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SERVICE DELIVERY AND CUSTOMER SATISFACTION IN SELECTED HOSPITALS

The case study in Black Lion, Dagmawi Menelik and Bethzata hospitals

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*Service Delivery and Customer Satisfaction in Selected Hospitals:
the case of Black Lion, Dagmawi Menelik and Bethzata hospitals*

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Abstract

Ethiopia experiences heavy burden of disease with a growing prevalence of communicable infections. Many Ethiopians face high disease mobility and mortality largely attributed to potentially preventable infectious diseases, nutrition deficiencies and poor health care. Black Lion and Dagmawi Menelik (public), and Bethzata (private) are the largest hospitals in Ethiopia. They have many specialized services which are unique to them. Patients who come from different parts of Ethiopia are undergoing treatment in these hospitals. However, there are problems in rendering services to clients.

To identify the problem, a cross sectional study was conducted from May1-15, 2007. Qualitative and quantitative techniques were used to collect the data from primary and secondary sources. 280 copies of a questionnaire were distributed to in/out patients of the three hospitals. Interview was conducted with selected officials and 12 doctors of the three hospitals. Furthermore, focus group discussion, observation and secondary data were used.

The results of the survey show that inequalities in health care (inequality in medical technology, in resource allocation, and in accessibility to health care) were observed among these hospitals. Further, there were shortages of professional doctors and medical instruments in the public hospitals. It was observed that the majority of the clients of the public hospitals were dissatisfied with the availability of drug , supplies of medicine and adequacy of communication. Also they were unhappy with access to and cleanliness of toilet; comfort of room and compound; quality of meal service; staff ethics; capacity of waiting area; location and distance of the hospitals; facilities like furnishings; time to get health service, and privacy during physical examination. On the other hand, in Bethzata Hospital, patients were satisfied in all cases except the price charged for health care service..

As to the professionals, all doctors in the public hospitals who were interviewed were not satisfied with their job and working condition. The usage of modern technology was also found to be low in these public hospitals.

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LIST OF ACRONYMS AND ABBREVIATIONS:

MIS: Management Information System
NPM: New public management
GNP: Growth national product
SSA: Sub-Saharan African countries

CHAPTER ONE

1.1 Introduction

This chapter outlines the background of the study, statement of the problem, research objective, scope of the study, significance of the study, methodology of the study and the organization of the chapter.

1.2 Background of the Study

Studies of the quality of medical care are becoming more important as a component of health care research. The consumer's opinion of service is being taken in to account in assessments of quality. Thus, evaluating the quality of medical care involves the measurement of its benefits to patients and the community at large (Lock and Dunt, 1978).

The emerging health care literature suggests that patient satisfaction is a dominant concern that is intertwined with strategy decisions in the health care services. Patient satisfaction should be indispensable to assessment of quality as to the design and management of health care system (Andaleeb, 2001).

Customers subsequently judge service quality as the extent to which perceived service delivery matches with the initial expectations. Besides, there are three levels of expectations that can be defined as service quality. The first one is the desired level of service, which reflects what the customer wants. The second is adequate service level, that is, the standard customers are willing to accept. The third is the predicted service level, which means the one that the customers believe to actually occur most likely (Palmer, 1995:155).

In addition, quality has to do with every aspect of a hospital's service starting from the time the patient is admitted until the patient is discharged. One of the qualities is simply knowing

where the patient is: whether in a certain room in bed, whether in the operating room or out of it. Another is keeping a central front office file of the patient's status, and delivering promptly and accurately a correct record of the patient's name, when admitted, what room, whether in the hospital or discharged and when. Furthermore, Rosander (1985) stated that there are four qualities of care, which are vital to the patient:

- the location and status of the patient which require accurate and up-to-the-minute record.
- the medical care which includes medicine, nurse care and doctor's care
- supportive medical care which includes food, housing, personal care, treatment, and security.
- financial control including bills, and medical care

Acceptable quality service does not only include the quality of direct medical services such as diagnoses, medicines, surgery, and treatments, but also indirect operations, such as administration, purchasing, etc. whose costs are reflected in what a buyer pays. They also include the quality of performance that is directly connected and closely related to health care such as food, housing, safety, security, attitude of employees, and other factors, which arise in connection with hospitals (*ibid*).

In public service sectors of Ethiopia, service delivery is the most neglected part and customers were not considered in provision of services as a result of the monopoly of the public health sector of the country in previous regimes. This situation is further aggravated because of highly controlled and centralized procedures. Even though the current government introduces decentralized health policy, the problem still exists in every public hospital.

Nevertheless, patients are quite competent to pass sound judgments on the food, the medicine, the treatment served, access and cleanness of compound and toilet, the cost of the service charged, and others which lead them to evaluate whether the medical service helped them, had no effect, or made them worse. Therefore, this paper will examine these factors with patient care in Black Lion, Dagmawi Menelik and Bethzeta hospitals and provide recommendations based on the study.

1.3 Statement of the Problem

Ethiopia has extremely poor health status relative to other low-income countries, even within Sub-Saharan Africa. This is largely attributed to low income level of population, low educational level, inadequate access to health facility, which have contributed to high burden of ill health in the country. The average life expectancy at birth is relatively low at 54 (53.5 for male, 55.4 for female) and is further expected to decline to 46.5 yearly if the present HIV infection rate continues (World Population Data Sheet, 2001).

Moreover, the Ethiopian health policy emphasizes the importance of achieving access to a basic package of quality health care service to all segments of the population, through a decentralized state system. The government has introduced a four tier system for health service delivery – primarily health care units, district hospital, zonal hospital and special referral hospital (Ministry of Health, 2002/3-2004/5 report). Despite this effort, the quality of health service delivery is extremely low compared to other countries.

Black Lion and Dagmawi Menelik (public) and Bethzata (private) are three of the largest hospitals in Ethiopia. They have many specialized services, which are unique to them. Many patients came from different parts of Ethiopia are undergoing treatment. However, there are many problems if we compare the mentioned public and private hospitals in the following aspects:

1. Inequality of medical and health service

- Inequalities in health care in these hospitals are seen in term of diffusion of medical and health technologies. Modern technologies of medical care are more available in Bethzata hospital than in these public hospitals
- Inequalities in resource allocation: the proportion of bed to population and personnel to population tend to be low in these public hospitals

- Inequalities in access to health care: the patients have unequal opportunities in getting access to health services in these hospitals. Further, there are problems related to lack of transparency, affordability, corruption especially in these public hospitals.

2. Problems related to quality and standard of health services

The quality and standard of services especially in these public hospitals does not meet customers' expectation. There is lack of system of quality inspection/assurances and service accreditations and the provision of medical code of this county is outdated. The problems that result in poor standard of health service delivery in these hospitals are related to the number of professionals (medical doctor, nurse etc.) to population ratio; size and accommodation of hospital rooms; availability of facilities like chair, bed, and others. The holistic care of these hospitals are inefficient and personnel's manners (ethics) and rapidity in service deliver are most complained about. The problem is more serious in the public hospitals than in Bethzata (private) hospital. The problems specific to these public hospitals include patient's convenience, and time while those in Bethzata hospital are related to price.

3. Problems of accessibility to emergency service

Most of the time, these problems occur in the public hospitals. There has been no systematically organized mechanism for handling emergency services.

4. Problems of efficiency of the health care system

Inefficiency is also another problem in the public hospitals because of inappropriate or under utilization of technology, high dependence on manual systems like card, etc.

5. Problems like brain drain and/ or turnover of professionals from the public hospitals.

1.4 Research Questions

The major research questions addressed in this study are the following.

- ❖ Are customers satisfied with the service provided by Black Lion, Dagmawi Menelik and Bethzata hospitals? If they are not satisfied, what are the main reasons?
- ❖ How would the client perceive adequate and quality service from these hospitals, for example, providing speedy service, quality service, employee treatment of the customer, etc.?
- ❖ To what extent are the employees of Black Lion, Dagamwi Menelik and Bethzata hospitals willing to help their customers and provide quality service?
- ❖ Are the employees of the Black Lion, Dagamwi Menelik and Bethzata hospitals satisfied with the work environment, for example, facilities, salary, work environment?

1.5 Research Objectives

The major objective of the research is to identify the problem of service delivery and examine the level of customer satisfaction. Besides, the specific objectives are

- to assess the availability of facilitating environment including drug, skilled manpower and other facilities in these hospitals,
- to assess the attitude of employees of the Black Lion, Dagmawi Menelik and Bethzata hospitals towards their clients/job,
- to measure the level of satisfaction of customers with the prevailing service delivery system of Black Lion, Dagmawi Menelik and Bethzata hospitals,
- to assess the cost of service charged by Black Lion, Dagmawi Menelik and Bethzata hospitals,

- and finally, to suggest the methods to improve the service delivery based on the results of the study.

1.6 Significance of the Study

This paper has invaluable importance to the management of Black Lion, Dagamwi Menelik and Bethzata hospitals and to those other responsible bodies because it provides vital information on the performance of service delivery and customer satisfaction of the hospitals mentioned. This will help them to know the problems, pay attention to the various issues that need attention, provide solution and improvement in the area of service delivery in their hospitals.

Moreover, this paper will also contribute in helping and guiding other researchers, who may conduct research activities on similar topics.

1.7 Definition of Key Concepts and Terms

Satisfaction of the need for improved health status largely depends on the use and/or the effectiveness of service. Patients (in/out) are those who suffer from diseases of minor, serious, acute and chronic nature and those who get service or wait for service

Outpatient: a patient who receives ambulatory care (examination, and treatment) without being admitted or occupying a bed.

Inpatient: a patient who is admitted and occupies bed in a health institution for diagnosis and /or treatment.

Hospital: an establishment with 25 beds that provides general medical care round the clock.

1.8 Scopes of the Study

Due to time and financial constraints, the study is limited to assessing service delivery of Black Lion, Dagmawi Menelik and Bethzata hospitals as a case study. This means the study does not include other public and private hospitals. Furthermore, as service delivery is a vast

and complex subject, in this paper the researcher shows only service delivery related to customer satisfaction (i.e. quality of food, employees' attitude toward their job, usage of information technology, availability of drug and supply of medicine, price charge and location of hospital).

1.9 Limitations of the Study

Although the researcher believes that the paper contains some reliable data on service delivery and customer satisfaction in these hospitals, it does not mean that the data is free from limitations. Therefore, this paper has the following limitations:

- Shortage of time: Collecting data from different source has taken so much time. This posed time limit to undertake other research activities that would have been vital to get comprehensive results.
- The researcher has studied Black Lion, Dagamwi Menelik and Bethzata hospitals as a case study, so it might not be representative of other hospitals in the country at large.

1.10 Methodology of the Study

1.10.1 Data Type and Source

The researcher used both primary and secondary data. The Primary data was gathered from questionnaire, interview, focus group discussion and observation, and the secondary data\source has been used from books, reports, hospital records, and policy and plan documents of the Ministry of Health.

1.10.2 Sampling Procedure, Design and Techniques

Black Lion and Dagmawi Menelik(public) and Bethzat (private) hospitals were selected for the study because they are the largest hospitals in Ethiopia. They have many specialized

services, which are unique to them. Many patients who came from different parts of Ethiopia are undergoing treatment.

The sample size was determined for outpatients based on average daily customers of these hospitals. Conversely, for inpatients it was determined based on 10-13% of the total beds. Furthermore, the total number of outpatients was determined by reviewing the annual documents of each hospital based on the number of patients who visited the hospital. The daily average number of outpatients in these hospitals is approximately 845 (485,200,160 for Black Lion, Dagmawi Menelik and Bethzata hospitals respectively). From the total population of the outpatients, (845) the sample size was determined to be 190 (103, 51, and 36 for Black Lion, Dagmawi Menelik and Bethzata hospitals respectively). Besides this, out of the total beds in Black Lion (560), Dagmawi Menelik (260) and Bethzata hospitals (50), 10-13% was taken as a sample of respondents (inpatients), i.e. 90 (56, 27, and 7 for Black Lion, Dagmawi Menelik and Bethzata hospitals respectively). The inpatients from the three different classes (class 1, 2, 3) were equally distributed in the selection of the sample size.

To summarize the target population for in/outpatients was 845 and the sample size was 280. However, among the total questionnaires distributed in May, 18 of them were not returned, so this paper has analyzed the 262 respondents' questionnaires.

Besides this, the researcher used both probability and non-probability sampling in this paper. From probability sampling, the researcher used stratified sampling, and from non-probability sampling purposive sampling / judgment sampling was used.

1.10.3 Data Collection, Processing and Analysis

The data was collected from primary and secondary source. SPSS version 13 statistical package was used for data management. The researcher performed data entry and cleaning. 20 percent of the questionnaires were also crosschecked with already entered data to maintain its validity. Pie chart, bar graph, table, frequency distribution, percentage, mean and chi square (χ^2) test to detect association at 95% confident interval or 5% level of significance for selected

variable were used and calculated. In addition, both quantitative and qualitative approaches to analyze the data collected from secondary sources, focus group discussion, and interview.

1:11 Structure of the Paper

The paper consists of five chapters. The first chapter deals with introduction, background of the study, statement of the problem, researcher question, objective of the study, significance of the study, the scope of the study, methodology and the structure of the paper.

The second chapter explains about the theoretical perspective of health service delivery. It includes theories, and concepts related to the subject matter. The third chapter discusses lessons, experience and data presentation.

The fourth chapter deals with the analysis of the data using statistical tools- pie chart, bar graph, table, frequency distribution, percentage and chi Squared(x^2) test to the variables.

The last chapter outlines the summary of the findings, conclusions and recommendations of the study.

CHAPTER TWO: THEORETICAL PERSPECTIVE OF HEALTH SERVICE DELIVERY

2.1 Introduction

The behavior of hospitals is determined by the combined influence of the external environment and hospital organization structure. Incentives from the external environment are associated with the function of governances, stewardship, private-public partnership, outsourcing and purchasing (individual market based and pooled). Incentives associated with organizational structure are associated with autonomous, market exposure, residual claimants, accountability and social function. The provision of health services is a complex matter involving a number of socio-economic, geographic, demographic and technical issues. Principal among these are availability and accessibility of service, quality, efficiency, price and equity. This chapter discusses the various theoretical perspective of health service delivery which are related to hospital care.

2.2 Definition of Health and Service

Health is a positive state of well being in which harmonious development of mental and physical capacity of individuals leads to the enjoyment of rich and full life. It implies adjustment of an individual to his total environment –physical and social (Goel, 1984:27).

Services are often intangible. Services are acts, deeds, performances, and efforts. Most services cannot be physically possessed, and the value of services is based on an experience; there is no transfer of title (Evans, 1982:132).

Services can be defined as economic activities that produce time, place, form, or philological utilities. A maid service saves the consumer's time from doing household chores himself or herself (Inman, 1985:4).

A service is an activity or benefit that one party can offer to another that is essentially intangible and does not result in ownership of anything. Its production may or may not be tied to a physical product.

2.3 Principles of Health Administration

Administration in health should know certain main principles in the formation of health policies. Some of the principles that Romer (2001) stated are:

1. Ensure basic health service available, accessible and acceptable to the society.
2. There should be a well structured administration design to implement a health policy
3. Planning the public health programs for the benefit of the society

2.4 Health System

Health status is at core of life quality for individuals in every country. Citizens place great value on having access to the kind of services that lessen illness and pain, cure diseases and trauma as these conditions occur on themselves, their relatives, friends and public heroes. Access to quality health care is probably among the core value in all society (Blendon et al, 1993:10-11).

According to Elling (1980), some theories of health systems have a psychological character. Health behavior is seen as a matter of individual or perhaps individual and group or social-psychological determinations, although it derives its explanatory principles from idealistic, holistic notion of "culture". Much of the work in medical anthropology share of recognition or focus on the importance of institutional arrangement of health service and facilities (Foster, 1976:1-9). To cite an example, the world health organization conducted a comprehensive study of the use of health service by assessing characteristics and orientation of individuals related to the level and type of utilization of physicians and other health services. Variations in political, economic contexts are given no attention at all, as if the WHO-management view

that health services can be efficiently and effectively arranged irrespective of their political, economic contexts (Elling, 1980:80).

The overall intention is that individuals need not be considered. Besides some very useful conceptual work has been done focusing on individual's health behaviors or orientation while suggesting links to the structure of the service system and its context. This kind of activity needs some of the intermediate goals of health service systems having to do with usage of modernization (sophistication), timely entry into care and satisfaction with care, as well as provider and user aspects (as distinct from payment and structural aspect) of the logic of care process. While conceptual work on the individual level is useful and necessary to the extent that is not simply psychological, it is nevertheless lacking in sociological imagination and misses the big picture and important variance (*Ibid*).

Another kind of conceptual work that Elligs (1980) stated in his book focuses on the structural aspects of health system and states that such matters as the structure, distributions of and control over resource and organizations of authority in society are very crucial. Despite the numerous variations, due consideration (attention) to legislative mandate, and administrative structures, financing, facilities, health personnel and their development, coverage of population in terms of public and private services, and organization of hospitals and primary care should be given.

The major trends Roemer states and that Elligs (1980) cited are as follows:

“Since political ideologies and economic levels, as we have seen, are major determinants of health care systems, one can design a classification of countries formed along both dimension—a conceptual blending that some scholars define as “Political Economy.” we can categorize countries in terms of the political economy of their health care system.

None of these types of health care system is absolutely pure anywhere, since in every nation these are special variants or subsystems and the complexity is compounded by further changes every year, even every month. However, in terms of the predominant characteristic of the health care system of different nations, we can identify five principal types: a) free enterprise, b) welfare state, c) underdeveloped,

d) transitional and, e) socialist. One must emphasize that countries subsumed under each of these type are in contextual flux”.

There are many ways of describing a health care system. Roemer (1991) analyzed this scheme with seven principal compounds.

1. **Economic support:** Since the methods by which health services are financed are basic determinants of their quantity, their quality and their impact on people, we will consider these first six fundamental mechanisms of individual and collective financing are definable and although all of them are used to some extent in almost every country, their proportions differ greatly.
2. **Manpower:** Historically the healing of the sick was possible with the provision of one type of person, the doctor but as medicine has developed, a great number and variety of more specialized health workers have evolved. Their functions' training and social controls of their performance must be considered as these features have taken shape in different nations.
3. **Facilities:** To shelter and care for the seriously sick, hospitals have been established in all countries. Their sponsorships, mode of operations, relative numbers and relationships to other components of health service differ greatly in various national settings. Other types of structure, such as health centers to serve the ambulatory person have also multiplied and revived around the world.
4. **Delivery patterns:** Perhaps the most striking differences among nations are in the patterns by which health service are provided or delivered. The same types of manpower and facilities or even the same mechanisms of financial support may be applied, but the methods by which the work is carried out show great variation. These patterns of delivery of medical care, which include the ways that personnel and facilities are paid, have large implications for the cost and quantity of services.
5. **Preventive service:** It was centuries before medical science matured in its understanding of disease process and health sufficiently to learn how to prevent sickness. The techniques for prevention depend, of course, on the nature of the disease problems in different counties and the characteristic of health care system. This core component of health service is growing with rising importance.

6. **Regulations:** Every complex system of manpower and facilities requires some regulation or surveillance to keep it effective and to assure the attainment of its goal with the greatest possible efficiency. The many ways that this is done in different nations' contexts have diverse influences in the functioning of health care system.
7. **Administration and planning:** Finally, management of the whole system of health services, keeping them supplied with economic support and resources and assuring their effective operation requires some sort of overall supervision. Planning also requires deliberate efforts. These methods of administration depend on the prevailing political and economic structure of various nations (Roemer, 1997).

Even though each nation is undergoing changes in ways that correspond to its political, economic and social cultural settings, the following broad trends are observed by Roemer as Elligs (1980) in turn cited as follows.

1. Economic support for health service is, on the whole, becoming more collectivized. Private payments are playing an increased relative role, whereas insurance mainly social rather than voluntary and general revenues are playing an enlarging role. Along with this, a slowly increasing share of a nation's GNP.
2. The supply of doctors relative to population in well developed countries is increasing. In the less developed countries, specialization is also growing, but in the more industrialized countries, a reaction against excessive specialization has set in and the general medical practitioner is being strengthened both in quality and number.
3. The range of other allied health personnel, either working with the doctor or doing special tasks independently, is widening and their supply (ratio to population) is also increasing. For primary health care in the less developed countries, many forms of doctor substitute are being produced in relatively short periods, and in some industrialized countries such personnel are being trained for underserved areas.
4. Health facilities are increasing in their technical capabilities. More general hospital beds in relation to population are being constructed in the developing countries, though in several affluent countries there is a sense that an adequate or even excessive supply has been built.

5. The patterns for delivery of all levels of medical care are becoming increasingly systematized. Primary and ambulatory care is more often being provided by teams in health centers of various sorts. Services in hospitals are increasingly being furnished by salaried specialists in different organizational frameworks. In general, the remuneration of doctors by fees for each unit of services is gradually being replaced by payment for the doctor's time, through salaries usually rather high.
6. The value of preventive service is becoming increasingly appreciated everywhere.
7. Because of the rising utilization and overall cost of health services everywhere (or the rising share of national GNP being allocated to health), greater attention is being given to regulation of these expenditure.
8. To cope with the mounting complexities of all the organized settings developed for providing different type of health services, efforts are being made everywhere to design more effective administration of total health care system.

According to Roemer (1991), the above issues tend to reinforce one another.

2.4.1 Health Care System Components

A health care system may be defined as the combination of health care institutions, supporting human resources, financing mechanisms, information systems, organizational structures that link institutions and resources, and management structures that collectively culminate in delivery of health services to patients (Lassey, 1994:3). Several basic concepts are raised in the definition that Lassey discusses by citing Adperson & Frank as follows:

- ❖ **Institutions** include local, state and federal public health departments; public and private providers of health care services, such as hospitals, clinics, health maintenance organizations and nursing homes; educational enterprises that provide training for health professionals, environmental health departments; and other types of organizations responsible for some dimension of health promotion, illness prevention, or health care.

- ❖ **Supporting human resources** include public health professionals, physicians, dentists, health service administrators, nurses, pharmacists, psychologists, public health workers, social workers, allied health personnel such as medical, technical and other professionals directly involved in health promotion, prevention of disease or health care.
- ❖ **Financing mechanisms** include direct government financing of services, national health insurance plans, private payroll and other taking systems that generate revenue for health care, private out-of-pocket expenditures and other sources that pay for the cost care.
- ❖ **Information system** include computer network within and between institutions, including electronic mail (e-mail); private media such as journals, magazines and newsletters; telephone system including voice mail and data transmission; interactive television and other video systems; and other information media or technology that facilitate sharing or exchange of information, summarizes and collects data or generally contributes to greater understanding of health and health care.
- ❖ **Linking organizational mechanisms** include local, state and national association of public health professionals, hospitals, physicians, nurses, health care administrators, pharmacists or pharmaceutical procedures, rural health, health professional schools and a great variety of other organizations that deliberately attempt to link together the organizational units related to health care.
- ❖ **Management structure** include public health system administrative system at federal, state and local level; administrative systems within multi-institution organizations such as hospital chains.

2.4.2 Some intermediate goals of health system

The ultimate goal of health systems is to achieve an improved health status for all persons in a nation's population within expenditure levels the nation can sustain. Further, the intermediate goal to be achieved by a broadly defined health service which can be seen as bearing upon health status:

- Improvements in pathogenic conditions and way of life (e.g. poor nutrition, housing, working and travel hazards, smoking behavior).
- Heightened understanding on the parts of the people, as well as health providers of health problems and what to do about them, including proper self help and use of health services.
- Enhanced anticipated satisfaction with using health services such that entry into primitive and other care will occur in a timely manner.
- Timely entry into care.
- Improved logic of the care process once a patient (or a community in the case of group levels health action) enables in to care (i.e. things which should be done are done, within or in relation to the health care resource available, things which should not be done are not done (Elling,1980:92-93).

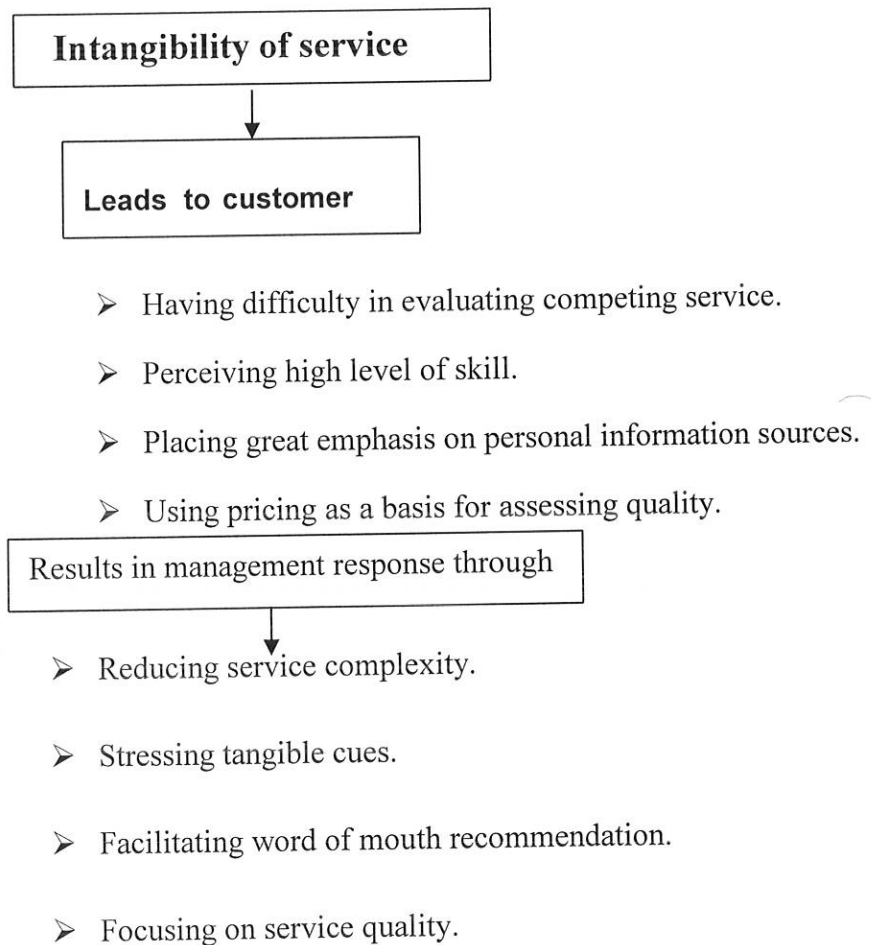
2.5 Distinguishing Feature of Service

“ **Pure** ” services have several distinctive characteristics that differentiate them from good and have implications for the manner in which they are marketed. These characteristics can be described as intangibility, inseparability, variability, perishability, and the inability to own a service (Palmer, 1995: 35-36).

2.5.1 Intangibility

A pure service cannot be assessed using any of the physical senses; it is an abstraction, which cannot be directly examined before it is purchased. A prospective purchaser of most goods is able to examine the goods for physical integrity, aesthetic appearance, taste, smell and so on. On the other hand, pure services have no tangible properties that can be used by consumers to verify the advertising that comes before the purchase is made. The intangible characteristics that define service, such as reliability, personal care, and attentiveness and friendliness of staff, can be verified only when a service has been purchased and consumed.

Figure 2.1 some implications of service intangibility

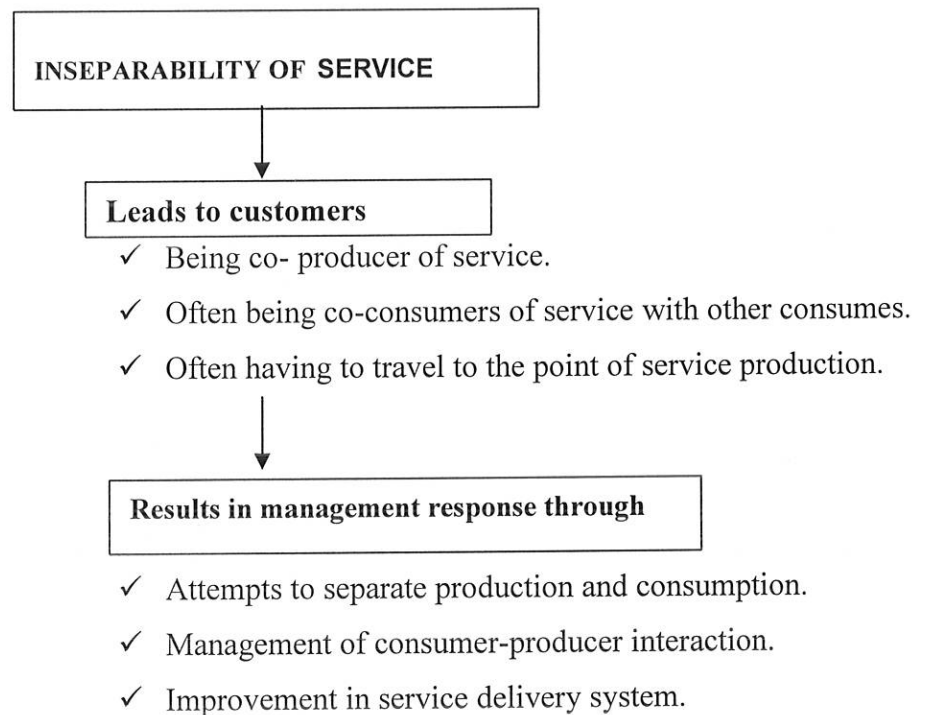


Source: (Palmer, 1995:36-37)

2.5.2 Inseparability

The consumption of a service is not separable from production. Producer and consumer must interact in order for the benefits of the service to be realized, both must normally meet at a mutually convenient time and place in order that producer can directly pass on service benefits.

Fig 2.2 Some implications of service inseparability

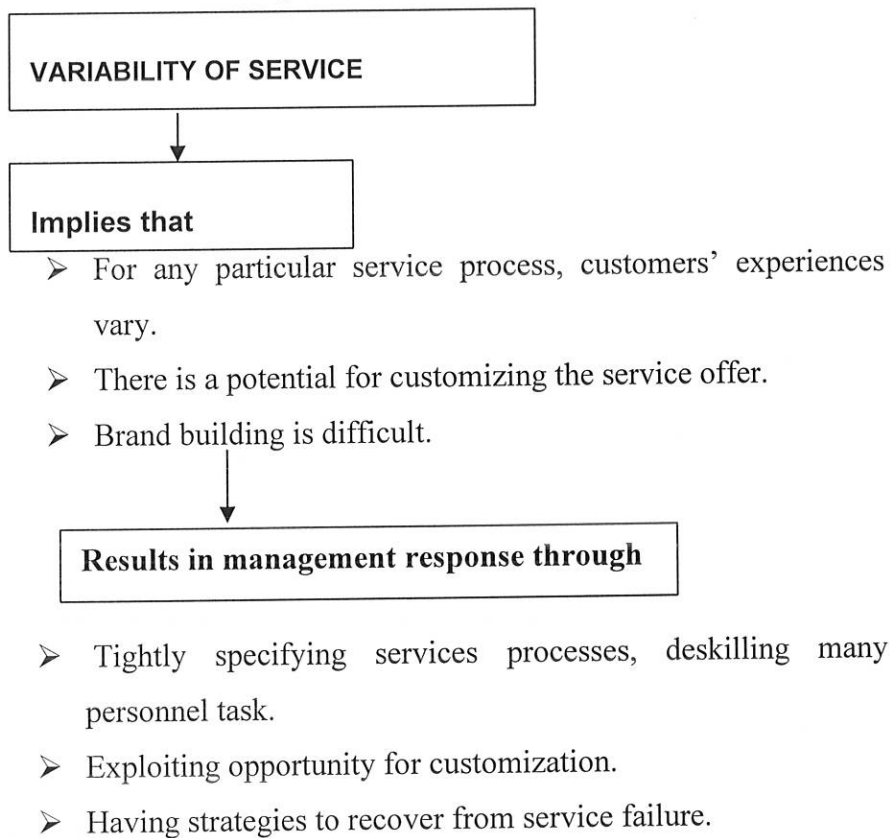


Source: (Palmer, 1995: 37-38)

2.5.3 Variability

The variability of service output can pose problems for brand building in service compared with tangible goods. For the latter it is usually relatively easy to incorporate monitoring and quality control procedures into production process order to ensure that a brand stands for a consistency of output. The service sectors attempts to manage variability concentrate on methods used to select, train, motivate and control personnel.

Fig. 2.3 Some implications of service variability

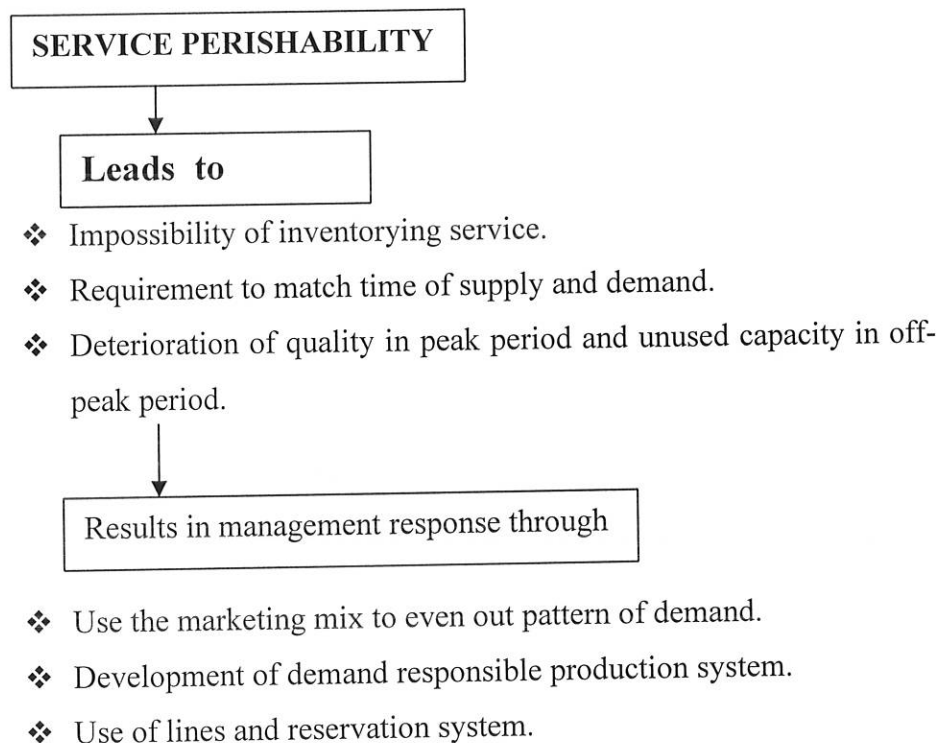


Source: (Palmer, 1995:38)

2.5.4 Pershiability

Most services, because they are simultaneously produced and consumed, are considered perishable, non-inventories. The person who phones in to a time service to find the correct time uses up the service as the time it is provided (Robert, 1990: 28).

Fig 2.4 Some implications of service pershiability



Source: (Palmer, 1995, 40)

2.5.5 Ownership

The inability to own services is related to their intangibility and pershiability. In purchasing goods, buyers generally acquire the title to the good in question and can subsequently do so as they want with them. On the other hand, when a service is performed, no ownership is transferred from the seller to the buyer.

2.6 Customer Satisfaction

Satisfaction is a person's feeling of pleasure or disappointment resulting from comparing a product's or service's perceived performance (or outcome) in relation to his /her expectation. Satisfaction is a function of perceived performance (Murdick, 1995). If perceived performance falls short of expectations, the customer is not satisfied. If the performance exceeds expectations, the customer is highly satisfied or delighted.

Customer satisfaction depends on the extent to which a customer's expectations about the product or service are fulfilled. Customer expectations are not static but keep changing. Therefore, organizations need to monitor customer expectations on a continuous basis and to be innovative in order to respond meaningfully to changes about the customer's expectation (Kotler, 1989, 203).

Customer satisfaction happens when a company focuses on quality service and produces real rewards for the company in the form of customer loyalty and corporate image. Lack in the form of customer satisfaction produces real liabilities and this is a fact that business call ill affords to ignore. ``As customers we go back to a business repeatedly because we know its quality. We know we can depend on the people there, and we know we get consistent service.”

Monitoring the quality of service is important but alone is not enough to ensure long-term success and customer satisfaction.

2.7 New public management (NPM)

According to Harding & Perker(2003) throughout the world governments are reassessing their role in health service delivery. They are being forced to do so by growing pressure, including cost escalation and increasing user dissatisfaction with service. With increasing frequency, automation and corporation are being considered and applied to improve performance of public run health service and new public management (NPM).

Wikipedia, the free encyclopedias discusses NPM as follows:

New public management is a broad and very complete term used to describe the wave of public sector reforms throughout the world since 1980s. From the point of view of public choice and managerial schools of thought, new public management seeks to enhance the efficiency of public sector and to eliminate government control. The main purpose of NPM-reform is the emphasis more on market orientation in public sector will lead to greater cost-efficiency for governments, without having bad effects on other objectives.

According to Borins (1995), the major characteristics of NPM are:

- ☛ Providing high-quality services that citizens value.
- ☛ Demanding, measuring and rewarding improved organizational and individual performance.
- ☛ Advocating managerial autonomy, particularly by reducing central agency controls.
- ☛ Recognizing the importance of providing the human and technological resources managers need to meet their performance target; and
- ☛ Maintaining receptive to competition and open mindedness about which public purposes should be performed by public servants as opposed to the private sector or nongovernmental organizations (Borins 1995:5-11).

Some of modern authors define NPM as a combination of desegregation (splitting large bureaucracies in to smaller, more fragmented one), competition (between different public agency, and between agencies and private firms) provision of incentives (on more economic /pecuniary lines/) (Dunleavy, Margetts et al, 2006).

Borins (1995) define it as, an agreement between the public and their elected representatives on the one hand and the public service on the other hand.

NPM, with contrast to other public management theories, is more oriented towards outcomes and efficiency through better management of public budget. It is considered to be achieved by applying competition, as it is known in private sector, to organizations of public sector

emphasizing economic and leadership principles. New public service considers customers and citizens as shareholders. Moreover, Bornis (1995) states that the public and politicians want high quality public services and better performance by public sector organizations. To achieve better work and customer satisfaction, the public servants should have more managerial autonomy as well as the human and technological resources (i.e. training and information technology) to meet their goals. Further, the public and politicians are willing to reward strong performance, for example through performance pay. The last component of NPM paradigm is a way of enforcing this agreement. If public servants do not improve performance, politicians and the public are willing to introduce competition within the public sector, or more activities to private sector or NGOs.

2.8 Decentralization

Health and health related services, which can be looked as a system in their own right, are also part of wider governmental and social systems that place limitation on their behavior. It is therefore, important to describe what they imply for the organization of the health system Mills(1990) cited Furniss:

“....decentralization may mean the transfer of authority over public enterprises from political officials to a relatively autonomous board; the development of regional economic inputs into national planning; the transfer of administrative functions either down wards in the hierarchy, specially or by problem; the establishment of legislative units of smaller size, or the transfer of responsibility to sub national legislative bodies, the assumption of control by more people with in an economically productive enterprise, the hope for a better world to be achieved by more individual participation”.

Decentralization can thus mean many different things. At the outset, however it is important to draw a distinction between functional and geographical (on what has been termed “a real”) decentralization, a distinction that is particularly relevant when it comes to health system organizations. In functional decentralization, authority for performing particular functions, for instance health care, is transferred to a specialized local office. In real decentralization, broad responsibilities for public function are transferred to local organizations that have well defined

geographical boundaries. The organization of health service may be decentralized in either way, but the ministry of health may well have more power to influence the degree of functional decentralization than that of real decentralization, where health will be only one of the government services that are being decentralized.

2.9 Exploring potential solutions to problems of health care service delivery

2.9.1 Technological change (reform)

Enhancing technological capacity in public hospitals is one of the tools that can lead to improved hospital performance. The prevalence of broken medical equipment and non-existence of management information systems (MIS) makes this an obvious place to start an effort to improve the operation of public hospitals. The common public sector tendency to allow wage to crowd out capital costs makes such problems endemic. Reforms (changes) usually consist of targeted investment in medical equipment, or computers, databases and soft wares needed to operate an effectible MIS. The skills required to operate the equipment or systems are often lacking. Therefore, technological reforms often include a capacity development component supporting training for relevant staff (Preker, 2003:37).

These reforms have been important in improving public hospitals in both developing and industrial countries. The rapid change in medical equipment and information systems technology make these initiatives necessary. However, in many cases, these “technological solutions” have not achieved the desire impact. Follow up visits to the hospitals show that much of the equipment is not properly maintained, often not in operation. New MIS systems may be generating valuable information, but often neither clinical nor managers are using it. In most cases, it is evident that these investments need to be accompanied by additional attention to incentives (*Ibid*).

2.9.2 Management reforms

Another way to address the problems related to health care delivery system in public hospitals is through management reforms. These reforms include efforts to strengthen the managerial expertise of health sector managers -both through staff training and through changes in recruitment policies to attract management skills. Commonly these efforts are accompanied by improvements to information systems to facilitate effective decision-making. Clinical directorates have been created in some systems and benchmarking of departmental performance has been introduced (Staltman and Figueras, 1997:213-214).

The growing tendency toward applying best practice management techniques from private companies to reform public hospitals is one effort to resolve problems in public hospitals. Frequently, reengineering, patient focused care or quality improvement techniques should apply in these hospitals.

2.9.3 Outsourcing

One of the mechanisms that help public hospitals in developing countries achieve high performance is employing outsourcing. Public hospital should treat outsourcing not simply as a cost-cutting exercise, but rather as a means to improve the process and increase service levels, and career growth and opportunity for employees when they are transferred to the outsourcing partner.

Contracting out is defined as “the practice of the public sector or private firms of employing and financing an outside agent to perform some specific task rather than managing it themselves” (*Ibid*). Contracting in implies that a subdivision of the parent organization (such as a hospital, a number of doctors, etc) is sub-contracted for the provision of goods or services. Typically, there are at least three type of contract:

- Fixed-Price Contracts. Under fixed-price contracts, the amount a contractor will receive is established in advance and cannot be changed unless the contract is amended.

- **Cost-Reimbursement Contracts.** Cost-reimbursement contracts set payments in line with the costs incurred by the contractor.
- **Performance-Based Contracts.** Performance-based contracts provide payment to contractors as they accomplish predetermined results. Payments can be related to services performed by the contractor, such as recruiting and enrolling a target number of clients in a **training program**. **Performance can also be defined according to outcomes achieved by clients.**

2.9.4 Public-private partnerships

These related issues dominate while reviewing the level of public-private interaction in the healthcare sector in transition countries. The familiar one is: What can governments do to make the public sector more responsive to a rapidly changing environment? The more recent focus is not whether the market should substitute where the public sector fails, but whether there can be a better match between the roles of state and private sectors, using their respective strengths to produce better results than either could produce alone. In most countries, this means rebalancing an already complex mix of public and private roles in the health sector. The prime mover in this must be government.

What can be done about the private health sector in low income countries¹ asks how the private sector activity can be influenced so that it helps to meet national health objectives. Although there is a limited evidence base, there is a fair amount of information on the types of intervention that are most successful in directly influencing the behavior of providers and on what might be the necessary conditions for success. There is much less evidence, however, of effective approaches to interventions on the demand side or on the purchasing and regulatory roles of governments.

Private health care in developing countries² recommends three objectives in relation to the private provision of care for conditions of public health importance: **widening access**,

¹On line at <http://www.eldis.org/ds/dicdisplay.cfm> accessed on May 6,2007

² On line at <http://www.eldis.org/ds/dicdisplay.cfm> accessed on May 6,2007

improving quality, and **ensuring non-exploitative prices**. None of these will be simple to achieve, and multi-faceted interventions involving policy-makers, providers, and users will be required. Increasingly, service users (or “consumers”) are seen as the key to driving improvements to achieve these goals. The role of consumers has, however, been little evaluated in developing countries. Community education opportunities, accreditation schemes, and free service targeting may potentially be means of attaining these objectives.

2.10 Criteria frequently used to identify service

According to Synder (1993), services are identified through the following characteristics:

- Services produce intangible output.
- Services produce variable, nonstandard output.
- A service is perishable i.e. it cannot be carried in inventory, but is consumed in production.
- There is high customer contact throughout the service process.
- The customer participates in the process of providing a service.
- Skills are sold directly to the customer.
- Service cannot be mass-produced.
- High personal judgment is employed by the individual performing the service.
- Service firms are labor-intensive.
- Decentralized facilities are located near the customer.
- Quality control is primarily limited to process control.
- Pricing options are more elaborate.

The above criteria is just listed to emphasize the scope of unique problems the manager of service operation encounters.

Labor intensiveness

The question of labor intensiveness versus capital intensiveness for service firms has important implications. Capital intensiveness offers a promise of continued increases in productivity and provides the cost of equipment can be kept in line. Although people tend to view services as inherently labor intensive, it is always the case that some are or some aren't.

Decentralized facilities near to the customer

It is commonly stated that service should be located physically near to the customers and manufacturing plant should be located near raw materials and suppliers. This has resulted in a proliferation of small, decentralized customer service region and large for services that involve physical contact with the customer. The high traffic of potential customer makes adjacent location important. (Robert, 1990: 31)

2.11 Service Quality

The quality of service product is determined by the user's perception. It is the degree to which the bundle of service attributes as a whole satisfies the user. This is called expectation-to perception match. Quality therefore comprises

- The degree to which attributes of the service desired by the users are identified and incorporated in the service.
- The degree to which desired levels of these attributes are perceived by the user to be achieved.

2.11.1 Quality defined as gaps between perceptions and expectation

Murdick, (1995) stated in his book the gap between perception and expectation in following ways.

- **Gap 1: Consumer expectation –management perception gap.**

Service managers do not always understand what feature of service can note high quality to the consumer.

- **Gap 2: Management perception service quality specification gap**

Management does always include in service specification all the quality attributes it perceives consumers want. This is at the same time due to lack of sufficient resources or unreasonableness of consumer expectations.

- **Gap3: Service quality specification – service delivery gap**

Even when appropriate quality guidelines exist, quality service may not be delivered to the customer.

- **Gap 4: Service delivery- external communication gap**

Media advertising and other communication by firm can affect customer expectations.

- **Gap 5: Expected service- perceived gap**

The key to ensure good service quality is meeting or exceeding customer satisfaction.

2.11.2 Causes of poor quality in service

- ❑ Labor shortages have fueled the trend towards self-service and automation.
- ❑ Service workers are often viewed as short term and service work as 'servitude'; consequently, service labor is typically under trained and overworked.
- ❑ The emphasis on increasing efficiency and productivity of service has taken its toll of quality.
- ❑ Customers typically expect less of service and do not demand more.
- ❑ There is more chance of making errors because of the variability inherent in service provided to a number of different customers, by the number of different people, in number of geographically disperse location.
- ❑ The customers typically consume the service as it is produced, leaving no time to test the service quality, correct mistake and rework or recall the service.
- ❑ The nature of service of service does not lend itself to quality control. Service produces intangibles. The qualities of intangibles are rated by opinion, perceptions, and expectation. (Murdick,1995)

2.11.3 Dimension of service quality

- **Tangibles:** appearance of physical facility, equipment personnel and communication material.
- **Reliability:** ability to perform the promised service dependably and accurately.

- **Responsiveness:** willingness to help customer and provide prompt service.
- **Competence:** possession of required skills and knowledge to perform the service.
- **Courtesy:** politeness, respect, consideration and friendliness of contact personnel.
- **Credibility:** trust worthiness, believability and honesty of service provider.
- **Security:** freedom from danger, risk or doubt.
- **Access:** approach and ease of contact.
- **Communication:** keeping customers informed in the language that can be understood and listening to them.
- **Understanding the customer:** making the effort to know customers and their needs. (Berkowitz, 1995: 64)

2.12 Service process planning and equipment selection

The service process refers to how a service is provided or delivered to the customer. Service systems use various resources, including material, equipment and people, to facilitate the service process. Therefore, service process planning must consider the selection of conversion process, material, equipment and skills. Specifically strategic decisions must be made in respect to:

❖ Primary technological decisions

- The primary technology decisions involve answering the following questions.
Is the technology available, or can it be developed, to provide the material, process and equipment to make the product or deliver the service?

❖ Material and conversion process

- Efficiency is achieved when the conversion process is specialized, i.e. when each person or machine supplying a service is dedicated to providing that specific service. Effectiveness, however, is achieved by flexibility in the conversion process. In other words, service providers should provide the broadest range of service they can.

❖ Specific equipment decisions

The selection of specific equipment is not a decision to be made at the lowest level of management. Important questions to address when selecting equipment include:

- ✓ Will this equipment be useful in producing both present and anticipated products and service over the next few years?
- ✓ Does this selection match the strategy of utilizing equipment for lowering short term operating costs?
- ✓ Is this equipment compatible with material selection and suitable for trade off between capital intensity and labor intensity?
- ❖ Process flow for conversion.
- ❖ Employee skill and job content.
- ❖ Site location and selection.
- ❖ Building and facilities.
- ❖ Facility layout and work flow
- ❖ Organization structure and socio psychological factor. (Murdick,1995)

2.13 Service location

Location options are:

- Enlarge an existing facility at the present site.
- Close the present facility and contract one or more new opens on new sites.
- Open a new site.

2.13.1 Dominant location factors

There may be a particular factor that dominates the selection process and limits the number of feasible locations to be evaluated. Below are nine dominant factors related to location and site selection.

- | | |
|-------------------------------|-----------------------------------|
| • Customer based | - Communication based |
| • Cost based | - Support systems |
| • Personal desires of the CEO | -Geographic or environment factor |
| • Competitor based | - Business climate |

2.13.2 Effect of criteria on location

The selection of optimization criteria influences service facility location. As part of the study, experts noted the effect of health- center location with respect to the following criteria:

- ❑ **Maximize utilization:** maximize the total number of visit to the center.
- ❑ **Minimize distance per capital:** minimize the average distance per capital to the closest center.
- ❑ **Minimize distance per visit:** minimize the average distance per visit (travel distance) to the nearest center.

2.13.3 Facility layout

The layout involves finding the best arrangement of the physical component of service system possible with time, cost and technology constraints of the situation. The objectives of designing good layouts are:

- Movement of people, material and paper work to the minimum distance possible.
- High utilization of space, balanced with means for expansion.
- Flexibility for rearrangement, service and growth.
- Satisfactory physical environment for workers.
- Convenience for customers during the service.
- Attractive appearance of room and office arrangement for management and customers (Murdick, 1995).

2.14 Technology in service

Technology is the application of scientific research to improve the practical process of our life. Everyday we read in our newspapers about advance in technology, such as artificial organs, space travel, optic fiber, automated language translation, and compact disks for entertainment system.

Technology may improve the process of providing the service to yield a competitive edge. Technology also may change the entire process through substitution.

Application area of technology in service

Technology applications in service industries are like financial service, government service, communication service, transportation services, education service, restaurant (food) service, and wholesaler/retailer trade.

According to Murdick (1995), technology is applied in service at four different points in the service process. These points occur when:

- (1) Processing the customer
- (2) Processing the customer's materials
- (3) Processing information
- (4) Creating new service

Processing the customer

Processing the customer is keeping the interest of individuals by providing additional inputs such as entertainment, media treatment,. There are areas where the technology can be applied to give some degrees of freedom like the following.

- Extend hours of answering and appointment service.
- Improve the benefit to the customer being treated.
- Improve the nature of the material used to provide multiple benefits.
- Provide music with sublimely message to make the client more restful when the work is completed.
- Improve the skills of the workers.
- Provide equipment for do it yourself steps for some treatments.
- Add gift as part of the benefit package that extend the treatment, provide
- additional treatment or provide gift- satisfactions.

Processing the customer's materials

The second area in the list of technology applications involves processing a customer's equipment or materials. The degrees of freedom for this example are quality, time, size, form of presentation and cost.

Processing information

The third area where technology may be applied to improving service is data and information processing. Basically, information that comes into a firm is edited and converted to a standard form. Multiple copies are prepared and distributed to different work sequence where operations are performed. The copies finally end up in files, are sent to some outside agency such as a customer or vendor, or are destroyed.

Creating new service

Finally, technology may create completely new services through development of new product or process. The development of television created the service of television programming and broadcasting and later, cable TV.

2.15 Dealing with time consumption

The manager service needs to be concerned about when the customers consume the service as he/ she is part of system when consuming. Many service providers find it very difficult to match demand and supply on all occasions and where demand exceeds supply on all occasions, queuing and reservation systems are put in to operation. Customer feedback highlights the fact that delays in service delivery, often-characterized by long queue can have a negative impact on customer evaluations of the services. The ideal solution would be to eliminate queues complete by careful operations management. However, where this is not possible, service providers are advised to change the customer's wait experience (by perception management) so that it results in less uncertainty and anger. Customers become most annoyed and frustrated when they are forced to wait for service without being given an explanation for the delay. Service providers are advised to communicate the customers as quickly as possible why they are being asked to wait. Where the reason can be clearly identified by customers themselves, for example, waiting for a ride at fun fair or to pay for

goods at a supermarket checkout, strategies must be put in place to make the wait as pleasant as possible for customers. Magazines, which are provided in dentists' waiting rooms for the customer to read, and videos played to customers waiting in a queue for a fun fair ride, are both examples of tactics used by services organizations to make the inevitable waiting time enjoyable to customers (Steven and Kim, 1995).

2.16 Conclusion

This chapter explains various theoretical perspectives of health service delivery related to hospital care. The behavior of hospitals is determined by the combined influence of the external environment and hospital organization structure. Incentives in the external environment are associated with the function of the governance's stewardship, private-public partnership, outsourcing and purchasing (individual market based and pooled). Incentives associated with organizational structure are associated with autonomous, market exposure, residual claimants, accountability and social function. If the external environment does not generate performance pressures, hospitals will not have a reason to strive for high performance. However, even with well-designed external incentives, the resulting hospital behavior might be moderate due to its organizational structure. Thus, synergetic design between the external environment and the organizational structure of hospitals create the incentives hospitals need, and hence their alignment is critical to successfully change organizational performance.

CHAPTER THREE: LESSONS, EXPERIENCES AND DATA PRESENTATION

3.1 Introduction

So far, we have seen in previous chapter the theoretical part of health service delivery. In this chapter, we will see researches done on health service delivery and client satisfaction, countries experiences with health service delivery especially with hospital care, and finally, data presentation and description of the study.

3.2 Gaps on health care

Globally, more advances in health science and technology have been made in the last 50 years than in the 500 years before the 20th century (World Health Organization,2002). Health infrastructure has been expanded and education, incomes and opportunities have improved. Public health interventions have raised life expectancy.

Unfortunately, these gains have by no means been universal. The health gaps within and between countries have widened, perhaps due to re-emerging health problems and unequal distribution of health care services (Van Schirnding, 2002). The gap has increased, with a third of the world population wallowing in absolute poverty (Taylor, 2002). In every year, we are loosing more than 1.551 million children to preventable diseases as a result of inequalities in health care services and development and problems are worst where resources are least available; those who are in need of more care have the least access (Kasseje 1996 quoted by Gwatkin et al,2002).

In the following sections the experiences of countries from Asia and Africa which had similar problems in health care services and which tried to reform their services are presented so as to compare and contrast the findings of the study with the situations in these countries. The countries are selected because the health care services they had was assumed to be similar to the one that our country has now at the moment, hence the reforms that these countries made could be taken as lessons for our country.

3.3 Studies in Bangladesh and Singapore

In William's study, throughout the world, there are many people who receive adequate hospital care, some receive excessive care. Throughout the world also are many more with out access to hospital care; such people are dragging diseased, sick and injured bodies and minds wearily through a life of frustration and bitterness. Besides this, a study in Bangladesh revealed that 40% vacancy rate for doctor posts in poor areas where people lacked access.

Singapore's ability to tackle organizational reform on two fronts was enabled by the high capacity of its public administration, as well as a political system that is relatively conducive to structural reform. The hospital reforms are interesting on their own. In Lim's & Tang's study, patients' expectations on hospital care in this country were listed as:

- Doctors, should thoroughly explain medical conditions to patents,
- Doctors /staffs should treat patients with dignity and respect,
- Doctors should posses a wide spectrum of knowledge, and
- Doctors/staffs should be friendly and courteous.

Further on this study out of the total 300 respondents, 30(11.9%) rated the quality of service is very good, 122(48.4%) rated good, 70 (31.0%) rated fair, 18(7.1%) rated poor and 4 (1.6%) rated the service quality very poor.

3.4 Study in Sri Lanka

In Sri Lanka study in Sri Lanka, a cross-sectional study was made on 445 mother -new born pairs from five hospitals in Pattalam district. The result showed as the proportion of mothers who were fully satisfied with hospital care varied from 10.8 % to 31.4 % for interpersonal aspects, and from 10.1% to 29.9 for technical aspect of care. The satisfaction rates were lower with physical environment (6.1-10%) and higher with outcome of care (41.0-48.0%).In general this study identified factors associated with client satisfaction on the following aspect. Hospital staff should ensure that these are addressed and develop interpersonal relationship especially with the first time mothers and in higher-level hospitals. The hospitals should be upgraded with essential facilities.

3.5 Health care in Africa

In Africa, more than 50% of the population do not have access to modern health facilities and 40% have no access to safe drinking water and sanitation (World Bank 2006). On the contrary, traditional faith and other informal sources of care are used more because they are more accessible, affordable and acceptable (Kaseje 2006).

On the other hand, most of sub-Saharan African (SSA) countries are constrained by resource scarcity, undermining the implementation of decentralization. In competing with other public service for scarce resources, the health sector is often ranked relatively low among national development priorities. The average expenditure in the health sector in SSA rarely exceeds 5 percent of the GDP with most Africa countries spending less than US\$10 per person on health care while the as least amount needed is US\$ 27 per person (*Ibid*)

In SSA especially low and middle income countries, public sector hospitals perform poorly. WHO's report reveals that insufficient staffing and lack of supplies may impede the efficient delivery of health care to patients in these countries. There is a general agreement that if hospital service is available to the public in these countries, it is often related to low quality. Many poor people by pass the closest public facility to go to more costly private facilities (World Development Report 2004).

Berman's (2000) study indicates that health care systems in most developing countries suffer from serious deficiencies in financing, efficiency, equity and quality and are poorly prepared to meet these challenges. In Margaret's (2000) study, patient satisfaction on hospital care in Mozambique showed that 55% satisfaction rate and failure to receive prescribed medication was found to be the most common complaint associated with lower satisfaction rate.

The World Health Organization (WHO), recommends a minimum ration of 100 nurses for every 100,000 people (1:1000), but many poor countries hardly come close: In the Central African Republic, Liberia, and Uganda, for example, the ratio is less than 10 nurses per 100,000 people, as compared to more than 2000 nurses per 100,000 people in Finland and

Norway. The annual exodus of 20,000 nurses and doctors from Africa is aggravating an already grave public health situation in the region mostly affected by AIDS and high maternal mortality. For example, in 1999 Ghana certified 320 new nursing graduates lost the same number to emigration. The following year, it lost twice as many. Meanwhile, more than half of Ghana's nursing positions are unfilled. This pattern prevails throughout much of sub-Saharan Africa. Africa as a continent gets only 1.3 percent of the world's health workers while it carries 25 percent of diseases (WHO, 2004). The shortage of skilled professionals in health care in Africa is caused by many factors such as inadequate production in some countries, inability to hire in other, brain drain, poor motivation, conflict of interest, corruption and misuse of resource including time in most countries. In many countries, an overwhelming majority of health workers are concentrated in a few urban areas. All categories, particularly doctors are nurses, are in short supply compared to the standards of population ratios for nurse and others.

Table 3.1 WHO report on health workforce

WHO region	Total health workforce	
	Number	Density (per 1000 population)
Africa	16400	2.3
Europe	16,630,000	18.9
America	21,740,000	24.8

Source: WHO report

3.6 How Zambia’s hospitals improved

Study conducted in Zambia in 1996 showed that deficiencies in Zambian health facilities, including long waiting time, high cost, favoritism, rude behavior, health worker misuse and pilferage of medicines or irregular availability of medicines (Foltz 1996). Further, this study also outlined health workers were not given continuing education to update their skills. After this study, the Zambian centerboard launched an accreditation program within the context of comprehensive health sector reform of the government. Accreditation was seen as a way to

address the problem(s) that could link funding to performance by defining and measuring acceptable hospital standards at the national level and by helping hospitals improve their performance in relation to the standard.

Rooney and Vanostenberg (1999) define hospital accreditation that applies to the Zambian program as follows:

Accreditation is a formal process by which a recognized body, usually a non-governmental organization (NGO), assesses and recognizes that a health care organization meets applicable pre-determined published standards. Accreditation standards are usually regarded as optimal & achievable, and are designed to encourage continuous improvement efforts within accredited organizations. An accreditation decision about a specific health care organizations is made following a periodic on site evaluation by a team of peer reviewers, typically conducted every two to three years, accreditation is often a voluntary process in which organization choose to participate, rather than one required by law and regulation.

When the program started, two studies were made. The first study report identifies ten milestones in building an accreditation program.

1. Conducting accreditation decision survey;
2. Developing the accreditation database format;
3. Refining rules, policies and procedures for accreditation;
4. Conducting educational campaigns and consultative survey;
5. Recognizing the need to improve quality and choosing accreditation as an approach to address the need;
6. Choosing the appropriate accreditation model to implement and making minor adaptations;
7. Setting up the formal structure to advise, operate, and manage the accreditation program;
8. Developing and testing the standards to be used and survey the process;

9. Recruiting , hiring and training surveyors;
10. Interpreting survey data and making accreditation decisions.

Furthermore, the first study report noted that several different accreditation models fall within their definition and that Zambia's program was an integrated model in which existing government assets were used to build a functional program for hospitals.

To know whether the performance of Zambia's hospitals improved after the accreditation program was launched, a number of studies were conducted using consultative survey (initially), accreditation survey (after a year of consultative survey). These studies revealed that twenty Zambian hospitals substantially improved their performance (patient care, etc.) in achieving accreditation standards in one -two years after joining a facilitative accreditation program. The improvements were consistent across the hospitals and across different functional areas although there was considerable variety. The study also showed that t hough all types of hospitals (district, mission, and general) started the accreditation program at about the same level of performance, general hospitals improved better than other types.

The patients' interviews indicated that patient satisfaction increased very slightly in the exposed hospitals between the consultative and first accreditation surveys: from 50.0% to 61.6%. The five district hospitals (49.6% to 59.3%) and six general hospitals (56.2% to 63.1%) improved in the patients' view, but the nine mission hospitals lost ground (65.0% to 61.9%). The difference in score of the three categories of hospitals and overall mean is significant at the $p < 0.05$ level.

With regard to variability, performance in patient care started high and went higher, the environment area started low and remained relatively low while interaction control area stated low but nearly doubled.

Staff interviews indicated that satisfaction was slightly higher for every indicator in the hospitals which started the accreditation compared to those that did not start (57% compared to 54%).

3.7 Ethiopia's Health Service Delivery

In Ethiopia in 1998 E.C. (2005/6 G.C.), there were 138 hospitals with a total bed of 13,922 at the ratio (1 bed to 5391 to the population). Out of these hospitals 86 of them were under control of the Ministry of Health, 7 under the control of regional government, 12 under non governmental institutions and 27 under private ownership.(Health and health indicator, 2005/6).Out of the total hospitals found in the country 22(29%) were in good condition, while 37(42%) needed a major repair. Roughly, more than 50 % of health facilities were in urban areas and over 30% of health facility needed either major repair or replacement.

3.2Health facility to the population

Health facility	Total in the country	Total in the Addis Ababa	Ratio in country	Ratio in Addis Ababa
Hospital	138	29	1:543964	1:102,517
Health center	1635	29	1:118216	1:102,517
Hospital bed	13922	2495	1:5392	1:119
doctors	2128	311	1:35493	1:1192
Nurse	17895	653	4207	4552
WHO minimum standard for 1:10,000,doctor;Nurse 1:5000				

Source: computed from Health and health indicator 2005/2006

A study in Jimma Hospital showed 57.5% level of satisfaction with outpatient health service. The most frequently problems affecting utilization which led to dissatisfaction were failure to obtain prescribed medications from the hospital pharmacy, long waiting time preceding consultation and difficulty to locate different sections easily (Gebreselilassie, 2001). A study in Godar town related to outpatient showed that 22.0% satisfaction rate. Similar study on satisfaction of patients in Amhara region showed that long waiting hours during registration, visiting doctor after registrations, laboratory procedure, re-visiting of the doctor for evaluation with laboratory result and obtaining drug from the hospital pharmacy were associated with dissatisfaction (Mitike et al, 2002) .

In general clients evaluated their satisfaction based on waiting time for registration, examination rooms; laboratory, drug and supplies of the pharmacy; behavior of health professionals, location of clients, and price charge for service. These factors are best measurement of hospital care and this paper will take these and examine the service delivery and customer satisfaction of Black Lion, Dagmawi Menelik and Bethzata hospitals

3.8 Data presentation and description

3.8.1 Brain drain

According to data form the Ministry of Heath, Ethiopia trained 3115 general practitioners between 1998 G.C. up to 2006 G.C., but in recent years, one third have already left the country seeking better employment opportunities in North American, Europe and South Africa. It is recently discovered that there are more Ethiopian doctors in Washington DC alone than in the whole of Ethiopia. Some of the causes of brain drain according to many practitioners are related to the working conditions, limited career and educational opportunity, low payment and economic instability among many others. (Groum, 2007)

3.8.2 Analysis of Questionnaires

There were 262 patient (in/out) selected in the study from Black Lion, Dagmawi Menelik, Bethzata hospitals, out of the total respondents, 173 (65%) were outpatients (86,5 &31 from Black Lion, Dagmawi Menelik, Bethzata hospitals respectively) and 89 (34%) were inpatient (55, 27 and 7 from Black Lion, Dagmawi Menelik, Bethzata hospitals respectively). The majority of the respondents, 145 (53%) were male, 76 (29%) were in age group 26-35 years, the mean age of clients was 30 years; 147 (56.1%) were single, 92 (35%) were married. Most of the respondents, 99 (35.9%) attended school up to grade 9-12, 17.9 (68.3%) paid for hospital service, 56 (21.4%) were private employees, and 178 (67.9%) came from Addis Ababa. Furthermore, out of the total respondents, 132 (50%) were new visitors and 235

(89.7%) came due to illness. When we see the income of the patients (respondents), out of three hospitals, the majority of respondents, 57 (41.1%) and 35 (44.9%) have monthly income less than 250 birr in Black Lion and Dagmawi Menelik hospital respectively, where as 11(26.2%) have monthly income more than 2000 birr in Bethzata hospital. Out of the total respondents, the majority, 93(35.9%), have monthly income less than 250 birr (table below show the socio-demographic feature of the respondents).

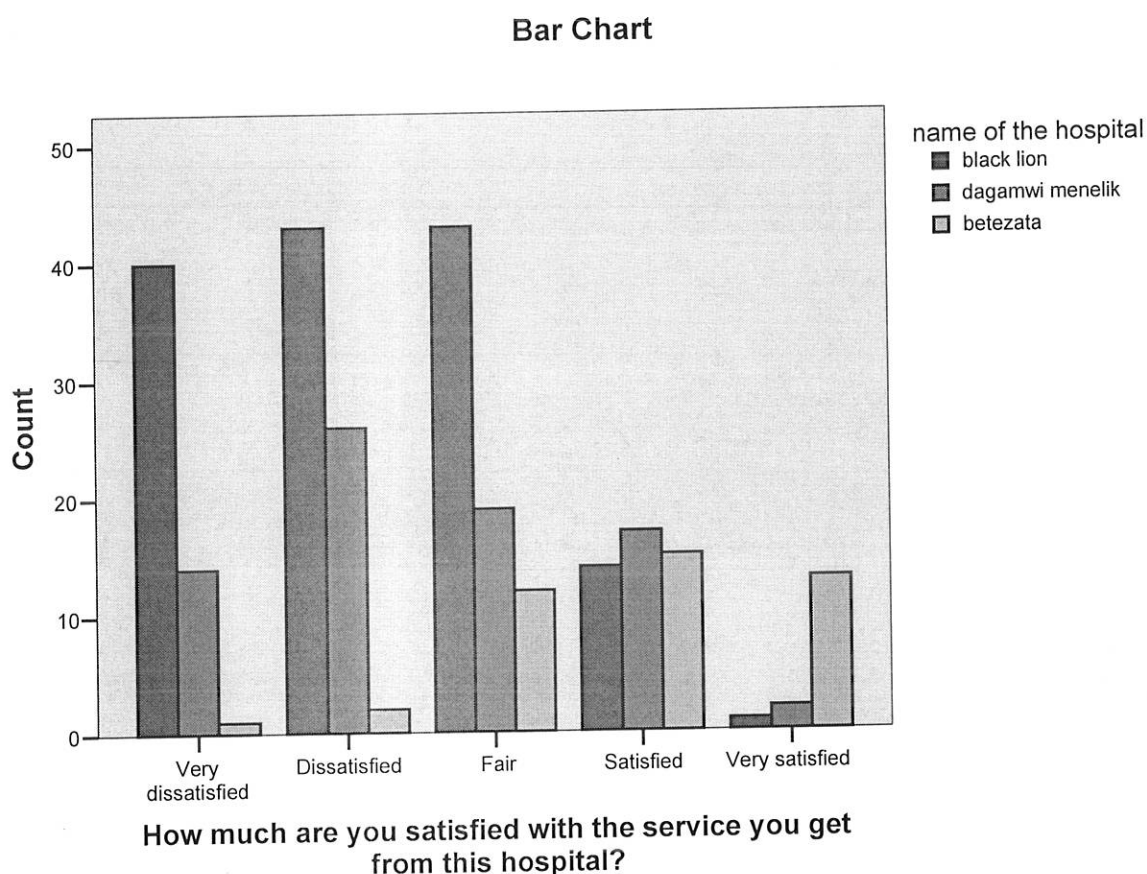
3.3 Table socio demographic characteristics of the respondents

		Name of the hospital						Total	
		Black Lion		Dagmawi Menelik		Bethzata			
patient	outpatient	86	61.0%	51	65.4%	36	83.7%	173	66.0%
	inpatient	55	39.0%	27	34.6%	7	16.3%	89	34.0%
sex	male	82	58.2%	42	53.8%	21	48.8%	145	55.3%
	female	59	41.8%	36	46.2%	22	51.2%	117	44.7%
Age	under18 years	7	5.0%	4	5.1%	2	4.7%	13	5.0%
	18-25	36	25.5%	13	16.7%	8	18.6%	57	21.8%
	26-35	35	24.8%	21	26.9%	20	46.5%	76	29.0%
	36-45	28	19.9%	21	26.9%	9	20.9%	58	22.1%
	46-55	17	12.1%	10	12.8%			27	10.3%
Marital status	56and above	18	12.8%	9	11.5%	4	9.3%	31	11.8%
	single	76	53.9%	40	51.3%	31	72.1%	147	56.1%
	married	59	41.8%	25	32.1%	8	18.6%	92	35.1%
	divorced	2	1.4%	5	6.4%	2	4.7%	9	3.4%
Educational status	widowed	4	2.8%	8	10.3%	2	4.7%	14	5.3%
	illiterates	15	10.6%	11	14.1%	3	7.0%	29	11.1%
	grade1-8	50	35.5%	18	23.1%	1	2.3%	69	26.3%
	grade9-12	47	33.3%	32	41.0%	15	34.9%	94	35.9%
	diploma	23	16.3%	14	17.9%	19	44.2%	56	21.4%
	degree and above	6	4.3%	3	3.8%	5	11.6%	14	5.3%
pay	paying	96	68.1%	41	52.6%	42	97.7%	179	68.3%
	free	40	28.4%	35	44.9%			75	28.6%
place	credit	5	3.5%	2	2.6%	1	2.3%	8	3.1%
	Addis Ababa	86	61.0%	57	73.1%	35	81.4%	178	67.9%
	other urban	32	22.7%	13	16.7%	7	16.3%	52	19.8%
Reason	rural	23	16.3%	8	10.3%	1	2.3%	32	12.2%
	illness	129	91.5%	74	94.9%	32	74.4%	235	89.7%
	accident	10	7.1%	3	3.8%	1	2.3%	14	5.3%
Frequency	other	2	1.4%	1	1.3%	10	23.3%	13	5.0%
	new visit	59	41.8%	45	57.7%	28	65.1%	132	50.4%
	repeat visit	82	58.2%	33	42.3%	15	34.9%	130	49.6%
income (monthly)	less than 250 birr	57	41.0%	35	44.9%	1	2.4%	93	35.9%
	250-500birr	46	33.1%	18	23.1%	6	14.3%	70	27.0%
	501-1000birr	22	15.8%	15	19.2%	9	21.4%	46	17.8%
	1001-1500birr	7	5.0%	5	6.4%	8	19.0%	20	7.7%
	1501-2000birr	5	3.6%	2	2.6%	7	16.7%	14	5.4%
	2000 and above	2	1.4%	3	3.8%	11	26.2%	16	6.2%

3.8.2.1 Customer Satisfaction

Customer satisfaction depends on the extent to which customer's expectations about the service are fulfilled. Customer expectations are not static but keep changing. This section addresses how customers are satisfied with the service provided by these hospitals.

3.1 Bar chart customer satisfaction with the service delivery of these hospitals



The details of the satisfaction of the service that the respondents got from these hospitals are presented for each hospital as follows.

Black Lion Hospital

Out of the total respondents, 40 (28.4%) and 43 (30.5%) respondents responded that they were very dissatisfied and dissatisfied respectively and while 43 (30.5%) responded that the service

was fair. On the contrary 14(9.9%) and 1(.7%) replied as satisfied and very satisfied respectively.

Dagmawi Menelik Hospital

Among the total respondents, 14 (17.9%) and 26 (33.3%) respondents replied that they were very dissatisfied and dissatisfied respectively while 19 (24.4%) responded that the services were fair. Only 17 (21.8%) and 2 (2.6%) replied that they were satisfied and very satisfied with the services respectively.

Bethzata Hospital

As shown in the above bar chart, 1 (2.3%) and 2(4.7 %) were very dissatisfied and dissatisfied with the services, while 12 (27.9%) replied the services were fair 15(34.9 %) and 13(30.2 %) were satisfied and very satisfied with the service they got from this hospital.

The respondents were asked to give their reason why they were (very) dissatisfied and they gave the following reasons as explanations for their dissatisfaction.

- They waited for long time to get health service.
- The system that used in these public hospitals is outdated and procedural. This problem is seriously seen in the card rooms- cards (files) are lost, damaged, and not easily found.
- There is no information desk in Dagmawi Menelik hospital and the patients do not know where they can go and take treatment.
- They were abused and neglected:
 - The staffs of these public hospitals isolate them in corridors and pass over them for many hours.
 - The staffs refuse to talk with them.
 - Employees are partial to their relatives and some of them are highly corrupted.
- They faced problem in emergency room and the unit (department) has great problem on reporting, planning and organizing to handle the emergency service. Moreover, these hospitals do not properly identify which patient needs treatment.

- The appointment day for them is too long and on the appointment day, they do not get service.
- Professional ethics is low in these public hospitals. Those who work in these public hospitals work in private hospitals with different courtesy or behavior compared to their conduct in public hospitals.
- Staff ethics (frontline worker to upper employees) in these public hospitals is not good
- Poor integration of functional units of these public hospitals lead to dissatisfaction

Therefore, in general, majority of client of these public hospitals were not satisfied with service whereas in Bethzata Hospital most of the respondents are satisfied with the service.

Table 3.4 Client satisfaction with access to and cleanliness of toilet and overall comfort of the compound of the hospitals

		name of the hospital						Total	
		Black Lion		Dagmawi Menelik		Bethzata			
		Count	Col %	Count	Col %	Cou nt	Col %	Count	Col %
How satisfied are you with access to toilet?	Very dissatisfied	61	43.3%	40	51.3%			101	38.5%
	Dissatisfied	53	37.6%	22	28.2%	2	4.7%	77	29.4%
	Fair	16	11.3%	10	12.8%	2	4.7%	28	10.7%
	Satisfied	9	6.4%	6	7.7%	17	39.5%	32	12.2%
	Very satisfied	2	1.4%			22	51.2%	24	9.2%
How satisfied are you with cleanliness of toilet?	Very dissatisfied	56	39.7%	34	43.6%	2	4.7%	92	35.1%
	Dissatisfied	37	26.2%	29	37.2%			66	25.2%
	Fair	29	20.6%	8	10.3%	5	11.6%	42	16.0%
	Satisfied	18	12.8%	6	7.7%	15	34.9%	39	14.9%
	Very satisfied	1	.7%	1	1.3%	21	48.8%	23	8.8%
How do you evaluate the overall cleanliness and comfort of the waiting area, examination room and compound?	Very dissatisfied	27	19.3%	12	15.4%	1	2.4%	40	15.4%
	Dissatisfied	37	26.4%	26	33.3%			63	24.2%
	Fair	55	39.3%	28	35.9%	6	14.3%	89	34.2%
	Satisfied	19	13.6%	9	11.5%	17	40.5%	45	17.3%
	Very satisfied	2	1.4%	3	3.8%	18	42.9%	23	8.8%

Table 3.4 shows the satisfaction of patient, particularly with access to toilet. Out of the respondents, 80.9% were not satisfied with accessing toilet in Black Lion hospitals where as in Dagmawi Menelik 79.5 % responded as not satisfied with access to toilet. On the other hand, 90.7% were satisfied with the toilet access in Bethzata Hospital.

As we can understand from the above table, among the sample respondents, 66.5% and 80.8% were not satisfied with the cleanliness of toilet in Black Lion and Dagmawi Menelik hospitals. On the other hand, 83.7% respondents replied to cleanness of toilet in Bethzata Hospital saying that they were satisfied.

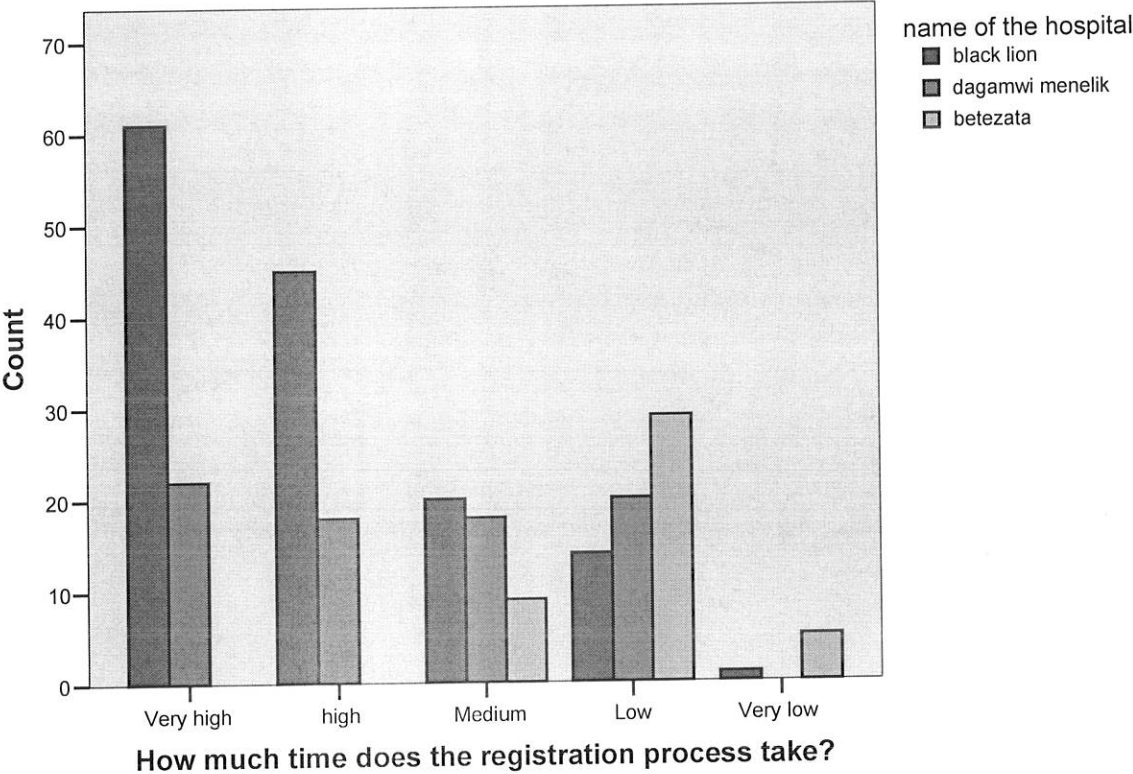
On overall cleanliness and comfort of the waiting area, 45.7% and more than half of respondents were not satisfied with over all cleanness and comfort of waiting room in Black Lion and Dagmawi Menelik hospitals. However, 83.4% were satisfied and very satisfied with over all cleanliness and comfort of Bethzata hospital.

3.8.2.2 Timeliness

Customers become most annoyed and frustrated when they are forced to wait for long period for service. If this happens, it is considered as sign of poor service. Based on this, the customers of these hospitals were asked and responded as follows.

3.2 Bar chart showing the time taken for registration

Bar Chart



As one can see from the above bar chart, 43.3% of the respondents responded that the time spent for registration process is very long in Black Lion Hospital; 25.6% and 67.4% replied very low in Dagmawi Menelik and Bethzata hospitals respectively. Therefore, from the above bar chart one can understand that respondents of Black Lion spent long time, but for Bethzata and Dagmawi Menelik hospitals, it is short.

Table 3.5: Timeliness

		name of the hospital						Total	
		Black Lion		Dagmawi Menelik		Bethzata		Count	Col %
		Count	Col %	Count	Col %	Count	Col %		
How long did you wait before seeing a doctor?	> 3hours	103	73.0%	48	61.5%	4	9.3%	155	59.2%
	1-2hours	32	22.7%	18	23.1%	16	37.2%	66	25.2%
	< 1hour	6	4.3%	12	15.4%	23	53.5%	41	15.6%
After seeing a doctor how long does it take you to attend by nurse/other staff for dressing, medication and other services?	> 3hours	104	73.8%	22	28.2%	6	14.0%	132	50.4%
	1-2hours	28	19.9%	19	24.4%	15	34.9%	62	23.7%
	< 1hour	9	6.4%	37	47.4%	22	51.2%	68	26.0%
Was a laboratory or X-ray &or ultrasound procedure prescribed for you?	Yes	130	92.2%	57	73.1%	36	83.7%	223	85.1%
	No	11	7.8%	21	26.9%	7	16.3%	39	14.9%
How long did you wait to get X ray service?	Not ordered	30	21.9%	27	35.5%	18	41.9%	75	29.3%
	> 3hours	89	65.0%	36	47.4%	6	14.0%	131	51.2%
	1-2hours	14	10.2%	8	10.5%	8	18.6%	30	11.7%
	< 1hour	4	2.9%	5	6.6%	11	25.6%	20	7.8%
How long did you wait to get lab service?	Not ordered	17	12.1%	24	31.6%	12	28.6%	53	20.5%
	> 3hours	101	71.6%	39	51.3%	9	21.4%	149	57.5%
	1-2hours	17	12.1%	7	9.2%	10	23.8%	34	13.1%
	< 1hour	6	4.3%	6	7.9%	11	26.2%	23	8.9%
How long did you wait to get ultrasound service?	Not ordered	49	44.5%	46	71.9%	21	51.2%	116	54.0%
	> 3hours	55	50.0%	14	21.9%	7	17.1%	76	35.3%
	1-2hours	3	2.7%	2	3.1%	8	19.5%	13	6.0%
	< 1hour	3	2.7%	2	3.1%	5	12.2%	10	4.7%
How long did you wait to see the doctor after receiving you result?	> 3hours	106	76.3%	33	42.9%	5	11.6%	144	55.6%
	1-2hours	20	14.4%	33	42.9%	13	30.2%	66	25.5%
	< 1hour	13	9.4%	11	14.3%	25	58.1%	49	18.9%

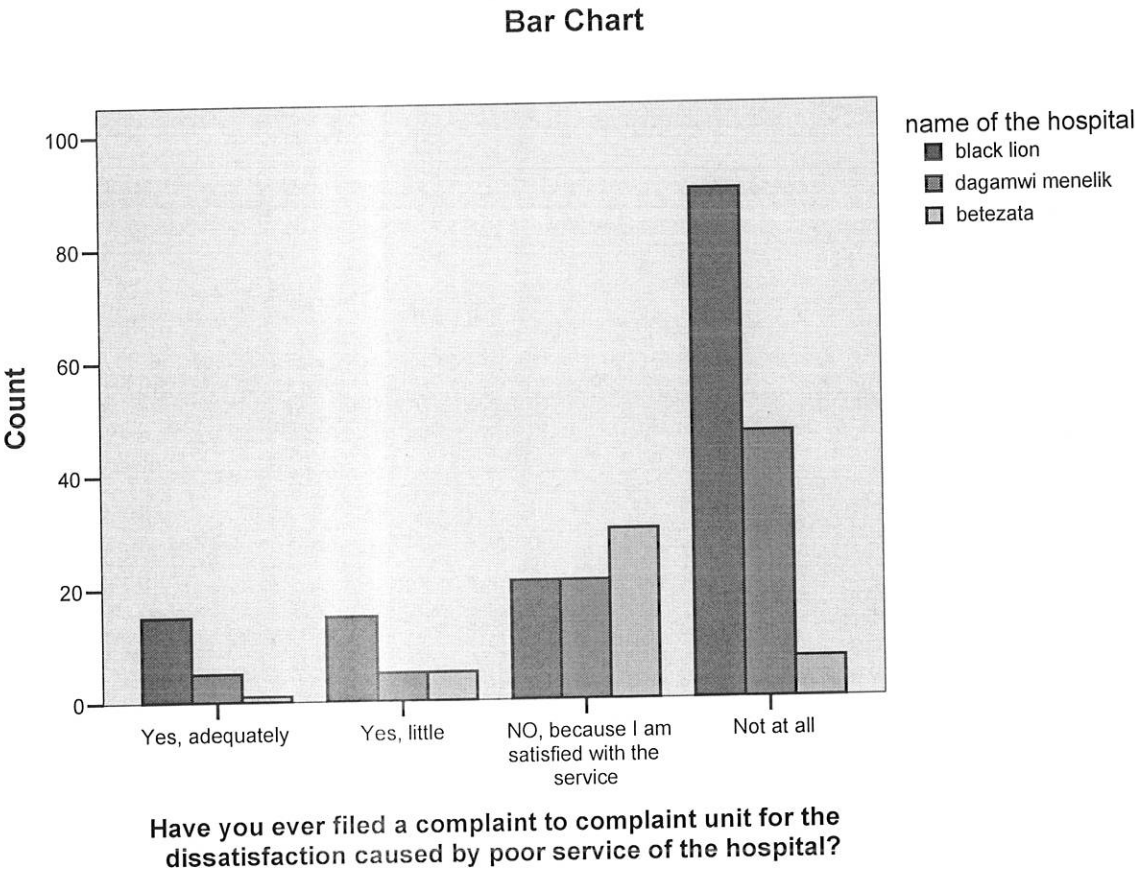
As shown in Table 3.4, the majority of respondents in Black Lion and Dagmawi Menelik hospitals replied that to be seen by the doctor, take other medication, waiting for lab, and x-ray and ultrasound service; and seeing a doctor after getting the result take more than 3hrs. Nevertheless, in Bethzata Hospital, most of respondents responded the waiting time to see the

doctor, taking other medication, waiting for lab and x-ray take less than one hour but waiting for ultrasound service takes one to two hours.

Therefore, we can conclude that the time take (waiting) to get health service in these public hospitals is higher than Bethzata Hospital.

3.8.2.3 Complaint handling

Bar chart 3.3: customer provision of complaint to the complaint-handling unit



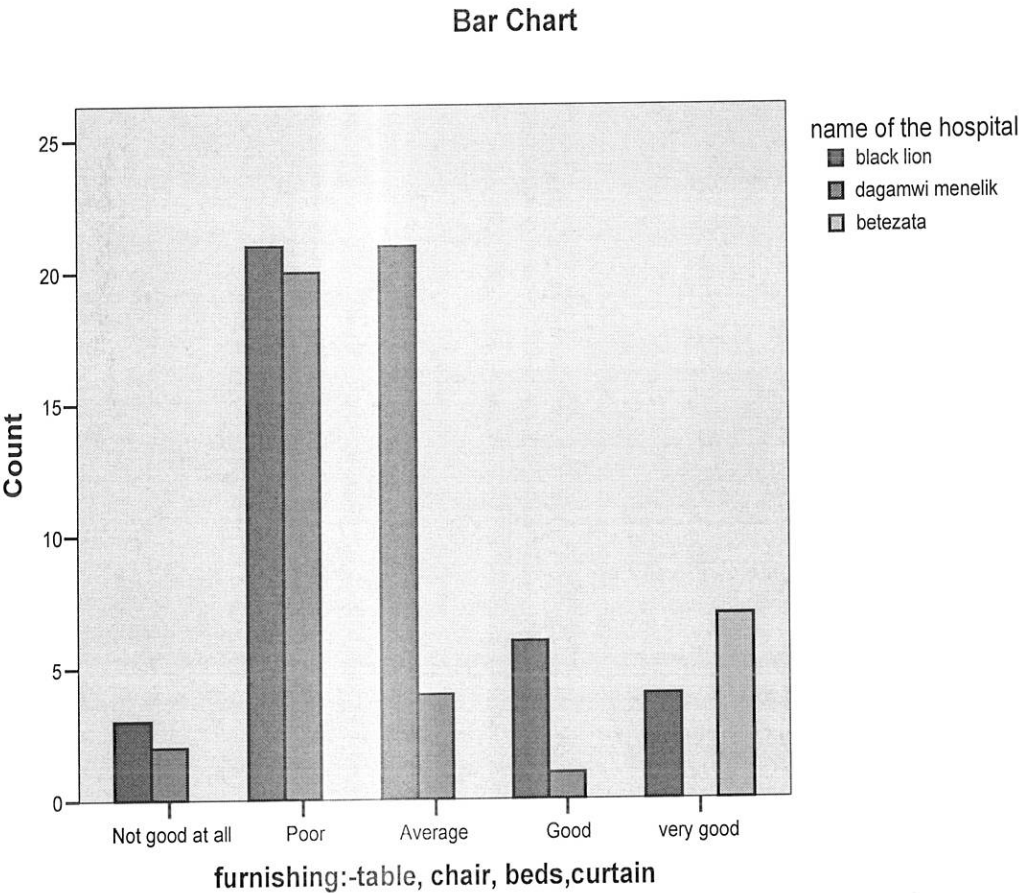
As shown in Bar chart 3.3, most of the respondents, 63.8% and 60.3% in Black Lion and Dagmawi Menelik hospitals did not file their complaint to the complaint unit. However, in Bethzata Hospital, 69.8% did provide their complaint to complaint unit because they were satisfied with the service of the hospital.

The respondents were asked to give their why they did not file complaints to the complaint units. Most of respondents in these public hospitals stated:

- they don't believe such unit can solve their problem
- they don't know whether such unit exist or not
- they observe (see) some individuals file complaints, but the service never changes, so they decided not to file complaint to the complaint unit.

3.8.2.4 Facility

Bar chart 3:4 Furnishing: table, chair, table, bed, curtain



As shown from the above bar chart, most of the respondent, 74.1% were replied in Dagmawi Menelik Hospital low (poor) in terms of furnishing and facility, while in Black Lion Hospital 38.2% replied the facility was average or poor. In Bethzata Hospital, on the contrary, 100% replied the facilities were very good.

Therefore, in both public hospitals, there is a problem of availability of furnishing- table, chair, beds, and curtain but the problem is more severe in Dagmawi Menelik Hospital.

Table 3.6 Size and comfort of the rooms

		name of the hospital						Total	
		Black Lion		Dagmawi Menelik		Bethzata			
		Count	Col %	Count	Col %	Count	Col %	Count	Col %
size of the room	Not good at all	1	1.8%					1	1.1%
	Poor	8	14.5%	2	7.4%	1	14.3%	11	12.4%
	Average	32	58.2%	13	48.1%			45	50.6%
	Good	8	14.5%	10	37.0%			18	20.2%
	very good	6	10.9%	2	7.4%	6	85.7%	14	15.7%
comfort of the room	Not good at all			3	11.1%			3	3.4%
	Poor	17	30.9%	13	48.1%			30	33.7%
	Average	20	36.4%	4	14.8%	1	14.3%	25	28.1%
	Good	11	20.0%	6	22.2%			17	19.1%
	very good	7	12.7%	1	3.7%	6	85.7%	14	15.7%

As it shown Table 3.5, the majority of the respondents 58.2%, and 48.1% evaluated the size of room as average in Black Lion and Dagmawi Menelik hospitals respectively, while in Bethzata Hospital 85.7% replied the size of rooms are very good.

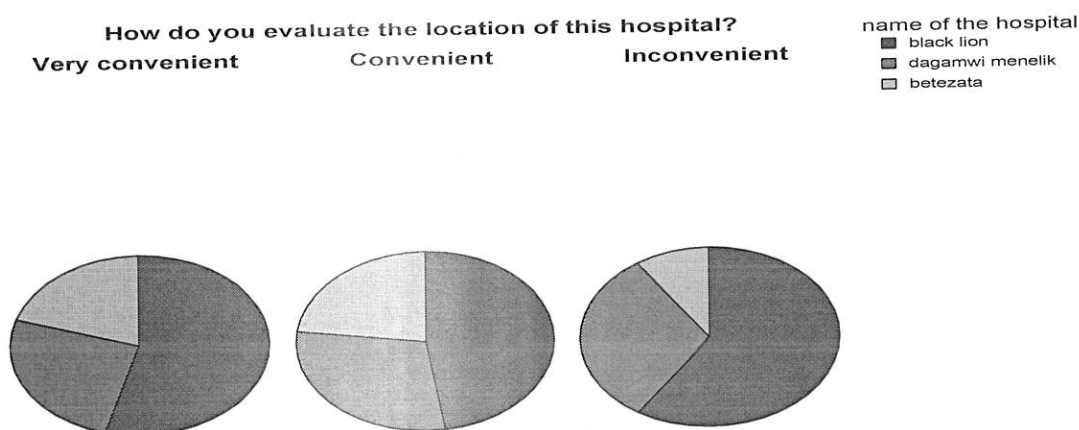
On the other hand, the inpatients evaluated the conformability of the rooms of these hospitals. Based on this, most of the respondents, 36.4% rated the conformability of the rooms average in Black Lion Hospital, but 48.1 rated in Dagmawi Menelik Hospital poor, while 85.7% in Bethzata hospital rated it very good.

Therefore, majority of respondents of Dagmawi Menelik Hospital responded that they do not see the room comfortable to them.

3.8.2.5 Location

The quality of service depends on the facility and location of the service area. Thus it is necessary to conduct an accurate assessment of geographical demand for service. This requires the selection both of some geographic unit work that partitions the area to be served and of some method for predicting demand for each of these partitions.

Pie chart 4.1 Location convenience



As it shown in the above par chart, the majority of the respondents, 49.6% and 47.4% from the Black Lion and Dagmawi Menelik hospitals respectively replied that the location of the hospitals were inconvenient, while most of respondents in Bethzata Hospital, that is 58.1% responded, the location was convenient but also a significant portion, 25.6% replied it was inconvenient.

Therefore, the location of these two public hospitals is somewhat inconvenient to the patients.

Table 3.7 Meal service from in the hospitals

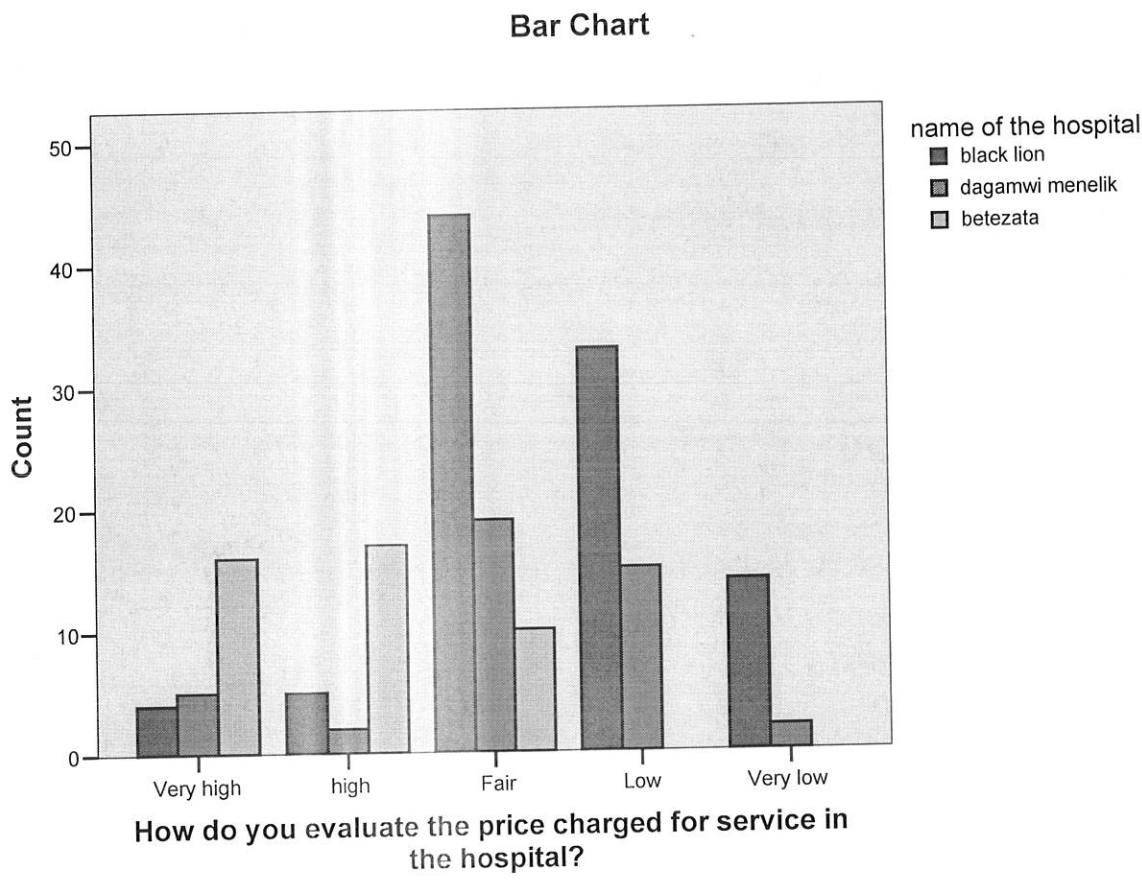
		Name of the hospital						Total	
		Black Lion		Dagmawi Menelik		Bethzata		Count	Col %
		Count	Col %	Count	Col %	Count	Col %		
Do you get meal service from this hospital?	Yes	55	100.0%	27	100.0%	7	100.0%	89	100.0%
	availability on time								
variety, choice	Not good at all			1	3.7%			1	1.1%
	Poor	5	9.1%					5	5.6%
	Average	7	12.7%			1	14.3%	8	9.0%
	Good	8	14.5%	12	44.4%			20	22.5%
	very good	35	63.6%	14	51.9%	6	85.7%	55	61.8%
	Not good at all	21	38.2%	10	37.0%			31	34.8%
	Poor	24	43.6%	16	59.3%			40	44.9%
	Average	6	10.9%	1	3.7%			7	7.9%
	Good					1	14.3%	1	1.1%
	very good	4	7.3%			6	85.7%	10	11.2%
quality of food	Not good at all	4	7.3%	3	11.1%			7	7.9%
	Poor	25	45.5%	20	74.1%			45	50.6%
	Average	15	27.3%	2	7.4%	1	14.3%	18	20.2%
	Good	11	20.0%	2	7.4%			13	14.6%
	very good					6	85.7%	6	6.7%
quantity of food	Not good at all			2	7.4%			2	2.2%
	Poor	11	20.0%	14	51.9%			25	28.1%
	Average	29	52.7%	2	7.4%	1	14.3%	32	36.0%
	Good	14	25.5%	4	14.8%	1	14.3%	19	21.3%
	very good	1	1.8%	5	18.5%	5	71.4%	11	12.4%

Table 3.7 shows that all inpatients get meal service from these hospitals. Besides, the majority of respondents responded that in all the hospitals, patient get meal service on time. On the other hand, respondents rated the variety, choice and quality of meal provide to them as not good in the public hospitals, but very good in Bethzata Hospital. As to the quantity of food 52.7% in Black Lion rated it average, 51.9% in Dagmawi Menelik rated it poor. In Bethzata hospital, however, 71.4% rated it very good.

Therefore, most of the respondents get meal on time, but the problem lies on the availability of choice, varieties of food in the pubic hospitals. However, in Bethzata Hospital, the majority of the customers were satisfied with the meal service.

3.8.2.6 Price

Bar chart 3:5 Evaluation of the price charge



At it is shown in the above bar chart, most of the respondents evaluated the price charged by these public hospitals as low and medium, but for Bethzata hospital as high, very high. No respondent from Bethzata Hospital rated the price charge by the hospital low and very low. Therefore, we conclude that the price charged by these public hospitals is low, but for Bethzata (private) Hospital it is high.

3.8.3 Focus Group Discussion

How do you see the availability of drugs, drug supplies, and the conditions in these hospital pharmacies?

Black Lion and Dagmawi Menelik hospitals

All participants said they got the prescribed drug in the time they were responding to the questionnaires. Out of the total participants, two of them reported that before 2 or 3 months, they weren't able to get the prescribed drugs- the staffs or employees of the pharmacy told them that there was no medicine. They said, "We are able to get drug because as you know this day (June 4) is the end of the budget year. Since there is a problem in purchasing in these hospitals we are able to get the drug now but what if before 3 months? We might not be able to get what we wanted." Another female participant expressed her feelings: "Before 2 weeks, a doctor prescribed a drug for me and I went to the pharmacy, paid money and took the medicine. I started to take the medicine but in the process, I just became sick and suffered and I stopped taking the medicine and went to the doctor. When I saw him, he told me that is was not what he ordered for me. And I went to the pharmacist and asked them why they did that to me. They said they were sorry. I was surprised and just thanked my God for saving my life." On the other hand, all participants expressed these hospitals should avail necessary (essential) drugs and supplies in their pharmacies and avoid dead stock medicine in their stores.

Therefore, from the above discussion, we can understand there is a lack of drug and supplies with in the date of prescription, and shortage of essential (necessary) drugs. Moreover low responsiveness, accountability of the staffs, especially pharmacists, was observed.

Bethzata Hospital

All participants reported that the availability of drug and supplies in the hospital is good. The problem is on the price charged by the hospital for service: it was rated somewhat higher than in other places.

How did you see the time spent for physical examination and privacy in these hospitals?

Black Lion and Dagmawi Menelik hospitals

All participants expressed their feelings about the physical examination. They said that it was not good at present time compared to the previous time. One of the participants in Dagmawi Menelik Hospital expressed his view in the following manner: "This hospital might have a tendency to close up in the future as the number of doctors is ever reducing. Though the number of doctors is declining in these hospitals, the number of patients is increasing from time to time. Moreover, these hospitals' capacity cannot match with the number of patients and the time that is spent to get medical care in these hospitals is also long". Almost all participants said there was no privacy in examination rooms in these hospitals. Even one can see a number of trainees (nurse) from different colleges frequently opening the door when a patient is being examined.

Therefore, from the above discussion, the time taken to get medical care increases as the number of patients increase while the capacity of the hospital is low, a number of doctors are leaving and there is low privacy in these hospitals.

Bethzata Hospital

All participants reported that there was adequate number of doctors and privacy in the hospital.

How did you see the behavior of the staff of the hospital?

Black Lion and Dagmawi Menelik hospitals

All participants expressed the courtesy of doctors was good but that of nurses, guards and others was not good in Black Lion Hospital. Two of the participants reported that the behavior of nurses was not good especially in the outpatient department: they insulted, ignored and

shouted at them and these workers were unethical, as they tend to be partial to their relatives or connections. There was a deviation between what was expected from frontline employees and the problem occurred because the personnel could not do their job since they were not properly skilled to handle the work. Furthermore, the frontline workers or their supervisors in these hospitals were not qualified to do the job, for example, they did not know how to deliver the service to their clients. Sometimes they even insulted them.

Bethzata Hospital

All participants explained that all employees are good. According to participants, the employees have a sense of accountability, responsibility, authority in all aspects. One participant explained, "I think the hospital has established good organizational culture which is exemplary to others."

Therefore, from the above discussion, we can understand that most of the participants in public hospitals were not satisfied with behavior of employees (nurses and other frontline employees), but in Bethzata Hospital, all participants were satisfied with all the employees' behavior.

3.8.4 Result of Interview

For further information and to get data from the service providers themselves, data was collected through interview.

3.8.4.1 Result of Structure Interview

A total of 11 doctors were interviewed in order to know their satisfaction on their job. Out of the total respondents (doctors), five were from Bethzata and seven from Black Lion and Dagmawi Menelik hospitals. By chance, most of the respondents were male. The salary of the respondents (doctors) in Bethzata Hospital was more than 2500 birr while in both Black Lion and Dagmawi Menelik hospitals, 5 of them said their salaries lie between 1001-1500 birr and 2 of them got a monthly salary between 1501 -2000 birr.

All doctors taken as sample from Bethzata hospital have an experience of working in a government hospital and when asked why they had left the government hospital, they stated the following reasons:

- Low salary (underpaid)
- Poor working conditions
- Poor and unjust handling of medical personnel by the Ministry of Health
- Poor motivation and incentive
- No resource
- Highly procedural (bureaucracy)

In addition, all doctors in these hospitals were also asked about the level of pay compared to the market and the satisfaction on their salary. Out of the total doctors in Bethzata Hospital, 3 of them replied that the level of pay was below the market, 2 of them replied that the pay was equal to the market and 3 of them said that they were satisfied with the salary they got from the hospital, 2 replied the salary was fair. On the other hand, 7 (100%) of the doctors in Black Lion and Dagmawi Menelik hospitals stated that the level of pay was below the market and they were no satisfied at all with their salary and some of them planned to leave the organizations if the salary does not change in the future. Doctors were also asked in Black Lion and Dagmawi Menelik hospitals whether they worked previously in other private hospitals. No one from the sample survey worked in a private hospital.

Finally, doctors were asked to give what improvement is needed in these hospitals. They sated the following.

Black Lion and Dagmawi Menelik hospitals

- salary scale
- benefit plan
- working condition
- adequate resource
- leadership

Bethzata hospital

- benefit plan (, transpiration)
- further education
- job security
- salary scale

3.8.4.2 Result of in-Depth Interview

The topic of this interview was about the use of information technology, facilities in providing the service. The researcher interviewed the medical (general manager) of these hospitals as follows:

Researcher: Do you think the system used in this hospitals is cable of providing fast service to service users?(Black Lion and Dagmawi Menelik hospitals)

Interviewee: “I can say fair. Even though we use manual system at this time, there are some departments at present which use computerized systems. We have planned in the future to establish an information system in all departments. We believe that the Ministry of Health has a plan to implement health management information system (MIS) in the future.

Researcher: Do you think the service that you provide to your customer is supported by adequate information technology?

Interviewee (Black Lion and Dagmawi Menelik hospitals): They did not think that these hospitals used adequate information technology. First, they did not have health management information at this time, and there are no adequate computers, which makes the level of information technology low.

Interviewee (Bethzata): “Yes, a little, because first we use computers at the present time to record the patient’s name, and address on the first entry. If the patient loses his/her ID, based on the addressee we entered, we can find his/her file. We did not implement management information system so far; we mainly use the manual system. Thus, I would say the level or adequacy of information technology is fair. We have a plan to use management information system in the future, though.”

Researcher: Do you have a plan in the future to improve the service of your hospital with skilled manpower and computers (information technology, i.e. database management system)?

Interviewee (Bethzata): “Yes, as I said to you before, we have planned to implement management information system as a strategy in the future and also we plan to train our employees.”

Interviewee (Black Lion and Dagmawi Menelik hospitals): They did(do)not know whether they can fulfill the skilled manpower, but they know that the Ministry of Health planned in the future to implement health information technology.

Researcher: Would you tell me what you have in your mind about your employees’ skill in information technology in the future?

Interviewee(Bethzata) “In the future, our employees should know how to run computer program (MIS),which help our company to make single corporate database trucks in the operation outlets and produce report that allow corporate management personnel to spot and resolve problem quickly.”

Researcher: Do you think this hospital had developed in modernized equipment to provide service to its customers?

Interviewee (Bethzata): “Yes, we are buying computers and other facilities in order to cope up with information technology.”

Interviewee (Black Lion and Dagmawi Menelik hospital): They did not think that these hospitals have adequate information technology because computers are found in some departments only, and that makes information technology low.

3.8.5 Conclusion

In many countries, an overwhelming majority of professionals are concentrated in a few urban areas. All categories, particularly doctor and nurses, are in short supply compared to the standard minimum standard by world health organization. The human recourse crises is caused by many factors such as inadequate production in some countries, inability to hire in

other, brain drain, poor motivation, conflict of interest still in other countries. Moreover, the gap is growing wider and wider between nations.

The majority of the clients found in the public hospitals in this study were dissatisfied because of lack of interest of the service providers, lack of essential drugs, low capacity and overcrowded waiting area, low privacy in conducting physical examinations and, little or no access to toilet and cleanliness of toilet, quality meal service, staff ethics, shortage of doctor, long wait to get health service, low facilities and low usage of information technology. However, in Bethzata Hospital, the patients dissatisfied with the price charged for the service, drug from hospital, but in all other cases, they were satisfied.

When we see employees (doctors) in these public hospitals, they were not satisfied because of low salary (underpaid), poor working condition, poor and unjust handling of medical personnel by the Ministry of Health, poor motivation, little or resources and highly procedural (bureaucracy) and the low salary, by these public hospitals and the little or no usage of modern systems.

CHAPTER FOUR

DISCUSSION

4.1 Introduction

In this chapter, the researcher outlines the gap of human resources and facility: tests the variable with the selected socio-demography with chi square and P value and also assesses the behavior of doctors and nurses toward to their clients by using mean and standard deviation.

4.1. General information

The researcher used in and outpatients in this study. The following table provides information on the patients in the sample hospitals.

Table 4.1. General information in Black Lion Hospital

Year	outpatient		Total outpatient	Inpatient	Total Patient
	Non referral	referral			
1998EC(2005/06GC)	115,490	61290	176,780	8963	185,743
1997EC(2004/05GC)	118,772	68670	187,442	12374	199,816
1996EC(2005/04GC)	104,125	55869	159,994	12032	172,026

Source: Statistical data from the hospital

Table 4.2 General information about the number of patient in Dagmawi Menelik and Bethzata Hospitals

Name of the hospital	Year	Total outpatient	Total inpatient	Total patent
Dagmawi Menelik	June 2006-may 2007	36264	5864	42,128
Bethzata	2006(1997/98)	26793	2054	28847

Source: Statistical data from the hospital

4.2 Distribution of human resources and facilities in these hospitals

Table 4.3 Distribution Doctors and Beds in the hospitals

Name of hospital	Beds		Doctors	
	No	Total inpatient	No	Total patient
Black Lion	560	8963	28	185,743
Dagmawi Menelik	260	5864	19	42,128
Bethzata	50	2054	43	28847

As shown in the above tables, there are high resource disparities among these hospitals. In Black Lion hospital, the doctor to patient ratio is 1:6647, where as in Bethzata 1:671; but the number of beds in Black Lion and Dagmawi Menelik hospitals is good compared to Bethzata hospital.

In these hospitals, inequalities in health care can also be observed in terms of diffusion of medical and health technologies. For instance, in the case of CT scanner, only Bethzata hospital has the scanners while there is no single such machine in the public hospitals. Therefore, we can understand from the above table that there are inequalities in resource distribution in these hospitals.

Table 4.4 Human resources in Black Lion Hospital.

Employees	need (desire)	Working at present	Gap (not fulfill)
Specialists	24	14	10(41.6%)
General practitioners	19	14	5(26.3%)
Nurses (all type)	418	400	18(3.75%)
Lab technicians	51	51	0(0%)
Radiographers	23	23	0(0%)
Pharmacists	9	9	0(0%)
Other par- medical	18	18	0(0%)
Supportive staff	<u>698</u>	<u>698</u>	<u>0(0%)</u>
Total	1260	1227	33(2.6%)

As one can see from the table, the number of specialist doctors fails to account for half of the total numbers of doctors. The total physicians that are working at present is 28, but the need is 43. Furthermore, shortage of nurses can also be seen from the above table: 18 (3.75%) in the hospital.

Therefore, there is high shortage of professionals in the hospital, but for other employees (Para-medicals and supportive staff) the figure is better.

Table 4.5 Human resources in Dagmawi Menelik Hospital

Employees	need (desire)	Work at present	Gap (not fulfill)
Specialists	23	14	9(39.2%)
General practitioners	36	5	31(86.1%)
Nurse (all type)	148	148	0(0%)
Lab technical	16	16	0(0%)
radiographer	9	6	3(33.3%)
Pharmacists	2	2	0(0%)
Other par- medical	31	31	0(0%)
Supportive staff	<u>275</u>	<u>183</u>	<u>92(33.4%)</u>
Total	540	405	43(8%)

As one can see from table 4.5, there is a great problem in human resources in the hospital, i.e. 86.1 % of the needed general practitioners (doctors) were not fulfilled or only 13.9% of general practitioners (doctors) are working at present time. This problem is also serious with regard to radiographers 33.3% shortage. Supportive staff (33.4%) were also not in a position to fulfill the manpower needs.

Therefore, shortage of professionals especially general practitioners is very critical in the hospital. There is also shortage of radiographers and supportive staff in the hospital.

Table 4.6 Human resources in Bethzata Hospital

Employees	Need (desire)	Work at present	Gap (not fulfill)
Specialist	31	31	0%
General Practitioners	12	12	0%
Nurse (all types)	53	53	0%
radiographer	5	5	0%
Pharmacists	1	1	0%
Other par-medical	-	-	0%
Supportive staff	114	114	0%

From the above table, this hospital (Bethzata) did not face human power shortages in all aspects. The researcher observed and found out that these hospitals with chronic shortage of manpower overcome the problem by hiring employees at part time basis for those positions not filled at full time basis and also by providing high incentives and good working conditions.

4.3 Employees effect on perceived quality

Personnel are important elements of customer perception of functional quality. The interaction between buyer and sellers is crucial in management of service quality. Those employees who directly perform a service have the best advantage point for observing it and are the most able to identify any impediment to its quality (Anadrain, 1995:160). Based on these, customers were made to evaluate doctors and nurses with regard to their attitude towards them (patients), competence, access, communication, security, courtesy and responsiveness. And the researcher evaluated the responses based on the mean, that is if the mean is below 3.00, the customers were not satisfied; if the mean is 3.00, the customers were neutral; and if it is between 3.01-5.00 customers were satisfied.

Table 4.7 Employees' attitude to their clients

Name of the hospital		Understanding of their customer--doctor	Understanding of their customer--nurse	Competence-doctor(s)	Competence-nurse(s)	Access-doctor(s)	Access-nurse(s)
Black Lion	Mean	2.97	2.89	3.31	2.87	2.28	3.04
	N	141	141	141	141	141	141
	Std. Deviation	1.114	1.080	1.116	1.068	1.215	1.149
Dagmawi Menelik	Mean	3.04	3.00	3.32	3.01	2.46	3.04
	N	78	78	77	78	78	78
	Std. Deviation	1.012	1.105	1.044	1.026	1.136	1.200
Bethzata	Mean	4.00	4.05	4.14	4.02	4.02	4.09
	N	43	43	43	42	43	43
	Std. Deviation	.816	.754	.915	.869	.963	.868

name of the hospital		Communication - doctor(s)	Communication--nurse(s)	Security - doctor(s)	Security-nurse(s)	Courtesy-doctor(s)	Courtesy-nurse(s)	Responsiveness-doctor(s)
Black Lion	Mean	2.98	2.88	3.24	3.11	3.15	3.06	2.94
	N	141	141	139	140	141	141	141
	Std. Deviation	1.065	1.059	1.250	1.194	1.276	1.297	1.191
Dagmawi Menelik	Mean	3.04	3.05	3.15	3.09	2.87	2.95	2.92
	N	78	78	78	78	78	78	78
	Std. Deviation	1.098	1.068	1.033	1.009	1.073	1.115	1.137
Bethzata	Mean	4.00	4.09	4.14	4.07	4.21	4.14	3.81
	N	43	43	43	43	43	43	43
	Std. Deviation	1.024	.921	.889	1.009	.888	.915	1.160

As one can see from the above tables, the patients in Black Lion Hospital were not satisfied with the attitude doctors and nurses towards them, with competence of nurses, with access to doctors, communication for both doctors and nurses; and with responsiveness of doctors (mean<3.00); where as in Dagmawi Menelik Hospital , the patients were not satisfied with access to doctors, courtesy of doctors and nurses; and responsiveness of doctors. However, in Bethzata Hospital the patients were satisfied with all the different aspects of the services.

4.5 Variable test

To test the variable, the researcher categorized them as satisfied (very satisfied +satisfied) vs. dissatisfied (very dissatisfied+ dissatisfied); dissatisfied (not good at all+ bad) vs. satisfied (excellent +v. good)

Comparison of socio-demographic variables with overall levels of satisfaction

Both outpatients and inpatients were found directly associated with overall health service, which is statistically significant ($p=0.44$). Being a patient of Black Lion and Dagmawi Menelik hospital were directly related with dissatisfaction, but for Bethzata Hospital it was directly related to satisfaction($p=0.00$).

Moreover, males were not satisfied compared to females but statistically insignificant. Similarly, educational status and occupation were not directly associated with overall satisfaction of clients ($p>0.05$). Statically significant difference was also observed for those who were paying for hospital service, more dissatisfied compared to those who got hospital service free or on credit basis ($p=0.02$). There was direct relation between place of residence and overall client satisfaction -those who were coming from Addis were more dissatisfied than others who came from other urban and rural areas($p=0.04$).

Finally, those patients whose monthly income was less than 250 birr were more dissatisfied, but those patients whose monthly income was 1000 birr were more satisfied($P=0.00$).(The table below shows comparisons of overall levels of satisfaction with selected socio-demographic variables).

Table 4.8 Comparison of overall levels of satisfaction with selected socio demographic variables.

characteristics		dissatisfied	satisfied	Total	χ^2	p-value
patient	Outpatient	84	38	122	4.062	.044
	inpatient	52	10	62		
name of the hospital	Black Lion	89	9	98	106.155	.000*
	Dagmawi Menelik	47	8	55		
	Bethzata	0	31	31		
sex	Male	73	23	96	.269	.604
	Female	63	25	88		
age	<18 years	7	2	9	9.464	.092
	18-25	34	8	42		
	26-35	35	21	56		
	36-45	28	8	36		
	46-55	16	1	17		
	56and above	16	8	24		
educational status	illiterate	16	3	19	5.381	.250
	grade1-8	41	9	50		
	grade9-12	43	17	60		
	diploma	30	17	47		
	degree &above	6	2	8		
pay	paying	86	43	129	12.097	.002*
	free	43	5	48		
	credit	7	0	7		
place	Addis Ababa	87	39	126	6.251	.044*
	other urban	32	8	40		
	rural	17	1	18		
income (monthly)	< 250 birr	57	8	65	28.607	.000*
	250-500birr	35	11	46		
	501-1000birr	25	8	33		
	1001-1500birr	9	5	14		
	1501-2000birr	6	6	12		
	>2000	2	9	11		

NB=* statistically significant

Patient satisfaction with availability of drug and supplies with the selected socio-demographic variable

Patients (in/out) were not directly associated with satisfaction of availability of drug and supply in these hospitals. Clients in Black Lion and Dagmawi Menelik hospitals were directly associated with dissatisfaction of availability of drug and supplies, but more satisfied in Bethzata Hospital ($p=0.00$). Furthermore, males between 26-35 years of age were dissatisfied compared to females and males of other age groups, however the finding is statically insignificant ($p>0.05$ i.e. sex $p=0.74$, for age $p=0.35$). It was also observed that education, pay, place were not directly associated with client satisfaction (not statistically significant ($p>0.05$)). Dissatisfaction was significantly associated with frequency of visit of patients to these hospitals -those patients who visited frequently were dissatisfied compared to new visitors ($p=0.035$). As to the income variable, patients whose monthly income was less than 250 birr were dissatisfied, while those patients who come for other reason than illness and those patients whose monthly income was more than 2000 birr were satisfied with the availability of drugs ($p=0.038$). The table below (Table 4.10) shows comparisons of client satisfaction on the availability of drug and supplies with selected socio demographic variables.

Table 4.9 Comparison of client satisfaction on the availability of drug and or supply with selected socio demographic variables

characteristics		dissatisfied	satisfied	Total	χ^2	
patient	outpatient	58	36	94	.536	.464
	inpatient	38	17	55		
name of the hospital	Black Lion	59	15	74	44.309	.000*
	Dagmawi Menelik	36	16	52		
	Bethzata	1	22	23		
sex	Male	53	27	80	.108	.743
	Female	43	26	69		
age	>18 years	5	2	7	5.592	.348
	18-25	19	10	29		
	26-35	24	14	38		
	36-45	23	13	36		
	46-55	15	3	18		
	56and above	10	11	21		
educational status	illiterate	11	9	20	7.687	.104
	grade1-8	30	6	36		
	grade9-12	30	22	52		
	diploma	21	13	34		
	degree and above	4	3	7		
pay	paying	60	36	96	1.866	.393
	free	33	17	50		
	credit	3	0	3		
place	Addis Ababa	62	42	104	6.251	.168
	other urban	23	8	31		
	rural	11	3	14		
income (monthly)	< 250 birr	38	16	54	11.804	.038*
	250-500birr	23	11	34		
	501-1000birr	22	7	29		
	1001-1500birr	6	6	12		
	1501-2000birr	3	4	7		
	>2000 birr	3	8	11		
frequency	new visit	34	29	63	4.451	.035*
	repeated visit	62	24	86		

NB=* statistically significant

Patient satisfactions with information provision by the staff of these hospitals with selected socio-demographic variables

As it is shown in Table 4.10 males were more dissatisfied compared to females, but it was statistically insignificant ($p=0.291$). Furthermore, patients' (in /out), age, educational status and place of residence were not significantly associated with client satisfaction, i.e. patients' age ($P=0.949$), educational status ($p=0.149$), place ($p=0.533$). On the other hand, those who paid for hospital service were more dissatisfied than those who got the services free or on credit basis. There is direct relationship between the type of hospital and provision of complete information of the hospital ($p=0.006$). Finally, dissatisfaction was significantly associated with monthly income and reason for patient to come to the hospital - those patients who came to the hospitals due to illness and those patients whose monthly income was less than 250 birr were dissatisfied while those patients who came for other reasons than illness and those patients whose monthly income was more than 2000 birr were satisfied ($p=0.026$ for income; reason $p=0.00$).

Table 4.10 Comparison of client satisfaction with the provision of complete information with selected socio-demographic variables

characteristics		dissatisfied	satisfied	Total	X ²	p-value
patient	Outpatient	70	47	117	.005	.946
	inpatient	40	25	65		
name of the hospital	Black Lion	70	26	96	44.588	.000
	Dagmawi Menelik	37	16	53		
	Bethzata	3	30	33		
sex	Male	62	34	96	1.115	.291
	Female	48	38	86		
age	>18 years	6	2	8	6.624	.250
	18-25	24	14	38		
	26-35	27	29	56		
	36-45	27	13	40		
	46-55	12	4	16		
	56and above	14	10	24		
educational status	illiterate	14	5	19	6.819	.146
	grade1-8	31	16	47		
	grade9-12	42	26	68		
	diploma	17	22	39		
	>degree	6	3	9		
pay	paying	68	59	127	10.233	.006
	free	35	13	48		
	credit	7	0	7		
place	Addis Ababa	68	49	117	.914	.633
	other urban	27	16	43		
	rural	15	7	22		
income (monthly)	< 250 birr	44	17	61	12.703	.026
	250-500birr	30	18	48		
	501-1000birr	19	13	32		
	1001-1500birr	8	7	15		
	1501-2000birr	6	6	12		
	>2000 birr	2	9	11		
reason	illness	105	55	160	18.176	.000
	accident	5	8	13		
	other	0	9	9		

NB=* statistically significant

4.6 Conclusion

In general, inequalities of health care (inequality in medical technology, inequalities in resource distribution) were observed in these hospitals. Further, there is high shortage of professional doctors in these public hospitals. Staffs (doctors and nurses) were not ethical in these public hospitals compared to Bethzata Hospital. Finally, based on the variable test with the selected socio-demographic factors, name of the hospital, income were directly associated with satisfaction of hospital care of these hospitals ($P < 0.05$).

CHAPTER FIVE: SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter has three sub sections and explains the summary of the findings, conclusions and recommendations respectively.

5.2 Summary of the findings

This study was conducted in Black Lion and Dagmawi Menelik and Bethzata hospitals. The major objective of the study was to identify the problems and to measure the level of patient satisfaction with hospital care. The specific objectives were to assess the availability of facilitating environment including drugs, skilled manpower and other facilities, to know the attitude of employees towards their clients/job and to assess the cost of service charged by these hospitals.

To gather pertinent information regarding service delivery and customer satisfaction, the researcher used both probability and non- probability sampling. Primary data were collected from 262 sample customers through questionnaires; moreover, the researcher used interview, focus group discussion and observation. Secondary data were also used to back up the results of the study.

Since similar researches were not conducted before in these hospitals, this study is believed to be very significant in that it paves a way to undertake further research in this area. Even though the researcher believes that the research is significant, it does not mean it is fully free from error and the paper has its own limitations as - the researcher proposed 280 sample customers but only 262 customers filled the questionnaire. Moreover, there is shortage of time. As a result, the accuracy of the data may decrease due to such limitations.

The researcher assessed service delivery and customer satisfaction in the hospitals in relation to location (accessibility), employee approach and satisfaction on their job,

information technology and price charge, waiting time, facility, adequacy of human resources, which are the best measure of customer satisfaction. The major findings on this study are:

- There is high shortage of professionals especially, specialist and general practitioners in the two public hospitals. In Dagmawi Menelik Hospital 86.1% of the post for general practitioners was not filled. Moreover, 39.2% of the posts for specialists, 33.3% for radiographers, 34.4% for supportive staff were not able to fulfilled. Besides, in Black Lion Hospital nearly half of the specialists and 26.3% of the physicians were not able to be fulfilled. However, no human shortage was found in Bethzata Hospital. In general, problem in human resources was found in these public hospitals.
- Inequality of health care was observed among hospitals
 - ✓ **Inequality of medical technology**

In Bethzata Hospital, modern technologies are available like CT scan, others, but these public hospitals were not able to obtain CT scan and other technologies.
 - ✓ **Inequalities in resource allocation**

The proportions of resources tend not good at all in the two public hospitals, for example in Black Lion Hospital, the doctor/total patient ratio is 1:6647, where as in Bethzata 1:671, but the number of beds in Black Lion and Dagmawi Menelik hospitals is greater compared to that of Bethzata Hospital.
 - ✓ **Inequalities in accessibility to health care also observed in these Hospital**

Based on the mailed questionnaire and focus group discussion, access to health care in the two public hospitals was not good because as the respondents stated there is lack of transparency, partiality(to friends and relatives), but in Bethzata Hospital most of the respondents replied that the hospital treated patients equally.

- Most of the respondents did not adequately present their complaints to the complaint unit for the dissatisfaction caused by poor service in these public hospitals because first they do not believe such unit can solve their problem, and second, they do not know whether such unit exists or not. However, in Bethzata Hospital most of the respondents did not present complaint because they were satisfied with the existing service.
- The majority of the clients were not satisfied with these public hospitals because of the following reasons:
 - lack of drugs, supplies in these hospitals
 - provision of communication
 - access, and cleanness toilet; comfort of room and compound
 - quality of meal service
 - systems of the hospital (procedural, manual especially in card room card loss and damage)
 - poor integration of different functional unit of the hospital
 - staff ethics
 - low capacity of these hospital and over crowded waiting area
 - location, distance of the hospitals
 - facilities like furnishing- table, bed
 - long time to get health service
 - physical examination and privacy

Nevertheless, in Bethzata Hospital, patients were dissatisfied with the price charged, i.e. the majority of the respondents were satisfied with all service of the hospital except with the price charge.

On the other hand, doctors in the public hospitals were not satisfied because of low salary (underpaid), poor working conditions, poor and unjust handling of medical personnel by the Ministry of Health, poor motivation, scarce resources and highly procedural (bureaucratic) system and low use of modern systems.

5.3 Conclusions

The Minister of Health, in one occasion, urged Ethiopia's health professionals to commit themselves and stay on their job. He also said, "The salary you get in Ethiopia could be lower than anywhere else, but you should be proud that your sacrifice results in a better future for our children and our country". The result of the study also indicated shortage of professionals in the public hospitals is critical as doctors are leaving the country and joining private hospitals. Inequalities of health care (inequality in medical technology, inequalities in resource allocation) were observed in the hospitals. In addition, the majority of the respondents also stated that they were not satisfied with almost all of the variables they were asked to respond to. To curb the problem, the researcher has forwarded suggestions in the recommendation part accordingly.

5.4 Recommendations

In light of the aforementioned findings and conclusions, the following possible recommendations are forwarded so that these hospitals and the Ministry of Health could use them to take corrective measures on many aspects of their operations.

- ✓ Establish an equitable health system
 - Government (MOH) needs to establish a new payment system and a regulatory framework that encourages health workers to provide effective and affordable health service while enabling them earn a reasonable income
- ✓ Tackle brain drain
 - Based on a thorough research and /or study that targets major relevant stakeholders, the government should articulate a policy that provides incentive package to health professionals and give lasting solution to brain drain as well as frequent turnover.
- ✓ Government and the relevant ministries such as the Ministry of Health should exert efforts to establish medical faculties in some regional universities to alleviate health care problems by producing health care professionals. This should, however, be done gradually

when resources that need to be deployed for the establishment of medical institutions in higher education institutions are made available. Further, students who live in shortage areas and who are interested in studying medicine should be encouraged to study and come back to those areas to serve for a longer period. This will reduce the burden of the patients who come from different parts of the country to these hospitals. In order to achieve this, the government should improve infrastructures like road, electricity, water and recreational places because if these things are not fulfilled, doctors may migrate to urban areas.

- ✓ Private institutions should produce health professionals, like doctors, in a large number and provide to hire these professionals so that they do not take the meager human resources that the public hospitals have.
- ✓ Develop efficiency in the public hospitals
 - Develop attractive work environment
 - Establish a regulatory mechanism
 - Establish public -private partnership
 - Streamline healthcare services by making the public hospitals more autonomous in managing their financial and human resources. This provides them with more flexibility in management, increased efficiency, and most importantly, increased community participation
 - Improve the referral system
These hospitals in the future should treat referred patients only. As it was observed, many patients come for minor treatments which can be treated in their villages by providing more doctors and health infrastructure in the future.
 - These hospitals should settle standard measurement of service quality, time, and quantity. Moreover, they should communicate with their employees about the customer needs.
 - Improve staff ethics
Customers want to be treated with common courtesy. They want someone who will help, who can and want to handle their problems. Some of these traits can be

developed through training, but a lot depend on finding the right people for a particular task. These would work when the hospitals provide adequate pay and benefit. Otherwise, they would not get professionals (employee) from the market.

- These hospitals should use appropriate customer technology like data base system, information technology and others to make their work effective and avoid redundancy, file loss, file damage and others.
- Provide monetary and non-monetary benefits to employees to increase the level of job satisfaction.
- Improve tools and equipment in these hospitals, provide necessary or essential drugs to their customers and, for Bethzata Hospital, since the price is high, the hospital should adjust reasonable price.
- In developing countries such as Ethiopia, it may be unlikely for the poor to pay for health care services. Therefore, the government should assist the poor and the powerless to be able cover basic health services. Further, it needs further investigations on price charge for hospital services.
- Develop an entrepreneurial spirit among personnel and different hospitals.

APPENDIX

Appendix one: Questionnaire for Data Collection on Service Delivery and Customer Satisfaction in various Hospitals

This questionnaire is designed by a 2nd year student of master of public administration at Addis Ababa University. The objective of this study is to identify the problems and to assess the level of customer satisfaction. I would be grateful to you if you could share experiences and opinions on hospital care while you are in this hospital. Your cooperation and willingness to fill this questionnaire is helpful in order to achieve the research objective. Please indicate your response by circling and give your suggestions and comments in the space provide if needed.

NB: Your name and address will not be stated in this research and all information that you provide will be kept strictly confidential.

Thank you in advance for your cooperation!

Patient

1. Outpatient 2. Inpatient

Name of hospital

1. Black lion

2. Dagmawi Menelik

3. Bethzata

A. General Question

101. Sex

- 1. Male
- 2. Female

102. Age

- 1. under 18 years
- 2. 18-25
- 3. 26-35
- 4. 36-45
- 5. 46-55
- 6. 56 and above

103. Marital status

- 1. Single
- 2. Married
- 3. Divorced
- 4. Windowed

104. Educational status

- 1. Illiterate
- 2. Grade 1-8
- 3. Grade 9-12
- 4. Diploma

- 5.Degree and above
105. Occupation
1. Merchant
 2. Farmer
 3. Government employee
 4. Private employee
 5. No job
 6. Other-----
106. Payment status
1. Paying
 2. Free
 3. Credit
107. Place of residence
- 1.Addis Ababa
 - 2.other urban-----
 - 3.rural
108. Reason for visit
1. Illness
 2. Accident
 3. Other-----
109. Frequency of visit
1. New visit
 2. Repeated visit
110. Income (monthly)
1. Less than 250 birr
 2. 250-500 birr
 - 3.501-1000 birr
 - 4.1001-1500 birr
 - 5.1501-2000 birr
 - 6.2000 and above

B. Measurement of Service

201. How much are you satisfied with the service you get from this hospital?
- 1.Very dissatisfied
 - 2.Dissatisfied
 - 3.Fair
 - 4.Satisfied
 - 5.Very satisfied
202. If your answer for the above question is unsatisfied (below the expectation), what do you think the reason(s) are?

203. How satisfied are you with measures taken to assure privacy during your examination?

1. Very dissatisfied
2. Dissatisfied
3. Fair
4. Satisfied
5. Very satisfied

204. How do you see the registration process of this hospital?

1. Not good at all
2. Bad
3. Fair
4. Very good
5. Excellent

205. How much time does the registration process takes?

1. Very high
2. High
3. Fair
4. Low
5. Very low

206. How much are you satisfied with the time spent waiting to be seen by:-

	Very	dissatisfied	Fair	satisfied	very
	Dissatisfied				satisfied

☛ doctor	1	2	3	4	5
☛ nurse	1	2	3	4	5

207. Were you happy with the queue that you have to be in order to get health service?

1. Yes
2. No

208. If your answer in the above question is No, what is (are) the reason(s)?

209. How long did you wait before seeing a doctor?

1. more than 3 hours
2. 1-2 hours
3. less than 1 hour

210. After seeing a doctor how long does it take you to be attend by a nurse/other staff for injection, dressing, medication and other services?

1. More than 3 hours
2. 1-2 hours
3. less than 1 hour

211. How long does it normally take you to get health service from this hospital?

212. was a laboratory or X ray and /or ultrasound procedure prescribed for you?
1. Yes
 2. No
213. If your answer for the above question is yes, did you manage to receive all the prescribed service from the hospital?
1. Yes, all
 2. Yes, some only
 3. None
214. How long did you wait to get:
- | | Not ordered | less than 1 hr | 1-2 hrs | more than 2 hrs |
|-----------------|-------------|----------------|---------|-----------------|
| ☛ lab service | 0 | 1 | 2 | 3 |
| ☛ X-ray service | 0 | 1 | 2 | 3 |
| ☛ Ultrasound | 0 | 1 | 2 | 3 |
215. How long did you wait to see the doctor after receiving you result?
1. More than 3 hours
 2. 1-2 hours
 3. Less than 1 hour
216. Have you ever filed a complaint-to-complaint unit for the dissatisfaction caused by poor service of the hospital?
1. Yes, adequately
 2. Yes, little
 3. NO, because I am satisfied with the service
 4. Not at all
217. If your answer to the above question is not at all, what is (are) you reason(s)?
-
-
-

218. How satisfied are you with:-
- | | Very dissatisfied | dissatisfied | Fair | satisfied | very satisfied |
|-------------------------|-------------------|--------------|------|-----------|----------------|
| ☛ access to toilet | 1 | 2 | 3 | 4 | 5 |
| ☛ cleanliness of toilet | 1 | 2 | 3 | 4 | 5 |

C. Facility

301. Were drug and/or supplies prescribed to you?
1. Yes
 2. No
302. If you answer in the above question yes, were you able to get them the pharmacy in this hospital?
1. Yes, all
 2. Yes, some of them
 3. None of them
303. How satisfied are you with availability of drugs and/or drugs supply of this hospital?

1. Very dissatisfied
 2. Dissatisfied
 3. Fair
 4. Satisfied
 5. Very satisfied
304. How do you evaluate the overall cleanliness and comfort of the waiting area, examination room and compound?
1. Very dissatisfied
 2. Dissatisfied
 3. Fair
 4. Satisfied
 5. Very satisfied
305. How satisfied are you with the completeness of the information given to you about your problem?
1. Very dissatisfied
 2. Dissatisfied
 3. Fair
 4. Satisfied
 5. Very satisfied
306. How do you evaluate the overall service of this hospital?
1. Not good at all
 2. Bad
 3. Good
 4. Very good
 5. Excellent

C. Employees’ attitude toward their client

401. Please rate the level service provide to you.

Features	Employees	very dissatisfied	dissatisfied	fair	satisfied	very satisfied
understanding of their customer	doctor	1	2	3	4	5
	nurse	1	2	3	4	5
competence	doctor	1	2	3	4	5
	nurse	1	2	3	4	5
access	doctor	1	2	3	4	5
	nurse	1	2	3	4	5
communication	doctor	1	2	3	4	5
	nurse	1	2	3	4	5
security	doctor	1	2	3	4	5
	nurse	1	2	3	4	5
courtesy	doctor	1	2	3	4	5

	nurse	1	2	3	4	5
responsiveness	doctor	1	2	3	4	5
	nurse	1	2	3	4	5

D. Location and price

501. How do you evaluate the location of this hospital?

1. Very convenient
2. Convenient
3. Inconvenient

502. How far (distance) is it from your home?

1. Very far
2. Far
3. Medium
4. Near
5. Very near

503. How do you evaluate the price charged for service in the hospital?

1. Very high
2. High
3. Fair
4. Low
5. Very low

504. Do you have any suggestion, comment regarding the service delivery of this hospital?

Only for inpatients

601. Please rate the following for this hospital.

	very good	good	average	poor	not good at all
☛ check in, speed/efficiency	5	4	3	2	1
☛ cleanness of room on first entrance	5	4	3	2	1
☛ cleanliness & service during your stay	5	4	3	2	1
☛ furnishing: table, chair, beds, curtain	5	4	3	2	1
☛ size of the room	5	4	3	2	1
☛ window, light of the room	5	4	3	2	1
☛ comfort of the room	5	4	3	2	1

602. Do you get meal service from this hospital?

- 1. Yes
- 2. No

603. If your answer for the above question yes, please rate the following.

	Very good	good	average	poor	not good at all
☛ availability on time	5	4	3	2	1
☛ variety, choice	5	4	3	2	1
☛ quality of food	5	4	3	2	1
☛ quantity of food	5	4	3	2	1

Appendix two: Amharic Version of questionnaire

ይህ መጠይቅ የተዘጋጀው በአዲስ አበባ ዩኒቨርሲቲ በህዝብና ልማት አስተዳደር ድዕረ ምረቃ ክፍል በሁለተኛ ዓመት ተማሪ ሲሆን፡፡ ዓላማውም በሆስፒታል አገልግሎት አሰጣጥ ችግሮችን ለመለየትና ምን ያህል ተጠቃሚዎች በአገልግሎት ላይ እንደረከ ለማወቅ ነው፡፡ ስለዚህም ሀርስዎ በሆስፒታሉ ቆይታዎ የተገነዘቡት አስተያየት ወይም ሃሳብ በዚህ መጠይቅ ላይ እንዲያስቀምጡ በትህትና እጠይቃለሁ፡፡ በተጨማሪም የእርስዎ ትብብርና ፍላጎት ለዚህ ጥናት ዓላማ መሳካት አጋዥነት አለው፡፡ ለሚሰጡት መልስ በማክበብና እንደየአስፈላጊነቱ በተጠቀሰው ክፍት ቦታ ላይ ሀሳቦችን እንዲያስቀምጡ በትህትና እጠይቃለሁ፡፡

ማሳሰቢያ፡- ስምዎን ወይም አድራሻዎን በዚህ መጠይቅ ላይ እንዳያስቀምጡ፡፡ ለሚሰጡት መረጃ ለጥናት ብቻ የሚያገለግል ነው፡፡

ለሚደረግልኝ ትብብር በቅድሚያ ከፍተኛ ምስጋናዬን አቀርባለሁ

I. ታክሚ

1. ተመላላሽ
2. ጸሐፊዎች

II. ሆስፒታል

1. ጥቁር አንበሳ
2. ዳግማዊ ምኒሊክ
3. ቤተሰብ

ሀ/ ጠቅላላ ጥያቄዎች

101. የታ

1. ወንድ
2. ሴት

102. ዕድሜ

- | | |
|-------------------|-------------------|
| 1. ከ18 ዓመት በታች | 4. ከ36 እስከ 45 ዓመት |
| 2. ከ18 እስከ 25 ዓመት | 5. ከ46 እስከ 55 ዓመት |
| 3. ከ26 እስከ 35 ዓመት | 6. ከ56 ዓመት በላይ |

103. የጋብቻ ሁኔታ

- | | |
|---------|------------------|
| 1. ያገባ | 3. የተፋታ |
| 2. ያላገባ | 4. ባለቤቱ ባለቤቱ የሞቱ |

104. የትምህርት ደረጃ

- | | |
|------------------|-----------------|
| 1. ያልተማረ | 4. ዲፕሎማ |
| 2. ከ1 እስከ 8 ክፍል | 5. ዲግሪና ከዚያ በላይ |
| 3. ከ9 እስከ 12 ክፍል | |

105. ሥራ

- | | |
|----------------|-------------|
| 1. ነጋዴ | 4. በግል ተቀጣሪ |
| 2. ገበሬ | 5. ሥራ የሌለው |
| 3. የመንግሥት ሠራተኛ | 6. ሌላ |

106. የክፍያ ሁኔታ (ለሆስፒታሉ)

- | | | |
|---------|--------|---------|
| 1. በክፍያ | 2. በነፃ | 3. በብድር |
|---------|--------|---------|

107. የሚኖሩበት ቦታ

- | | | |
|------------|-----------|--------|
| 1. አዲስ አበባ | 2. ሌላ ከተማ | 3. ገጠር |
|------------|-----------|--------|

108. ወደ ሆስፒታሉ የመጡበት ምክንያት

- | | | |
|----------|--------|-------|
| 1. በመታመም | 2. አደጋ | 3. ሌላ |
|----------|--------|-------|

109. ወደ ሆስፒታሉ አመጣጥ

- | | |
|------------|--------------|
| 1. አዲስ የመጣ | 2. ተመላልሶ የመጣ |
|------------|--------------|

110. ገቢ(በወር)

- | | |
|---------------------|----------------------|
| 1. ከ250 ብር ያነሰ | 4. ከ1001 እስከ 1500 ብር |
| 2. ከ250 እስከ 500 ብር | 5. ከ1501 እስከ 2000 ብር |
| 3. ከ501 እስከ 1000 ብር | 6. ከ2001 ብር በላይ |

ለ/ የአገልግሎት መስጫ

201. ሆስፒታሉ በሚሰጠው አገልግሎት ምን ያህል እረክተዋል?

- | | |
|---------------|---------------|
| 1. በጣም አልረካሁም | 4. እረክቻለሁ |
| 2. አልረካሁም | 5. በጣም እረክቻለሁ |
| 3. ደህና | |

202. ከላይ ወይም በተራ ቁ. 201 መልስዎት ከሚጠብቁት ቦታች ከሆነ ምክንያትዎ ምን ይመስልዎታል?

203. በምርመራ ጊዜ የእርስዎን ነፃነት ለመጠበቅ የሚደረጉ ጥንቃቄዎች ምን ያህል ይረካሉ?

- | | |
|---------------|---------------|
| 1. በጣም አልረካሁም | 4. እረክቻለሁ |
| 2. አልረካሁም | 5. በጣም እረክቻለሁ |
| 3. ደህና | |

204. የሆስፒታሉ የምዝገባ ሂደት እንዴት ያዩታል?

- | | |
|-------------------|---------------|
| 1. በጠቅላላ ጥሩ አይደለም | 4. በጣም ጥሩ |
| 2. መጥፎ | 5. እጅግ በጣም ጥሩ |
| 3. ደህና | |

205. ለምዝገባ ምን ያህል ጊዜ ይፈጃል

- | | |
|-----------|------------|
| 1. በጣም ብዙ | 4. ትንሽ |
| 2. ብዙ | 5. በጣም ትንሽ |
| 3. ደህና | |

206. ለመታከም (ለመታየት) በሚፈጁበት ጊዜ ምን ያህል ይረካሉ?

በጣም	አልረካሁም	የሀፍ	አረክቻለሁ	በጣም	አልረክቻለሁ
➤ በጽኑነት	1	2	3	4	5
➤ በነርህ	1	2	3	4	5

209. ጽኑነት (ረገግ) ለማግኘት ምን ያህል ጊዜ ፈጅቶብዎታል?
 1. ከ3 ሰዓት በላይ 2. ከ1 - 2 ሰዓት 3. ከ1 ሰዓት በታች

210. በጽኑነት (ረገግ) ለማግኘት ምን ያህል ጊዜ ፈጅቶብዎታል?
 1. ከ3 ሰዓት በላይ 2. ከ1 - 2 ሰዓት 3. ከ1 ሰዓት በታች

211. በአጠቃላይ ህጻንዎ ለማግኘት በዚህ ሆስፒታል ምን ያህል ጊዜ ፈጅቶብዎታል?
 (ለተመላሽ ታካሚዎች ብቻ)

- 1. ከ7 ሰዓት በላይ
- 2. ከ4 - 7 ሰዓት
- 3. ከ1 - 3 ሰዓት
- 4. ከ1 ሰዓት በታች

212. ላብራቶሪ ፣ አክባሪ ወይም አልትራሳውንድ ታዘብሎት ነበር?
 1. አዎ 2. አይደለም

213. መልስዎ ላብራቶሪ ቁ. 212 አዎ ከሆነ እርስዎ ሁሉንም የታዘዙላቸውን አገልግሎት
 (ለብራቶሪ ፣ አክባሪ ፣ አልትራሳውንድ) አግኝተዋል?
 1. አዎ ሁሉንም 2. አዎ በጥቂት 3. አላገኘሁም

214. ምን ያህል ጊዜ ቆይተዋል እነዚህን አገልግሎት ለማግኘት?
 አልታዘዙልኝም ከ2 ሰዓት 1 - 2 ሰዓት ከ1 ሰዓት በታች

➤ ላብራቶሪ	0	1	2	3
➤ አክባሪ	0	1	2	3
➤ አልትራሳውንድ	0	1	2	3

215. ወጡት ካገኙ በኋላ ጽኑነት ለማግኘት ምን ያህል ጊዜ ፈጅቶብዎታል?
 1. ከ3 ሰዓት በላይ 2. ከ1 - 2 ሰዓት 3. ከ1 ሰዓት በታች

216. በሚሰጥዎት ጥሩ ያልሆነ አገልግሎት ለቀራ ሰሜ ክፍል ቅራታ አሰምተው ያውቃሉ?

1. አዎ በሚገባ
2. አዎ በመጠኑ
3. አላደርግም ምክንያቱም ጥሩ የሆነ አገልግሎት ስላገኘሁ
4. አልደረግም

217. መልሱን ለተራ ቁ. 216 አይደለም ከሆነ ምክንያቱን ይግለጹ?

218. ምን ያህል አረክተዋል?

በጣም አልረካሁም	ደህና አረክቻለሁ	አልረካሁም				
1	2	3	4	5		
		አቅርቦት				
1	2	3	4	5		
		ዎ መፀዳጃ ሲት				
1	2	3	4	5		
		ዎ መፀዳጃ ሲት				
1	2	3	4	5		

ሐ/ አቅርቦት

301. መደሃኒት/ወይም አቅርቦት ታብላሉ? ያውቃሉ?

1. አዎ
2. አይደለም

302. በተቁ. 301 መልስዎ አዎ ከሆነ የታዘዘላችን መደሃኒት/ወይም የመደሃኒት አቅርቦት ከሆነ ስሆኑ መደሃኒት ሲት አግኝተዋል?

1. አዎ በሙሉ
2. አዎ በመጠኑ
3. አላገኘሁም

303. በሆከፒታሉ መደሃኒት ሲት መደሃኒትና የመደሃኒት አቅርቦት አረክተዋል?

1. በጣም አልረካሁም
2. አልረካሁም
3. ደህና
4. አርግጠኛ
5. በጣም አርግጠኛ

304. በአጠቃላይ በሆከፒታሉ (መጠበቂያ፣ መመርመሪያ ክፍልና የገቢው) ገፅህና ምቹት አገደሁት ያዩታል?

1. በጣም አልረካሁም
2. አልረካሁም
3. ደህና
4. አርግጠኛ
5. በጣም አርግጠኛ

305. ስለ ጤናዎ ትግር ስለሚሰጥዎ የተሟላ መረጃ ምን ያህል አረክተዋል?

1. በጣም አልረካሁም
2. አልረካሁም
3. ደህና
4. አርግጠኛ
5. በጣም አርግጠኛ

2. አልረካሁም

5. በጣም አርግጠኛ

3. ደህና

306. በአጠቃላይ በሆከፒታሉ ስለተሰጥዎት አገልግሎት አገደሁት ያዩታል?

1. በአጠቃላይ ጥሩ አይደለም
2. መጥፎ
3. ጥሩ
4. በጣም ጥሩ
5. እጅግ በጣም ጥሩ

ሐ/ ሠራተኛው ለተጠቃሚው ያለው

401. ከዚህ በታች ያሉት እንዴት ያዩታል

ባህሪ	ሠራተኛ	በጣም አልረከሁም	አልረከሁም	ደህና	እረክቻለሁ	በጣም እረክቻለሁ
1. ህመማችንን መርዳት	ይክተር	1	2	3	4	5
	ነርስ	1	2	3	4	5
2. ብቃት	ይክተር	1	2	3	4	5
	ነርስ	1	2	3	4	5
3. ማግኘት	ይክተር	1	2	3	4	5
	ነርስ	1	2	3	4	5
4. መረጃ በተገቢ ሁኔታ መስጠት	ይክተር	1	2	3	4	5
	ነርስ	1	2	3	4	5
5. ጥንቃቄ	ይክተር	1	2	3	4	5
	ነርስ	1	2	3	4	5
6. ትህትና	ይክተር	1	2	3	4	5
	ነርስ	1	2	3	4	5
7. ተነሳሽነት	ይክተር	1	2	3	4	5
	ነርስ	1	2	3	4	5

መ/ ቦታና ክፍያ

501. የሆስፒታሉ ሥፍራ (ቦታ) ከርስዎ ቦታ አንፃር እንዴት ያዩታል?

1. በጣም ምቹ
2. ምቹ
3. ምቹ አይደለም

502. ሆስፒታሉ ከእርስዎ ቤት ምን ያህል ይርቃል?

1. በጣም ሩቅ
2. ሩቅ
3. መካከለኛ
4. ቅርብ
5. በጣም ቅርብ

503. ሆስፒታሉ ለሚሰጠው አገልግሎት የሚያስከፍለውን ክፍያ እንዴት ያዩታል?

1. በጣም ብዙ
2. ብዙ
3. ደህና
4. ትንሽ
5. በጣም ትንሽ

504. በአጠቃላይ በዚህ ሆስፒታል አገልግሎት አሰጣጥ መሻሻል አለባቸው የሚሉትን ነገሮች ይጥቀሱ?

ከዚህ በታች የተጠቀሱት ጥያቄዎች ተኝተው ለሚታከሙ ህመማን ብቻ ነው

601. ከዚህ በታች የተጠቀሱትን እንዴት ያዩታል?

	በጣም ጥሩ	ጥሩ	ደህና መጥፎ	እ.በጣም መጥፎ
➤ የህክምና ክትትል				
ፍጥነትና ብቃት	5	4	3	2 1
➤ የክፍሉ ንፅህና	5	4	3	2 1
➤ ንፅህናው በሆስፒታሉ ቆይታዎ	5	4	3	2 1
➤ ቁሳቁስ፡- ጠረጴዛ፣ ወንበር፣				
አልጋ፣ ቁም ሳጥን	5	4	3	2 1
➤ የክፍሉ ስፋት	5	4	3	2 1
➤ መስኮትና የክፍሉ ብርሃን	5	4	3	2 1
➤ የክፍሉ ምቹት	5	4	3	2 1

602. በሆስፒታሉ የምግብ አገልግሎት አግኝተዋል?

1. አዎ

2. አላገኘሁም

603. በተራ ቁ. 602 መልስዎት አዎ ከሆነ ከታች የተገለጹትን ነገሮች እንዴት ያዩታል?

	በጣም ጥሩ	ጥሩ	ደህና	መጥፎ	እ.በጣም መጥፎ
➤ በጊዜ ማግኘት	5	4	3	2	1
➤ የተለያየ መርጦ	5	4	3	2	1
➤ የምግቡ ጥራት	5	4	3	2	1
➤ የምግቡ ብዛት	5	4	3	2	1

Appendix 3: Interview questions for data collection on service delivery and customer satisfaction in various hospitals

Greeting (good morning/good afternoon). My name is----- . I would like to ask you a few questions about your experience of and opinion on hospital care while you are working in this hospital. The objective of this study is to identify the problems and to asses the level of customer satisfaction. So, your cooperation and willingness in this interview is helpful in order to achieve the research objectives.

N.B.: Your name and address will not be state in this research and all information that you provide will be kept strictly confidential.

Thank you in advance for your cooperation.

A. General Questions

1. Sex-----
2. Age-----
3. Occupation-----
4. Total service time in this hospital-----
5. Education background-----
6. Current salary
Up to 500 birr ☐ 1501-2000 birr ☐
501-1000birr ☐ 2001-2500 birr ☐
1001-1500birr ☐ 2501and above birr ☐

7. Before you joined this private hospital, have you ever worked in any government hospital? (Only to respondents of private hospital)

Yes ☐ No ☐

If your answer to the above question is yes, what is the reason for which you left the government hospital?

8. Before you joined this government hospital, have you ever worked in private hospital (only to respondents of government hospital?

Yes ☐

No ☐

If your answer to the above question yes, what is the reason you left private hospital?

9. How do you see the level of pay of your organization?

Pay above the market ☐

pay the same as with market ☐

Pay below the market ☐

10. Are you satisfied with the salary of this organization?

Very dissatisfied ☐

Satisfied ☐

Dissatisfied ☐

Very satisfied ☐

Fair ☐

11. Are you satisfied with the benefits (housing, transport, house.....) you get from this hospital?

Very dissatisfied ☐

Satisfied ☐

Dissatisfied ☐

Very satisfied ☐

Fair ☐

12. What improvements are needed in this hospital (you can choose more than one alternative)?

Benefit plans ☐

leadership ☐

Promotion opportunity ☐

security to employees ☐

Salary scale ☐

further education ☐

Working condition ☐

Other specify _____

Interview

1. Do you think the system used in these hospitals is cable of providing speedy service- to the service user?
2. Do you think the service that you provide to your customer is supported by adequate information technology?
3. Do you have a plan in the future to improve the service of your hospital with skilled manpower and computers (information technology, i.e. database management system)?
4. Would you tell me what you have in your mind about your employees' skill in information technology in the future?

5_ Do you think this hospital had developed in modernized equipment to provide service to its customers?

Focus Group Discussion

- 1, How do you see the availability of drug, supplies, and the condition in these hospital pharmacies?
2. How do you see the time spent for physical examination and privacy in these hospitals?
3. How do you see the behavior of staff of the hospital?

DECLARATION

I declare that this thesis is my original work and has not been presented for a degree in any university and all the sources of material used for the thesis are duly acknowledged.

Name of candidate:

Biruk G/Michael

Signature:

Date:

This thesis has been submitted for examination with my approval as a university advisor.

Mulugeta Abebe (PhD)

Signature:
