IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 18, Issue 8 Ser. 4 (August. 2019), PP 11-26
www.iosrjournals.org

What Patients Value Vs What They Experience: Benchmarking for Patient Satisfaction with Quality of Care in the Family Medicine Clinic of a Tertiary Hospital in Nigeria.

Abah Vivien O.
Department of Family Medicine, University of Benin Teaching Hospital, Benin City Edo State, Nigeria

Abstract:
Background*: Acceptability is one dimension of quality of health care demanding that patient satisfaction with care be evaluated and incorporated into planning and implementation of continuous quality improvement. In the global trend towards patient centeredness, what the Patients value in any given facility should be the benchmark for satisfaction with services as these vary with different populations and other factors. Rated importance of service components is proposed as a benchmark for rated patient satisfaction and the difference between them as the Service Gap providing measurable index for continuous quality improvement.*
Aim*: To determine the pattern of patient satisfaction with service quality, patients' rated importance of service components and existing Service Gaps.*
Method*: Randomly selected 300 patients were recruited using the self-administered Satisfaction With Out-Patient Services questionnaire and a customized questionnaire in cross sectional study. p =.05.*
Results*: Overall satisfaction was high (3.59/5) unrelated to sociodemographic variables. Provider attributes, clinical and service information were rated high but process and structural components poor. Perceived availability of good doctors and safe, quality care determined user decision. Environment quality was valued above technical components and cost. Calculated Service Gaps were consistent with expressed values, highest for structural and process components, least for provider attributes.*
Conclusion*: Patients were satisfied with service experience. Provider attributes were rated high offering a trade-off for poor structural and process service components in perceived satisfaction. Patient- centered benchmarking with rated importance of service components provided calibration of satisfaction with service experience yielding calculated service gaps to benchmark continuous quality improvement.*
KeyWords*: patient-satisfaction, service quality, benchmarking, rated-importance, service gaps.*

Date of Submission: 22-07-2019 Date of Acceptance: 07-08-2019

I. Introduction

The quality of care delivered in any health care organization is of paramount importance to all the stakeholders in that organization. For the clients it is the primary determinant of what health care provider they would use. For the managers, it is a major goal for the survival of the business of that organization, and therefore the yardstick for measuring managerial competence.[1] For the government it is a measure of their capacity to meet their obligation to the citizenry in ensuring their health related wellbeing.[2] The major dimensions of health care quality include, effectiveness, efficiency, patient centered (acceptability) timeliness, equity and safety.[3] These dimensions cover a wide range of attributes of health care services which need to be assessed individually from the various perspectives of the stakeholders in order to measure quality of care. The emergence of acceptability as a major dimension of Quality of Care (QoC) has empowered the patients and the measurement of their satisfaction with care received is important in health care planning and evaluation.

The quality of care literature views health care delivery as a service rendered to clients. A service is defined as a "social act which takes place in direct contact between the customer and representatives of the service company."[4] Patient satisfaction is the extent to which the service delivered meets or exceeds client's expectation in keeping with Maister's first law of Service which states that Satisfaction =Perception – Expectation.[4] The importance of consumer experience is in the fact that the service is being produced and consumed in real time. The provider – client interaction defines the experience and the client is the ultimate judge of the quality of that experience.[1]

Patient satisfaction is a multifaceted subjective construct encompassing both cognitive and emotional responses integrating what they value and their perception of what is offered them.[5,6,7] There is a lot of context, temporal and personal subjectivity in patient satisfaction assessments especially overall quality scores. In

keeping with Maister's law therefore, it is necessary to determine what the patients' expectations are when they seek services in any given health facility. Expectation is a complex construct incorporating what the patient values and how he articulates the extent to which he reasonably expects his desires to be met.[8] His values include ideals, desires, aspirations, perceived entitlements, beliefs and standards.[9.10] The articulation of the extent of deliverables from the facility is determined by a host of factors including past experience of the index facility and other facilities, age, gender, health status, socio economic status, the socio- political, economic and cultural setting of the country, the responsiveness of the health system, and peer reports of service experience etc.[8,11,12] Expectation therefore can be divided into ideal, realistic and met expectation in an effort to understand its relationship with satisfaction.[11] Realistic expectation represents the trade-off between ideals and existing realities. Expectations met defines the experience of service. Realistic expectation is complex integrating both cognitive and affective components and presents major measurement challenges especially in health care.[10,11] Health system evaluations and standards also shape patient expectations as they provide benchmarks for assessing care experience and satisfaction. Evaluations and standardization have been well established in developed countries with instruments and processes customized to the existing realities in those countries.[12] Instruments measuring patient expectations are rare and given the fact that they must take cognizance of existing realities of the health systems cannot be applicable across widely different contexts.[8] Applying consumerism and patient centeredness in assessing patient satisfaction in our locale requires that a measure of what patients value be incorporated in assessing their satisfaction with services they receive.[6] A central element of expectation is the value attached to the components of the services.[10]This is proposed to be a measurable proxy for expectation given the above limitations. In this study, the rated importance of service components will be used as a benchmark for assessing rated satisfaction with services where both parameters are rated on the same scale of five. The difference between rated importance and rated satisfaction of any component will be termed the **Service Gap**. Benchmarking has become necessary as most studies in Nigeria yield evidence of moderate to high patient satisfaction despite the well- known poor standards in most public hospitals. Tracking changes over time is also difficult for researchers and stakeholders, especially for managers in planning and following improvement efforts. It is expected that rated importance of any component will be reasonably stable over time so that pre and post intervention service gaps can give objective and quantifiable measure of continuous quality improvement efforts. Using a patient determined benchmark ensures that patient centeredness and acceptability as a dimension of quality of care is being addressed.[13] It also serves to put in proper perspective the similar numbers assigned to quality ratings in different health services and socioeconomic settings as it incorporates the interaction between existing realities, patient values and experience specific to those settings. Also using standardized patient satisfaction measures will make the survey results more meaningful, comparable and applicable.[6] This is easier in the domains of measurable and modifiable behaviors and parameters as found in the Satisfaction with Out Patient Services questionnaire used in this study.[5]

The aspects of care that are usually amenable to patient appraisal include quality structure factors like adequacy of staff (numbers and efficiency) comprehensiveness of services, safety, organization of the service points, amenities and accessibility. Process quality factors like waiting time, provider – patient relationship, confidentiality, privacy and cost. Outcome Quality factors including efficacy, quality of life and functional status.[4,5,9] Generally, the capacity of consumers to assess these factors varies to a large extent depending on the same factors that determine expectation as mentioned above. Developed countries have benchmarks for assessing performance of hospitals, patient satisfaction and experience stories.[13] This has not yet been achieved by the developing countries including Nigeria and so consumerism in health care is very far from our reality. Regulation of standards of hospital structures and processes is yet to achieve a benchmark for measurement of performance of health facilities across the country making it necessary for satisfaction surveys to take cognizance of facility and location peculiarities. Theneed for benchmarking and understanding of the relationship between patient satisfaction and actual events occurring in service delivery led to development of another patient centred metric for QoC which is the "Patient experience." In the United States of America, the Hospital Consumer Assessment of Health Care Providers and Systems(HCAHPS) is a health system survey that seeks to objectively measure patient experiences against benchmarked standards providing a valid means of comparing hospitals and providing incentive for improvement in quality of care.[13]

Many studies on quality of care in Nigeria found that causes of dissatisfaction include long waiting time, poor facilities, cost of services and poor patient provider relationship.[14,15,16] The studies also found that majority of the clients in the public hospitals are of the lower social class and that despite the well-known poor state of facilities, excruciatingly long waiting time, patients still assessed the quality of care as satisfactory.[14,15]The health care system in Nigeria is situated within a sociopolitical environment where the health of the citizens has not received the required level of priority from government resulting in poor facilities, organization and regulation of the health sector.[17,18,19] More than 90% of the citizens are not covered by health insurance.[18] Health budget is consistently below WHO recommendations.

Client satisfaction with a service determines whether they will continue to utilize that service. This ordinarily holds true in most service industries and in health systems of developed countries where consumerism has been established among patients.[20]However it does not apply in our public health sector due to the factors mentioned above. This is especially so for the tertiary hospitals, among whose clientele consideration of availability of expertise, facilities, ethical practices and cost of care may override the reality of inconvenience experienced in accessing care thereby modulating their expectations and satisfaction ratings. At population level however it has negative impact on the health seeking behavior of the masses and is a major contributor to prior utilization of alternative sources of care like chemists, herbalists, spiritual houses etcetera and late presentation to the hospital in most clinical conditions.[21] The consequence on the health of the nation is enormous and therefore performance evaluation of facilities in our health sector demands attention.

Managing quality of care in any hospital requires a culture of continuous quality improvement best entrenched in a clinical governance structure requiring institutional will to implement. This study is aimed at providing a pre intervention evaluation for our practice.

Statement of the Problem:

The quality of care in the hospital needs to be assessed periodically to guide improvement. The patient's perception of the services provided is key to evaluation and planning in keeping with the global trend towards patient centered care. Studies have shown that management priorities often differ from patient priorities and that patient priorities and expectations vary with different population and the type of service they need.[12,22,23,24] There is need to understand what our patients value, determine their satisfaction with services they experience and the existing gaps between what they value and what they experience in the clinic in order to develop a patient centered metric to guide and track efforts at quality improvement and satisfaction.

II. Aim and Objectives

To determine the pattern of patient satisfaction with the quality of services in the clinic, the patients' rated importance of service components and the existing Service Gaps as a guide to Quality Improvement.

Methodology

Study Area: The Family Medicine Clinic is located at one extreme of the hospital. It offers primary care services to patients every day and serves as the gateway to the secondary and tertiary care units of the hospital. The clinic is run by the Family Medicine Department of the hospital with residency training in situ and receives patients on a walk in basis every day. About 150- 250 patients attend the clinic per day on week days and about 40-80 patients on weekends. It opens at 8am and closes at 6pm. It has medical, nursing, records, revenue, laboratory and pharmacy units. Radio diagnostic services are located in the main hospital within some walking distance. There is usually a minimum of ten doctors (Consultants and Residents) available to attend to the patients. Patients are required to pay for consultation and obtain their card from the revenue and records units respectively. Both units are adjacent to each other in the waiting hall. A patient flow management mechanism operates such that patients take numbers on arrival and queue discipline is maintained as much as possible in giving them access to the doctors for consultation. There is an information /help desk in the waiting hall giving patients all information required to facilitate their access to care in the clinic and the main hospital. There is a television set in the hall offering programs on local channels. The clients are given a health talk every morning by the nurses. Emergency cases are stabilized and then taken by ambulance to the emergency department in the hospital if needed. Most of the patients are students, artisans, traders, civil servants, retirees and business owners reflective of the communities the hospital serves.

Sample Population: This was made up of all clients that attended the clinic in the study period about 5480 clients in a month.

Selection Criteria: All patients or patient relatives above 10 years of age who consented to participate were recruited into the study. All patients who were too ill to participate were excluded.

Sample Size: The Leslie Kish formula was employed for sample size calculation using prevalence of patient satisfaction in Nigeria of 52%-91% an average of 71.5%.[21,25] Calculated sample size was 298.6 rounded to 300 for ease of data analysis.

Research Instruments:1) The Satisfaction with Out-Patient Services Questionnaire (SWOPS)[5]was used with modification to include assessment of Pharmacist care. The SWOPS is a standardized self -administered instrument developed by Seibert et al 1996 for measuring patient satisfaction with services in outpatient departments. It has six sections covering, Registration process, Nursing Care, Physician care, Information, Testing services and Overall satisfaction. The various dimensions have Cronbach alpha scores ranging from 0.84 -0.95. The parameters were rated on a 5 point Likert scale.

2) A customized semi structured questionnaire to capture sociodemographic data, determinants of decision to use the clinic and rated importance of components of services (rated on a 5point Likert scale same as the SWOPS rating). The instrument was interviewer administered for illiterate participants.

Sampling Method: Random sampling method by simple balloting was used.

Study duration: The calculated sample size of 300 was recruited over a period of October 2017 to February 2018.

Study Procedure: About 5 patients were recruited each day. The selected participants had the study explained to them. Informed consent was obtained, and they filled the questionnaire at their own pace as they went through the clinic for their care. The questionnaires were retrieved at the pharmacy which is the last service point in the clinic. Participants who were illiterate were assisted by a trained research assistant.

Ethical Consideration:

Ethical Approval was obtained from the hospital Research and Ethics Committee. PROTOCOL NUMBER: ADM/E 22/A/VOL.VII/1480. Informed consent was obtained from all the participants. Confidentiality was maintained in data collection, collation, analysis and reporting.

Data Analysis:

The data was collated using Microsoft Excel and analyzed with SPSS version 21. P value was set at 0.05. The distribution of satisfaction with the various components of services was done using frequencies and percentages. The 5 points Likert scale was scored 1-5 from poor to excellent. The mean of the scores for all the participants on each parameter was calculated as the satisfaction score for the parameter. Spearman correlation was used to determine the relationship between perception of care parameters and satisfaction. The mean score of the rated importance of service components was used as benchmark score to compare the mean satisfaction scores of related service components to calculate the Service Gaps. The one sample t test was used to test the significance of Service Gaps.

III. Results

Most of the respondents were adults aged between 20-59 years (58. 3%) adolescents (24.7%) and elderly (23%) of the sample population. Gender distribution was almost equal. Majority of the respondents were Christians (94.3%) and were educated. Tertiary education (57%) secondary education (13.%). (Table 1)

The composite satisfaction scores ranged from 3.35-3.62. perception of waiting time was least (89% of respondents satisfied) and doctor professionalism was highest (98% of respondents satisfied). Overall satisfaction with treatment was rated 3.59(97.7%) of respondents, satisfaction with clinic management 3.57(96.4% of respondents). The mean of composite scores for the service components was 3.49+/- 0.0822(SD). At mean + 1SD=3.55, the service components that rated high (>3.57) include doctor professional rating, pharmacist professional rating and information domain. Components that had low rating (Mean -1SD =/<3.41) were canteen facilities and perception of waiting time. All other components had average satisfaction ratings. (Table 2)

There was a weak negative correlation between educational status and ease of getting laboratory results. There was no significant correlation between age and sex and other process quality components (Table 3).

There was a weak negative correlation between female gender and satisfaction with cleanliness of laboratory area. Other structural components had no correlation with sociodemographic characteristics (Table 4).

There was no correlation between sociodemographic characteristics and satisfaction with interpersonal and professional ratings of nurses and registration clerk (Table 5).

There was a significant weak correlation between female gender and interpersonal skills and professional rating of doctors and pharmacists except for helpfulness of pharmacists. Age had a significant negative correlation with caring attitude of doctors only. Educational status had no significant correlation with satisfaction with these parameters (Table 6).

There was no significant correlation between sociodemographic characteristics and overall satisfaction with treatment and clinic management (Table 7).

Correlation with p = .000 is denoted with ** Attitude of the clerical staff had an average rating of 3.5 and had very strong positive correlation with perception of registration process (.745**) and clinic services (.623**) (Table 8).

Among Nurses, politeness and caring were rated lower (3.48, 3.49) than helpfulness (3.51) but had very strong and higher correlation with rating of Nurse professionalism (.788**,.729**). Nurse professionalism had moderate correlation with overall satisfaction with treatment (.566**) and overall satisfaction with clinic services (.549**) (Table 9).

Rating of doctor professionalism had moderate to strong correlation with clinical care components: Time spent with doctor (.671**) and instruction on medication had the strongest correlation (.665**) followed by thoroughness (.613**), health talk (.600**), and explanation of care (.585**). Perception of professionalism strongly correlated with overall assessment of medical care (.728**) and satisfaction with treatment (.600**). Overall assessment of doctor's care had the strongest correlation with health talk (.621**), instruction on medication (.603**), time with doctor (.605**) and thoroughness of care (.601**). Outcome of consultation was strongly correlated with answers after visit (.792**), health talk (.725**), explanation of care (.702**) instruction on medication (.658**) and thoroughness of care (.652**). (Table 10).

Among doctors, inter personal skills were rated high (3.61-3.65) and had very strong correlation with Professionalism: Caring attitude (.899**) politeness (.827**) and helpfulness (.816**). Interpersonal skills correlation with overall rating of doctor's care was very strong, with helpful attitude (.780**) and politeness (.805**) being much stronger than caring (.700**). Correlation with perception of outcome was moderate: caring being the highest (.529**). Correlation with Satisfaction with treatment was also moderate: caring attitude (.587**), helpfulness (.585**), politeness (.558**).

Components of clinical care correlated more strongly with outcome than Inter personal skills(IS) but Interpersonal Skills correlated more strongly with rating of professionalism and overall medical care rating.

Both groups of parameters correlate about equally with satisfaction with treatment but components of clinical care correlate more strongly with satisfaction with clinic services. (Table 11).

Among Pharmacists interpersonal skills were rated high (3.56- 3.59) with caring attitude being the least. Caring however had the highest correlation with ratings of professionalism (.855**), overall pharmacist care (.858**), satisfaction with treatment (.683**). All Interpersonal Skills had strong correlation with overall satisfaction with pharmacist care (score 3.55, r=.783**-.858**), higher than correlation with professional rating (score 3.59, r=.712**- .855**). Information delivery by pharmacist had very strong correlation with rating of professionalism (.804**) and perception of overall pharmacy care (.862**), satisfaction with treatment (.667**) (Table 12).

Among the health providers, doctors were rated highest (3.62) on professionalism. Pharmacists were next (score=3.59) but had the highest correlation with satisfaction with treatment (.703**) and clinic services (.677**) Nurses were rated least (3.51) with moderate correlation with satisfaction with treatment (.566**) and clinic services (.549**) (Table 13).

Rating of administrative processes was poor (3.35-3.42). Perception of waiting time rated the least but had the highest correlation (.613**) with satisfaction with clinic services. Signposting to the Lab was rated average at 3.49 but had strong correlation with clinic services (.722**). Information provision was rated high (3.61) and had very strong correlation with satisfaction with clinic services (.727**) (Table 14).

The environmental indices were rated low: canteen facility 3.39, average: quality of waiting area 3.41, privacy of registration 3.47, cleanliness of lab 3.53. They had moderate correlation with satisfaction with clinic services. Lab cleanliness (.678**), quality of waiting area (.618**), privacy of registration (.561**) and canteen facility (.557**). (Table 15)

The service components received high rated importance with mean scores ranging from 3.80 (affordable cost) –3.97(hospital environment). Staff competence (3.91) rated higher than facilities and drugs available (3.90) and patient /provider relationship and ease of administrative processes rated 3.84 and 3.85 respectively. (Table 16).

The difference between the mean rated importance of provider competence and rated satisfaction with professionalism for nurses, doctors and pharmacists was highly significant at p= .000 for all three professional categories. The Service Gap for nurses was largest =.403. next for pharmacists =.318 and least for Doctors=-.290. (Table 17)

The difference between the mean rated importance of ease of administrative processes and rated satisfaction of related parameters was large for all three parameters and significant at p= .000. The Service Gap for registration process = -. 407, ease of getting lab results = -.426 and waiting time = -.503. (Table 18)

The difference between the mean rated importance of environmental factors and rated satisfaction with related parameters was large for all four parameters and significant at p=.000: The Service Gaps for privacy of registration process = -.503, quality of waiting area = -.557, canteen facility = -.577 and cleanliness of the lab = -.444. (Table 19)

The difference between the mean rated importance of patient provider relationship and rated satisfaction with registration clerk, nurses, doctors and pharmacists were highly significant at p= .000 for all staff categories. Service gaps was least for Doctors =-.21, Pharmacist =-.30, Registration clerks= -.32 and largest for Nurses= -.34. (Table 20)

The distribution of decision factor for using the clinic among the respondents showed that quality related factors were determinants for over 85% of the respondents. Perceived availability of good doctors was the highest factor (38%) followed by perceived availability of good care (27.7%), good medical services (19%),

safe care (13.7%) and good environment (9.7%). Cost was significant only for 5% of the respondents. (Table 21)

IV. Discussion

The sociodemographic characteristics of the study participants showed most of the respondents were educated, adults and with almost equal gender representation. (Table 1) Sociodemographic characteristics had no significant correlation with overall satisfaction with treatment and clinic services similar to findings in other studies.[26] (Table 7) Among service components, educational status had negative correlation with ease of getting lab tests only.(Table 3) Age had a negative correlation with caring attitude of doctors only. (table 6) This is contrary to findings in a study on general practitioners where the elderly were more satisfied with their relationship with the doctors, attributed to the higher likelihood of interpersonal continuity which is not readily available in our clinic.[27] Female gender was correlated with rating of professionalism and interpersonal skills of doctors and pharmacists. (Table 6) These findings are also contrary to the study cited above in which significant male gender satisfaction with interpersonal relationship was attributed to most providers being male facilitating development of rapport.[27] However, in this study, this is probably due to the females being more demanding of personalized attention.

The mean rating of overall satisfaction with treatment and clinic services were 3.59/5 (71.8%) and 3.57/5 (71.4%) respectively. (Table 2) This represents the opinion of majority (>96%) of the respondents suggesting that majority of patients were satisfied with the quality of services in the clinic. Comparing these findings to that in other outpatient clinics in tertiary hospitals in Nigeria, this rating is higher than the 3.45(69%) in Enugu, 52% in Sokoto, 65.9% found among insured patients in Kano,[14,21,26] but lower than 83% found among uninsured patients in Kano.[16] These scores suggest most of the patients in these facilities were satisfied with the services they received. This is however contrary to the general findings that health facilities in Nigeria are of poor quality. The paradox of above average mean satisfaction scores despite poor facilities is shown in the study in Bangladesh where mean scores were better than average (3.49/5) in public hospitals despite loud complaints about the standard of the hospitals and services.[28] This can be explained by the fact that experience of a service and other related factors facilitates calibration of expectations and therefore makes realistic expectations closer to deliverables resulting in higher satisfaction ratings.[8,10,11] Ideal and realistic expectation have been found not to predict overall satisfaction but post visit experiences did.[11]

Among the doctors, perception of both interpersonal skills resources and parameters of clinical care were studied. Perceived thoroughness of care was rated highest (3.70) followed by time spent with the doctor (3.67), then explanation of medication (3.64), health talk (3.61) and explanation of care (3.58). (Table 10) These parameters are established to be important to patients and impact their satisfaction.[4,29] These ratings are reasonably high and suggest most of the respondents were satisfied with their experience of these components. This is contrary to findings in a lot of studies across the world indicating otherwise.[6,21,28,30]

The three parameters related to health information from the doctor (health talk, explanation of care, opportunity to have answers after visit) had stronger correlation with rating of outcome of the treatment than the others. The subset of clinical care components of time with doctor, thoroughness and explanation of medications had stronger correlation with rating of doctor professionalism than the information related parameters. The appropriate correlation of factors displaying doctor competence (thoroughness, time spent and explanation) to professionalism and factors related to improved capacity for self-care to outcome of consultation (health talk, explanation of care and answers after visit) validates the ratings and confirms that patients are objective in their assessments.[5,23] This is further confirmed in the similarity in the correlation of both sets of parameters with satisfaction with treatment confirming the expectation that all the factors put together contribute to patient satisfaction. The high value placed on health talk is further displayed by the consistently high correlation of health talk with outcome, overall doctor rating, professionalism, and satisfaction with treatment. This is particularly important given the fact that information delivery especially health talk is time consuming and demands commitment from the doctor. It was rated 3.61 suggesting that despite the constraints of work load pressure the doctors were managing to meet this need unlike the finding in other studies.[12,31]This is probably because the clinic is run by Family Medicine trainers and trainees with high premium on patient education as supported by other studies.[4,27] Doctor-Patient communication covers a variety of issues including clinical problem solving focused talk, counselling and social talk. All types of communication is important with all the other forms supporting partnership building for improved problem focused communication and outcome.[8,12,32]Health literacy of patients depends on health provider communication to a large extent and it is evidenced to correlate with health attitudes, practices, adherence, satisfaction, service utilization and outcome among populations.[8,23,32] The amount of time spent with the patient reflects on the amount of communication with the patient and has impact on their satisfaction.[12,32] Communication underscores every aspect of the provider patient interaction and transmits the information, humaneness and relationship that are critical to quality care. This is well expressed by the importance attached to it in various studies and populations and the

relationship it has with satisfaction.[l14,22,33] Communication failure is well known to be the commonest cause of medical errors, malpractice suits and change of physicians among patients.[33,36]

Interpersonal skills resources (ISR) among the doctors were rated high (Table 11): politeness (3.61), caring (3.64), helpfulness (3.65) similar to a study in India.[35] This is also attributed to the fact that the clinic is run by Family Physicians who are known to put high premium on doctor –patient relationship.[11]The correlation between ISR and rating of doctor professionalism was higher (r=.816-.899, p=.000) than the clinical care components (r=.546-.671, p=.000). Also their correlation with overall rating of doctors was higher (r=.700-.805 p=.000) than with clinical care components (r=.513-.621 p=.000). The correlation of ISR with outcome was lower (r=.518-.529 p=.000) than the clinical care components (r=.615- .729 p=.000) and about the same with satisfaction with treatment. This further shows the discerning capacity of the respondents in assigning their ratings. ISR and clinical care components are related to perceived professionalism among doctors confirming that humaneness and perceived competence are the core attributes of professionalism expected of doctors by their patients. This is consistent with evidence that shows patients value interpersonal aspects of care more than the technical components.[8]Humaneness of care is very important to patients and these are core attributes of professionalism as they relate to implementing trust in the patients and the public.[11,36,37] Humaneness of care has also been linked to establishing a therapeutic relationship that facilitates healing and are described as the little things like active listening, being open, removing barriers, letting the patient explain, sharing authority, being committed and trustworthy.[36,38] All these attributes are deployed and experienced by the patient in the consultation and require a length of time to adequately happen. This further explains the importance attached to consultation time and its' relationship to satisfaction especially in primary care and evidenced in this study.[39]

Apart from doctors, the impact of ISR of providers on satisfaction is evidenced by the finding of higher correlation of perceived empathy and support of nurses with satisfaction than outcome.[40,41]In this study among nurses, ISR were rated average:3.48-3.51 (politeness, caring and helpfulness) as well as nurse professionalism (3.51). (Table 9) There was strong correlation between interpersonal skills of nurses and rated professionalism consistent with the pattern found among doctors. The correlation of nurse professionalism with patient satisfaction with treatment was moderate (r=.566, p=.000) and comparable to outcome (r=.587, p=.000) like in the study cited above suggesting that the nurse component in this study was as important as in the cited survey.

Among the pharmacists, ISR were scored high (3.56-3.59) and had stronger correlations with overall satisfaction with pharmacy care (score 3.55, r=.783**-.858**) than professional rating (score 3.59, r=.712**-.855**) unlike the pattern among doctors. (Table 12) Caring attitude was rated the least but had the highest correlation with ratings of professionalism (.855**), overall pharmacist care (r=.858**), satisfaction with treatment (r=.683**). Information delivery by pharmacists had very strong correlation with rating of professionalism (.804**), perception of overall pharmacy care (r=.862**) and satisfaction with treatment (.667**). This again demonstrates the value patients place on health literacy from providers.[8,31]

All the ISR had strong correlations with rating of professionalism among the three provider categories and moderate correlation with satisfaction with treatment and clinic services. This is similar to findings by other authors in Nigeria and China.[16,26,33] Across the three attitudes measured, the nurses were rated the least (3.48-3.51) followed by pharmacists (3.56-3.59) with doctors (3.61-3.65) scoring the highest. This finding is similar to other studies.[42]

The ISR rating had the same pattern among doctors and nurses: helpfulness, caring and politeness (highest to lowest). Caring attitude consistently had the highest correlation with professional rating and satisfaction with treatment emphasizing the importance of empathy in patient satisfaction. Politeness was rated the least among doctors and nurses and had higher correlation than helpfulness. This trend was also observed for pharmacists where caring was the least rated but had the highest correlation with professionalism. This is probably an expression of an important deficiency requiring intervention (expression of a Service Gap).

The registration clerk was rated average (score= 3.52. 94% of respondents) on attitude higher than findings in other studies.[11,27] There was however a very strong correlation with the satisfaction with registration process (r=.745, p=.000) and satisfaction with clinic services (p=.623, p=.000). (Table 8) The importance of the attitude of the reception staff is demonstrated here in the correlation with satisfaction with perception of clinic services that is higher than that of doctors and nurses. The mismatch between the low scores assigned and the strong correlation is another evidence of the expression of a Service Gap.

The Process factors surveyed had poor ratings among the respondents. (Table 14) Perception of waiting time was low (score =3.35, 89% of respondents) and had moderately strong correlation with satisfaction with clinic services (r=.613. p=.000). This finding is supported by another study on waiting time in our clinic showing about 70% of patients were satisfied with services and waiting time was a major negative predictor of satisfaction.[43]The difference in proportion of satisfied patients is explained by the fact that waiting time was the only service component under consideration in that study and so the trade- staff off effect of other favorable components like staff interpersonal skills and competence observed here were not at play as confirmed by other authors.[30] Timeliness of services has been linked to perception of respect and responsiveness accorded patients

in a facility and affects their disposition to the staff and facility.[12,21,44] It has major negative impact on satisfaction and utilization of services and constitutes a major component of "non-monetary" cost of accessing health care.[44,45]This is similar to findings in other studies across varying socioeconomic strata including Nigeria.[12,14,21,46]However it is well documented in many studies that despite this, most facilities still receive high satisfaction ratings as was found in this study.[15]This is attributable to a trade-off effect as explained above. In developed countries with appointment systems, waiting time is no longer about pre consultation wait in the health facility but about getting convenient appointments to visit the facility or get a procedure done.[11] In Nigeria and other developing countries, lack of appointment systems and electronic medical records results in poor management of patient arrivals and long waiting times.[15] The details of the dynamics of waiting time found in this study are discussed separately in another article to allow for full exploration of the findings.

The registration process was rated 3.44 and moderately correlated (r=.572, p=.000) with satisfaction with clinic services. Privacy of registration was rated 3.47 and moderately correlated (p=.561, p=.000) with satisfaction with clinic services.

Ease of getting lab tests was rated low at 3.42 and had moderate correlation (r= .595, p=.000) with satisfaction with clinic services. This is similar to findings in other studies in Nigeria and India.[26,35] Signposting to the lab was rated average at 3.49 and had very strong correlation with satisfaction with clinic services (r= .722 p=.000) showing the importance of signposting as documented in literature.[44] Process parameters were rated lower than the professionals but had correlation with satisfaction with clinic services equal to or greater than the professional providers. This clearly demonstrates the value attached to these parameters by patients and demonstrates an expression of the Service Gaps in this quality dimension requiring intervention.

The rating of information delivery was high at 3.61 and had very strong correlation (r=.727 p=.000) with satisfaction with clinic services. The high rating approximated its' high correlation with satisfaction with clinic services showing that there seems to be a good match between the respondent's perceived value for information and their experience of that component in the clinic. This is probably because there is an information/help desk in the waiting hall where all inquiries related to service access and delivery are handled. The importance of information delivery to patients has been evidenced to rank second only to clinical competence of the providers.[23]

The structural dimension also received poor ratings.(Table 15) Quality of the waiting area was rated 3.41, Canteen facility ; 3.39, lab cleanliness; 3.53 but all had moderately strong correlation with satisfaction with clinic services (r=.618, r=.557, r=.678, p=.000). These factors again had stronger correlation with satisfaction with clinic services than the rating of health professionals under scoring their importance to the patients and expressing the existing Service Gaps. Environment of the care delivery is viewed by some authors as the foundation of satisfaction providing aesthetics, comfort, signs and directions, lighting and cleanliness.[44] Patients demand comfortable and conducive waiting halls to ease the stress of waiting.[42,47]This finding is different from that among patients in a staff clinic of a Nigerian tertiary hospital where environment factors had no relationship with satisfaction and similar to a Pakistan study where environment was rated low and had high correlation with satisfaction (expression of a Service Gap).[26,31]

The distribution of the factors determining the respondent's decision to use the clinic (using an open ended question), showed majority (>85%) of respondents depended on quality of care with perceived availability of good doctors being the highest factor, and next were good medical care, good services and safe care. Cost was significant only for 5% of the respondents. (Table 21) This is consistent with the satisfaction ratings in which the professionalism of the providers was reasonably high and so apparently offered a trade-off for poor process and structural factors. Also the impact of the prevailing reality of the standard of our health system on calibration of expectations and therefore satisfaction is demonstrated.

The service delivery components surveyed got very high mean rated importance ranging from 3.80-3.97of 5 points (Table 16). The least rated parameter was cost. This is highly instructive as it shows that clients at the clinic want high quality care and considerations of cost was not allowed to deter their quest for it. This is consistent with the findings on the determinants of the respondents' decision to use the clinic. Generally, cost of care is an important determinant of choice of provider or facility especially for uninsured patients.[44] A survey in America showed majority of patients sought information on technical and service quality but did not check cost of services while in search of a provider. This shows a similarity in behavior in these two sets of respondents despite the wide gap in their socioeconomic circumstances underscoring the value placed on quality of care by patients.[40] This is unlike in a study on Syrian patients where they placed premium on price satisfaction.[48]

Ease of administrative processes was rated high at 3.85. This represents the value placed on the level of inconvenience inherent in the service processes. The scoring here equates that of patient provider relationship which is well known to be very key to satisfaction with services demonstrating the high value our patients place on this.

Drugs and facilities available was rated 3.90 and staff competence got 3.91 placing them high on the hierarchy of valued service components. In this context encompassing all service components, parameters of

technical quality were valued above patient provider relationship (3.84) different from the trend observed in assessment of provider attributes. This suggests that in seeking service, technical quality is paramount but beyond resolution of what facility can offer that, provider ISR is paramount in delivering care as found in this study. The highest ranking parameter was the hospital environment at 3.97. It has been shown that the importance attached to various aspects of care varies with different populations.[22] The findings here are similar to others where professional skills of physicians was valued above interpersonal skills.[22] In China among an urban population, professional competence was valued above interpersonal skills similar to this study, while the rural dwellers valued environment most above all the other factors similar to our findings.[33] This could reflect a trade-off between what is found lacking, what is desirable and a need to draw attention to the gap.[30] It is probable that the rural hospital in China had poor environment making it a top priority for the patients while the urban hospital had more modern and decent facilities thereby shifting priorities to other service components. The highest rating given to environment in this study reflects an expression of perceived Service Gap as above. This demonstrates the need for facility based survey of patient priorities and service gaps as important guides for hospital management decisions especially as most providers and managers would place environment behind technical quality components in their priority.[23] Studies have shown that quite often this disparity in patient and provider priorities occurs confirming the need for studies like this to bridge the gap.[23,30] Also the hierarchy of needs found in this study demonstrates the discernment of the respondents irrespective of the fact that sociodemographic characteristics especially educational status did not significantly discriminate between their satisfaction ratings.

The rated importance of service components studied were used as benchmarks for the mean satisfaction rating of these components. The Service Gaps were defined as the difference between rated importance and rated satisfaction and was highly significant at p=.000 for all the service components studied. The service gaps calculated in the patient provider relationship domain ranged from - .21(doctors) to -.34 (nurses) and was the least among all the domains surveyed. (Table 20) The service gap for staff competence was moderate, highest for the nurses at -.40 followed by pharmacists (-.32) and then doctors (-0.30). (Table 17) This shows that the staff performance was better than other domains and may constitute a trade- off for poor structural and process factors resulting in the good satisfaction ratings observed. However, the existing significant gaps need to be addressed across all provider categories with the nurses having the greatest need. The need for interpersonal skills training and practice monitoring has been stressed by other authors as this deficiency among nurses has been reported by various studies.[41]

The calculated Service gap for administrative processes was large for all three parameters; registration process = -.407, ease of getting lab results = -.426 and waiting time = -.50. (Table 18) Components of the environment domain had the greatest service gaps ranging from - .444 (lab cleanliness) to - .577 (canteen). (Table 19) These findings show that the need for intervention is greater in the process and structural dimensions of quality. The values of the service gaps provide objective indices of areas of needed intervention and benchmarks for post intervention evaluations.

V. Conclusion

Patients were satisfied with their service experience. Provider attributes were rated high offering a trade-off for poor structural and process service components in perceived satisfaction. Patient centered benchmarking with rated importance of service components provided calibration of satisfaction with service experience yielding calculated Service Gaps to provide benchmark for continuous quality improvement.

VI. Recommendations

Based on above findings, Continuous Quality Improvement efforts in the clinic should target the structural and process components of care.

Despite the lower service gaps established for the staff competence and partnership, an exploration of their constraints in developing effective partnerships with the patients should be done to guide interventions with greater priority for the nurses.

Post intervention survey should be done to evaluate impact using the service gaps found in this study as benchmarks.

More studies should be done using service gaps as a patient centered metric for objective measurement and tracking of continuous quality improvement programs in other health care facilities to further explore its utility and validity.

Strengths of this Study: This study has attempted to provide a feasible patient centred calibration of satisfaction with health care services. This provides an objective basis for evaluating satisfaction surveys and tracking changes over time in any health facility. Without such benchmarking similar numbers in satisfaction surveys of different facilities, socioeconomic settings and populations are difficult to evaluate.

Using patient rated importance of service components ensures patient centeredness in benchmarking and that implementation based on the calculated service gaps will directly address what patients want thereby improving satisfaction.

It also provides a simpler method of assessing patients' values than trying to measure expectation which has proved to be complex in literature and practice. This is particularly important for developing countries given the myriad of limitations existing therein.

Limitations:

Many service components like revenue staff and process, health assistants, laboratory staff, quality of consulting rooms and the pharmacy, and cost of services were not evaluated in this study.

Courtesy bias may not be ruled out but the consistency in the pattern of correlations of staff ratings suggests this was minimal.

Rated importance of service components is expected to vary over time and with changes in the socio-cultural and economic circumstances of the index population and health facility. This study did not explore this.

VII. Results

Table 1: Distribution of Sociodemographic Variables among the Respondents.

Variable	Frequency	Percentage
Age		
10-19	**74**	24.7
20-29	58	19.3
30- 39	48	16.0
40-49	44	14.7
50—59	7	2.3
60—69	54	18.0
70>	15	5.0
Sex		
Male	**144**	**48.0**
Female	156	52.0
Educational Status		
None	**8**	**2.7**
Primary	82	27.3
Secondary	39	13.0
Tertiary	171	57.0
Religion		
Christianity	**283**	**94.3**
Islam	17	5.7

Table 2: Distribution of Mean Scores of Rated Satisfaction with Service Components.

S/No.	Service Component	Mean Satisfaction Score	% of Respondents rating satisfaction =/> good (=/>score of 3)	Remark
1	Registration Process	3.44	93.0	Average
2	Attitude of Registration clerk			
	Privacy of registration	3.52	94	Average
3	Quality of waiting area	3.47	94	Average
4	Canteen facility	3.41	91.4	Average
5	Perception of Waiting time	3.39	91.7	Low
6	Nurse professional	3.35	89	Low
7	Doctor professional	3.51	95.7	Average
8	Ease of getting Lab tests	3.62	98	High
9	Sign posting to the Lab	3.42	92.5	Average
10	Cleanliness of Lab Area	3.49	93.4	Average
11	Information	3.53	96.6	Average
12	Pharmacists professional	3.61	97.4	High
13	Overall Satisfaction with treatment	3.59	96	High
14	Overall Satisfaction with Clinic services	3.59	97.7	High
15	**Mean rating for all service components**	3.57	96.4	High
16	Mean +/- 1 SD	**3.4884 +/-0.0822**		
		3.41-3.57		
17				

Table 3: Correlation between Sociodemographic Characteristics and Satisfaction with Process Quality Service Components.

	Registration process	Privacy of registration	Perception of waiting time	Ease of getting lab result	Signposting to lab	Information
Sex	.058 .319	.046 .425	.020 .732	.127 .051	.119 .072	.077 .183
Age	-. 059 .308	-.088 .127	-.041 .474	.006 .926	-.035 .596	-.086 .138
Educational Status	-.090 .120	-.077 .183	-105 .068	-.139* .033	-.121 .069	.016 .780

*sig <.05

Table 4: Correlation Between Sociodemographic Characteristics and Satisfaction with Structural Quality Service Components.

	Quality waiting area	Canteen Facility	Cleanliness lab area
Sex	.086 .136	.016 .781	.132* .045
Age	-. 059 .309	-.074 .199	-.045 .495
Educational Status	-.042 .466	-.076 .192	-105 .111

*sig <.05

Table 5: Correlation Between Sociodemographic Characteristics and Satisfaction with Technical Quality Service Components: Staff Interpersonal and Professional Ratings; Nurse and Registration Clerk.

	Nurse Helpful	Nurse Polite	Nurse Caring	Nurse Professional	Registration Clerk attitude
Sex	.019 .741	.018 .756	.005 .934	.056 .336	.022 .705
Age	-. 090 .121	-.031 .597	-.063 .279	-.057 .329	-.073 .210
Educational Status	-.036 .529	-.054 .348	-073 .210	-.066 .251	.003 .958

*sig <.05

Table 6: Correlation Between Sociodemographic Characteristics and Satisfaction with Technical Quality Service Components: Staff Interpersonal and Professional Ratings; Doctors and Pharmacists.

	Doctor Helpful	Doctor Polite	Doctor Caring	Doctor Professional	Pharmacists Helpful	Pharmacists Polite	Caring	Professional
Sex	.123* .033	.128* .027	.147* .011	.189** .001	.125 .059	.166* .012	.148* .026	.149* .026
Age	-. 100 .083	-.094 .105	-.134* .020	-.101 .082	-.026 .699	-.083 .209	-.069 .303	-.053 .434
Educational Status	-.008 .893	-.021 .718	-028 .627	-.057 .324	-.042 .525	-.022 .734	-050 .627	-.027 .686

***sig <.05, **sig < .005**

Table 7: Correlation Between Sociodemographic Characteristics and Overall Satisfaction Scores.

	Overall Satisfaction with Treatment	Overall Satisfaction with Clinic Services
Sex	.110 .056	-.079 .171
Age	-. 076 .188	-.106 .067
Educational Status	-.043 .456	-.063 .277

*sig <.05

Table 8: Mean Score and Correlation of Rating of Attitude of Clerical Staff with Registration Process and Satisfaction with Clinic Services.

	Mean Score	Registration Process	Satisfaction with Clinic Services.
Attitude of Clerk	3.52	.745 ** .000	.623 ** .000

****sig <.005**

Table 9: Mean Scores of Nurse Parameters and their Inter Correlation with Satisfaction Ratings.

Variable	Nurse Helpful	Nurse Polite	Nurse Caring	Nurse Professional	Overall sats. Treatment	Overall sats. Clinic Services
Mean Score	3.51	3.48	3.49	3.51	3.59	3.57
Nurse Professional	.673** .000	.788** .000	.729** .000	1.000	.566 ** .000	.549 ** .000

****p<.005**

Table 10: Mean Scores and Inter Correlation Between Rating of Clinical Care Components by Doctors and Satisfaction Ratings.

Variable	Time with Dr	Thorough care	Instruction on meds.	Health promo Talk	Explanation of care	Answers after Visit	Outcome Of consultation	Pro. rating	Overall Satsmed.care
Mean Score	3.67	3.70	3.64	3.61	3.58	3.51	3.56	3.62	3.54
Outcome of consultation	.615** .000	.652** .000	.658** .000	.725** .000	.702** .000	.792** .000	1.000	.522** .000	.521** .000
Overall sats. med care	.605** .000	.601** .000	.603** .000	.621** .000	.513** .000	.580** .000	.521** .000	.728** .000	1.000
Professional	.671** .000	.613** .000	.665** .000	.600** .000	.585** .000	.546** .000	.522** .000	1.000	.728** .000
Satisfaction treatment	.569** .000	.575** .000	.585** .000	.613** .000	.545** .000	.575** .000	.587** .000	.600** .000	.574** .000
Sats. clinic services	.603** .000	.598** .000	.643** .000	.556** .000	.621** .000	.590** .000	.581** .000	.515** .000	.604** .000

**p<.005.

Table 11: Mean Scores and Inter Correlation Between Interpersonal Skills of Doctors and Rating of Professionalism and Satisfaction.

Variable	Dr Helpful	Dr Polite	Dr Caring
Mean Score	3.65	3.61	3.64
Outcome of consultation	.518 ** .000	.527** .000	.529** .000
Overall med care	.780 ** .000	.805 ** .000	.700** .000
Professional	.816** .000	.827 ** .000	.899 ** .000
Satisfaction treatment	.585 ** .000	.558** .000	.587** .000
Satisfaction Clinic services	.553** .000	.539** .000	.536** .000

**p<.001.

Table 12: Mean Scores and Inter Correlation Between Pharmacist Parameters and Satisfaction Ratings.

Variable	Pharmacist Helpful	Pharmacist Polite	Pharmacist Caring	Pharmacist Information	pharmacist Professional	Overall Ph
Mean Score	3.59	3.59	3.56	3.59	3.59	3.55
Professional	.729** .000	.712** .000	.855** .000	.804** .000	1.000	.859** .000
Overall Ph care	.783** .000	.809** .000	.858** .000	.862** .000	.859** .000	1.000
Sats. treatment	.644** .000	.652** .000	.683** .000	.667** .000	.703 ** .000	.673 ** .000
Sats. Clinic Services	.637** .000	.661** .000	.678** .000	.715** .000	.677 ** .000	.745 ** .000

**p<.005

Table 13: Correlation Between the Rating of Provider Professionalism and Satisfaction with Treatment and Clinic Services.

Variable	Nurse Professional	Doctor Professional	Pharmacist Professional
Mean Score	3.51	3.62	3.59
Satisfaction treatment	.566 ** .000	.600** .000	.703** .000
Satisfaction clinic services	.549 ** .000	.515** .000	.677 ** .000

**p<.005

Table 14: Mean Scores and Inter Correlation Between Rating of Administrative Process Parameters, Information Parameters and Satisfaction with Clinic Management.

Variable	Waiting time	Registration Process	Ease of Lab tests	Information provision	Signposting to Lab
Mean Score	3.35	3.44	3.42	3.61	3.49
Sats. clinic Services	.613** .000	.572** .000	.597** .000	.727** .000	.722** .000

**p<.005

Table 15: Mean Scores and Inter Correlation Between Rating of Environmental Parameters and Satisfaction with Clinic Management.

Variable	Privacy of Registration	Quality of Waiting Area	Canteen Facility	Cleanliness Lab Area
Mean Score	3.47	3.41	3.39	3.53
Sats. clinic Services	.561** .000	.618** .000	.557** .000	.678** .000

**p<.005

Table 16: Pattern of Mean Scores of Rated Importance of Service Components.

Service Components	Number of Respondents	Range	Sum	Mean	Standard Deviation
Staff competence	300	1-5	829	3.91	.946
Ease of admin process	300	1-5	832	3.85	.923
Hospital environment	300	1-5	804	3.97	.943
Facilities/drugs available	300	1-5	801	3.90	.969
Pt Provider Relationship	300	1-5	819	3.84	.996
Affordable Cost	300	1-5	798	3.80	1.062

Determination of Service Gaps:

Table 17: Staff Competence: t test of Significance of the Difference Between Rated Importance and Rated Satisfaction of Staff Professionalism.

	Observed Mean	SD	Sample size	Null hypothesis	Diff. in mean	t-statistic	Df	P-value	95%CI for mean
Nurse professional	3.51	0.828	300	3.91	-.403	-8.437	299	.000	-.50—-.31
Doctor professional	3.62	.831	300	3.91	-.290	-6.042	299	.000	-.38—-.20
Pharmacist Professional	3.59	0.827	225	3.91	-.318	-5.743	222	.000	-.43—-.21

Table 18: Administrative Process Parameters: t test of Significance of the Difference Between Rated Importance and Rated Satisfaction for Related Service Components.

	Observed Mean	SD	Sample size	Null hypothesis	Diff. in mean	t-statistic	Df	P-value	95%CI for mean
Registration process	3.44	0.822	300	3.85	-.407	-8.569	299	.000	-.53—-.32
Ease of getting Lab tests	3.42	0.796	238	3.85	-.426	-8.250	299	.000	-.53—-.32
Waiting time	3.35	0.877	300	3.85	-503	-9.941	299	.000	-.60—-.40

Table 19: Hospital Environment Parameters: t test of Significance of the Difference Between Rated Importance and Rated Satisfaction with Related Service Components.

	Observed mean	SD	Sample size	Null hypothesis	Diff. in mean	t-statistic	df	P-value	95%CI for mean
Privacy of reg. process	3.47	0.786	300	3.97	-.503	-11.093	299	.000	-.59—-.41
Quality of wait area	3.41	.819	300	3.97	-.557	-11.767	299	.000	-.65—-.46
Canteen	3.39	0.865	225	3.97	-.577	-11.550	299	.000	-.67—-.48
Cleanliness of Lab	3.53	.755	232	3.97	-.444	-8.954	231	.000	-.54—-.35

Table 20: Patient –Provider Relationship: t test of significance of the Difference Between Rated Importance and Rated Satisfaction with Related Service Components.

	Observed Mean	SD	Sample size	Null hypothesis	Diff. in mean	t-statistic	df	P-value	95%CI for mean
Reg. Clerk ISR	3.52	0.82	300	3.84	0.32	-6.792	299	.000	.42—-.61
Nurse ISR	3.50	0.71	300	3.84	-0.34	-8.2943	299	.000	.26—-.42
Doctors ISR	3.63	0.75	300	3.84	-.21	-4.552	299	.000	-.53—-.72
Pharmacist ISR	3.54	0.79	225	3.84	-.30	-5.6962	224	.000	.20—-.40

Table 21: Distribution of Decision Factor for Using the Clinic among The Respondents.

Decision Factor	Frequency	Percentage
Good care	83	27.7
Good medical services	57	19
Good doctors	114	38
Safe care	41	13.7
Good environment	28	9.3
Best in town	9	3
"I like the clinic"	12	4
Affordable prices	15	5

References

[1]. Goodrich J., Cornwell J. Seeing the Person in the Patient: The Point of Care Review Paper. The King's Fund 2008. available @www.kingsfund.org.uk/publications. Accessed 23/07/16

[2]. Creel L.C., Sass J.V., Yinger N.C. Client-Centered Quality: Clients' Perspectives and Barriers to Receiving Care. Population Council and Population Reference Bureau. Available@ www.measurecommunication.org or www.prb.org. Accessed 10/04/16.

[3]. Agency for Health Care Research and Quality: The Six Domains of Health Care Quality. Available @ www.ahrq.gov. Accessed on 5/6/16

[4]. Yeddula V. R. "Healthcare Quality Room Issues" (2012). Industrial and Management Systems Engineering-Dissertations and Student Research. paper 29. http:/digital commons.unl.edu/imsediss/29. Accessed 10/04/16

[5]. Keegan O, McGee H.A. A guide to hospital Outpatient Satisfaction Surveys, Practical Recommendation and the Satisfaction with Outpatient Services (SWOPS) Questionnaire. Dublin Royal College of Surgeons in Ireland; 2003. Available athttps://epubs.rcsi.ie>psycholrep. Accessed 10/04/16.

[6]. Kravitz R. Patient Satisfaction with Health Care: Critical Outcome or Trivial Pursuit? J Gen Intern Med. 1998 Apr; 13(4): 280–282. doi: 10.1046/j.1525-1497.1998.00084.x

[7]. Koteswara R., Kondasani R., Panda R.K. Customer perceived Service Quality. Customer perceived service quality, satisfaction and loyalty in Indian private healthcare", International Journal of Health Care Quality Assurance, Vol. 28 Issue: 5, pp.452- 67, https://doi.org/10.1108/IJHCQA-01-2015-0008.

[8]. Berhane A., Enquselassie F. Patient expectations and their satisfaction in the context of public hospitals. Patient Prefer Adherence: 2016 Sep 22:10 :1919- 1928. eCollection 2016.

[9]. Kohn LT, Corrigan JM., Donaldson MS., To err is human: building a safer health system. Committee on Quality of Health Care in America. Available at https://www.ncbi .nlm.nih. gov>pubmed

[10]. Crow R, Gage H., Hampson S., Hart J., Kimber A., Storey L. Et al. The measurement of satisfaction with healthcare: implications for practice from a systematic review of literature. Health Technology Assessment 2002: Vol: 6 No: 32

[11]. Bowling A, Rowe G, Lambert N, et al. The measurement of patients' expectations for health care: a review and psychometric testing of a measure of patients' expectations. 2012. In: NIHR Health Technology Assessment program: Executive Summaries. Southampton (UK): NIHR Journals Library. 2003.

[12]. Valentine N.B., De Silva A., Kawabata K., Darby C., Murray C.J.L., Evans D.B. Health System Responsiveness: Concepts, Domains and Operationalization. In; Health Systems Performance Assessment. Chapter 43 pg. 574-590. Available at https:www.who.int.>publications>hspa

[13]. Agency for health care research and quality. What Is Patient Experience? Available at www.ahrq.gov>cahps. Accessed 6/3/19.

[14]. Umeano-Enemuoh J.C, Onwujekwe O.E., Uzochukwu B.S.C., Ezeoke O.P. Patient Satisfaction and Quality of Care in a Tertiary Institution in Southeast Nigeria. International Research Journal of Basic and Clinical Studies Vol2 (2) 14-19 Feb 2014

[15]. Obamiro J.K. Queuing Theory and Patient Satisfaction: An overview of Terminology and Application in Ante Natal Care Unit. Petroleum Gas University of Ploiseti. Vol. LXII No. 1/2010 p 1-11 Economic Science Series.

[16]. Iliyasu Z, Abubakar I S, Abubakar S, Lawan U M, Gajida A U. Patients Satisfaction with Services Obtained from Aminu Kano Teaching Hospital, Kano, Northern Nigeria. Niger J ClinPract2010;13:371-8

[17]. Oluwole A. Babatunde, Emmanuel Aiyenigba, Olugbenga A. Awoyemi et al. Primary Health Care Consumer's Perception of Quality of Care and It's Determinants in North Central Nigeria. Journal of Asian Scientific Research.2013, 3 (7):775-785.

[18]. Okpani AI, and Abimbola S. Operationalizing Universal Health Coverage in Nigeria through Social Health Insurance. Nigeria Medical Journal.2015 Sep-Oct:56(5):305-31.

[19]. ZakariyauYK, Mohammed MW, AliyuBalarabe. Social Security Reform and Service delivery: A stu1dy of NHIS (client-service providers relationship) in Kebbi state, Nigeria.. International Journal of Humanities and Social Sciences Invention. Vol 2 No51 may2013 pg 86-94

[20]. University of York. Center for Reviews and Dissemination. Enhancing Access in Primary Care Settings. Available at https://www.york.ac.uk>media>crd. Accessed 10/04/16

[21]. Adamu H., Oche M.O. Patient Satisfaction with services at a General Outpatient Clinic of a Tertiary Hospital in Nigeria. British Journal of Medical Research 4(11) 2014 SCIENCEDOMAIN international available @ www. Sciencedomain.org

[22]. Alazawi A.J. et al.: People's Expectations from Healthcare Providers – a Turkish perspective. BMC Health Services Research 2012 12(Suppl 1):P7. doi:10.1186/1472-6963-12-S1-P7

[23]. Wadhwa S.S. Customer Satisfaction and Health Care Delivery Systems: Commentary with Australian Bias. The Internet Journal of Health. 2 002Vol. 3. No. 1 p24.

[24]. Gang Ye, Rosen P., Collins B. et al, One-size does not fit all: Pediatric Patient Satisfaction within an integrated Health Network. American Journal of Medical Quality Web (October 7, 2015)

[25]. Ilesanmi O.S., Ige O.K. Equity of Care: Comparism of National Health Insurance Enrollees and Fee- Paying Patients at a Private Health Facility in Ibadan, Nigeria. Journal of Public Health and Epidemiology. Vol. 5(2)pp 51-55,February 2013 DOI:10.5897/JPHE12.047.

[26]. Michael GC., AliyuI.,Grema BA.,Thacher TD. Impact of structural and interpersonal components of health care on user satisfaction with services of an outpatient clinic in Nigerian tertiary hospital. Trop JMedRes2017;20:139-148

[27]. Tabler J., Scammon D.L., Jaewhan K., Farrel T. Tomoaia-Cotisel A., Magill M.K. Patient Care Experiences and Perceptions of the Patient –Provider Relationship: A mixed Method Study. Patient experience Journal: Vol.1: Iss.1, Article 13.

[28]. Bangladesh Syed S.A., Nazlee S., Shahjahan K. Patient Satisfaction with Health Services in Bangladesh. Health Policy and Planning, Volume22, Issue 4, July 2007.

[29]. Chen –Tan Lin, Gail A. Albertson, Lisa M. Schilling, Elizabeth M. Cyran, Susan N .Anderson, Lindsay Ware.et al. Is Patients' Perception of Time Spent with the Physician a Determinant of Ambulatory Patient Satisfaction. Archives of Internal Medicine July 2001. DoI:10.1001/161.11.1437

[30]. Berhane A, Enquselassie F. Patients' preferences for attributes related to health care services at hospitals in Amhara Region, northern Ethiopia: a discrete choice Experiment. Patient Prefer Adherence 2015 Sep 10;9:1293-301. Doi: 10.2147/PPa.S87928.eCollection 2015.

[31]. Abid Hussain., Muhammed S.S., Sardar M.U., Jinsoo H., Yushi J., Awaisra S. What Factors Affect Patient Satisfaction In Public Sector Hospitals: Evidence from an Emerging Economy. Int J. Environ. Res. Public Health. 2019,16,994; doi:10.3390/ijerph16060994.

[32]. Ha J.F., Longnecker .N. Doctor-Patient Communication: A Review. The Oschner Journal. Spring 2010:10(1):38-43

[33]. Wang X., Chen J., Burstrom B., Burstrom K. Exploring Pathways to Outpatients' Satisfaction with Health Care in Chinese Public Hospitals in Urban and Rural Areas Using Patient –Reported Experiences. Int. J. for Equity in Health Feb.2019.

[34]. Brennan MD. The Role of Professionalism in Clinical Practice, Medical Education, Biomedical Research and Health Care Administration. J Transl Intern Med 2016; 4:64-5.

[35]. Qadri S.S, Pathak R., SinghM., Ahluwalia S.k., Saini S., Garg P.K. An Assessment of Patients Satisfaction with Services Obtained from a Tertiary Care Hospital in Rural Haryana. International Journal of Collaborative Research on Internal Medicine & Public Health Vol. 4 No. 8 (2012).

[36]. Agency for Healthcare Research and Quality. Strategy 6G: Training to Advance Physicians' Communication skills. Available at https://www.ahrq.gov>cahps>strategy6… Accessed 29/3/19

[37]. Zarei E., Daneshkohan A., Arab M. The Effect of Hospital Service Quality on Patient's Trust. Marian Red crescent medical journal. 2015 Jan. :17(1): e17505.

[38]. Li H, Ding N, Zhang Y, Liu Y, Wen D. Medical Professionalism: A Systematic Review of Instruments and Their Measurement Properties. 2017 PLoS ONE 12(5): e0177321. https://doi.org/10.1371/journal.pone.0177321

[39]. Doubova S.V., Guanais F.C., Pérez-Cuevas R., Canning D., Macinko J., Reich M. R. Attributes of patient-centered primary care associated with the public perception of good healthcare quality in Brazil, Colombia, Mexico and El Salvador, Health Policy and Planning, Volume 31, Issue 7, September 2016, Pages 834–843,

[40]. Cordia J., Kumar R., Moss C. Debunking common myths about healthcare consumerism. December 2015 Article available at …https://healthcare.mckinsey.com>our insights

[41]. Norouzinia R, Aghabarari M, Shiri M, Karimi M, Samami E. Communication Barriers Perceived by Nurses and Patients. Glob J Health Sci. 2015 Sep 28;8(6):65-74. doi: 10.5539/gjhs.v8n6p65.

[42]. Sathish A.S., Indradevi R., Gangineni S. Service Quality and its Influence on Customer Satisfaction in a Multi-Speciality Hospital. IJRTE. ISSN :2277-3878, Volume-7.Issue-4S2, December 2018.

[43]. Enabulele O., Ajokpainiovo J., Enabulele JE. Patient Waiting and Consultation Time in the General Practice Clinic of the University of Benin Teaching Hospital Edo State Nigeria. J Family Med Community Health 5(2):1146

[44]. Efuteba C. Factors Influencing Customer Satisfaction in Health Care Services: The Case of Public and Private Hospitals in North Cyprus. Available at i-rep.emu.edu.tr>EfutebaCatherine

[45]. Pevec T, Pisnik A. Empirical Evaluation of a Conceptual Model for The Perceived Value of Health Services. ZdrVarst. 2018;57(4):175-182. doi: 10.2478/sjph-2018-0022.

[46]. Ogunfowokan O. and Mora M. Time Expectation and Satisfaction: Patient's Experience at National Hospital Abuja, Nigeria. Afr j Prm Health Care Fam Med. 2012;4(1), Art#398,6pages.http://dx.doi.org/10.4102/phcfm.v4i1.398.

[47]. ZhabyizShafiyeon. Affecting Emotion Through Design. How Design Can Affect the Emotions Of Waiting Time In Health Centers. Politecnico Di Milano.Dottorato Di Ricerca in design Cycle 27 Feb 2016 Available from The National Academies Press at http://www.nap.edu/catalog.php?record_id=1250

[48]. AnasAllahham. Determinants of Customer Satisfaction in Healthcare Services. International Journal of Business and Management Invention. ISSN (Online): 2319 – 8028, ISSN (Print): 2319 – 801X. www.ijbmi.org Volume 2 Issue 12 December. 2013 PP.59-63.

Abah Vivien O. "What Patients Value Vs What They Experience: Benchmarking for Patient Satisfaction with Quality of Care in the Family Medicine Clinic of a Tertiary Hospital in Nigeria." IOSR Journal of Dental and Medical Sciences (IOSR-JDMS), vol. 18, no. 8, 2019, pp 11-26.