomes and processes of care (Laura, 2007)

Concepts of Patient/Client Satisfaction

Client/Patient/Consumer: These terms are interchangeably used in health care settings to refer to the person receiving care and treatment from physicians and allied health care personnel. The client is often seen as both the individual and the client system or those in the client's environment. The term consumer is also used in settings that view the client as the consumer, that is, one capable of deciding what is best for her or himself and encourages self-advocacy and self-judgment in negotiating the social service and welfare system (Barker, 2003) ,as cited from(NASW,2005).

"Patient satisfaction is the result of a process of evaluation (and comparison) of the service obtained from an object (e.g., a physician) in the patient's health care system" (Jagdip, 1989)

Patient satisfaction by a health care service has been interpreted as the art of care, technical quality of care, accessibility and convenience, efficacy of outcomes of care, cost

of care, physical environment, and availability and continuity of care as (Bekele) , cited from (Fakhoury,1998).

Satisfaction with health care is closely related to concepts of health care quality. It is a qualitative indicator of quality of care that represents the needs, preferences and subjective experience of clients. Patient satisfaction is an increasingly important issue, both in evaluation and the shaping of health care. In addition, patient evaluations can help to educate medical staff about their achievements as well as their failure, assisting them to be more responsive to their patients' needs. Therefore, patient satisfaction surveys should be carried out routinely in all aspect of health care to improve the quality of services. Survey results can guide policy makers in introducing changes as competition between health care providers increase (Middle East Journal of Family Medicine, 2005).

(Ware, 1977) , proposed that patient satisfaction should be a multidimensional concept. These dimensions include "the art of care", which focuses on the personality attributes of the health provider; "technical competence", or the patient's perception of the provider's knowledge and expertise; "the physical environment" as perceived by the patient; and "efficacy of care", or the client's perception of outcome (http.//www.ncbi.nlm.gov).

(Linder-Pelz, 1982) further suggested ten constructs or elements that should be used to determine satisfaction: accessibility or convenience, availability of resources, continuity of care, efficacy or outcomes of care, finances, humanness, information

gathering, pleasantness of surroundings, and quality or competence (http.//www.ncbi.nlm.gov).

Patient satisfaction as a measure of quality of health care:

There is growing consensus that assessment of the quality of hospital services should be based in part, on patients' perceptions of overall care and patient satisfaction. The dominance of market-oriented approaches to reforms in health care delivery and cost, and the emergence of a normative perspective on clinical practice that emphasizes the need to deliver patient-centered care, are also driving attention to patient perceptions of quality (World Bank, 2008).

In this review of the theoretical and empirical work on patient satisfaction with care, the most consistent finding is that the characteristics of providers or organizations that result in more "personal" care are associated with higher levels of satisfaction. Studies suggest that more personal care will result in better communication and more patient involvement, and hence better quality of care (Cleary &,Neil, 1988) .

According to Donabedian, patient satisfaction should be investigated since it is an objective of care, a consequence of that care (outcome) that can contribute to the effects of care, as a satisfied patient is more likely to comply with advice, and it is the patient's judgment on the care that has been provided.

Although, Patient satisfaction has stayed a long to be a measure of quality in other countries, in Ethiopia it has recently got a growing attention. It is a primarily used measure to assess the quality of service provided and is one of the meaningful indicators of patient experience of health care services. Asking patients what they think about the

care and treatment they have received is an important step towards improving the quality of care, and to ensuring that local health services are meeting patients' needs. Various studies have reported that satisfied patients are more likely to utilize health services, comply with medical treatment, and continue with the health care provider (Abebe,Grum, Yared Woldemariam, Ambaye ,Asnakech&Amare,2008)

Client satisfaction is an integral component of service quality and expanded definitions of health service quality typically make explicit mention of patient satisfaction. The argument has been offered that the effectiveness of health care is determined, in some degree, by consumers' satisfaction with the services provided. Support for this view has been found in studies that have reported a satisfied patient is more likely to comply with the medical treatment prescribed more likely to provide medically relevant information to the provider, and more likely to continue using medical services. The logic has been extended to developing countries; patient satisfaction and perceived quality will influence utilization of services, as well as compliance with practitioner commendations (Bekele ,2005).

Patients are the best source of information about a hospital system's communication,Education, and pain-management processes, and they are the only source of information about whether they were treated with dignity and respect. Their experiences often reveal how well a hospital system is operating and can stimulate important insights into the kinds of changes that are needed to close the chasm between the care provided and the care that should be provide. Unlike clinical process measures, which are strictly

facility centered, patient satisfaction is a"patient centered" process measure (Abebe et al, 2008).

As it is also cited from (National Institutes of Health, 2008)

According to Donabedian , Client/patient satisfaction is not only an important component of the quality of care, but also a heavy contributor to the definition of quality from the perspective of clients' values and expectations. Essentially, satisfaction could be seen as an objective of care (psychological health) or a contributor to other objectives and outcomes. For example, satisfied patients are more likely to better comply with providers' medical regimens, and to cooperate or maintain relationship with specific providers. Learning from these concepts, we know that satisfaction plays an important role in quality measure and improvement (National Institutes of Health, 2008)

(Jeanmarie, 2006) described quality of health care in the perception of patients satisfaction as . "In order to understand the scope and importance of patient/customer satisfaction, it is necessary to discuss the idea of satisfaction in the context of the quality of care delivered to patients". With regards to patient satisfaction, quality from the perspective of a physician, administrator, or clinician is generally judged by clinical outcomes. However, quality from the perspective of the healthcare consumer is rarely judged on the basis of which organization has the best clinical quality. In general patients determine the quality of a healthcare experience by the way they are treated as a person, and not by how they are treated for their specific medical condition (Jeanmarie , 2006).

(EMOH) also illustrate patient satisfaction as patient satisfaction with the health care they receive at the hospital is a measure of the quality of care

provided. By monitoring patient satisfaction hospitals can identify areas for improvement and ensure that hospital care meets the expectations of the patients served. The Out-Patient Assessment of Healthcare Survey (O-PAHC) and In-Patient Assessment of Healthcare Survey (I-PAHC) have been developed for use in Ethiopian health facilities. These survey tools measure the patient experience related to service availability, cleanliness, communication, respect, medication (prescription, availability and patient information) and cost(EMOH ,2011Page,79)

Findings from previous Quality Assessment and Patient Satisfaction Studies

Findings from a study of BMC, Health Service Research Showed that, there is an inter connected relationship between Inter personal Based Medical Service Encounters ,Service Quality ,Patient Trust and Patient Satisfaction .

As a result the findings of the study point out, the content and structure of the role of professional service provider from the aspects of professional service provider, such as professional personnel as well as the general administrative personnel, and the study also concluded that patients will distinguish between ideal role and expected role and describe professional service role according to the traits of professional ethics, professional skill, communication skill, interpersonal skill and personal characteristic.

Deserving of special attention is that, as interpersonal based medical service encounter will positively influence service quality and patient

satisfaction, and the differences for patients' perception of the professional skill and communication attitude of personnel in the interpersonal-based medical service encounter will influence patients' overall satisfaction in two ways: (A) interpersonal-based medical service encounter directly affects patient satisfaction, which represents a direct effect; and (B) service quality and patient trust are used as intervening variables to affect patient satisfaction, which represents an indirect effect.

According to the above findings, we learn that patients' perception of the professional skill and communication attitude of professional personnel in the interpersonal-based medical service encounter also positively influences their satisfaction, with the requirement of service quality and patient trust as the intervening variables. This finding varies from the previous assumption that service quality alone can positively influence patient satisfaction. The results of the study reveal that the higher the patients' perception of the professional skill and communication attitude of personnel, the better the service quality, patient trust, and patient satisfaction shall be(Ching-Sheng Chang, Su-Yueh Chen and Yi-Ting 2013)

The findings of a study conducted at the private clinics of Addis Ababa Ethiopia showed that ,high rates of satisfaction were generally reported in all aspects of medical care that include: waiting time, cleanliness of facilities and equipment, courtesy and competence of providers and the effectiveness of the services provided. Relatively lower proportion of respondents has reported dissatisfaction with the services provided.

The aspects of the private sector services for which dissatisfaction was reported were too high service charge and too little information given about nature and prospect of diseases. These imply that the private facilities included in the study are generally doing well in terms of structural as well as in most process attributes of quality while provider-patient interaction and competitive pricing of services seem to be areas that need improvement (Afework , Mariam & Demeke, 2003)

In some studies patient characteristics are found to be determinant factors of patient satisfaction. Older patients are generally more satisfied than younger patients. Other demographic characteristics such as sex and race seem to be unimportant. Patients reporting their health as poor are less satisfied than those who describe themselves as healthy. Satisfaction may also be influenced by the patient's mental state: psychological distress, depression and personality disorders have been associated with lower levels of satisfaction. (Jeffrey L.Jackson, J. Chamerin, K.Kroenke, 2001). Although different studies have pointed out levels of satisfaction to vary among different types of health facilities and hospitals, the common determinants of patient satisfaction reported are, self judge health status, expectations about the services, perceived health care providers technical competency, perceived welcoming approach, perceived adequacy of consultation duration and perceived cleanliness of the hospital.

Communication as an important tool in a health care:

(Josh, 2009) describes the importance of communication in a health care setting as: "It is crucial that every patient understands everything about their diagnosis, test that needs to be done, intended treatment and medications. This takes time and requires plain

language that the patient can easily understand and be able to repeat when they get home According to Josh, medical errors have been estimated to cause 44,000 to 98,000 deaths in U.S hospitals each year. He stated that both the complexity of the health care delivery as well as communication issues can play a role in the continuation of the problem" (Josh, 2009).

The importance of communication was also seen by the Institutes of Medicine (2001). As cited in it "when patients perceive motives, communication, empathy, and clinical judgment positively, they will respond more positively to care...Sobel (1995) claims that improved communication and interaction between caregiver and patient improves actual outcome. Donabedian (1988) noted that "the interpersonal process is the vehicle by which technical care is implemented and on which its success depends" (Institutes of Medicine, 2001).

As it is also stated in (Sarah, 2009):

> Effective communication is important in nursing and has many aspects. It is, for example, respectful, assertive, empathetic, clear, attentive, honest and non-judgmental. Communication in nursing is a skill that can be learned and continually improved. It is a sharing of health-related information between a patient and a nurse, with both participants as sources and receivers. The information may be verbal or nonverbal, written or spoken, personal or impersonal, issue-specific, or even relationship-oriented, to name a few possibilities. The power of creative and effective nursing care is strengthened by good communication skills. Patients share their stories, symptoms, and concerns by talking with nurses. Both the spoken word and the

body language convey information about the patient's experience (http: nursing-information2u.blogspot.com, 2009)

With regard to effective patient –doctor communication, a doctor or practitioner who is a good communicator has respect for patients and being respectful goes a long way toward helping that patients explain symptoms, take responsibility for decision-making, and complying with instructions. A practitioner who is a good communicator has the ability to share information in terms patients can understand. Practitioner who is a good communicator knows that if it can't be done right to begin with, it will need to be done over. Listening carefully and respectfully will go a long way toward better outcomes for the patient. A practitioner who is a good communicator has the ability to effectively manage patients' expectations. By helping patient understand what the next steps will be, and what the possible outcomes and their ramifications might be, the doctor can go a long way toward helping that patient understand his problem (Trisha Torrey, 2011).

Theories and models

Client-Centered Theory

According to Rogers, if one wants to be an effective helper, client-centered principles are something one must learn (they are necessary), and nothing else is required (they are sufficient). The theory guiding this therapeutic method is a theory of process. As such, the approach is firmly aligned with the belief that we do not help our clients through an expertise with theories of personality, knowledge of family dysfunction, or a deep appreciation for critical ecological systems theory. Rather, we they assist people's growth by providing a particular kind of relationship, through communications that have specific

qualities. According to client-centered theory, those essential qualities are the Rogerian core conditions: congruence, acceptance, and empathy.

As has been written in the book, theoretical perspectives for direct social work practice, Biestek (1957) argued that the emphasis on relationship is so important that it serves to define us:

"This is one principal difference between social work and some of the other professions. In surgery, dentistry, and law, for example, a good interpersonal relationship is desirable for the perfection of the service, but it is not necessary for the essence of the service. The surgeon may not have a good bedside manner; the dentist may be inconsiderate of the patient's feelings; the lawyer may be cold and overly businesslike. But if the surgeon operates successfully, if the dentist heals the ailing tooth, and if the lawyer wins the case, they have performed the essential service requested. Not so the caseworker. A good relationship is necessary not only for the perfection, but also for the essence, of the casework service in every setting." (Nick & Peter, p.299)

As (Patrick &Saundra,2008) described ,the major concern regarding the use of patient satisfaction measures to represent quality of care or patient outcome evaluation is that health professionals often consider patient's evaluation to be incorrect or biased.

In Patrick et al (2008), a two-part definition of patient satisfaction based on a "contrast and assimilation model" offered by, Pascoe (1983) were used to illustrate patient satisfaction and quality of health care. Accordingly, Pascoe's model takes into account expectations that patients bring to an encounter and the fact that patients may not be fully able to judge a service encounter because they do not have the requisite clinical

knowledge. In the contrast model, the patients enter the situation with expectations, and the perceived difference between expectation and experience offers net satisfaction in simple encounters. When experience is greater than expectations, the experience is satisfactory" (Patrick et al, 2008)

In the assimilation model, when patients confront a situation they do not fully understand, they may adjust their expectations downward if the experience falls short of what is expected. This theory may help to explain why most patients are satisfied with medical care or personnel, while a greater variance usually exists with respect to other aspects of services during health care delivery (Patrick et al, 2008)

Patient –centered approach of health care

According to (Benjamin,2013*)*, " patient-centeredness means many things to many different people, but at its core are issues of shared decision-making and balancing how much the patient should really be in the driver's seat. Patients want more information, but too much is overwhelming. They want to be nudged to do the right thing for their health, but not nagged. They want to choose health care wisely, but they don't necessarily want less. Doctors want to involve patients in decision-making but don't know how, or what evidence to use for the discussion."

Patient –centered approach emphasizes that effective communication with patients and families are a cornerstone of providing quality health care. The manner in which a health care provider communicates information to a patient can be equally as important as the information being conveyed. Patients, who understand their providers are more likely to accept their health problems, understand their treatment

options, modify their behavior and adhere to follow-up instructions (Benjamin, 2013). If the single most important criterion by which patients judge us is by the way we interact with them, it stands to reason that effective communication is at the core of providing patient-centered care. Patient surveys have demonstrated when communication is lacking, it is palpably felt and can lead to patients feeling increased anxiety, vulnerability and powerlessness (Benjamin, 2013) .

Communication-centered Health Care Model

According to communication- centered health care model, communication is a basic principle in health care. It is most relevant in the clinical encounter between doctors and patients or any health care professional-client relationship. It is also at the core of the consumers' perception of the various health care systems (http://.www.bing.com/medical communication). All encounters in health care need to be recognized as a communicative relationship. Medical facilitation is an awareness based model that includes impersonal knowledge of facts and communication rules with an interpersonal subjective dimension. The interactional level integrates the awareness of communicative backgrounds that go beyond surface meanings and interfere with the primary purposes of the communication. The communicative backgrounds refer to diverse experiential frameworks that relate to gender, age, class, cultural, and health differences as well as to general differences in perspectives and values. They are often the source of communication problems and misunderstandings (http://.www.bing.com/medical communication) .

Communication with clients in health care must address the subjective as well as the objective aspects of the communication between clinician and client. In objective medicine things operate by cause and effect, but not so in the world of relationship and communication. Communicative interactions take place in a complex field of forces (contextual, psychological, social, and cultural) governed by an uncertainty principle. Social and cultural beliefs or values and individual feelings and goals create an atmospheric field in which there is a prospective uncertainty as to the outcome of a given communicative interaction. The dynamic interactions among these biological, physical, social, cultural, ethical and emotional elements are unpredictable (http://.www.bing.com/medical communication).

The Bio psychosocial Model of Health and Illness

In 1977, American Psychiatrist George Engel introduced the major theory in medicine, the BPS Model. The model accounted for biological, psychological, and sociological interconnected spectrums, each as systems of the body. In fact, the model accompanied a dramatic shift in focus from disease to health, recognizing that psychosocial factors (e.g. beliefs, relationships, stress) greatly impact recovery the progression of and recuperation from illness and disease.

"To provide a basis for understanding the determinants of disease and arriving at a rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a bio psychosocial model" (Engel, 1977).

Strength based approach

Strengths-based approach is an organizing principle for theories and strategies which focus on the untapped gifts, positive attributes and underdeveloped capabilities of people who have been in some way compromised in their abilities or are seeking help for problems. They are an alternative to problem- or deficit-based approaches, which are characterized by negative labeling, a focus on what is 'wrong' with a person and practitioner-driven interventions. Strengths-based approaches actively find direct and amplify a client's capabilities and potential for positive functioning (Australian Social Inclusion Board, 2010).

Therapists (and other health professionals, like physicians) are often comfortable and confident in their role as expert. Effective strengths-based practice entails that, in the life of people we work with, we are not yet significant. However, we can use our guidance to locate and integrate those who are significant into the helping process. (Strength-Based Social Work Practice, 2005)

Deficiency based approach

Need based assessment and intervention focuses on people's needs or deficiencies. It directs people to seek solution for their problems from external agents instead of trying to take part in the problem solving process. This approach makes people to believe that their wellbeing depends on being a client. When clients consider themselves as people with special needs to be met by outsiders, they gradually become consumers of services with no incentive to be producers (McKnight and Kertzeman, 1998).

In the early days, social work operated on the premise that individuals require assistance because they have deficits or pathologies and therefore are inherently weak or flawed. Over time, a focus on individual flaws diminished due to the belief that individuals are able to solve and overcome problems (Vick, 2010).

Summary of literature review

In the literature review part, various literatures including theories and models which are supportive of good practices in a health care setting is assessed. Most of the literature review parts of the study have given emphasis on the need to focus on quality of health service in the process of care. Activities in the process of care are preparations, interactions, and interventions that occur prior to and during care. Important indicators of patient satisfaction and patient satisfaction as a measure of quality of health care is major constituent of the literature review. Furthermore, the implementation of health care financing reform with its components to improve the quality of health services at public hospitals is the most important part of the literature review that was focused. Definition of key terms of the study is also the other part that the literature review has tried to address.

CHAPTER THREE: RESEARCH METHOD

3.1 Study design

Across- sectional quantitative study design was used to assess the quality of health service provided at the private wings of three selected public hospitals.

3.2 Study area and period

The study was conducted in Addis Ababa between the months of April and May/2013 among patients those seen in the outpatient departments of private wings. The three hospitals are purposively selected for the reason private wing service is currently well functioning.

3.3 Source and Study Population

3.3.1 Source and Study Population

All patients who were seen in the outpatient departments of the private wing services of three public hospitals in Addis Ababa, Zewditu Memorial,Ras desta, and Yekatit 12 hospitals Addis Ababa public hospitals whose ages are 18and above .

3.3.2.1 Inclusion criteria

All patients who are 18years and above, visited the outpatient departments of the private wings on the interview date, who were prescribed for drugs, who were volunteers for the exit interview.

3.4 Sample size and Sampling techniques

3.4.1 Sample size determination

The sample size is determined by the formula of single population proportion. Since patient satisfaction at private wings is not known before, assumption of 50% with a marginal error of 5% between the sample and the population at 95% confidence level was taken for the calculation. Possible non-response rate of 10% of the sample size determined was added and calculated. Although the calculated sample size is 422 only 50% of it (212) was taken for the assessment. This is because the limited time period for data collection, 422 patients were not to be seen in the private wing services.

Since the population was very small, I used the correction factor formula

3.4.2 Sampling technique and procedure

Three public hospitals were selected by using purposive sampling technique. The main reason for the selection was the well functioning and full implementation of the private wing service in those hospitals. From the selected hospitals, all patients who came in the outpatient departments who full filled the inclusion criteria were interviewed. For patients who didn't fulfill the selection criteria, the next patient was included in the sample.

3.5 Measurements and variables of the study

3.5.1 Outcome (Dependent) variable was satisfaction of patients by the private wing service measured by variables which include , health professionals courtesy and respect, listening ,explanation ,advice and information sharing , cleanliness of the physical environment ,and availability of basic services .

3.5.2 Explanatory (Independent) variables were, clients Socio-demographic variables. Included in it were sex, age, education, occupation and income and variables which were

used to measure quality of health care in the three aspects, structure, process and outcome, categorized into measures of service characteristics and providers' characteristics. Cleanliness of the examination room and latrine, availability of laboratory and pharmacy services, cost of the private wing service and reason for patients' preference of the private wing service were categorized under service characteristics. Professionals' courtesy and respect, listening explanation, advice and information sharing were categorized under professionals characteristic.

3.6 Data collection tools and procedure

3.6.1 Data collection instrument

Data was collected using a pre-tested and structured questionnaire which is prepared in English and translated to Amharic adapted and developed by (EMOH). It was modified depending on the service behaviour the private wing. The questionnaire consists of three parts which are socio- demographic variables, interpersonal and technical skills and organization's service characteristics. 21 questions which were able to gather patients' satisfaction information and service availability were prepared.

3.6.2 Data-collecting procedures

Data collectors were three individuals including the investigator. The two data collectors were fully oriented about the interview procedure. Such as, whom to interview, where to get the clients for the interview at what time and in what condition were the general information given to them . Data was collected in the evening of working days and in the weekends during which the private wing service is provided. Prior to the actual data collection, questionnaire was pre tested with an interview of fifteen patients. The pre-test

served to rectify and revise the data collection instruments. The collected data were assessed based on the required measurements and variables of study.

3.7 Data processing and analysis

Data was checked for completeness, cleaned manually for inconsistencies and missing values and entered in to statistical package for social sciences (SPSS) windows version 16 for analysis. Analysis of descriptive statistics was first carried out to have percentage values. Binary logistic regression analysis was also done and Variables having p-value less than or equal to 0.2 in binary logistic analysis were entered to back ward multiple regression analysis separately for each group. Finally variables having p values less than or equal to 0.05 in multivariate analysis is considered as having a statistically significant association with status of patient satisfaction. OR and 95% CI was also used.

4. Ethical consideration

Ethical clearance was tried to be obtained from the Ethical review board of Addis Ababa Regional Health Bureau. Communication was made with hospital managers and medical directors through formal letter obtained from the University. The purpose and objective of the study was informed for the respected study subjects and data collectors. Data was collected with oral or written informed consents of clients based on the information in the consent form. In order to keep confidentiality of any information provided regarding the study subjects, data collection procedure was anonymous. The dissemination of the finding not refers specifically to the study subjects or health institutions but the general source population.

Limitations of the study

The subjectivity nature of patient satisfaction measure that might not be able to judge the actual quality is one of the limitations. This is because patients clinical evaluation of the clinical service might be influenced by their clinical knowledge, their under and over expectation behavior and other personal situations such as social desirability criteria. A sample size of 212 may not big enough to detect any significant association between socio-demographic characteristics and level of patients' satisfaction. Shortage of time was another main limitation of this study.

CHAPTER FOUR: FINDINGS AND DISCUSSION

Findings

Socio-Demographic Characteristics of Participants

A total of 212 adult patients were participated in the exit interview, which was conducted at the outpatient departments (OPD) of the private wings of Zewditu Memorial, Ras Desta and Ykatit 12 hospitals. Full responses of 208 patients were obtained with a non response rate of 1.9%. The mean age of participants was 40.5 (SD=12.54). Concerning gender 121/58.2%of them were females and 87 /41.7% were males. Among the age groups of study subjects the majority of them 59 /28.4%were within the age ranges of 36-45 and the least 20/9.6% were 56and above years. High proportion of the patients 86/ 41.3% had educational level of diploma with the lowest amount number them 12/5.8%having certificate. Regarding occupation and income, the majority of clients were government employee 75 /36.1%with high proportion of the respondents182 /87.5%having monthly income of 2000Br and above. **(Table 1)**.

Table 1: Socio- demographic Characteristics of Respondents at the private wings of three public hospitals of Addis Ababa (n=208)

Variables	Number	Percent
Sex		
Male	87	41.8
Female	121	58.2
Age (Years)		
18-25	42	20.2
26-35	59	28.4
36-45	54	24.5
46-55	36	17.5
≥ 56	20	9.6
Education		
Grade 12 and below	77	37
Certificate	12	5.8
Diploma	86	41.3
Degree & above	**33**	15.9
Occupation		
Government employee	75	36.1
Private employee	61	29.3
House wife	35	16.8
Merchant	15	7.2
Unemployed	22	10.6
Monthly income in Br.		
<1000	27	13
1000-2000	1 30	62.5
Above 2000	50	24.1
Total	**208**	**100%**

Level of satisfaction of patients by providers characteristics.

The level of satisfaction of patients was assessed using a likert scale measurement which ranged from very dissatisfied to very satisfied, however, for the sake of analysis purpose clients it was categorized under satisfied and dissatisfied.

Hence, among 208 clients who were fully responded 185/89% were satisfied with health professionals courtesy and respect and listening with slightly higher number of them186 /89.4% to be satisfied by professionals explanation of things in away patients could understand. The professional characteristics patients were less satisfied were professionals' advice and information sharing. Only 91/43.8% of them were satisfied with advice given to them and 117/56.2%were satisfied by the information they got regarding their illness. **(Table2)**.

Table 2: Level of patients' satisfaction by providers' characteristics

Variables	Number(n=208)	Percent
Health professionals courtesy and respect		
Satisfied	185	89
Dissatisfied	23	11.1
Health professionals listening of patients		
Satisfied	185	89
Dissatisfied	23	11
Health professionals' explanation of things		
Satisfied	186	89.4
Dissatisfied	22	10.6
Health professionals information sharing		
Satisfied	147	70.6
Dissatisfied	61	29.4
Health professionals' advice		
Satisfied	91	43.8
Dissatisfied	117	56.2

Correlation of the socio-demographic characteristics with quality related Variables

The result of the bivariate logistic regression analysis showed that, clients' sex, age and occupation were found independently associated with the levels of satisfaction they got from the professionals characteristics. Accordingly, clients' sex was found to have a significant association with listening, explaining things in away patients could understand, information sharing and advice given to clients. When this result was repeated in multivariate logistic regression analysis at a significant level of < o.o5, the satisfaction level of male patient by providers' characteristics was higher than female patients. Accordingly, males were more likely satisfied than females (AOR 0.67; 95% CI: 0.38, 1.53).

With regards to occupation, providers' courtesy and respect, listening and explanation had significant correlation with the kind of occupation they had. Hence house wives were generally less satisfied by providers courtesy and respect explanation and listening of their idea than other occupation groups , the multivariate result showed ,(AOR3.32;95%CI:1.07,10.26). The analysis result is showed in **(Table3)**.

Table 3: Correlation of the socio-demographic variables with levels of patient Satisfaction

Variables	Satisfaction		95%CI	
	Yes	No	*COR	*AOR
Sex				
Male	50	37	0.67(0.38,1.53)	2.36(1.19,4.66)
Female	61	60	1	1
Age				
18- 35	25	17	1.37(0.45,4.11)	2.96(1.19,4.66)
36-45	29	22	0.94(0.33,2.69)	1.63(0.48,5.51)
46-55	14	22	1.07(0.36,3.19)	1.87(0.52,6.69)
≥ 56	11	9	0.56(0.18,1.74)	0.67(0.19,2.31)
Occupation				
Private	27	34	0.45(0.16,1.20)	0.32(0.09,1.08)
Government	42	33	0.72(0.27,1.94)	0.55(0.10,1.89)
House wife	20	15	0.76(0.23,2.28)	1.52(0.09,1.08)
Merchant	15	8	0.65(0.17,2.45)	0.68(0.13,3.41)
Monthly income				
<1000	43	27	1	1
1000-2000	50	33	1	1
Above 2000	24	20	1	1

COR**= Crude Odds RatioAOR**= Adjusted Odds Ratio, at 95% Confidence Interval at significant level of $p< 0.05$

Respondents level of satisfaction by service characteristics
At private wing service of three selected public hospitals.

Two hundred and eight clients were fully responded for the exit interview. With regards to the main intention clients had preferred to visit the private wings service, majority of the patients 79/38.3% were responded for reasons of convenient or opportunity time the private wing had, followed by reasons of getting specialists 57/27.4%. Only least of them 20/9.6% came informed by others. Among respondents who were prescribed for drugs, only 51 /24.5% got the medication in the hospitals' pharmacy while , 154 /81.5% got the laboratory service in the hospitals' laboratory.

Patients' opinion regarding the cost of the private wing service and waiting time were another area of the assessment. Hence, high proportion of the clients 129/62% considered the cost not expensive. Regarding the amount of time clients stay before getting examined, 111 /53.4 of the respondents were answered as it was optimal. Variables which were used to indicate patient's satisfaction with the physical environment were cleanliness and comfort of the waiting area, the cleanliness of the examination room and latrine. Accordingly, 146/70.2 % of the respondents were satisfied with the cleanliness of the waiting area, while 62 /29.8%were dissatisfied. Regarding to the satisfaction of patients by the cleanliness of examination room 159/76.4% were satisfied, while 49/23.6% were dissatisfied. Among 165 patients who visited the latrine only 55/34.6% of the clients were satisfied by the cleanliness, while two fold of them 110/69.2% found to be dissatisfied. **(Table4)**.

Table 4: Respondents level of satisfaction by service characteristics At private wing service of three selected public hospitals

Category	Number	Percent
Reason to be seen in the private wing		
Better quality service	42	20.2
Informed by others	20	9.6
Convenient service hour	79	38
Chance of getting specialists	57	27.4
Other reason	8	3,8
Availability of the prescribed drug		
Yes	49	24.5
No	154	70.5
Availability of laboratory tests		
Yes	152	73.1
No	37	17.8
Waiting time until getting treatment		
waiting time was longer	80	**38.6**
waiting time was shorter	127	**61.3**
Service cost		
Expensive	64	**31.4**
Not expensive	140	**68.6**
Service recommendation to others		
I will recommend	173	**82.1**
I will not recommend	32	**15.1**
Cleanliness and comfort of the waiting area		
Satisfied	145	**69.7**
Dissatisfied	63	**29.8**
Cleanliness of the examination room		
Satisfied	157	**75.5**
Dissatisfied	49	**23.6**
Cleanliness of the latrine		
Satisfied	55	**26.5**
Dissatisfied	110	**52.9**

COR**= Crude Odds RatioAOR**= Adjusted Odds Ratio, at 95% Confidence Interval at a significant level of $P< 0.05$

Correlation of quality related variables with levels of patient satisfaction

The bivarate and multivariate logistic regression analysis result has showed that, significant correlation were observed between the professional characteristics of explanation and listening and the satisfaction level of clients by the service. Accordingly, clients who have got enough explanation were highly satisfied than those who got less explanation, (COR 0.56; 95% CI: 0.04, 6.73) and (AOR 0.56; 95% CI: 0.04, 6.73). Clients whose opinion were listened by health professionals were also highly satisfied than those who were not, (COR 1.62; 95% CI: 0.10, 26.05) and (AOR 0.25; 95% CI: 0.08, 0.80).Among the quality variables which were used to measure the service characteristics, cleanliness of the examination room was found to have strong association with the level of satisfaction of patients. Hence those were better satisfied with the cleanliness of the examination room were highly satisfied by the providers characteristics. (COR 0.83; 95% CI: 0.24, 2.98) and (AOR 0.82; 95% CI: 0.23, 2.86).No associations were found between the satisfaction level of clients and other service characteristics, waiting time, service cost, drug availability, and patients reasons for visiting the private wing service **(Table5)**

Table5: Correlation of quality related variables with levels of patient satisfaction

(n=208)

Variables	Satisfaction		95% CI	
	Sat(n)	Dis(n)	*COR	*AOR
Professionals Explanation				
Dissatisfied	19	189	3.03(1.01,9.05)	0.64(0.05,7.99)
Satisfied	183	25	0.56(0.04,6.73)	3.03(1.04,8.81)
Information sharing				
Dissatisfied	60	148	1.63(1.16,2.30)	0.47(0.23,0.99)
Satisfied	142	66	1	0.72(0.31,1.70)
Drug availability				
Dissatisfied	31	86	1.00(5.70,0.00)	1
Satisfied	16	64	1.00(9.22,0.00)	1
Cleanliness of examination room				
Dissatisfied	20	29	0.03(0.00,0.32)	0.04(0.00,0.38)
Satisfied	100	57	0.83(0.24,2.89)	0.82(0.23,2.86)
Waiting time for treatment				
Long	53	33	1.82(0.45,7.27)	1.85(0.45,7.27)
Short	74	47	0.36(0.15,1.20)	0.44(0.15,1.30)
Service cost				
Expensive	40	24	1.23(0.39,3.80)	1.24(0.39,3.94)
Not expensive	78	62	1.44(0.57,3.65)	0.44(0.15,1.30)

COR**= Crude Odds RatioAOR**= Adjusted Odds Ratio, at 95% Confidence Interval at a significant level of $P< 0.05$

Discussion

This study is the first of its kind conducted in the private wings of public hospitals to assess quality of health service provided. An exit interview of 212 Adult patients who were seen in the outpatients of three hospitals was conducted and a response rate of 98.1% was obtained. The study hospitals were, Yekatit 12, Ras Desta and Zewditu Memorial hospital.

Quality of service provided was evaluated based on three aspects; structure, process and outcome. The process aspect was evaluated mainly on the professionals' characteristics, the structural aspect on the availability of basic services and the physical setup on which the service was provided and the outcome aspect was the patients' level of satisfaction by the service.

The process aspect of quality which mainly is connected to professionals' characteristics was part of the service, patients were highly satisfied. Among fully responded patients, 89% of them were equally satisfied with professionals courtesy and respect and listening and 98.4% was satisfied with professionals explanation of things in away patients could understand .A relatively low satisfaction of patients which was reported in the professionals characteristics was professionals advice and information sharing of clients, 43.8% and 70.6% respectively.

The assessment result showed that health professionals were serving clients in a better professional manner. Possible reasons could be, in one thing the incentives health care providers are getting from the private wing service, especially physicians are paid

high proportionate amount of the revenue generated by the private wing service. The other possible explanation could be the current civil service reform which has aroused sense of customer handling on public servants. The third factor could be minimum patient load in the private wing service compared to the regular service of public hospitals, which allowed better client provider interaction. The fourth possible factor is the convenient service hour the private wing offer to clients together with chance of getting specialist physicians.

When the result of some of the professional activities were compared with other previous studies , in this study 89% of clients were satisfied with providers courtesy and respect which has close similarity with previous study in Addis Ababa at private for profit health institutions which was 93% (Tigist, etal,2008). As the multiple logistic regression result of this study showed, information sharing to clients was found to be predictor of patient satisfaction; clients who were not given enough information regarding their illness were less satisfied than who got enough information. This assessment result has similarity with previous patient satisfaction study in Addis Ababa (Bekele Chaka ,2006)and Jimma(Mirkuze Woldie,2010)

The structural aspect of quality is part of the quality assessment where relatively low performance was reported. Overall /57.2/ % of the clients were satisfied with the general cleanliness of the physical environment .Only /24.5%/ of clients had got the prescribed drug in the hospitals pharmacy, /58%/were satisfied with the waiting time. Availability of laboratory service and service cost are among the structural aspect (service characteristics) better satisfaction result were reported. Accordingly, /73.1%/ of client had

got the ordered laboratory test, and/ 68.6% /of them responded the cost of the service was not expensive

These result showed that, no special effort has been performed in the structural aspect, to improve the quality as well as to attract patients to the private wing service which indicated that the principles of private wing service which states, the service is supposed to be provided in a more cleaner and comfortable environment was not practically implemented.

Evaluation of the result of this study based on the private wing policy: One of the objectives of this study was to know whether the private wing service is performing as per the private wing policy which is stated that the service is intended to be provided in a more customer service, in a more comfortable and cleaner physical set up, convenient service time with preference of specialist physicians or personal choice of doctors.

In this regard, patients were better satisfied with health professional's interaction, such as courtesy and respect, listening and explaining things in away patients could understand which indicated health professionals were giving service with better personal values. During the assessment, convenient service hour is found to be main factor that patients were coming to the private wing service and got satisfied which indicated that the other second principle of the private wing service is said to be met. The other point of evaluation regarding the policy statement is the chance of getting specialist physicians. Regarding this, patients were satisfied with getting specialists who are few in number even at a country level such as Eye, Nose and Throat (ENT) specialists which in the regular service requires longer appointment time.

Provision of service in a more convenient, cleaner and comfortable environment is another policy statement of the private wing. To realize this principle every public health institution has to prepare a separate set up called "Private wing" which will be more comfortable and cleaner so that clients would be attracted for the service. However, the findings of the client satisfaction assessment showed that, clients were dissatisfied with the cleanliness of the waiting room and the examination room with high dissatisfaction of the latrines. During observation no special set up was established in all the three hospitals, the waiting areas especially in the two hospitals were not attractive and comfortable ,the latrine in the three hospitals were so unhygienic.

Hence, for full achievement of the strategies of private wing service more effort has to be done especially on creating convenient and attractive environment that could attract more customers.

Cost of the private wing service was one of the focus areas of the study. The finding has showed, most of the respondents were expressed the cost of the service was not expensive. Possible explanation for this could be, most of the patients could be using the private wing service as an alternative to the private health institutions. Hence, comparing the two costs may result in satisfaction by the cost of the private wing service. Another explanation is in the outpatient level, clients are supposed to pay only for cards and laboratory tests.

The overall satisfaction of patients by the private wing service.

Generally satisfactory results were reported on the satisfaction of patients by the providers' characteristics .Cost of the service and waiting time for getting service were

clients satisfied by the service characteristics. Besides, the response of clients for a general question that was asked to evaluate the overall satisfaction by the private wing service was satisfactory. Among all respondents 93.7% of them were satisfied and 84.1% of them answered they will recommend the service to others .Cleanliness of the physical environment and un availability of drugs were the major causes of dissatisfaction by the private wing service

The client satisfaction result of this study was tried to be evaluated based on different factors determining patient satisfaction. Different studies have indicated different predictors of patient satisfaction. Among the socio-demographic factors, gender, age, occupation, employment, income and educational level are commonly identified predictors of client satisfaction by most of the studies. This study showed that, there were more male patients (57%) who were satisfied than female patients (49%) . This is consistent with a study by (Birina Abdosh, 2006) ,a study in Kuwait ,while contrary to Bekele,Chaka,2006)

Different studies indicated that older patients are generally more satisfied than younger patients. This study also showed that older patients had scored high satisfaction mean than younger patients. In this study age groups 46-55 had scored (91.6%) satisfaction than age groups 18-35 which only scored (7.1%) mean satisfaction. This assessment result has similarity with the Kuwait study and contrary to (Bekele, et al). In the Kuwait study, possible explanation given to the finding was that, older patients have less expectation on others who provide care for them, like health care providers' advice and information sharing. On the other hand younger patients are expecting further information and facts.

In this study occupation was found to be predictor of patient satisfaction. Accordingly, house wives were more satisfied than all other occupation groups. This has exactly similar result with a study at private hospitals of Addis Ababa (Taye Tatek,2012) and a study in Jimma by (Zewdie Birhane, et al,2010).

CHAPTER FIVE: CONCLUSION AND RECOMMENDATION

Conclusion

Improvements in the quality of health care require a focus on all aspects of care which are structure, process and outcome. According to the findings of this study, patients were better satisfied with the attributes of care linked to some of the professional activities which involve courtesy and respect, listening and explanation skill of nurses and doctors. In this regard it is possible to conclude that patient- centered aspect of the private wing principle is practiced on. However, there were also some other important professional activities where patients were less satisfied. These were advice and information sharing. Regarding the structural aspect of quality, the physical setting, availability of necessary materials and supplies cleanliness of the waiting area examination room and the latrine were areas patients showed a satisfaction level of below average. In this respect it is possible to conclude the other principles of the private wing service, which states that, the private wing service is to be offered in a cleaner and comfortable environment unmet.

Most of the respondents were satisfied with the cost of the service. Although this may be connected to patients' comparison of the cost with private institutions, it has implication for the health care financing reform to meet its objective of attracting patients

from private health institutions to public health institutions that would strengthen their financial capacity and improve the quality of service provided .

Another indicator which was used to test the general satisfaction of patients by private wing was, their recommendation of the service provided in the private wing to their friends and families, 83% of them were answered "I will definitely recommend it". This indicates that most people currently prefer the private wing service for many reasons which this assessment might not fully addressed.

As this quality assessment study has tried to reveal, the private wing service is working towards the satisfaction of patients. However, this does not mean there are various gaps which may not be addressed by this study. This is because patient satisfaction measures usually are subjective measurement that does not really provide an objective and perfect information about the quality.

According to the result of this study, although the quality of the private wing service is not provided at the required level and according to its policy statement, it has contributed some initiations of better health service in public hospitals.

Recommendation

In this quality assessment study, improvements have been observed in the process aspect of quality of care, especially on the professional activity of handling patients as customer. Patients were greatly satisfied with nurses and doctor's courtesy and respect, listening of patients and explanation of things in way patients could understand. However, very important professional activities which were given less attention and patients were less satisfied were on advice and information sharing of clients by health professionals, Since quality improvement in the process of care is part of effective outcome, health professionals should go on practicing practice more on these aspect .

During the assessment, the structural aspects of quality of health care provided in the private wings were the area patients were dissatisfied and less performance was observed. The main areas of weakness in this aspect were the cleanliness of the physical environment and the in availability of the prescribed drugs. Thus, the cleanliness the physical environment of the outpatient department has to get due attention by the hospital management in order to create cleaner and comfortable environment to patients. Hospitals have to follow the standards of hospital implementation guide lines of Ethiopia in order to avail 24hour pharmacy service

The finding of this study revealed that convenient service hour, optimal amount of waiting time and service cost are specific conditions that private wing service has offered to patients as well as patients were satisfied in the private wing service .Hence, it should be strengthened and continued in the future.

Moreover, for the private wing service to be sustained in the future through attracting patients, the need to provide equal attention to all aspects of quality improvement activities by technical and administrative staffs is recommended. This can be done through providing training to staffs about client handling, so that, problems associated to the process aspect of quality will be improved. Issues connected to the structural aspect of quality will also be addressed by managers through availing necessary materials and medical supplies and creating cleaner and comfortable environment to patients. Moreover, implementation of the full packages of the private wing policy has to get great attention and should be practiced soon in order to retain both clients and the professionals.

Although the general assessment of this study showed health service improvements, under the existing reality of the health service problem, more effort has to be done by the Addis Ababa regional health bureau to expand the service through full filling the infrastructural, the material and specialized physicians of various health disciplines. In addition, arrangement of more service hours so as to serve more patients is recommended.

In addition for the private wings of public hospitals to achieve its objectives of providing better quality service and improving the satisfaction of patients by public hospitals all of the policy statements of the health care financing policy in general and the private wing policy in particular has to be fully implemented

Finally, since the observed improvements are very much related to the implementation of health sector reforms; HCFR, BPR, EHRIG, and others, fully

implementation of the reforms should be strengthened and regularly monitored and evaluated by all levels of health responsible bodies and other stakeholders.

Future research areas recommended by this study are assessment of staff satisfaction, the correlation between staff satisfaction and quality of health care service. A comparative quality assessment study of regular service of public hospitals and the private wing service is also another recommended area for future study.

Social Work Implication

Implication for social policy:

The health policy and the social welfare policies of the country are the major policy areas related to this study. In this regard the Ethiopian Ministry of Health (EMOH) has to strengthen its effort on the provision of quality of service to the population. Moreover, the practical/actual implementation of the policy documents should be evaluated at all levels of the health care system by responsible government officials.

From Social welfare policy perspective, each segment of the population has the right to access quality of health service. The implication of this study on this point is that, since, healthy population is the key for the overall development of a society, collaborative effort by all stake holders is compulsory to improve and strengthen the health care system of the country and make certain the population is getting quality of health care.

Implication for social work practice:

Hospitals or other health institutions usually addressed patients' problems which are lasted to their biological dysfunctions / illnesses, while giving little or no attention to their psychosocial problems. Hence, social workers can take part in health institutions for addressing the psychosocial problem of the patients, so that, they can get service in a wholistic approach.

The basic values of social work, from promoting an individual's right to self determination to having an attitude of empathy for the individual, are the foundation of social work practice. When confronting dilemmas or needs in health care, social workers

can use the principle of client self determination in matters where clients or their proxies are faced with such issues (NASW, 2004)

Good client provider interaction which is expressed by good communication skill, respect of clients, confidentiality and informed decision are principles social workers have to be guided in the helping process. This principle is also included in the Ethiopian medical ethics which health professionals have to follow. However, in most of the clinical areas these are often given less attention. The result of this study has also showed gaps in the health providers' interaction especially on advice given and information shared to patients which are basic conditions for informed decision making and clients self determination.

Implication to social work education

The implication of this study to social work education is, since, one of the field placement areas of social work students is health institutions, students and their field liaison should recommend on observed gaps in addressing patients' rights. Respective and responsible bodies of the health institutions should also be informed regarding violation of patients' rights during getting treatment. Clients have to participate on the decision making process that is made on them. They have to get enough information about the treatment and care they received. Furthermore, since clients are the ones that can evaluate the service provided for them, their view should be taken productive for improvement of the service. Patient satisfaction survey is a very important tool addressing clients need clinical practice.

Recommended future research areas of social workers in the clinical practice are:

1) The relationship between social work ethics and principles and medical ethics and Principles

2) Assessment of practical areas in the clinical practice in which social workers can involve to address clients need and to solve their problem.

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Consent form

Good morning/good afternoon, I am a student at Addis Ababa university school of social work social. If you are willing, I would like to ask you some questions regarding yourself and the service you are receiving in this hospital. In the first place I would like to remind you that your response to the questions has no any effect on the service you get. The purpose of my assessment is to explore the services given in this hospital and to assess how the service provided is perceived by clients. The interview is entirely voluntary. Even after the interview begins, you can refuse to answer specific questions of decide to terminate the interview at any point. Strict confidentiality will be maintained and no reports of this study will ever identify you in any way.

1. I agree for the interview ----------
2. I disagree for the interview----------

የቃለ መጠይቅ ስምምነት ፎርም

ጤና ይስጥልኝ እኔ የአዲስ አበባ ዩንቨርስቲ የሶሽያል ወርክ ተማሪ ነኝ ለመመረቂያ ጽሁፍ የሚረደኝን መረጃ ለማሰባሰብ ቃለመጠይቅ አዘጋጅቻለሁ። እርሰዎም ለቃለመጠይቁ ፈቃደኛ የሚሆኑልኝ ከሆነ እዚህ ሆስፒታል አሁን በተሰጠዎት አገልግሎት ዙሪያ አንዳንድ ጥያቄዎችን ለመጠየቅ ነው ። የቃለመጠየቁ አላማ የግል ህክምና መስጫው ለታካሚወች የሚሰጠው አገልግሎት እንዴት እነደሆነ ለማጥናት ሲሆን በምታገኙት አገልግሎት ላይ ምንም አይነት ተጽእኖ የለውም። ለሚደረግልኝ ትብብር ከወዲሁ አመሰግናለሁ።

ለቃለ መጠይቁ መስማማት አለመስማማትዎትን አስማማለሁ----------አልስማማም----------

በማለት መግለጽ ይችላሉ። ቃለመጠይቁ ከተጀመረም በሁዋላ ግልጽ ያልሆነልወትን ጥያቄ የለመመለስ እና ቃለመጠይቁን የማቋረጥ መብትዎ የተጠበቀ ነዉ።

አመሰግናለሁ !!

Addis Ababa University

School of Social work Masters Program

Questionnaire

This questionnaire is designed to collect information on the quality of health service provided at the outpatient department of private wing and regular service of public hospitals.

Dear respondents!

In the first place, I would like to remind you that your genuine and candid response to the questions has a great value for the success of the study, and has no any effect on the service you get. The purpose of my assessment is to investigate the quality services provided in this hospital and how the service is evaluated in the perception of patients. The interview is entirely voluntary and strict confidentiality will be maintained and no reports of this study will ever identify you in any way.

Thank you for cooperation!

Name of the hospital_____ Questionnaire No._____

Date _____Time _____Payment ; Pay _____Free_____

Part One: Socio demographic Characteristics

Instruction: please put tick (√) mark in the box

1/sex Male ☐ Female ☐

2/ Age 18-25 years ☐ 26-35 years ☐ 36-45years ☐ 46-55years ☐ 56 and above ☐

3/ occupation; private employee ☐ government employee ☐ house wife ☐

merchant ☐ unemployed ☐

4/ Educational level 12 grade and under ☐ certificate ☐ diploma ☐ degree and above ☐

5/ Income in Ethiopian birr; below <1000 Br. ☐ from 1000-2000br ☐ above2000 ☐

Part two: Interpersonal and technical skills

Likert scale (1 =very dissatisfied, 2 = fairly dissatisfied 3 = fairly satisfied 4= very satisfied

6/ what is the main reason you want to get service at the private wing

1/ **hopping that better quality of service is provided in it** ☐ **2/ people informed me to be seen at the private** ☐ **3/ because the service hour is convenient to me** ☐ **4/since it is possible to get specialist physician** ☐ **5/other reason** ☐

7/ during this visit how much do you satisfied with health professionals courtesy and respect?

Very dissatisfied, ☐ **fairly dissatisfied** ☐ **fairly satisfied** ☐ **very satisfied** ☐

8/ during this visit how much do you satisfied with professionals listening of your opinion?

Very dissatisfied, ☐ **fairly dissatisfied** ☐ **fairly satisfied** ☐ **very satisfied** ☐

9/ during this visit how much do you satisfied with clear health professionals explanation of your health condition in a way you could understand? **Very dissatisfied** ☐ **fairly dissatisfied** ☐ **fairly satisfied** ☐ **very satisfied** ☐

10/ during this visit how much do you satisfied with the information you have got from health professionals regarding you illness? **Very dissatisfied,** ☐ **fairly dissatisfied** ☐ **fairly satisfied** ☐ **very satisfied** ☐

11/ during this visit how much are you satisfied with advice given to you from health professionals regarding risk factors and precautions to take after you left the hospital? **Very dissatisfied,** ☐ **fairly dissatisfied** ☐ **fairly satisfied** ☐ **very satisfied** ☐

art Three: organization's service characteristics

12/ how do you get the cleanliness of the waiting area? **Very dissatisfying,** ☐ **fairly dissatisfying** ☐ **fairly satisfying** ☐ **very satisfying** ☐

13/ how do you get the cleanliness of the examination room? **Very dissatisfying,** ☐ **fairly dissatisfying** ☐ **fairly satisfying** ☐ **very satisfying** ☐

14/ How did you get the cleanliness of the latrine? **Very dissatisfying,** ☐ **fairly dissatisfying** ☐ **fairly satisfying** ☐ **very satisfying** ☐

15/ Have you got all the prescribed drugs in the hospital's pharmacy? Yes ☐ No ☐ If yes how much do you satisfied with getting the prescribed drugs in the hospital pharmacy; **Very dissatisfying,** ☐ **fairly dissatisfying** ☐ **fairly satisfying** ☐ **very satisfying** ☐

16 / Have you got all the ordered laboratory tests in the hospital's laboratory? Yes ☐ No ☐ If yes how much do you satisfied in getting the ordered laboratory tests in the hospital laboratory ; **Very dissatisfying,** ☐ **fairly dissatisfying** ☐ **fairly satisfying** ☐ **very satisfying** ☐

17 / How do you get the amount of time you wait before getting the service? **Very dissatisfying,** ☐ **fairly dissatisfying** ☐ **fairly satisfying** ☐ **very satisfying** ☐

18/ How do you get the cost of the private wing service? **Very expensive** ☐ **fairly expensive** ☐ **fairly not expensive** ☐ **not expensive** ☐

19 / how did you get the cleanliness of the latrines? **Very dissatisfying,** ☐ **fairly dissatisfying** ☐ **fairly satisfying** ☐ **very satisfying** ☐

20/ would you recommend the service you got here to be used by friends and families? **Not at all**☐**, probably not** ☐**probably yes**☐ **definitely yes** ☐

21/ over all, how did you get the service you had given here? **Very dissatisfying,** ☐ **fairly dissatisfying** ☐ **fairly satisfying** ☐ **very satisfying** ☐

<u>አዲስ አበባ ዩንቨርስቲ</u>

<u>የሶሻል ወርክ ትምህርት ክፍል ማስተርስ ፕሮግራም</u>

<u>የአማረኛ ቃለመጠይቅ</u>

ቃለመጠይቁ የተዘጋጀው በመንግስት ሆስፒታል ውስጥ በሚገኘው የግል ህክምና መስጫ (ፕራይቬት ዊንግ) እና በመደበኛው አገልግሎት የሚሰጠውን የ አገልግሎት ጥራት ለማጥናት በሚደረገው የዳሰሳ ጥናት መረጃ ለማሰባሰብ ነዉ።።

<u>ውድ የቃለመጠይቁ ተሳታፊዎች</u> !

ቃለመጠይቁን የሚሞላው ሰው የሚሰጠው መረጃ ትክክለኛነት ለጥናቱ ስኬት በጣም ጠቃሚ መሆኑን እየገለጽኩ የምትሰጡት ምላሽ ከልብ የመነጨ እና በታመኝነት እንዲሆን ትብብራችሁን እጠየቃለሁ፡ የምትሠጡት አስተያየት በአሁኑ ሰአት ከምታገኙት አገልግሎት ጋር ምንም ግንኙነት የሌለው እና ሚስጥራዊነቱ የተጠበቀ በመሆኑ አስተያየታችሁን በነጻነት መስጠት እንደምትችሉ ላረጋግጥላችሁ አወዳለሁ።። ቃለመጠይቁ በሙሉ ፈቃደኝነት ላይ የተመሰረ ነው ።።

ለሚደረግልኝ ትብብር በቅድሚያ አመሰግናለሁ !

<u>ክፍል አንድ</u>

የሆስፒታሉ ስም _____የቃለመጠይቁ ቁጥር _____

ቀን _____ ሰዓት_____የክፍያ ሁኔታ ፤ከፋይ_____ነጻ_____

<u>መመሪያ</u> ፡ ምርጫዎን በሳጥኑ ውስጥ የ √ ያስቀምጡ

1/ጾታ ወንድ ☐ ሴት ☐

2/ ዕድሜ ፡ 18-25 አመት ☐ 26-35 ☐ 36-45 ☐ 46-55☐ 56 እና ከዛበላይ☐

3/ የትምህርት ደረጃ ፡ 0-12ኛ ☐ ሰርተፍኬት☐ ዲፕሎማ ☐ ዲግሪ እና ከዛበላይ ☐

4/ ስራ ፡ የግል ተቀጣሪ ☐ የመንግስት ሰራተኛ ☐ የቤት እመቤት☐ነጋዴ☐ስራ የሌለው ☐

5/ የገቢ ሁኔታ በብር፡ 1000 በታች☐ ከ1000-2000ብር ☐ ከ2000ብር በላይ ☐

6/ በግል ህክምና መስጫው(ፕራይቬት ዊንግ) መታከም የፈለጉበት ምክኒያት ምንድን ነው

1/ ጥራት ያለው ህክምና ይሠጣል ብየ ስላመንኩ☐ 2/ሰዎች ጥሩ አገልግሎት እንደሚሰጥ

ስለነገሩኝ ☐ 3/አገልግሎቱ የሚሰጥበት ሰዓት አመች ስለሆነልኝ☐ 4/ እስፔሻሊስት

ሀኪሞችን ማግኜት ስለሚቻል ☐ 5/ ሌላ ምክኒያት ካለዎት☐

<u>ክፍል ሁለት</u> : የጤና ባለሙያዎች የአገልግት አሰጣጥ ሁኔታ

7/ በዛሬው ህክምናዎ የጤና ባለሙያዎች ባደረጉልዎ አክብሮት እና ትህትና ምንያህል ረክተዋል ? በጣም አልረካሁም ☐በመጠኑ አል ረካሁም☐በመጠኑ ረክቸሃለሁ☐በጣም ረክቻለሁ ☐

8/ በዛሬው ህክምናዎ ጤና ባለሙያዎች የእርስዎን ህሳብ ለማዳመጥ ባደረጉት ጥረት ምንያህል ረክተዋል ? በጣም አልረካሁም ☐በመጠኑ አል ረካሁም☐በመጠኑ ረክቸሃለሁ☐በጣም ረክቻለሁ☐

9/ በዛሬው ህክምናዎ የ ጤና ባለሙያዎች ነገሮችን እርስዎ በሚገባዎት መልኩ ለማብራራት ባደረጉት ጥረት ምን ያህል ረክተዋል? በጣም አልረካሁም ☐ በመጠኑ አል ረካሁም ☐በመጠኑ ረክቸሃለሁ ☐ በጣም ረክቻለሁ☐

10/ በዛሬው ህክምናዎ ጤና ባለሙያዎች ስለ ጤንነትዎ ጉዳይ በቂመረጃ ሰጥተዉሆታል ?

አዎ☐ አልሰጡኝም☐ አዎ ከሆነ መልስዎ በተሰጠዎት የጤንነት መረጃ ምንያህል ረክተዋል ?

በጣም አልረካሁም ☐ በመጠኑ አል ረካሁም ☐በመጠኑ ረክቸሃለሁ ☐ በጣም ረክቻለሁ☐

11/ በዛሬው ህክምናዎ የጤና ባለሙያዎች የጤናወን ሁኔታ በተመለከተ ምክር እና እቤት ከሄዱ በኋላም ቢሆን ምንምን ምልክቶችን መገንዘብ እንዳለብዎት ነግረዉሆታል? አዎ☐

አልሰጡኝም☐ አዎ ከሆነ መልስዎ በተሰጠዎት ምክር ምንያህል ረክተዋል ? በጣም

አልረካሁም ☐ በመጠኑ አል ረካሁም ☐በመጠኑ ረክቸሃለሁ ☐ በጣም ረክቻለሁ☐

<u>ክፍል ሦስት</u> : የሆስፒታሉ የአገልግሎት አሰጣጥ ሁኔታ

12/ የመቆያ ክፍሉን ንጽህና እና ምቾት እንዴት አገኙት? በጣም የማያረካ ☐ በመጠኑ የማያረካ ☐ በመጠኑ የሚያረካ ☐ በጣም የሚያረካ ☐

13/ የምርመራ ክፍሉን ንጽህና እንዴት አገኙት ? በጣም የማያረካ ☐ በመጠኑ የማያረካ ☐ በመጠኑ የሚያረካ ☐ በጣም የሚያረካ ☐

14/ የመጸዳጃ ቤት ተጠቅመው ከሆነ የመጸዳጃ ቤቱን ንጽህና እንዴት አገኙት ? በጣም የማያረካ ☐ በመጠኑ የማያረካ ☐ በመጠኑ የሚያረካ ☐ በጣም የሚያረካ ☐

15 / የታዘዘለዎትን መድሃኒት በሙሉ በሆስፒታሉ ፋርማሲ ውስጥ አግኝተዋል ? አዎ □አላገኘሁም

☐ አዎ ከሆነ መልስዎ መድሃኒቶችን በማግኘትዎ ምን ያህል ረክተዋል?በጣም አልረካሁም ☐

በመጠኑ አል ረካሁም ☐በመጠኑ ረክቸሃለሁ ☐ በጣም ረክቻለሁ☐

16/ ሁሉንም የታዘዙልዎትን የላቦራቶሪ ምርመራዎች በሆስፒታሉ የላቦራቶሪ ክፍል አግኝተዋል ? አዎ

☐አላገኘሁም ☐ አዎ ከሆነ መልስዎ ምርመራዎችን በማግኘትዎ ምን ያህል

ረክተዋል?በጣም አልረካሁም☐በመጠኑ አልረካሁም☐በመጠኑ ረክቸሃለሁ☐ በጣም ረክቻለሁ☐

17 / አገልግሎት እስከሚያገኙበት ጊዜ የቆዩበትን ሰዓት እንዴት አገኙት ? በጣም ረጅም ነበር ☐

በመጠኑ ረጅም ነበር☐ በመጠኑ አጭር ነበር☐ በጣም አጭር ነበር☐

18/ ለተደረገልዎት ህክምና የከፈሉትን ክፍያ እንዴት አገኙት? በጣም ውድ ነው ☐ በመጠኑ

ውድነው☐ በመጠኑ ውድ አይደለም☐ ውድ አይደለም☐

19/ በዚህ ሆስፒታል አገልግሎት እንዲያገኙ ለጓደኞችዎ እና ለቤተሰብዎ ይመክራሉ ? ፈጽሞ

አልመክርም ☐ ምን አልባት አልመክርም ☐ ምንአልባት እመክራለሁ☐ በጣም

እመክራለሁ☐

20/ በአጠቃላይ አገልግሎት አሰጣጡን እንዴት አገኙት? በጣም የማያረካ ☐በመጠኑ የማያረካ☐በመጠኑ

የሚያረካ ☐ በጣም የሚያረካ ☐