Deanship of Graduate Studies
Al-Quds University

Patients' Satisfaction with the Quality of Services Provided at the Outpatient Department at Al-Shifa Hospital

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MPH Thesis

Jerusalem-Palestine

2010م / 1431هـ

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A thesis Submitted in Partial Fulfillment of Requirements
for the Degree of Master of Public Health
Al-Quds University

1431 / 2010هـ

Al-Quds University
Deanship of Graduate Studies
School of Public Health

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Jerusalem- Palestine

1431 / 2010

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed: ……..

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Date: January, 2010

Acknowledgement

I would like to express my deep gratitude to Dr. Yousef Al-Jeesh my supervisor for his inspiration, guidance, energetic commitment, unlimited support and encouragement.

Special thanks for Dr. Bassam Abu-Hmad, my academic instructor, and Dr. Yehia Abed for teaching us a new knowledge, skills, concepts of research techniques and interpretation of the results.

My thanks extended to all the academic and administrative staff of the School of Public Health for their guidance, academic services and support.

I would like to express my appreciation to Mr. Izzeldeen Al-Habbash and Mr. Raafat Alkhudary the administrator of the outpatients' department and his deputy for their advices and supports.

Special and great thanks for all my colleagues in Dr. Abdelazeez Al-Ranteesy specialized hospital.

I would like to deeply thank Miss. Neveen Al-Shaikh and Miss. Rabab Zomlt for their invaluable help in data collection process.

Special thanks to Mr. Saleh Al-Degess for his help in data analysis process.

Finally yet importantly, special thanks to the nice group with whom I spent the most beautiful days of my educational life, my classmates at the School of Public Health.

Naeem Shaban Al-Kariri

Abstract

Patient's satisfaction regarding health services is an indicator of the quality of the health care. This study aims to assess the patients' satisfaction with health services provided at Outpatients' Department at Al-Shifa Hospital.

The design of this study is descriptive, analytical one for eligible subjects. Self-administered questionnaire was developed and focused on patient's satisfaction with health services provided at the Outpatients' Department at Al-Shifa Hospital. Probability systematic random sample was used in this study and 450 participants were interviewed with a response rate of 90%. Validity and reliability of the instrument were tested and the total instrument reliability test (Cronbach's Alpha) was 0.91.

Five dimensions of patients' satisfaction were considered in this study; namely, access to care, physical environment, patients' expectations, waiting time in addition to information and interaction. The overall patients' level of satisfaction was 63.9%. The patients' expectation dimension reported the highest level of satisfaction (68.1%), while, the waiting time dimension reported the lowest level of satisfaction (58.5%). The study illustrated important differences in satisfaction in relation to patients' socio-demographic characteristics, health status and organizational characteristics.

The study revealed that, there were statistically significant differences in the overall satisfaction with old patients, females, low educated, patients with low income and patients with chronic diseases are more satisfied than their counterparts (P value less than 0.05). In contrast, residency place, marital status, number of visits, presence of disability, the recipient outpatient clinic and the residency place did not show statistically significant difference on patients' level of satisfaction (P value more than 0.05).

The study recommended that reducing the patients' time in the outpatient clinic, introducing improvement on existing physical environment of the department and improving the way of communication and interaction between health care providers and patients are important factors for improving the patients' level of satisfaction.

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List of abbreviations

ANOVA	Analysis of Variance
ASH	Al-Shifa Hospital
ASHR	Al-Shifa Hospital Record
CBR	Crude birth rate
CDR	Crude death rate
ESS	Earth Sciences Sector
GDP	Gross domestic product
GHI	Government Health Insurance
GNP	Gross National Product
GS	Gaza Strip
IMR	Infant Mortality Rate
MOH	Ministry of health
NCDs	Non-Communicable Diseases
ND	Neonatal Deaths
NGO	Non-Governmental Organization
NIS	New Israeli Sheqalim
OPsDs	Outpatients' Department
OPT	Occupied Palestinian Territory
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
PNA	Palestinian National Authority
PSI	Patient Satisfaction Index
SD	Standard Deviations
SPSS	Statistical Package for Social Sciences
TQM	Total Quality Management
UN	United States
UNRWA	United Nations Relief and Work Agency
US $	United States Dollar
WB	West Bank
WHO	World Health organization

Chapter (1)

Introduction

Introduction

1.1 Background

Patients deserve to meet their expectations and to be satisfied when they receive health care. It was decided early that the people have the right and sense of duty to participate individually and collectively in the planning and implementation of their health care (Declaration of Alma Ata, 1978). Patient satisfaction with health care is often associated with better compliance with treatment instructions, prompt seeking of care and a better understanding and retention of medical information. The greater the responsiveness of the health system to the expectations of individuals' regarding the non-health enhancing dimensions of care, the higher will be the level of welfare achieved, irrespective of its impact on health. For instance, while the ability to access emergency care promptly contributes to better survival and recovery rates, knowing that emergency care can be accessed rapidly provides peace of mind that has its own innate value. Likewise clean hospital surroundings and pleasant health care workers, who treat one with respect, improve a person's quality of life (WHO, Paper No, 32). Studies of Patient's satisfaction extend to various medical staff in health care organizations such as physicians, nurses and other medical professionals. The views and perceptions of these patients have an impact on the overall success of health care systems, also it is used as an indicator that recognized by managers for making organizational changes and improvements in their performance. Gathering the views and perceptions of patient is key of features of recent developments in society, and the health care systems have identified methods for assessing the views of patients, especially in the last decade (Wensing and Elwyn, 2002).

One of the main goals of quality improvement is to meet the needs and expectations of the customers, both internal and external. Therefore, for a quality improvement program to succeed, it has to identify its customers and learn their needs and expectations carefully, and find ways to meet them (WHO, 2004). Research in health outcomes takes into consideration patients' functional status, well being and satisfaction with care. In this time of scarce resources, it has become increasingly necessary to justify the impact of any health care circumstances.

The study of health outcomes looks beyond the physiological measures of success to examine the effects of the health care process on patients and populations. Health outcomes research seeks to understand the effects of health care providers' practices and interventions. Researchers in this field use various measures of outcomes in hope of using their findings to develop better ways to monitor and improve the quality of care; examples of measures of outcomes are psychosocial functioning, costs of care and patient's satisfaction with care (Arnold, et al., 2004).

In fact, a key lesson is that in many cases quality can be enhanced by making changes to health care systems without necessarily increasing resources. Interestingly, improving the processes of health care not only creates better outcomes, but also reduces the cost of delivering health care: it eliminates waste, unnecessary work, and rework (Massoud, 1994). There is strong evidence that design changes makes the environment more comfortable, aesthetically pleasing, and informative relieve stress among patients and increases satisfaction with the quality of care provided. Renovating a traditional waiting area in the clinic by making small changes to the general layout, color scheme, furniture, floor covering, curtains, providing positive environmental appraisals, improved mood, altered physiological state, and greater reported satisfaction among waiting patients (Ulrich, et al., 2004).

In a recent research Hillis (2008) recommends in her study about patients' satisfaction with physiotherapy services that, health professionals, physiotherapy managers and policy makers need to establish evaluative and monitoring system to detect and solve any problems that face patients and their families.

Hospitals are considered as appropriate settings for health promotion. The hospital environment should be supportive to health and benefiting not only the staff but also the patients and the community. A hospital should not only be a place to treat what affects the body but also a special place that offers source of comfort to the mind and spirit (MOH, Malaysia, 2003). The patient expects safety, security, support, competence, physical comfort and psychological comfort in the health care service environment (Fottler, et al., 2000). The physical environment of a hospital should be created to be healing in manner and the facilities designed to support its patients in coping with stress and promoting wellness (Ulrich, 1991). Scientific research suggests that positive health effects can be

gained in human well beings from exposure and interaction with natural environments (Frumkin, 2001). Health organization may have to close its doors without patients. Al-Shifa Hospital (ASH) is the biggest hospital in Palestine**,** much quality improvement research and programs had taken place in it, all departments of this hospital are important and considered good places for training and conducting research aiming to improve the satisfaction level of the employees and the patients (MOH, 2005). This research was conducted in the Outpatients' Department (OPsD) of this hospital, it concerned with the patients' who have changeable level of satisfaction as a response to the received health care services.

Many patients' related dimensions of satisfaction were studied, these dimensions contributed to improving the quality of health services for the individuals and the community (Arnold, et al., 2004). This study assessed the patients' level of satisfaction with the current health services provided at the OPsD at ASH. These dimensions included access to care, physical environment, patients' expectations, waiting time in addition to information and interaction**.** The researcher evaluated patients' level of satisfaction with these services from patient's perspective.

The findings of this study could be used effectively to provide the staff with greater understanding of their patients' expectations and needs. Therefore, this study could be considered as important base to improve the quality of health services and to increase patients' level of satisfaction with these services.

1.2 Problem statement

Issues intend to improve quality of health services are occupying significant attention of health planners thinking, who concentrate their efforts on ways that make patients more satisfied with health services, whether in governmental or non-governmental health facilities. It is always more pleasant to have care provided in an acceptable environment. A facility that pays attention to the minute details of its customers' comfort and well-being is a good quality facility (WHO, 2004)

Client quality is the domain that receives most attention in discussion of quality of health care based on how satisfied client are with their care. So, the real challenge is to improve

staff performance and patient satisfaction in order to minimize rework, wastage, delay and cost (Gadallah, et al., 2003). Assuring the good quality of services is an ethical obligation of health care providers. Good quality also offers practical benefits to clients and programs. These benefits include safety and effectiveness, Client satisfaction and Job satisfaction for providers, better program reputation and competitiveness, expanded access to services (El-Haj, 2008).

Inspite of the presence of high qualified health care providers, advanced diagnostic procedures and modern medical supplies in governmental facilities in Gaza Strip (GS) and West Bank (WB), there is a noticeable client's dissatisfaction with the quality of care in different health care settings (Massoud, 1994). There are benefits (decision making, strategic planning and program modification) in conducting evaluation of the quality of our services from the patient's view (Zarinpoush, 2006). Satisfaction studies are still considered as outcome indicators (Streveler and Skeik, 2004). Therefore, the patients' level of satisfaction of the Outpatients' Department was evaluated in this study. The services that may affect the level of outpatients' satisfaction and have been evaluated in this study are access to care, physical environment, patients' expectations, waiting time in addition to information and interaction. Thus, recommendations to the policy makers in the health organization were suggested for consideration in quality improvement issues.

1.3 Significance of the study

Patient's satisfaction studies show different and new dimensions of health care, which provide an open view towards improving the quality of patient's life, and increase health professionals and public awareness regarding health. One of the major problems in Palestinian health care system is lack of consideration of clients' satisfaction (Abu-Saileek, 2004). Taking client's satisfaction into consideration will decrease miss trust and clashes between public and health professionals. Client satisfaction evaluations are an excellent opportunity to involve clients or patients in the process of evaluating your program (WHO, 2000). Involvement of patients in evaluating health program will initiate new ideas and visions that lead to understand the patients' needs, therefore, embody their needs in health planning. Meeting patient's needs and expectations will improve their satisfaction level, this may lead to increase patient's adherence to the health instructions and habits, which in turn affects the whole health income. Studying of various dimensions of health services

will direct planning and implementation efforts to new dimensions of health services, which may be the reasons of dissatisfied patients who receives health care in governmental health facilities (Massoud, 1994).

This study has been conducted in the Outpatients' Department of Al-Shifa Hospital which provides health care for more than half million of Palestinians in Gaza Strip (MOH, 2005). Total number of patients served in year 2007 was 98028, and in year 2008 was 81891, with average numbers are 90000 patients per year, 7500 patients per month and 341 patients per day (ASHR, 2009). It's very important to evaluate the quality of health services provided to this number of citizens and to explore their opinions regarding these services to be included in future health planning. Also, this study assessed the effect of selected demographic, socio-economic, patients' health status and organizational factors on patients' level of satisfaction.

1.4 Overall aim and objectives of the study

1.4.1. Overall aim:

The aim of this study was to assess the patients' level of satisfaction with the quality of health services provided at ASH in Gaza Strip (GS).

1.4.2. Objectives:

1- To identify the effect of selected demographic, socio-economic, patients' health status and organizational factors on patients' level of satisfaction with the quality of health services provided at ASH.
2- To identify the effect of access to care on patients' level of satisfaction.
3- To identify the effect of existent physical environment on patients' level of satisfaction.
4- To identify the effect of information and interaction system on patients' level of satisfaction.
5- To identify the effect of patients' expectations on patients' level of satisfaction.
6- To identify the effect of waiting time on patients' level of satisfaction.

7- To suggest recommendations for policy makers in the health organizations that could help in improving patients' level of satisfaction and quality of the health services provided at ASH.

1.5 Research questions

1- Is the patients' level of satisfaction affected by demographic factors?
2- Is the patients' level of satisfaction affected by socio-economic factors?
3- Is the patients' level of satisfaction affected by the patient's health status factors?
4- Is the patients' level of satisfaction affected by organizational factors?
5- Is access to care affect patients' level of satisfaction?
6- Does existent physical environment affect patients' level of satisfaction?
7- Does information and interaction system affect patients' level of satisfaction?
8- Does patients' expectations affect patients' level of satisfaction?
9- Does waiting time affect patients' level of satisfaction?
10-What are the best strategies that could be used to improve clients' level of satisfaction and quality of health services provided at ASH?

1.6 Feasibility of the study

This study conducted to assess the patients' level of satisfaction with the quality of health services provided at the OPsD ASH in (GS), as a part of the researcher's graduate study at Al-Quds University. Approval for conducting the study was obtained from responsible professionals in both the Ministry of Health (MOH) and Al-Quds University. Additionally, an official letter of approval to conduct the study was obtained from Helsinki committee which is the national ethical research committee in GS. The access of Al-Shifa Hospital is not difficult and the cost of transportation is tolerable. An agreement with general director of Al-Shifa Hospital was obtained, that makes the implementation of the study more feasible. The study was mainly self funded, and was supervised and coordinated by responsible peoples in MOH and Al-Quds University.

1.7 Context of the study

The study was conducted in GS in Palestine. Therefore, it is worthwhile to understand the circumstances that contribute in forming the Palestinian health system's features and their effect on the Palestinian population. So, the researcher presents some background information about the geographical context, Palestinian population, Palestinian economy that may interact with each other to influence the health situation and health care services in Palestine.

1.7.1. Demography:

Palestine is located in Western Asia on the eastern coast of the Mediterranean Sea. It has common borders with Lebanon, Syria, Jordan, and to Egypt (Annex 1.1). The entire area of Palestine is about 27000 sq. km. (MOH 2005). Palestine comprises a significant variation of morphological and climatic regions, and this makes it of important geographic position (Dellapergola, 2001). The population size in Palestine was estimated at 3,761,646 in 2007. Out of the total number 2,345,107 in the WB and 1,416,539 in the GS with percentages of 62.3% and 37.7% respectively. Al-Khalil governorate had the highest rate of population at 13.9% of the total population, followed by Gaza governorate at 13.2%. Jericho governorate had the lowest rate of population at 1.2% (PCBS, 2007).

GS goes along with the Mediterranean Sea between occupied land on 1948 and Egypt. Gaza strip is about 365 square kilometers (Annex 2.1). Its length from Rafah in the south to Beit-Hanoon in the north measures 50 kilometers long and 5-12 kilometer wide. The GS administratively divided into five governorates, North, Gaza, Midzone, khanyounis and Rafah (17%, 20.3%, 15%, 30.5% and 16.2% of GS total area respectively). It has four towns, fourteen villages and eight refugee camps (MOH, 2005). The mid year population size of GS is estimated at 1,416,539 and constitutes about 37.7% of total population in GS and WB (PCBS, 2007). Regarding population density in GS, it is about 3,881 inhabitants per one sq. km. which considered as the second most populated place on the earth after Hong Kong (World Bank, 2002). The following are some demographic indicators in NPA:

Population under 15 and above 65 years: The percentage of population under 15 years old is 46.3% of the total population in Palestine (44.2% in WB and 49.1% in GS). The

percentage of Palestinians who are 65 years and more in Palestine is 2.8% (3.1% in WB and 2.5% in GS) (PCBS, 2007).

Sex ratio in Palestine: The estimated number of males in Palestine is 1,908,432 compared with 1,853,214 females; the sex ratio in Palestine is 103. In WB, the number of males 1,189,724 compared with 1,155,383 for females. In GS, the number of males 718,708 compared with 697,831 females (PCBS, 2007).

The median age in Palestine: There is a slight increase in the median age for population in Palestine between 1997 and 2005, where it increased from 16.4 years in 1997 to 16.7 years in 2005. Regional comparison shows that in WB the median age increased from 17.4 years in 1997 to 17.7 years in 2005 and from 14.8 years in 1997 to 15.4 years in 2005 in GS (PCBS, 2007).

Population natural growth rate: The natural growth rate has increased in Palestine at 3.3% (3.0% in WB and 3.8% in GS). MOH has reported that Population natural growth rate in Palestine is 2.5% in 2005 (3.1% GS and 2.1% WB) (PCBS, 2007).

1.7.2. Palestinian economy:

In Palestine, during the last five years, there were high fluctuations in economic status. According to World Bank report, the Palestinian economy is highly sensitive to external stimuli, due to its degree of dependence on Israel and in foreign assistance; the impact of the suspension of clearance revenue transfers and restrictions on movement. The report stated that, suspending revenue transfers, constraining Palestinian movement and access and reducing aid flows would cause severe economic damage. Real Gross Domestic Product (GDP) per capita declines by 27 percent in 2006, and personal incomes by 30 percent; a one year contraction of economic activity equivalent to a deep depression. By 2008, unemployment hits 47 percent and poverty 74 percent (World Bank, 2007). The following are some economic indicators in PNA:

Gross National Product (GNP): In Palestine GNP had been subjected to fluctuations since 2000. GNP was US $ 5,454 million in 1999 and dropped to US $ 4,169 million in 2005 (World Bank, 2007).

Gross Domestic Product (GDP): In 1999, the GDP was US $ 4,512 million. But since 2000 when Israel imposed a strict closure on Palestinian territories as a response to the second Intifada, it decreased to US $ 3,557 millions in 2002. In 2004, the GDP recovered slightly and continue in this recovery for nearly two years. But, due to continued growth in settlements and the cut off in the direct aid as a result of last parliament elections, GDP fell again in 2006. GDP is expected to be about US $ 3,901 million in 2007 (World Bank, 2007).

Unemployment rate: The unemployment rate has increased from 11.8% in 1999 to 32% in 2005. In general, the unemployment rate in the GS was higher than it in the WB (World Bank, 2007).

Poverty rate: The poverty rate in Palestine is about 44% in 2005, And it increased to 67% in 2006 (MOH, 2005). World Bank expected that the rate at 2008 will be about 74 percent (World Bank, 2007).

1.7.3. Educational indicator:

The Palestinian population appears to be relatively well educated. In 2006, the illiteracy rate among individuals 15 years and over in the Palestinian Territory reached 6.5%, it was decreased in the period 1995-2006 from 15.7% to 6.5% (PCBS, 2007).

1.8 Health Care System and health indicators

1.8.1. Health situation in Palestine:

MOH today will not be able to outdo the challenges of diseases, without available data of the prevalence, incidence and severity of diseases. The first one of these challenges is Non-Communicable Diseases (NCDs) like cardiovascular diseases, hypertension diseases, diabetes mellitus and accidents. MOH focuses on mortality rate to estimate the impacts of these diseases. The second challenge is the non computerized system, as in Primary Health Care (PHC) system which accounts the visits of the patients to their clinics that used non computerized system, which does not reflect the real prevalence or incidence. Also, there is no information about disabilities that resulting from the chronic

diseases. This scarcity of information leads to inability to estimate the direct and indirect cost; other required resources such as drugs, policy and decision-making regarding prevention and treatment (MOH, 2005). The third challenge is the need to physiotherapy services which are increased during Intifada and after the war on Gaza Leads to accommodate the needs of people with disabilities and injuries which are given to all ages by specialized physiotherapists and physiotherapists assistants (Hillis, 2008).

On the other hand, there is available data about cancer morbidity by Cancer Registry Centers in both Gaza and Beitjala that play main role in documenting, reporting and classifying cancer cases. According to data about accidents are available in MOH that provides the data about mortality and in Police directorate that provides information about morbidity. Although, the statistical data is rare on NCDs and the bad political situations, which have negative effects on our lives. MOH works with all efforts to organize and implement a unified health strategy for the prevention and controlling these diseases. Additionally, the Palestinian health authority has strong surveillance system and succeeded in preventing and controlling many infectious diseases through the effective programs of vaccination, early detection of diseases and health education of people. Nowadays, there is a remarkable improvement in the health care services, health awareness and the living standards that revealed by:

Infant Mortality Rate (IMR): Reflected the improvement of health care services according to MOH data in 2004. The average of IMR during the last five years was 22.5 (per 1000 live births). In 2004, the IMR in the GS was 20.5 per 1000 and 14 in WB (MOH, 2005).

Crude birth rate in Palestine (CBR): The CBR in Palestine dropped from 42.7 births per 1000 population in 1997 to 37.5 per 1000 population in 2005. However, there are regional discrepancies where the CBR in WB decreased from 41.2 births per 1000 population in 1997 to 34.5 per 1000 population in 2005. In GS, the CBR dropped from 45.4 in 1997 to 41.7 per 1000 population in 2005. MOH has reported that CBR in Palestine is 27.5/1000 population in 2005 (33.7 GS and 23.9 WB) (PCBS, 2007).

Crude death rate in Palestine (CDR): The CDR in Palestine declined from 4.8 deaths per 1000 population in 1997 to 4.0 in 2005. There is slight difference between WB and GS. In

WB, the CDR dropped from 4.9 in 1997 to 4.1 in 2005, where it dropped from 4.7 to 3.8 in GS for the same period. These results indicate that there is an improvement in the living standards, health services, and health awareness among people. MOH has reported that CDR in Palestine is 2.7/1000 population in 2005 (3.1 GS and 2.5 WB) (PCBS, 2007).

The median age in Palestine: There is a slight increase in the median age for population in Palestine between 1997 and 2005, where it increased from 16.4 years in 1997 to 16.7 years in 2005. Regional comparison shows that in WB the median age increased from 17.4 years in 1997 to 17.7 years in 2005 and from 14.8 years in 1997 to 15.4 years in 2005 in GS (PCBS, 2007).

Life expectancy: In Palestine the life expectancy was 71.7 years for males and 73 years for females in 2005. There are regional discrepancies; life expectancy in WB is 71.7 years for males and 73.4 years for females compared with 71.2 years for males and 72.3 years for females in GS. The improved health situation and the gradual decline in the infant and child mortality rate contributed to longer life expectancy (PCBS, 2007).

In 2005, the causes that lead to death in the Occupied Palestinian Territory (OPT) (among all age groups) were cardiac diseases (21%), vascular and brain accidents (11%), cancer (10.3%), neonatal conditions (8.6%), and accidents (5.4%) (MOH, 2005).

1.9 Palestinian health system Overview

The health care system in the West Bank and Gaza is extraordinarily complex and fragmented. It has various layers. Today it has at least five distinguishable components:

Ministry of Health (MOH): In 2002 it operated 23 of the 76 hospitals in the WB and GS with a total of 2613 beds. Hospitals of MOH are somewhat larger on average, however, it accounted for 55% of beds. In 2002 it also operated 375 of the territories 603 PHC centers. This represents a very rapid growth since the creation of the MOH in 1994. About 170 new facilities were opened - mostly in the WB – in fewer than 10 years. Some of these were taken over from the Non-Governmental Hospital (NGO) sector and about 90 of them are so-called “village health rooms” or “Level I” units (World Health Assembly, 2005).

United Nation Relief and Work Agency (UNRWA): This is primarily an outpatient system which in 2001 operated 51 centers and one hospital. UNRWA serves all those individuals and their descendents who were displayed in the war of 1948. This now applies to 1.5 million Palestinians 30% of the population in the WB and more than 75% of those in GS (World Health Assembly, 2005).

Non-Governmental Organizations (NGOs): These sectors are vary widely from longstanding missionary hospitals, to facilities supported by international organizations, to community health centers organized by political factions, and/or supported by Islamic charities. These sectors tend to be relatively small and have been declining in number since 1994. However, NGOs are the second largest hospital provider controlling 1644 beds in 31 hospitals or about 1/3 of the total beds. This includes some very substantial hospital and outpatient facilities in East Jerusalem and the WB (World Health Assembly, 2005).

The private sector: In 1997 a household survey suggested that half of all outpatient consultations went to private providers. However, there is no way to know on an ongoing basis how many visits they now provide, although the numbers appear to have been declining in recent years as noted above. We do know that in 2002 the private sector operated nearly 500 beds, in 21 hospitals, many of which were specialized maternity beds. As these numbers indicate, many of these institutions are quite small. There are also some private diagnostic units (World Health Assembly, 2005).

Hospitals outside the territory of the Palestinian Authority (PA): According to the World Bank (2002) these institutions were accepting over 100 admissions a week in the first 6 months of 2003 with the largest share (3/4) going to Egypt. By the end of 2004 these numbers were considerably larger. Several institutions notably, Palestine Hospital and Nasser Institute in Cairo, Jordan Hospital in Amman, in addition to Tel-Hashomer and Echelof Hospitals in Israel play especially significant roles. A substantial number of cases were also referred to institutions outside the territory of the PA for outpatient treatment. Again 2003-04 saw a very substantial increase over 2002 levels (World Health Assembly, 2005).

1.10 Health services in Palestine

The mainly health services provided by the Palestinian health care system are Primary Health Care (PHC), laboratories and blood banks, hospitals, health human resources, health finance, governmental health insurance, treatment abroad, and health projects (MOH, 2005).

PHC is one of the most important components of the Palestinian health care system. PHC centers provide accessible and affordable health services for all Palestinians, especially for children and other vulnerable groups (MOH, 2005). MOH is working with other health sectors in providing the primary health services, mainly UNRWA and NGOs. It is worth mentioning that private sector plays an important role in providing PHC services to the Palestinians (MOH, 2005). Hospitals and the other for mentioned components of Palestinian health care system are also of key importance for the effective and complementary performance of the Palestinian health care system (MOH, 2005).

Secondary health care is mainly provided by MOH. The other component of Palestinian health system is providing secondary health services in different degrees (MOH, 2005).

Tertiary health care. MOH is the main health provider beside other health providers like Medical Services for Police and General Security, UNRWA, NGOs and private health sector which provide physiotherapy services which increased during Intifada. During 2004, the physiotherapy departments in the MOH hospitals in the GS and WB offer about 62,588 sessions. The main bulk was rendered in the GS MOH hospitals 45,465, with 72.64% of the total (MOH, 2005). There are a number of physiotherapy departments in MOH hospitals that estimated 8 departments and two physiotherapy departments in PHC, seven physiotherapy departments in UNRWA, three physiotherapy departments in Medical Services for Police and General Security and many physiotherapy departments in NGOs and private health sector which offer physiotherapy services (MOH, 2005). The Palestinian National Authority (PNA) purchases services from foreign institutions for the residents of the GS. Some of the services do not exist at all in the GS and some services although exists, it is performed at a low level of performance that is insufficient to treating the most complicated cases. The purchased services include catheterization, cardiac surgery, burns management, pediatric cardiology, neurosurgery, orthodontic surgery, and

radiotherapy and radio diagnosis in addition, to transplant surgery and oncology (MOH, 2005). Egypt, Israel, and Jordan are the main countries from which the PA has purchased the services at a full cost. About 7,805 certificates of referral for medical treatment outside GS were issued by the Palestinian authority in 2003 (MOH, 2005).

1.11 Hospitals in Palestine

There are 78 hospitals in Palestine. The population/hospital ratio is 47,920. In GS there are 24 hospitals with population/hospital ratio 57,098. In WB and Jerusalem, there are 54 hospitals with population/hospital ratio 43,844. The average bed capacity per hospital in the GS is 79.88 beds, while it is 51.15 beds in WB (MOH, 2003). According to hospitals categories, they are divided into 45 general hospitals with 3726 beds, 10 specialized hospitals with 812 beds, 19 maternity hospitals with 322 beds, and 4 rehabilitation centers with 165 beds. Despite the availability of maternal departments in the general hospitals, MOH doesn't own any obstetrics or gynecology hospitals. All rehabilitation centers are owned and operated by NGOs (MOH, 2005). In general, access to Palestinian hospitals is considerably good (MOH, 2005). Recently, the Jordan hospital is a new hospital constructed to treat many specialized diseases. It received patients in order to treat and make minor and major operations for a big number of patients.

1.11.1. Al-Shifa Hospital (ASH):

ASH is the biggest governmental health organization in Palestinian. It considered as a secondary health care delivery organization. The hospital has been established in 1946 on an area of over 45.000 Sq. M. and it is developed over years until now and several constructions were established like radiotherapy department, burn department, special surgery department, second floor in internal medical department. ASH is subdivided into 3 hospitals as surgical hospital, medical hospital and obstetric and gynecology hospital. In 2006 the hospital capacity grow to be 590 hospitalization beds, distributed in medicine departments, general and specific surgeries departments, burn unit, intensive care unit, obstetric and gynecology and neonatal departments. There were 93 daily care beds in the hospital, that included oncology, dialysis, emergency department and other specialized clinics, also a total number of employees are 1285 represents all categories work in the hospital (400 physicians, 432 nurses, 23 pharmacists, 143 administrators, 109 technicians,

112 workers and 22 others). The hospital offers paramedical services such as laboratory, radiotherapy, pharmacy and physiotherapy, each hospital has its own managerial team and each manager submit to the general director of the hospital. The average occupancy rate at ASH in 2002 was 84.6% including the occupancy rate of day care beds. The average length of stay was 3 days (MOH, 2005).

1.12 Outpatients Department (OPsD) at Al-Shifa Hospital (ASH)

OPsD is the biggest department in ASH It includes twenty one sub-clinics related to the medical, surgical and paramedical services like, x-ray department, laboratory, minor operations room and administration department. The sub-clinics were distributed over the five days. It serves about 90,000 patients every year, 7500 patients per month and 341 patients per day treated in different sub-clinics present in the OPsD (ASHR, 2009). This study was conducted in this department in order to assess the outpatients' level of satisfaction with the quality of health services provided at ASH.

1.13 Operational definitions

Evaluation: It's a periodic progression of gathering data and then analyzing or ordering it in such a way that the resulting information can be used to decide whether your organization or program is effectively carrying out planned actions, and the degree to which it is achieving its stated objectives and expected outcomes (Martinez, 2005).

Quality: It may be defined in different perspectives: From patient's perspective is getting his care when he needs it, and to cure his condition in the fastest possible way, from qualified and skilled health providers in the OPsD of ASH. While from perspective of the administrator is to provide effective care in a cost-conscious environment that may include the rationing of health care especially when resources are limited.

Health services: Are the facilities and the procedures that the clients or the patients receive in the OPsD. It may be direct interventions to the clients as treatment, diagnostic measures and minor operations, or indirect interventions as discipline of the work, waiting time, health insurance, and good ventilation.

The client/patient: Is the person who suffers of abnormal health situation and seeks for treatment or diagnosis.

The outpatient: Is the sick person who treated or diagnosed in the OPsD without being admitted to the internal departments of ASH.

Outpatients' clinic: Is a health center that provides health care to the clients and community without admission. It has the right of referral cases to the main hospitals in the country. Big hospitals as ASH have OPsD in order to follow up or to receive new patients.

Satisfaction: Is a situation whereby the person feels pleased.

Patient's satisfaction: Is a situation whereby the patient meets his needs and expectations from the health services provided at OPsD at ASH.

Level of patient's satisfaction: Is the degree or the point that the health services obtained by OPsD meet the patient's needs or expectations.

Access to care: It means easy attendance of the person to the OPsD at ASH, readiness of health care providers, medical supplies, laboratory examinations, pharmacy, x-ray department, the ability of the patient to pay for those services and to benefit from the care.

Patient's expectations: The needs, wants, and predetermined ideas of a patient about the OPsD, the patient expects to encounter efficiency, helpfulness, reliability, confidence in the staff, and a personal interest in his or her support (Medical dictionary/expectation).

Information and Interaction: It's a process of cooperation between health care providers and the patients in order to achieve the common goals.

Physical environment: It means all of physical circumstances in the OPsD, such as noise, weather changes, wide space, clean water, lightening, ventilation, odors and easy movement.

Waiting time: The time patient spends from going to the OPsD, acceptance into an eligible class for treatment, meeting the physician, getting needed health services till going outside of the OPsD (Medical Professional Liability, 2004).

1.14 Layout of the study

Chapter one: Introduction:

At the beginning of this chapter, the researcher gave an introductory background of the study, and then the researcher sets the problem, significance, the aim, objectives, the research questions and the feasibility of the study. Then the researcher discussed in some details the context of the study. Lastly, the researcher clarified the operational definitions of the study concepts.

Chapter two: literature review:

The literature review aims to recognize the theoretical framework that the concepts of the study can be discussed and analyzed. Also, it aims to be depending on a scientific base that the study aimed to participate in building it. So, the researcher discussed in details the study concepts such as, evaluation process, the term quality and revealed the definitions of the concept satisfaction. Furthermore, the researcher illustrates the dimensions of patients' satisfaction and the factors that affect patients' level of satisfaction with health services. Consequently the researcher revealed results of studies concerned with patients' satisfaction, global studies were set firstly, then studies that conducted in Arab world and finally studies that conducted in Palestine. After that the researcher summarized these studies and compare between them and link that to this study.

Chapter three: Methodology of the study:

This chapter present practical steps of the study, it illustrates the study design, and the type of the study. Also it illustrates the intended population, study sample and the selected process of the participants. Further, it gives information about the place of the study and training of the collectors of data. Then, steps of data collection, entry and analysis were set. Ethical consideration, questionnaire designing, pilot study, psychometric properties

(reliability and validity), response rate, eligibility criteria (inclusion and exclusion), period of the study and the budget of the study were presented in this chapter.

Chapter four: Results and Discussion:

The aim and the objectives were achieved, and the study questions also were answered in this chapter. Firstly, descriptive of the study population characteristics were illustrated, demographic, socio-economic and health status of the respondents were presented, the system related factors also presented. Then, the differences between these characteristics regarding the selected satisfaction dimensions were presented in this chapter, the results of this study were compared with results of previous studies that conducted mainly in Palestine. Finally, the study dimensions of satisfaction and selected items of each dimension were discussed in details, comparison between the dimensions of the study was presented.

Chapter five: Conclusion and Recommendations

The extract of the previous chapters was presented in this chapter. The researcher presented the conclusions extracted from the study. Then recommendations for each of the administration of the hospital, the health providers and for the patients were presented, then general recommendations also presented. Then the researcher suggested areas for more research.

Chapter (2)

Literature review

Literature review

2.1 Introduction

This chapter illustrates issues that are related to patients' satisfaction. It starts with the theoretical framework of the study that illustrates the main dimensions of patients' satisfaction and the factors that may affect it. Then, the chapter depicts the definitions of patients' satisfaction and the link between patient satisfaction and quality of health care. Also, it defines evaluation of health programs and their benefits in health improvement. In addition, it presents the methods of measuring patient satisfaction. Moreover, it identifies dimensions of satisfaction and revealed the impact of selected patient's and organizational characteristics on patients' satisfaction. Furthermore, it demonstrates the factors affecting patients' satisfaction and shows the relationship between patients' satisfaction and health care settings. Lastly, it depicts the previous studies related to the patients' satisfaction with health care services globally, in Arab world and in Palestine.

2.2 Theoretical definitions

The researcher decides to study the outpatients' services provided at ASH and their possible effects on the patients' level of satisfaction. It's worthwhile before going deep in the forest, to draw the road map. The following paragraph illustrates the theoretical definitions of the dimensions of the study.

Quality: The totality of features and characteristics of a product or service that bears on its ability to meet a stated or implied need (Shouroki, 2007).

Patient satisfaction: The degree to which the individual regards the health care service or product or the manner in which it is delivered by the provider as useful, effective, or beneficial (Biology-online, 2008).

Access to care: Defined as the ability of a person to receive health care services, which are a function of, availability of personnel, supplies and ability to pay for those services (Medical Dictionary/access). Also, it could be defined as the degree to which health care

services are unrestricted by geographic, economic, social, organizational, linguistic, or other barriers (Massoud, 1994).

Physical environment: The external surrounding and conditions in which the situation exists, the extent of positive perception of living, facilities, equipment and supplies in acute or long-term care settings (Medical Dictionary/physical).

Patient's expectations: The needs, wants, and predetermined ideas of a patient about a health care, the patient expect to encounter efficiency, helpfulness, reliability, confidence in the staff, and a personal interest in his or her support. If patient's expectations are met, then patient satisfaction results (Medical Dictionary/expectation).

Waiting time: The time that a person spends from going to the clinic, acceptance into an eligible class for treatment, meeting physician, and getting needed health services till going outside the clinic (Concise Dictionary, 2004).

Information and Interaction: The two-way process in which includes both care providers and patient have a responsibility to the other. A successful care providers-patient relationship is largely dependent upon effective communication skills and the care providers' sensitivity to the patient's needs. Effective medical practice requires positive interaction between physicians and patients (Medical Professional Liability, 2004).

Fig. (2.1) illustrated the dependent and independent factors of the study as the following:

The dependent factors: Access to care, physical environment, patients' expectations, waiting time in addition to information and interaction**.**

The independent factors: Demographic characteristics (gender, age and residency place), socio-economic characteristics (marital status, educational level and monthly income), patient's health status characteristics (number of visits, type of the disease and disability) and organizational characteristics (type of the clinic, the consumed time and area that consumed more time.

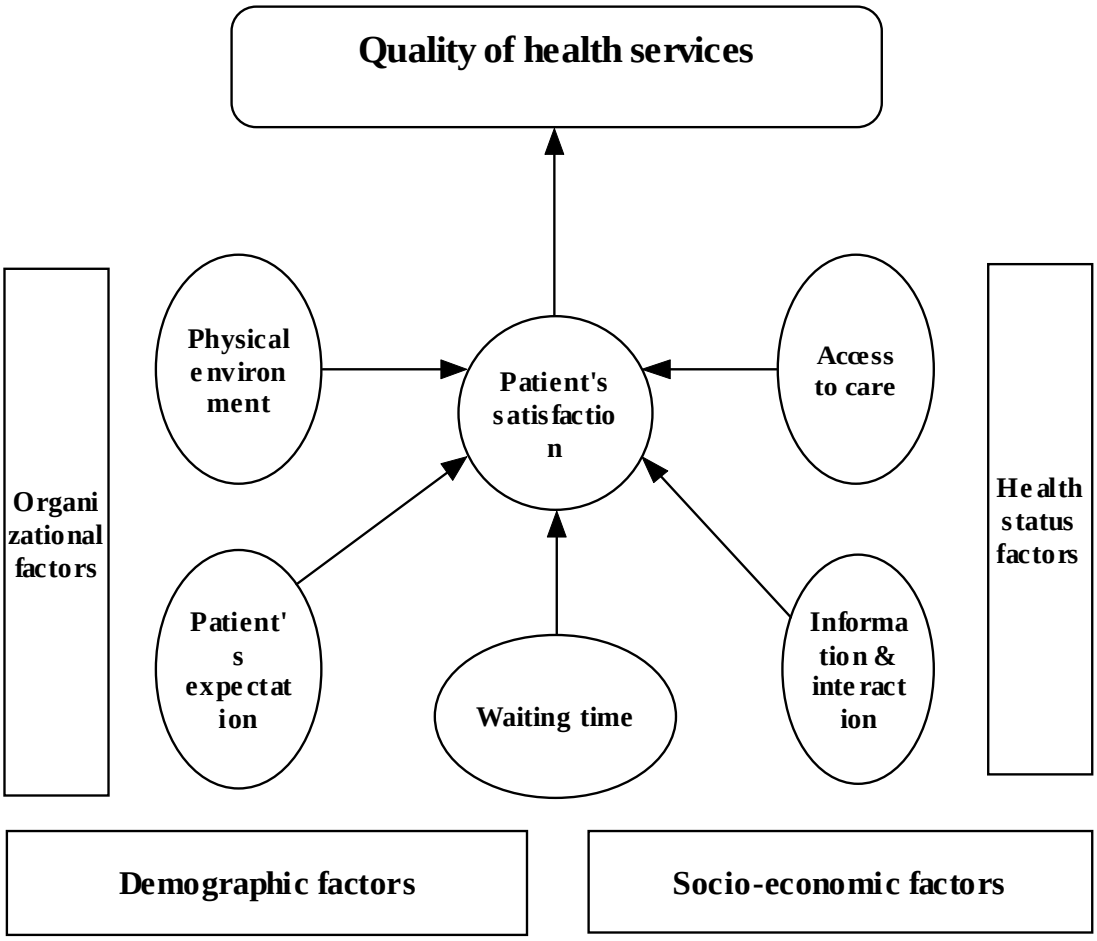

Fig. 2.1: Study dimensions of patients' satisfaction and the factors that may affect it in the Outpatients' department at Al-Shifa Hospital. (Self developed)

2.3 Theories of satisfaction

Maslow's hierarchy of needs: Maslow was the first theorist who connect the creation of the existence of peoples perception with the maintenance of the classified needs However, the hierarchy is usually shown as ranging through five main levels, the lowest level physiological needs, through safety needs, love needs, love needs and esteem needs to the needs of actualization at the highest level ((Maslow, 1943). He assumed that a person attempt to satisfy the more basic needs (physiological) before directing behavior toward satisfying upper level needs (self actualization).

Alderfer's ERG theory: Alderfer presented a modified need hierarchy model, Alderfer concised the hierarchy level of Maslow by three levels (ERG Theory) as follows: existence needs based on survival, relatedness needs based of people to live and function in social environment and growth needs based on the people to develop their potential. The ERG theory implies that individuals are motivated to engage in behavior to satisfy one of the three sets of needs. In addition, it states that an individual is motivated to satisfy one or more basic set of needs. Therefore, if a persons needs at a particular level are blocked then the manager should pay attention to focus on satisfying the needs at the other levels (Alderfer, 1972).

Locke's Goal Theory: lock accepted the importance of perceived value, as indicated in expectancy theories and suggests that these values give rise to experience of emotions and desires, people strive to achieve goals in order to satisfy their emotions and desires. Goals guide people's responses and actions. In addition, goals direct work behavior and performance and lead to certain consequences or feedback (Locke, 1979).

Vroom Expectancy Theory: Vroom (1982) was the first person who linked expectancy theory to work motivation. The model contains three key elements that are valance, instrumentality and expectancy (VIE theory). Valance refers to the feelings about specific outcomes, instrumentality links to the achievement with performance and expectancy is the relationship between a chosen course of action and its predicted outcome.

2.4 Definitions of patient satisfaction

A review of the health literature relating to the term "patient satisfaction" shows little research on the topic in the 1960s and 1970s. However, things began to pick up dramatically in the early 1980s. Between 1980 and 1996, there was a five-fold increase in the number of articles devoted to this topic. The causes of this development of the topic may be due to natural outgrowth of the consumer movement begun in the 1960s and 1970s, the maturation of the family medicine research agenda, take patients satisfaction into account of policy makers and competitive nature of health organizations (Carolyn, 2007).

> "Satisfaction, like many other psychological concepts, is easy to understand but hard to define. The concept of satisfaction overlaps with similar themes such as happiness, contentment, and quality of life. Satisfaction is not some pre-existing phenomenon waiting to be measured, but a judgment people form over time as they reflect on their experience" (Al-Sharif, 2008).

Patient satisfaction is a crucial aspect of health care (Fottler, 1987; Clearly and McNeil, 1988; Fitzpatrick, 1991).

Due to the fact that patient satisfaction is a multidimensional concept, there is no any standard definition of satisfaction was observed in the literature that is difficult to be accurately defined and measured (Schomer and Kucukarslan, 1997). Although attempts were made to describe the concept satisfaction and how the patient becomes satisfied with some services and not satisfied with others. Different definitions of the concept satisfaction were generated by different persons depend on the individual's experiences and background (Ware and Stewart, 1978). In their comprehensive review of the literature on patient satisfaction Crow et al. (2002) stated that two conclusions were generated: *(a)* Satisfaction does not imply superior services, only adequate or acceptable services. *(b)* Satisfaction is a relative concept, therefore, what satisfies one person may dissatisfy another. Even though satisfaction is not the only form of patient assessment of care, patient satisfaction and its correlates are predominant in quality care assessment studies. Most reviews of the literature have been critical of it use since there is rarely any theoretical or conceptual development of patient satisfaction, little standardization, low reliability and uncertain validity of measures (El-Haj, 2008).

Wright (1998) suggested that patients' satisfaction is associated with need fulfillment and patient's experience, for example, the patient who not received good communication with the medical team or not complete his examinations in one day become dissatisfied with this care. Pascoe (1983) defined patient satisfaction as a health care recipient's reaction to salient dimensions of the context, process and result of their process experience. Whereas Gerteis et al. (1993) defined the concept by examining two distinct domains: the first is "technical" domain that relate to the skills and techniques of care providers and the effectiveness of the results. The second is "experiential" domain that relate to the subjective perspective of quality based on a patient's experiences with care.

People are satisfied when they get what they expect, or better than they expect. However, others argue that there is little evidence to support this claim and that some research data can challenge the proposed link between expectations and satisfaction (Medigovich et al., 1999). Singh (1990) noted that there is consensus in the literature that patient satisfaction is as a multidimensional construct with evaluations influenced by three primary sources: physicians, other caregivers and insurance providers. According to the multi-dimensionality construct of patient satisfaction, Linder-Pelz (1982) defined patient satisfaction as positive evaluations of distinct dimensions of the health care that a patient has received. The care which is being evaluated might be a single clinic visit, a treatment throughout an illness episode, a particular health care setting or a plan. Hence, it is suggested that there are two dimensions to the construct of patient satisfaction: expectation and experience, many authors use expectation versus perceived experience along the multidimensional lines. This is an attempt to capture the process through which patients assess quality of health care from their own perspectives. Simply, the patient enters the situation with expectations, and the perceived difference between expectations and experience offers net satisfaction, if experience is greater than expectations, the experience is satisfactory and vice versa. Generally, patient satisfaction means perception and experience (Steiber and Krowinski, 1990). Another definition of Linder-Pelz (1982) about patient satisfaction, patient satisfaction as an attitude, is based on the summation of the very subjective assessments of the dimensions of the care experience. Bernna (1995) defined patient satisfaction as the evaluation of the extent to which the care provided has met patient's expectations and preferences. Other researchers defined satisfaction as an emotional response to the difference between what customers expect and what they ultimately receive, satisfaction refers to an insider perspective, the patient's own

experiences of a service where the outcome has been evaluated in terms of what value was received (Liljander and Strandvik, 1994).

In general, several studies seem that satisfaction is an affective construct rather than a cognitive construct (Oliver, 1997; Olsen, 2002). Exploring and knowing level of satisfaction contribute to our understanding of how patient's perception affects the patient's own behavior. Studies have shown that patients who satisfied with the services are more compliant, cooperative and more likely to participate in their treatment procedures (Brown, 2001; Bartlett, 2002). Here we face critique of using patient satisfaction as a measure of quality. If satisfaction is a result of both expectations and experiences, we can never be sure if variations in ratings from one patient to another are a result of differences in their expectations or in their experiences. Thus, someone with relatively low expectations may be satisfied with experiences of care that a person with high expectations would find totally unacceptable. This is a serious problem in today's environment, when as often as not, we are trying to assess patients' satisfaction either to identify better performers or to identify where improvement in quality are needed (El-Haj, 2008).

Donabedian (1988) considers patient satisfaction as one element of the desired outcomes of care. An expression of satisfaction or dissatisfaction is also the patient’s judgment on all dimensions of quality of care, particularly as concerns the interpersonal process. This focuses that it is the patient’s subjective perspective that is central to patient satisfaction unlike Linder-Pelz (1982) and Ware et al. (1983). However, Donabedian (1988) was quite precise in defining the concept of the patient’s satisfaction. Few others have attempt to define the concept of satisfaction by including various dimensions of care rather than emphasizing the interpersonal process. Goldstein et al. (2000) stated that patient satisfaction as a health care recipient’s reaction to dimensions of the service delivered and satisfaction over time which result in overall perceptions of quality of service. Patient satisfaction was described in more recent explanations as a concept partially driven by consumer demands for quality health care and accountability of health care services (Oermann, et al., 2002). Other researchers consider patient satisfaction as a way to be responsive to the public and often seen by health care professionals as a suitable vehicle for addressing the issues of doing the best that they can (Nystrom, et al., 2003). Otherwise, on searching for interpretation the concept of patient satisfaction, studies emphasized the "natural attitude" of individuals, within which they interpret their experiences. This view

depend on the fact says "the patients are different" and implementation of different interventions may promote individualized care. Individualized care, as seen from a patient point of view, can be evaluated from two different perspectives: by exploring patients' views on how they think with their individuality was supported through health caring intervention, and by examining how they perceived individuality in their own care (Suhonen, et al., 2004).

The researcher defines patient satisfaction operationally in terms of the situation whereby the outpatient meets his needs and expectations from the health services provided at the OPsD at ASH.

2.5 Evaluation of health services

Health services evaluation is a process of collecting and analyzing information in order to understand the progress, success, and effectiveness of the health services. Evaluation is an important aspect of the health services management. It can facilitate the successful completion of the services, and inform decisions about the future of the service (Moynihan, 2004).

Systematic evaluations are being produced by many organizations around the world, and they are being used across much of the health care settings. Growing numbers of nurses, pharmacists, doctors and other health professionals, patients, insurers, policymakers, advocates and health care executives are looking to systematic evaluation of the health programs and provided health services to update their thinking, decision making, and practice. But systematic evaluation has significant limitations as well as benefits. The health programs evaluations are often incomplete, deficient, or skewed toward the most profitable treatments. Sometimes systematic evaluations themselves are poorly conducted, as for example when the evaluation of relevant dimensions of health services has not been as comprehensive as possible (Moynihan, 2004).

The purpose of any evaluation is to provide information for action (e.g., decision making, strategic planning and program modification). Once evaluation information is available, it should be integrated into management practices. If this is not done, evaluation is a waste of organization resources. The results of the health services evaluation can be used to:

identify ways to improve activities, facilitate changes in the plan, plan for the sustainability of the services, learn more about the environment in which the services are being or have been carried out, learn more about the target population of the services, present the worth and value of the services to stakeholders and the public, compare among projects to plan for their future, and make evidence-based organizational decisions (Zarinpoush, 2006).

Evaluation of health services is a way of finding out what we know and don't know about what work and what doesn't work. A good systematic evaluation can generally give us the most reliable estimate of the effectiveness of a specific intervention, and it can identify gaps in our services that require further improvement. It can also give us a sense of the quality of existed health services, thereby indicating how much confidence clinicians, patients, policymakers should have in the results. A systematic evaluation can also at times help us find out how well a treatment works for different kinds of patients and inform us about its potential to cause harm. Some systematic evaluation can shed light on the pros and cons of different ways of organizing or delivering care. A systematic review that includes considerations of patients can help shape our judgments about whether particular technologies or policies provide good value for them (Moynihan, 2004).

2.6 Evaluation of client satisfaction

Client satisfaction evaluation/measurement is the process of obtaining qualitative and quantitative information which indicates the extent to which client expectations are being met. Such information can be obtained in a variety of ways, both formally and informally. Within Earth Sciences Sector (ESS) this information is typically retrieved through: surveys, feedback forms, evaluative studies, focus groups, advisory panels, meetings, conferences and other interactions which occur in the normal course of business. In addition to these primary sources of information, secondary sources such as complaint records and logs of client visits can also prove valuable in assessing client satisfaction (Natural Resources Canada). Several studies revealed many approaches including both quantitative and qualitative approaches and a wide variety of methods and questionnaires available for measuring patient satisfaction (Ford, et al., 1997). Measurement of patient satisfaction fulfils distinct dimensions: understanding patients' expectations of health care, identifying problems in health care and evaluation of health care (Sitizia and Wood, 1997). Validation of an instrument that designed to measure patient satisfaction is important issue,

the process starts with conceptual relevance, simplicity of instrument and measuring content and constructs validity. Whenever the instruments measure what they are designed for, their reliability coefficient is considered to be high and the result could be interpreted with the maximum level of accuracy (Fagerstron, et al., 2000).

Client satisfaction evaluations are an excellent opportunity to involve clients or patients in the process of evaluating your program. Client satisfaction evaluations can be viewed as an opportunity to consult with clients about their experiences in your program, provide means for clients to express concerns about the services received, and to express their views about new services that are needed. Client satisfaction evaluations can address: The reliability of services, or the assurance that services are provided in a consistent and dependable manner. Also, the responsiveness of services or the willingness of providers to meet clients/customer needs. Further, the courtesy of providers. In addition, the security of services including the security of records (WHO, 2000).

2.7 Methods of evaluating patient satisfaction

The main two methods that can be considered to evaluate patient satisfaction are: the interview and the questionnaire:

Interviews: The more personal form of surveys than questionnaires. Interviews can occur on an individual basis or within groups and either over the telephone or in person. Properly conducted interviews can provide managers and decision makers with a deeper understanding of patient perceptions about their hospital environment. The advantage of interviews is their personal form. The interviewer has the opportunity to probe or ask follow-up questions, allows interviewer the opportunity to correct misunderstandings, provides for a wide variety of views and high levels of flexibility and interviews are generally easier for the respondent, especially if what is required were opinions or impressions. Disadvantages of the personal interviews are that time consuming for both parties involved, skilled interviewer is required, costly, interviewer bias can influence and must be conducted in analogous environment (Grimes, 2003).

Questionnaires: The most typical method of eliciting patient satisfaction is by a questionnaire, typically administered after the patient received his treatment in the hospital.

There are many advantages to a written survey, they are relatively inexpensive to administer and can send the exact same survey to a wide number of people. Also, they allow the respondent to fill it out at their own convenience. In addition, they can be completely anonymous and confidential, removing the fear of responding honestly. However, the disadvantages are that response rates from written surveys are often very low and they are not the best vehicles for asking for detailed written responses. In addition, poorly designed questions can be miss-interpreted by respondents and incorrectly designed surveys may produce invalid and misleading results (Grimes, 2003). Client satisfaction surveys are most useful when they are designed to meet specific objectives and when they use appropriate methods and measures. This involves choices of sampling procedures, timing, cultural acceptability, and sensitivity of the questions to various levels of satisfaction (WHO, 2000).

The result of absence a solid conceptual basis and consistent measurement tool for consumer satisfaction leads to, over the past 10 years, to a proliferation of surveys that focus exclusively on patient experience of the care dimensions such as waiting times, the quality of basic amenities, and communication with health-care providers, all of which help identify tangible priorities for quality improvement. In the future, measures of patient experience will intend to capture the "responsiveness" of the health system. A concept developed by WHO, are likely to receive even greater attention as physicians and hospitals come under growing pressure to improve the quality of care, enhance patient safety and lower the cost of services. Health system responsiveness specifically refers to the manner and environment in which people are treated when they seek health care (WHO, 2003).

Patient satisfaction was measured/evaluated by research studies with focus of different dimensions of health services. Vera (1993) study concentrated in five dimensions of health services as indicators of client satisfaction. They are; cleanliness, service availability, time, learning opportunity and cordial treatment. Another study conducted by Oskowitz et al. (1997) searched of three dimensions of health service and they are interpersonal relations, confidentiality and technical competence. At the same year four dimensions of health services were studied by Koenig et al. (1997) as indicators of patient satisfaction these dimensions are; trust relationship, welcoming, accepted standard of care and views of services. Waiting time, distance of reaching and price of services were three others health services dimensions investigated as indicators of patient satisfaction by William (1994).

Furthermore, dimensions such as atmosphere interaction, quality of object, process and infrastructure were deliberated by Zineldine, (2006). Rao et al. (2006) indicated that medicine availability, medical information, staff behavior, provider behavior and hospital infrastructure are dimensions of patient satisfaction and reflect the quality of health care.

The researcher selected five dimensions of patient's satisfaction. They are access to care, physical environment, patients' expectations, waiting time in addition to information & interaction.

2.8 Quality of health care and patient satisfaction

2.8.1. Historical view of concept quality:

History has noticed a significant change in both the concept and application of quality in health care. The word "quality" has been perceived differently throughout history. During the Babylonian king Hammurabi's time (about 2000 BC), quality meant that errors were out of the question. People make mistakes were suffering the same consequence their mistake had had on others: "fracture for fracture, eye for eye, and tooth for tooth", as the Bible later put it. During the early seventh century, Islamic civilization began to flourish as the Prophet Muhammad صلي الله عليه وسلم and his followers introduced new ideas and new ways of life. It was apparent throughout his teachings that "quality" was to be interpreted as "perfection". His famous hadith "who ever does a job should do it perfectly", denotes a perceived outcome of perfection in everyone's job. Other leaders throughout history have taken a similar approach, while still others have developed specific criteria for "quality". However, quality assurance as a science was never recognized until the mid-nineteenth century with the work of Florence Nightingale. A British nurse in the Crimean war, Nightingale introduced the idea of performance measurement and improvement of processes. She was instrumental in the decrease of mortality rate among wounded soldiers during one of the bloodiest wars of the time by simply introducing modern nursing practices to care for these soldiers. Her success during the war led to her continued inquiry into the relationship between quality processes and outcomes. She completed studies that demonstrated this relationship, and she was also a strong advocate for structured approaches to improve outcomes (Al-Assaf, 1993).

Donabedian (1966) introduced a model of measuring quality based on "simple system theory". Any health care system can be described as a fully developed system with a set of objects and components. For health care quality he described this system that is has three components: structure, process and outcome. Structural elements are those related to resources, human and physical, such as patients, doctors, medical records, hospital building and drugs. The second component is process which referred to all those activities, procedures and tasks performed in that system. Examples of processes in health care include surgical operations, physical examinations and admission. The third component of a system is outcome. Outputs or results of processes are outcomes. Examples of outcomes are infection rate, patient satisfaction rate and morbidity rate (WHO, 2004).

AT 1970S, a shift of focus began from structure related standards to process related standards and guidelines. In the US, the government called on the private sector to develop peer review organizations in order to develop, disseminate and monitor process or care standards. Providers of health care were then "judged" on their compliance to certain explicit standards of care and practice parameters by their peers. Further monitoring was also performed in certain circumstances using implicit criteria and performed by closely related peer groups. This era of process related quality activities continued well into the 1980s. By the late 1980s, the health care sector was again looking for alternative ways to measure and develop quality. The trend started shifting from an emphasis on process related standards back to outcomes. This trend was augmented by a strong movement of the industrial sectors towards a new theory, Total Quality Management (TQM). The health care industry started experimenting with the introduction of the principles and philosophies of TQM into its institutions and organizations. With such initiatives as continuous quality improvement, total quality improvement and performance improvement, the health care sector was ripe again for new quality measures and standards. A number of trends began to shape this sector. It was first a shift from quality assurance to improvement. Then, it was outcome management (Al-Assaf, 1993).

2.8.2. Definition of the health care quality:

Quality is the totality of features and characteristics of a product or service that bears on its ability to meet a stated or implied need (Shouroki, 2007). Moreover, quality means different things to different people. There are different perspectives to quality in health

care. From the provider's perspective, quality might mean providing the best possible care offered to the patient. Quality from the perspective of the administrator is to provide effective care in a cost-conscious environment that may include the rationing of health care, especially when resources are limited. While, from the patient's perspective, quality is getting his care when and where he needs it and from whomever he chooses to cure his condition in the fastest possible way. Therefore, one quickly realizes that quality has different meanings for different health care players. Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skilful implementation; it is the wise option of many alternatives. The most applicable and certainly most important definition is meeting the requirements of the customer, both internally and externally, for defect-free products and services (WHO, 2004). Another definition of quality is that it is achieved when an organization's processes and activities are designed and implemented in order to meet continuously the organization's customers' needs and expectations (Al-Assaf, 1996).

The health service quality has three domains: client quality, professional quality and management quality. Client quality is the domain that receives most attention in discussion of quality of health care based on how satisfied client are with their care. So, the real challenge is to improve staff performance and patient satisfaction in order to minimize rework, wastage, delay and cost (Gadallah, et al., 2003). One of the goals of the quality management is to provide the health care provider with information to assure the health care quality (Zineldine, 2006)

2.8.3. Dimensions of the health care quality:

A numerous national and international surveys of consumers and providers of quality describe these dimensions of health care quality as follows and in this sequence: effectiveness, efficiency, technical competence, safety, accessibility, interpersonal relations, continuity and amenities. Effectiveness and efficiency top the list, stressing that quality can be achieved only if processes are performed appropriately and in a cost conscious environment (Binns, 1991; Jensen, 1991).

Massoud (1994) who stated that the needs and expectations of clients change with technology and education. Although needs vary, some common concerns of internal and

external clients have been identified through research and have been labeled as dimensions of quality. There are many dimensions of quality, some of the most important ones are: technical performance, effectiveness of care, efficiency of service delivery, safety, access to services, interpersonal relations, continuity of services, Physical infrastructure and comfort and choice.

Many studies assessed client satisfaction with health care services that identified several dimensions like: Boshoff and Gary, (2004) studied the relationship between service quality, customer satisfaction and loyalty among patient. The result showed that the service quality dimensions of nursing staff empathy, assurance, and tangibles impact strongly on patients' loyalty. Also, Zebiene et al. (2004) investigated the relationship between meeting patients' expectations and patients' satisfaction with medical consultations. While, respect and privacy, approach of care, information and communication, hotel services, hospital culture, and meeting expectation are six dimensions of patients' satisfaction were investigated by El-Haj (2008). According to Zeithaml et al. (1990) the ten most common dimensions cited by clients in judging quality are: tangibles, reliability, responsiveness, competence, courtesy, credibility, security, access, communication, understanding the client.

New quality dimensions have recently been introduced in the US by the prestigious Institute of Medicine group, these dimensions are safety, timeliness, equity, effectiveness, efficiency, and patient centeredness (WHO, 2004).

The researcher determined five dimensions of health services present in the OPsD and considered them as indicators of patient satisfaction that reflect the quality of health services provided to outpatients at ASH. The study dimensions are access to care, physical environment, patients' expectations, waiting time in addition to information & interaction.

2.9 Factors affecting patients' satisfaction

Satisfaction is a relative measure which research literature shows. It may be influenced by many factors that should be considered (Al-Sharif, 2008). It has been claimed that patients' views should be sought in order to improve the awareness of health care to their needs (Wensing, et Al., 1997). Linder-Pelz (1982) identified ten elements that can be used

to determine satisfaction: accessibility/convenience, availability of resources, continuity of care, efficacy/outcomes of care, finances, humaneness, information gathering information giving, pleasantness of surroundings, and quality. Ware et al. (1983) argued that patient characteristics are the determinants of satisfaction, whereas interpersonal manner, technical quality, accessibility, cost, efficacy, continuity, the physical environment, and availability of resources are the components of satisfaction**.** However, it is important to know which factors play a role in determining whether a patient's judgment of the health services received is satisfied or not?. This would help health care providers and planners to focus their changes on these factors. The most of literature and research appear to be a mixture of numerous factors that are represented in patients, health providers and the health system itself may affect the patient level of satisfaction. The following paragraph describes these factors and their effects in the patient level of satisfaction.

2.9.1. Patient's-related factors:

As shown in literature and studies, the patient's-related factors consist of three main types of factors affect the patient level of satisfaction, these types are demographic, socio-economic and health status of the patient. Some studies focused that patient demographics are a minor characteristic in patient satisfaction (Hall and Dornan, 1990), while others concluded that demographics represent 90 percent to 95 percent of the variance in rates of satisfaction (Sixma, et al., 1998). The following are some patient's-related factors that may affect the patient's level of satisfaction:

The Age: It is well known determinant of the Patient Satisfaction Index (PSI) with older patients scoring more highly and being more satisfied than young and middle aged patients (Hall and Dornan, 1990; Wilde, et al., 1994; Cohen, 1996). Elder respondents generally record higher satisfaction (Pope and Mays, 1993; Owens and Batchelor, 1996). On the contrary Jenkinson et al., (2002) found age was only weakly associated with satisfaction.

Gender: Studies on the effect of gender are contradictory (Carolyn, 2007). Some studies revealing that women tend to be less satisfied (Ehnfors and Smedby, 1993; Hoff, et al., 1999; Thi, et al., 2002). Women tend to rate their care more dissatisfied than men in some studies (Al-Doghaither, 2004). Others revealed that there is no significant relationship between gender and satisfaction (Al-Hindi, 2002; Abu-Saileek, 2004)

Ethnicity: A study that has looked at ethnicity that means a minority group is associated with lower rates of satisfaction. In a ranking of degrees of satisfaction, non-Hispanic whites had the highest satisfaction, followed by African Americans, Asian/Pacific Islanders and Hispanics. The lowest degree of satisfaction was found in Indians/Alaskan natives (Haviland, et al., 2005).

Income: Studies have founded that individuals of lower income tend to be less satisfied with their health care (Rogut, et al., 1996; Young, et al., 2000). Others found that income has significant influence in patient satisfaction (Al-Hindi 2002; Abu-Saileek, 2004).

Education: Lower educated people tend to be higher satisfied with their health care (Mousa, 2000). Others found that the education level has significant influence in patient satisfaction (Al-Hindi, 2002; Abu-Saileek, 2004).

Patient expectation: Meeting patient expectations is assumed to play a role in the process by which an outcome can be said to be satisfactory or dissatisfactory (El-Eisa, at al., 2005). Some literature however suggests that a link between satisfaction and fulfillment of patient expectations is not necessarily the case, since it is possible that the patient's evaluation of a service may be largely independent of actual care received (Williams, 1994).

Health status: Abu-Saileek (2004) study found that the clients who had chronic illness were more satisfied with nursing care than others. Patients with chronic illness were more satisfied (Zapka, et al., 1995). Patients with two or more chronic illnesses less satisfied with the health care system than those with a single chronic illness (Redekop, et al., 2002).

However, one study found that frequent visitors to a family practice had lower educational status, lower perceived quality of life, and higher anxiety and depression scores were more satisfied with their family physician (Frostholm, et al., 2005). Other studies have shown that poorer satisfaction with care is associated with experiencing worry, depression, fear or hopelessness (Desai, et al., 2005). Parchman et al., (2005) pointed that when communication and coordination of care increased the patients' perception of hassle decreased and satisfaction improved.

2.9.2. Health providers-related factors:

The physicians: Physicians have been considered as an important element between all of the health providers. According to the literature, the physicians can promote higher rates of satisfaction by improving their interactions with their patients. The most important lesson for physicians is to take the time and effort to listen patients' expectations. When physicians recognize and address patient expectations, satisfaction is higher for both the patient and the physician. It may help to remember that patients often show up at a visit desiring information more than they desire a specific action (Rao, et al., 2000). In addition, approximately 10 percent of patients in one study had one or more unvoiced desires in a visit with their physician (Bell, et al., 2001). The communication between doctor and patient can also affect rates of satisfaction. Physicians can also improve patient satisfaction by ignore some control over the encounter. Studies have founded that when physicians exhibited less dominance by encouraging patients to express their ideas, concerns and expectations, patients were more satisfied with their visits and more likely to adhere to physicians' advice (Cecil and Killeen, 1997). Patient satisfaction can also be influenced by physicians' medical decision making. Patients expressed a preference for physicians who recognized the importance of their social and mental functioning as much as their physical functioning (Sherbourne, et al., 1999). Time spent during a visit plays active role in patient satisfaction, with satisfaction rates improving as visit length increases (Gross, et al., 1998). Also, time spent chatting during the visit was also related to higher rates of satisfaction (Zyzanski, et al., 1998). Interestingly, one study showed that while physicians felt rushed ten percent of the time, patients felt that way only three percent of the time. Patient satisfaction was identical whether the physician did or did not feel rushed. The physicians may be more sensitive to feelings of being rushed and their feelings may not reflect the actual time spent during the visit (Lin and Schneider, 1992). However, another study found that a physician's ability to make the correct diagnosis and craft an effective treatment plan were more important than his or her "bedside manner" (Otani, et al., 2005).

Nurses: In their exploratory study that investigated patients' satisfaction with nursing care at a major teaching hospital in Jordan Alasad and Ahmad (2003) found that patients in surgical wards associated with lower levels of satisfaction than patients in medical or gynecological wards. A study to assess the level of clients' satisfaction with nursing care

provided at selected hospitals in GS, was conducted at the two major governmental hospitals in south of GS. The results showed that gender, educational level, and having other diseases were significant indicators for patients' satisfaction with nursing care. Also, it revealed that there is a significant relationship between the service providers and satisfaction level (Abu-Saileek, 2004). In another large database of surveys, nurses were the next most important source of satisfaction (Wolosin, 2005).

2.9.3. System-related factors:

Patient satisfaction is also affected by the health system in which care is provided. Despite, it's clear that patients' first concern is their doctors, they also value the team cooperation. One study found that while physician care was most influential to patients' satisfaction, the compassion, willingness to help and promptness of the physician's staff were next in importance (Otani, et al., 2005). While, a study done by Rosemann et al. (2006) pointed that effective referrals play a role in patient satisfaction. He found that patient satisfaction with the referral's outcome was higher when the family physician initiated the referral. Similarly, another study of patients treated for recurring headaches revealed that those who self-referred to a neurologist were less satisfied than those whose primary doctor had referred them (Bekkelund and Salvesen, 2001). It is clear that patients who have been followed by their physician for more than two years are more satisfied with their care particularly when they are able to see their own physician (Donahue, et al., 2005). The following are some of system-related factors that may affect the patients' level of satisfaction:

Patient-professional relationship: There is consistent evidence across settings that the most important health service factor affecting satisfaction is the patient/client-practitioner relationship, including information and technical competence (Scott, 1993).

Waiting time: Excessive waiting is perhaps the greatest irritation and dissatisfaction (Scott, 1993). It has been documenting that the negative association between increased waiting time and patient satisfaction with primary care (Dansky and Miles, 1997). Also, Anderson et al. (2002) found that time spent with the physician is most powerful determinant of overall patient satisfaction. However, the combination of long wait times and short visit times produced the lowest level of satisfaction (Qannam, 2001).

Continuity of care: In the context of quality of care an important concept is continuity in the care process. Shortell (1976) defined the concept of continuity of care as the extent to which services are received as part of a coordinated and uninterrupted succession of events consistent with the needs of the patient. Fan et al. (2004) found continuity of care is strongly associated with higher patient satisfaction, this suggests that improving continuity of care may improve patient satisfaction with providers as well as with their health care organization.

Accessibility to needed services: Patients who have difficulty with accessibility are less satisfied (Padberg and Padberg, 1990).

Other factors: Jenkinson et al. (2002) indicated that the major determinants of patient satisfaction were physical comfort, emotional support, and respect for patient preferences.

The researcher used patient's demographic, socio-economic, health status and organizational factors to assess the effects of these factors on the patient's level of satisfaction with the health services provided at OPsD at ASH.

2.10 Health services and patient satisfaction

Health organizations either governmental or non-governmental looking for improving their services, they generate more than one way to achieve their goals. The patient is the core interest of the health organizations and reaching to high satisfied patient with the health services is in the first priority for them. Many studies and research were conducted globally and nationally in order to explore and evaluate both the quality of health services and the patient level of satisfaction when receiving these services**.**

2.10.1. Selected global satisfaction studies:

Hill et al. (1992) study conducted in Leeds General Infirmary in United Kingdom aimed to investigate the satisfaction with care among outpatients with rheumatoid arthritis. The authors developed the Leeds satisfaction questionnaire and tested reliability (Cronbachs alpha and stability). A total of 70 rheumatoid arthritic patients on at least three previous

occasions. Generally, the results showed that patients satisfied with the care. The highest satisfaction level assigned to technical quality and competence of health professionals. While, the lowest satisfaction level assigned to the difficulty of unscheduled access to the clinic and the lack of continuity with the providers of care. The time spent in the waiting area before consultation was highlighted as the one aspect which caused the greatest dissatisfaction.

Lee and Kasper (1998) this study aiming to recognize the individual characteristics and factors related to health and patterns of health care utilization associated with their satisfaction with medical care. The data collected from the 1991 Medicare Current Beneficiary Survey (MCBS) on 8,859 persons age 65 and over living in the community. The design was items reflecting general satisfaction with care and views of physician quality are examined, based on factor analysis, grouped in dimensions of two (global quality, access) and three (technical skills, interpersonal manner, information giving) respectively. The findings showed that level of satisfaction is high, with over 90%, but there is substantial variation with less likelihood of high satisfaction among those 80 or older, with less education and income and in poorer health. Longer waiting time at visits and less frequent visits are factors in lower satisfaction as well. A favorable perception of physician quality, especially regarding technical skills, appears to play a significant role in satisfaction with global quality of care. The study concluded that studies of patient satisfaction in elderly people are rare. Some factors were expected to be related to positive assessment based on earlier studies as, better health and shorter waiting time, while others were not as, increasing age. Elderly people appear to place greater concerns on physician technical skills, as contrasting to interpersonal dimensions, in assessing global quality. The authors recommend the need for a better understanding of how elderly people evaluate care and what they value in interactions with the health care organization.

Aldana et al. (2001) this study aimed to evaluate user expectations and degree of client satisfaction and quality of health care provided in rural Bangladesh. A sample of 1913 persons selected by systematic random sampling was successfully interviewed directly after receiving care in government health facilities. The findings revealed that the strongest predictor for client satisfaction with the government services was provider behavior, especially respect and politeness. For patients, this factor was much more important than the technical competence of the provider. Furthermore, a reduction in

waiting time was more important to clients than a prolongation of the quite short consultation time with 75% of clients being satisfied. Waiting time, which was about double at outreach services than that at fixed services, was the only element with which users of outreach services were dissatisfied. The study concluded that the emphasis of client satisfaction is determined by the cultural background of the people. It showed the dilemma that though optimally care should be capable of meeting both medical and psychosocial needs. In reality care that meets all medical needs may fail to meet the client's emotional or social needs. Conversely, care that meets psychosocial needs may leave the clients medically at risk. It seems important that developing countries promoting client-oriented health services should carry out more in-depth research on the determinants of client satisfaction in the respective culture.

Olusina et al. (2002) study conducted in Nigerian General Hospital aimed to assess satisfaction level of patients and staff in an acute admission psychiatric ward with the health care quality. Physical environment, freedom, comfort, attitudes of staff towards patients, access to staff, and duration of hospitalization were studded as dimensions of the health care quality. The authors used a descriptive study of all patients admitted for functional psychiatric disorders in a 5-month period were conducted. Patients and staff completed similar 16-item self-rated Likert-type questionnaires. Satisfaction was rated as follows: dissatisfaction < 50 %, bare satisfaction (50-65 %), moderate (66-74 %), and highest satisfaction (> or = 75 %). The results showed 118 patients were dissatisfied with items that indicated cutting of their freedom, while the 35 staff were dissatisfied with the physical services for care. The highest satisfaction for patients and staff were for items on staff-patient relationship. Barely satisfactory items for patients included the time spent with doctors. Patients had a higher positive appraisal of the adequacy of physical services than staff, while staff had a more positive appraisal of their relationship with patients. There were no considerable differences in satisfaction among diagnostic groups. The study concluded that logical and discriminating method in which patients assessed satisfaction supports the impression that they can be relied upon to make objective evaluation of the process of care, and that patient satisfaction is a valid indicator of the quality of care.

Boduret et al. (2002) research aimed to illustrate the level of patient satisfaction with health centers services and related factors. This research was performed on eight randomly

selected health centers in urban areas of Ankara and Konya by interviewing patients who were about to go home after receiving care. The questionnaire included demographic variables and a four-point rating scale of 13 items measuring the satisfaction of outpatients. The authors were used chi-square test to assess differences in proportions. The results showed that 70% of the patients were satisfied with the patient care of health centers. The level of satisfaction was related to educational level and age. The ratio of satisfaction was very high regarding the politeness of physicians and nurses, but was the lowest with regards to technical competence. Generally, outpatients were satisfied with health centers, and described them as humane. The study concluded that complaints of patients should be taken into consideration by the policy makers and staff of health centers.

Kersnik (2003) study used self-administered patient questionnaire at thirty-six family practice clinics, Slovenia. This study designed to determine whether patients' suggestion of their family doctor to others correlates with patient satisfaction scores, and to investigate other factors influencing patients' suggestions. A sample of 2160 consecutive adult patients' attendance the clinics were elected to complete a self-administered questionnaire, to be returned in a prepaid envelope. The questionnaire included validated tools of patient satisfaction and gathered data on health related quality of life, patient demographic, socio-economic and health characteristics, and attitudes and experience of health services. Patients also selected a response to the statement "I can strongly recommend my family doctor to my friends" on a five-point scale, from strongly disagree to strongly agree. The results showed that overall satisfaction was 92% of respondents were in agreement with the statement that they would strongly recommend their family doctor to their friends. Patient satisfaction in the group of patients strongly supportive with the statement was 11.1 points higher than that for the group responding they agreed only (92.4 versus 81.3 points; $P<0.001$). Multivariate analysis showed that 51.5% of the variation in the response to the statement could be explained by patient, doctor, and practice characteristics investigated. The study concluded that higher agreement with the statement "I can strongly recommend my family doctor to my friends" was associated with higher patient satisfaction with the doctor's working style, with some patient demographic characteristics, dimensions of patients' health care utilization, and some doctor characteristics. Using a simple question regarding suggestions of the doctor to friends can be used as a substitute measure of patient satisfaction, but should be interpreted with caution.

Jovanovi (2005) study intended to explore level of satisfaction of patients with physicians and nurses and to offer information of patients' expectation of health care professionals at the Institute of Oncology Sremska Kamenica. The data were collected from the patients of four various hospitals departments using a survey questionnaire designed by the Institute of Public Health of Serbia and Ministry of Health of the Republic of Serbia. That included eight items concerning physicians and nurses were selected from this questionnaire. The sample was every appropriate patient discharged from the Institute of Oncology Sremska Kamenica, from 1 to 5 November 2004 (n = 65). The findings validate positive feedback of the most surveyed patients with health care professionals. On the other hand, the results showed different level of satisfaction of patients with physicians and nurses. The study concluded that the survey results showed that patients had mostly positive level of satisfaction with physicians and nurses, these results can be used to prioritize patient centered improvements in health care in this institute.

Trumble et al. (2006) study aimed to explore the changes in patients' satisfaction after involvement their doctor in a brief educational intervention on medicolegal risk management. A questionnaire was fulfilled by ambulatory patients, measuring satisfaction with their doctor's communication skills before and three months after the doctor involved in a three hour workshop on medicolegal risk management. The number of doctors was 75 obstetrician and gynecologists and 99 general practitioners were each rated by 60 of their patients following a consultation in their clinical rooms. The findings showed patient satisfaction as evidenced by change to "complete satisfaction" with doctor's communication skills and overall satisfaction with the clinical came across. The participants had high initial patient satisfaction ratings and these were founded to have improved across all parameters three months after the educational intervention. The authors pointed to value of this study, the educational intervention lead to improve doctors' communication skills as evidenced by improved patient satisfaction in all key dimensions, including those most frequently related with patient complaint, legal actions and adverse results.

2.10.2. Selected satisfaction studies in the Arab world:

Abdelkariem et al. (1996) study conducted in the State of Qatar and aimed to assess outpatient satisfaction in government health organizations. The data collected on a mail, self administered survey of patients who received care in two major government outpatient health care organizations (Hamad General Hospital and the Khalifa Town Health Center) in the State of Qatar, to provide data to improve service delivery and the quality of primary care provided in that country. A total of 444 participants were selected. The authors used seven dimensions of patient satisfaction with medical care: general satisfaction, availability of services, convenience of services, facilities (physical environment), humaneness of doctors, quality of care, and continuity of care. The study pointed to a number of deficiencies in the availability and delivery of services in government health facilities in the State of Qatar. It also surfaced methodological issues that should be addressed in comparable studies of culturally diverse populations.

Al-Doghaither et al. (2000) study performed in Kuwait city, Kuwait, to assess patient satisfaction with respect to primary health care services and explore the association of socio-demographic variables on the patient level of satisfaction. The selected sample consisted of 301 patients selected systematically from five PHC centers to represent various geographic areas in Kuwait city. Just over 56% of the sample were females, 59% were married, the great majority (70.4%) were government employees, more than 60% had a monthly income of less than 900 Kuwait Dinar, more than 54% were intermediate and high secondary school graduates, and 37% were university graduates or had advanced degrees. The data was collected by personal interview using structured questionnaire. The results showed that the overall mean satisfaction was 3.1 points out of five (62%). The mean satisfaction scores were 3.64, 3.29, 3.08, 3.05, 2.21 for laboratory, pharmacy, radiology, dental and physician services, respectively. The highest mean score for physician services was obtained for communication skills (2.23); for pharmacy services, the availability of medicine (4.01); for laboratory services, the availability of lab materials (3.73); for radiology services, the waiting time for x-ray (3.60); and for dental services, the adequacy of dentists (3.27). The results indicated that gender, income, marital status and occupation were the most consistent demographic characteristics of satisfaction, with females, those with lower income, lower education levels and the unemployed having higher mean satisfaction scores. The study concluded that there is a need for corrective

intervention in some service areas and for an educational program to inform patients of the objectives and limitations of primary health services.

Margolis et al. (2003) study performed in the United Arab Emirates to examine the fitness of a questionnaire designed to evaluate patient satisfaction with health care was performed in the United Arab Emirates. A cross sectional survey used an Arabic language questionnaire that drew upon concepts of patient satisfaction measurement in western research literature. All participants were interviewed on one occasion by experienced interviewers to ascertain their levels of satisfaction with their health care service. A random sample of patients attending the only resource-intensive clinic in the United Arab Emirates and one resource-thrifty clinic located in an adjacent suburb and serving essentially the same population over a 5-day period. The authors were measured six domains of patient satisfaction. The results showed that the patients with the resource-thrifty clinic (n = 125), the resource-intensive clinic (n =156) scored significantly higher in continuity ($P = 0.001$), comprehensiveness ($P < 0.001$), health education ($P = 0.05$), effectiveness ($P = 0.001$), and overall satisfaction ($P < 0.001$), while accessibility ($P = 0.130$) and humaneness ($P = 0.102$) were not significantly different. Older people were reported higher satisfaction for comprehensiveness, otherwise the same as those who were younger. More highly educated people's satisfaction was lower for effectiveness, but otherwise the same as those who were less educated. Men and women had the same levels of satisfaction. The study concluded that the significantly higher patient satisfaction in the resource-intensive clinic compared with the resource-thrifty clinic was a strong priori expectation, suggesting that this satisfaction questionnaire is a useful quality assurance tool in this setting.

Alasad and Ahmad (2003) exploratory study that investigated patients' satisfaction with nursing care at a major teaching hospital in Jordan. The sample size was 266 inpatients participated. Patients were recruited from the medical, surgical, and gynecological wards. The methods of analyses were used Pearson correlation, one-way analysis of variance (ANOVA), and logistic regression. The results showed that patients in surgical wards associated with lower levels of satisfaction than patients in medical or gynecological wards. Gender, educational level, and having other diseases were significant indicators for patients' satisfaction with nursing care. Methodological challenges, implications to nursing practice, and recommendations to nursing research are discussed.

Al-Doghaither (2004) study conducted at King Khalid University Hospital, Riyadh, Saudi Arabia aimed to evaluate inpatient satisfaction with physician services. The sample included 400 inpatients with physician services at King Khalid University Hospital, Riyadh was evaluated. Patient's characteristics and ward of admission were collected and a questionnaire based on the standardized Likert scale was used. The results showed that the highest mean satisfaction score was for admission and the lowest for communication. Among service items, the highest mean score was for physicians enquiring about patient conditions and opinions when planning care and the lowest for physicians asking for opinions about care quality and problems. Female and less educated patients tend to be more satisfied with their care than male and educated patients. Male surgical and medical ward patients were the most dissatisfied with physicians' services. The results offer hospital management information about areas requiring remedial intervention.

Zineldin (2006) study applied the five qualities (5Qs) as exploratory investigation model to evaluate quality of health care at some Egyptian and Jordanian medical clinics. This broad study aimed to examine the major factors affecting patients' perception of cumulative satisfaction and to address the question whether patients in Egypt and Jordan evaluate quality of health care similarly or differently. The author used a conceptual model including behavioral dimensions of patient-physician relationships and patient satisfaction has been developed. As the empirical research setting, this study concerns three hospitals in Egypt and Jordan. The survey instrument was designed in a questionnaire form. A total of 48 items (attributes) of the newly developed five quality dimensions were identified to be the most relevant. A sample of 224 complete and usable questionnaires was received from the inpatients. The findings showed that hospital C has above-average total and dimensional qualities and patients are the most satisfied in accordance with all dimensions of services. Hospitals A and B have under-average total qualities as the majority of patients are not satisfied with services. Comparing hospitals A and B, in the majority of dimensions (with the exception of Q5), the quality in hospital B is higher than in hospital A. Patients' satisfaction with different service quality dimensions is correlated with their willingness to recommend the hospital to others. A cure to improve the quality for health-care services can be an application of total relationship management and the 5Qs model together with customer orientation strategy. The result helped to reengineer and redesign creatively their quality management processes and the future direction of their more effective health care quality strategies. The author described that involving a new

instrument and a new method which assure a reasonable level of relevance, validity and reliability, while being explicitly change-oriented. This study argues that a patient's satisfaction is a cumulative construct, summing satisfaction with different 5Qs of the hospital: quality of object, processes, infrastructure, interaction, and atmosphere.

2.10.3. Selected satisfaction studies in Palestine:

Mousa (2000) study assessed clients' satisfaction with family planning services at MOH and UNRWA clinics, and identified the effective factors on clients' satisfaction, and provided some improvement ideas to health providers. A sample of 377 clients were interviewed by client model home visit interview in six various areas in GS. The response rate was 87.3%. The study presented that the overall satisfaction with the family planning services was 72%. The satisfaction domains identified in this study were attitude and expectation, information and counseling, communication and interaction, interpersonal relationships, mechanism of care and delivery of care. The results showed higher level of satisfaction with information and counseling, but the lowest level of satisfaction with communication and interaction. Also, clients attending UNRWA clinics were more satisfied than clients attending MOH clinics. Younger, less educated and clients living in refugee camps were more satisfied than older highly educated and clients living out-side refugee camps. The study concluded that the enhancement is important to improve services by many factors like, technical solutions such as training in counseling, communication and human relations that lead to improve the clients' level of satisfaction of family planning in GS.

Al-Hindi (2002) study assessed clients' level of satisfaction with radiology services at two major radiology centers, ASH as governmental services and Gaza Diagnostic Center (GDC) as the private sector in Gaza. The author used the dimension related to the clients' satisfaction and some organizational and demographic, socio economic variables affecting their satisfaction. A cross-sectional design with a systematic randomized sample was used. A standardized structured questionnaire was designed concentrated on services features. A representative sample 410 clients were participated after receiving the radiology services. The response rate was 78.04%. Reliability and validity measurement were assessed of the questionnaire. The study explored seven dimensions of satisfaction consisting of: organizational culture, continuity and affordability, availability, interaction and

communication, attitude and perception, comfort and privacy and approach of care. The results showed high level of satisfaction with radiology services 82.5%. The study concluded that the type of institution and the organizational variables including the number of visits, waiting time and procedure time showed a great impact on the level of clients' satisfaction. The study illustrates significant relationship between financial status, and educational level and level of satisfaction. On the other hand, there are no significant relationships between age, gender, residency place and occupation regarding the level of satisfaction.

Abu-Saileek (2004) study evaluated the patients' level of satisfaction with nursing care provided at two major governmental hospitals in south of GS (European Gaza hospital and Nasser hospital), and recognized the major domains regarding clients' satisfaction that related to some organizational and demographic variables. The author used across-sectional design with systematic randomized sample. Standardized structured questionnaire was developed. A total of 427 patients admitted to medical and surgical wards and receiving nursing care during hospitalization, 159 patients from European Gaza hospital and 268 patients from Nasser hospital. The response rate was 93.6%. SPSS was used to analyze data. The study identified six domains of satisfaction with nursing care including; information and interaction, availability/attentiveness and openness, comfort and environment, nurses skills and professionalism, organizational culture, counseling and advising. The results showed that there is significant relationship between the service provider and satisfaction level. Overall satisfaction was 70.1% in both hospitals. The clients' in European Gaza hospital reported higher satisfaction 84.2% than the clients' in Nasser hospital 61.7%. The study concluded that the demographics, socioeconomic variables including age, place of living, marital status, income, and education level showed a great influencing on the patients' level of satisfaction. Also, the type of institution and organizational variables including the payment of medical care, referral source, previous hospitalization in other hospitals, admission days, medical diagnosis groups, and choosing the same hospital in the future showed a significant relationship on the level of clients satisfaction. On the other hand, gender, and the ward showed no considerable relationship on the level of clients' satisfaction with nursing care. Lastly, the research provides some information to improve the quality of nursing care services that led to improve the patient level of satisfaction with nursing care.

Abu-Harbeid (2004) study evaluated the level of women's satisfaction with the quality of antenatal care provided at the two major health sectors in GS (MOH and UNRWA). The response rate was 92.8%. The selected 504 clients were interviewed randomly selected at PHC in GS. The study reported eight dimensions of satisfaction, the findings showed that, the level of satisfaction represented with provider competence was 83%, service provider consultation was 62%, interpersonal relation was 81%, waiting time was 86%, accessibility was 89.5%, infrastructure was 82%, during availability was 79.5%, general satisfaction was 89.5%, and overall satisfaction was 79.3%. The study revealed some variables that affect on satisfaction contain age, educational level, employment status, services provider consultation, waiting time, health provider manners and type of health sector. The study concluded that there are high level of women's' satisfaction but the author suggests the level of satisfaction could be improved when considered the findings of this study like the health education issues particularly services provider consultation needs intensive attention from health decision makers also the waiting time has real impact on satisfaction level and active participation in communication process. So, it's needs creative solutions to improve health services and achieve satisfactory women's needs and expectations. The study recommends to some of perspective, perception and information, education and practice of both clients and health provider towards antenatal care to improve the level of satisfaction.

Abu-Hashem (2007) study designed to assess the patient's level of satisfaction, and the expenses of the treatment abroad services that offered by Palestinian MOH. A purposeful sample was 102 subjects who were transferred in year 2005 for treatment in Jordan, Israel, and Egypt. A cross-sectional design was used. The study findings presented 52% tend to satisfied from the services that offered by Abroad Unit at MOH. About 52.9% of subjects reported their satisfaction with the performance of the medical doctors at local hospital before traveling to abroad. The subjects were reported 69.9% of satisfaction level from the treatment abroad as follows: The highest satisfaction level from Jordan 88.9%, then Israel 76.9%, and the lowest percentage was Egypt 60.3%. Also, the study revealed that high cost of medical services abroad that led to a financial burden on MOH. Finally, the study recommended that the need to improve the performance of doctors to alleviate burden on MOH and patients from travel suffering.

2.11 Summary

At the begging of this chapter, the main concepts of the study were defined and the road map of this study illustrated by (Fig. 2.1) which revealed the study's dimensions of patient satisfaction. Then, the researcher picked up some definitions of patient satisfaction from several recent studies that give an impression of understanding the concept as a multidimensional concept that determined as an important element to be involved in services planning and evaluation of quality of health care. The researcher defined patient satisfaction as is a situation whereby the patient meets his needs and expectations from the health services provided at OPsD at ASH.

Subsequently, the researcher depicted the evaluation process and the benefits that we can achieve from evaluation of our health services. More than one definition of the evaluation, a comprehensive definition as a periodic progression of gathering data and then analyzing or ordering it in such a way that the resulting information can be used to decide whether your organization or program is effectively carrying out planned actions, and the degree to which it is achieving its stated objectives and expected outcomes. This was followed by client satisfaction evaluation/measurement, which defined as the process of obtaining qualitative and quantitative information which indicates the extent to which client expectations are being met. Such information can be obtained in a variety of ways, both formally and informally. Client satisfaction evaluations are an excellent opportunity to involve clients or patients in the process of evaluating your program. Client satisfaction evaluations can be viewed as an opportunity to consult with clients about their experiences in your program, provide means for clients to express concerns about the services received, and to express their views about new services that are needed.

Then, the researcher presents the most common tools that measure patient satisfaction which are the questionnaire and the interview. The standard self-constructed questionnaire was used in this study as a tool of measuring patients' level of satisfaction.

After that, a brief history about quality and developing of the quality term was presented from several literature. The researcher defines quality from patient's perspective as is getting his care when he need it, and to cure him condition in the fastest possible way, from qualified and skilled health providers in the OPsD of ASH. While, from perspective

of the administrator is to provide effective care in a cost-conscious environment that may include the rationing of health care especially when resources are limited. Literature review regarding quality, considered quality as never an accident; it is always the result of high intention, sincere effort, intelligent direction and skilful implementation; it is the wise option of many alternatives. Quality has many dimensions such as effectiveness, efficiency, technical competence, safety, accessibility, interpersonal relations, continuity and amenities and others. The researcher encompasses five quality dimensions to evaluate and explore them in this study, these dimensions are access to care, physical environment, patients' expectations, waiting time in addition to information and interaction.

In addition to presenting the dimensions of the quality, this chapter presents factors that may affect the patient's level of satisfaction. More than one study mentioned these factors and the relationship between them and the patent's level of satisfaction. These factors divided into three types: The first is patient's-related factors such as gender, age, ethnicity, income, education, patient expectation and health status. The second is health providers-related factors such as and mainly the physicians and the nurses. The third is system-related factors such as patient professional relationship, waiting time, continuity of care, accessibility to needed services. The researcher encompassed these factors in this study to evaluate their effects on the patient's level of satisfaction.

Regarding the above mentioned studies there are many similarities and differences between them. All of them interested in evaluation the patient's level of satisfaction, but from different sides, (Hill, et al., 1992; Abdelkariem, et al., 1996) studded the satisfaction of the outpatients, while (Abu-Saileek, 2004; Zineldin, 2006; Olusina, et al., 2002; Al-Doghaither, 2004) interested in admitted patients. On the other side there are studies conducted in GOs (Abdelkariem, et al., 1996; Abu-Saileek, 2004), while others conduct their studies in both GOs and NGOs (Abu-Harbeid, 2004; Mousa, 2000).

About the dimensions that have been studied, the researchers tend to study different dimensions of quality with conformation in some dimensions and differences in the others, but they move in the same area except Margolis et al. (2003) study that interests in the fitness of a questionnaire to evaluate patient satisfaction with health care. Interview questionnaire used in most of the studies except in (Abdelkariem, et al., 1996; Kersnik, 2003) studies uses mailed questionnaire.

Concerning the instrument that used in these studies, most of them used self structured questionnaire however, Zineldin (2006) study used five qualities (5Qs) model to conduct his study.

Regarding the studies samples, there are obvious differences between the sample size. Studies that have small number of participants such as (Hill, et al., 1992; Olusina, et al., 2002) with samples 70, 118 patients and 35 staff respectively. Studies that have moderate number of participants such as (Al-Doghaither, et al., 2000; Alasad and Ahmad, 2003; Abu-Harbeid, 2004) with samples 301, 266, 504 respectively. Studies that have a big number of participants such as (Lee and Kasper, 1998; Aldana, et al., 2001; Kersnik, 2003) with samples 8,859, 1913, 2160 respectively. All of these samples were systematic random sample such as (Aldana, et al., 2001; Al-Doghaither, et al., 2000; Al-Hindi, 2002; Abu-Saileek, 2004). The sample size of this study is 450 participants selected by using systematic random sample from all patients attend to the OPsD at ASH at the time of the study.

About the suggestions and recommendations of the studies, most of the studies recommend that improving the dimensions of care will lead to improving the patient's level of satisfaction. There is a need for educational program to inform patients of the objectives and limitations of health services (Al-Doghaither, et al., 2000). Recommendations to improve nursing research (Alasad and Ahmad, 2003). Margolis et al. (2003) suggested that the satisfaction questionnaire is a useful quality assurance tool. The researcher concluded that the patients need more information about their health status, and improving the communication way between health providers and patients will improve the patient's level of satisfaction. Furthermore, meeting patient's expectations will also increase the patient's satisfaction.

Chapter (3)

Methodology

Methodology

This chapter discusses the methodology that is used in this study. It starts by the design selected to conduct this study. Then, it present the study population, sample, sampling process, place of the study, training of data collectors, ethical consideration and procedures, questionnaire design, pilot study, collection of data, data entry and data analysis. In addition, it illustrates the psychometric properties of the questionnaire and the eligibility criteria of the study. Lastly, it depicts the limitations, response rate and the period of the study

3.1 Study design

The design of this study is descriptive, analytical one. This design is useful for descriptive studies, inexpensive, can provide analytic clues, less prone to error about exposure recall, and enables the researcher to collect needed data over a short period of time, it's useful in satisfaction studies and sometimes used for comparison purposes **(**Dowson and Trapp, 2004).

3.2 Study population

The study population is all the patients who arrived and received health care at the Outpatients' department at Al-Shifa hospital at the time of the study.

3.3 Sample and sampling process

According to the ASHR (2009) the study population is huge, it was 98,028 in year 2007 and 81,891 in year 2008, with average number is 90,000 patients per year, 7,500 patients per month and 341 patients per day. The sample size was calculated by statistical equation [n = N/[$(0.05)^2$(N)] +1] (Afana, 1997). Therefore, the sample size is 398 patients. However, the researcher increased the sample size to be 450 instead of 398 patients. That's to increase the representative rate of the study. Then the data was collected over four weeks, in an average of 20 to 25 patients daily. Systematic random sample used to determine the sample interval *(k = 341/25 = 13)* (every thirteen patient). The researcher

used a dice to determine the first interviewee patient, and then the researcher choices every thirteen patient form the patients' reports of the specified days (one for males and another for females). According to the ASHR (2009) there is no significant deference between number of males and females (average percent of male is (52%), and of female is (48%) per day). Patients who meet the inclusion criteria were interviewed and asked to participate and fill the prepared questionnaire.

3.4 Place of the study

The place of the study is the Outpatients' department of Al-Shifa hospital in Gaza strip. The Outpatients' department includes medical archive, x-ray room, laboratory room, minor operations room, and two main sections, which are the medical and the surgical sections. Each section includes several clinics related to the main section where patients receive health services in these clinics.

3.5 Training of data collectors

Researcher selected two assistants who were graduated from a nursing college (research methodology course has been studied in university nursing curriculum) to assist the researcher in collecting the needed data from the participants in this study. Assistants received explanation and training from the researcher about the study's purposes, objectives, clarifications, interpretation of each question and how to encourage patients to participate and complete filling of the questionnaire, with respect to confidentiality. To carry out these goals, full explanation about the study and previous goals was performed before and after conducting the pilot study.

3.6 Ethical consideration and procedures

1- Agreement from the Helsinki Committee to conduct this study was obtained (Annex 3.1), and an ethical letter from School of Public Health, Al-Quds University sent to the responsible person in MOH to allow the researcher to start data collection in OPsD of ASH (Annex 3.2). An ethical approval to carry out the study has been obtained from the responsible person in MOH and administrative approval from the General Directorate of ASH (Annex 3.3).

2- Every participant was invited to give verbal consent to participate in the study, and has been provided with an explanatory form about the study attached to the questionnaire (Annexes 3.4.1 in Arabic, and 3.4.2 in English), this form includes the purposes of the study, confidentiality of information and some instructions. Also, it includes statement about people's right to participate or to refuse participation in the study. Ethical concepts, anonymity, right of withdraw at any time. Respect for truth and for people was considered in this study.

3.7 Questionnaire design

Self-administered questionnaire was used in this study to facilitate completion of it by explaining clearly each item to the patient. It has been developed by the researcher into two parts; the first part includes information about patient's demographic, socio-economic, patients' health status and organizational characteristics. The second part includes scale of five points to explore the outpatients' level of satisfaction with health services provided at OPsD at ASH. Items in this part reflect the five study's dimensions of patient's satisfaction. The researcher designed the questionnaire to express the patients' level of satisfaction by rating five points Likert scale (1 = strongly disagree, 2 = disagree, 3 = uncertain, 4 = agree, 5 = strongly agree). Literature review, supervisor's instructions, consultation of experts and the researcher's experience and observations in the health field were bases to constructing the questionnaire. Constructing the questionnaire takes the study's dimensions of satisfaction and the nature of participants and the place into consideration.

3.8 Pilot study

The instrument has been piloted by using sample of forty five patients selected from the patients attended and received health care at OPsD at ASH. They were interviewed in the place of the study after receiving their services. This allowed the researcher to examine the instrument carefully by detecting any difficulties, misunderstanding of some items and the time that needed to complete it as perfect as possible. The instrument has been modified (by changing some words and removing six questions from the questionnaire) to be easy understood and completed in reasonable time. The researcher interviewed patients in different days because the work in the OPsD is vary from day to day, and the clinics

(medical or surgical) assigned to meet their patients in specific days in the week. As a result of the minimal changes in the questionnaire, the collected questionnaires in pilot study were excluded from the data analysis.

3.9 Collection of data

A standardized self-administered questionnaire was used in this study. Each selected and eligible patient received full information about the study and its purposes and encouraged to participate in the study. A small colored card provided to these patients at the registration office to return back after receiving his/her care. Then, the patients were interviewed inside the OPsD after receiving their care, and asked to fill the questionnaire with assistance of the researcher and/or trained interviewers. Collection of data continued over four weeks (20 days). Self-administered questionnaire method was used to ensure highest possible response rate, and to encompass difficulties that may arise in completing or understanding the questionnaire.

3.10 Data entry

The researcher develops an entry model by using the computer software Statistical Package for Social Sciences (SPSS). The steps that have been performed before data entry are checking the number of the questionnaires, inspecting the questionnaires, excluding any unfinished one and coding questionnaires. The coded questionnaires entered into the specified SPSS model by the researcher and with help of the statistician. Data cleaning has been done to ensure that all data were entered accurately and in suitable way. This has been achieved by checking out a random number of the filled questionnaires and operating frequencies and descriptive statistics for all variables.

3.11 Data analysis

Data analysis was done by the researcher with consultations of the supervisor and the statistician. Means and Standard Deviations (*SD*) have been computed for the continuous numeric variables. To illustrate the main characteristics of the respondents, frequency tables have been used. Advanced statistical analysis was conducted to explore potential relationships between variables, student t-test and one way ANOVA test to examine

potential relationships between the continuous variables. *P* value equal or less than 0.05 was considered statistically significant. All these tests have been performed to investigate the relationships between the independent study variables (access to care, physical environment, patients' expectations, waiting time in addition to information and interaction), with the selected patient's demographic, socio-economic, health status characteristics and organizational factors that may affect the patients' level of satisfaction.

3.12 Psychometric properties of the questionnaire

3.12.1. Reliability:

Data has been collected by the researcher and the trained data collectors. Self-administered questionnaire method was used and interviewing all participants in the same manner was facilitating understanding and completing the questionnaire. Pilot study for forty five patients has been done, and reevaluation of the questionnaires for understanding of its items, time consuming, purposes and shortages if present, questionnaire adjustment were done according to the results of the pilot study. Then standardized questionnaire for all participants has been developed. Daily checking for data entry day by day also was performed in order to guarantee that the reliability of the tools was appropriate.

Reliability of an instrument reflects the degree of consistency of an instrument during measurement the attribute (Polit, 2004). A reliable measure is one that maximizes the true score component and minimizes the error component (Hillis, 2008). The researcher used Cronbachs' Alpha Coefficient test to measure the reliability of the instrument between each domain and the whole of the instrument. Cronbachs' Alpha value is between "0.00 to 1.0". In this study the Cronbachs' Alpha value of the instrument was 0.912, which is very high and reflects a highly degree of reliability of the instrument. The following table illustrates Cronbach's Alpha value of the study's dimensions of patients' satisfaction and distribution of their items through the study's questionnaire.

Table 3.1: Dimension sub-scale reliability estimates

No.	Dimension	No. of cases	No. of items	Distribution of items in the questionnaire	Cronbachs' alpha
1	Access to care	405	9	From 22 through 30	0.634
2	Physical environment	405	11	From 31 through 41	0.699
3	Patients' expectations	405	13	From 42 through 54	0.836
4	Waiting time	405	12	From 55 through 66	0.699
5	Information & Interaction	405	13	From 67 through 79	0.869
6	Total	405	59	From 22 through 59	0.912

3.12.2. Validity:

3.12.2.1. Face validity:

Face validity is a property of a test intended to measure something. The test is said to have face validity if it "looks like" it is going to measure what it is supposed to measure (Banks, 2005). The questionnaire has been prepared in suitable papers, pointed, cleared statements and proper arranged of ideas to make fullness of the questionnaire easy and simple. The pilot study respondents were asked to give their opinions about the format, layout, structure and type writing clarity of the study instruments.

3.12.2.2. Content validity

The content validity ratio was conducted by helping of experts to ensure relevance, clarity and completeness, recommendations of the experts for changing were taken into consideration. Approvals of eight experts about accreditation of the study instrument were accepted and names of them illustrated by (Annex 3.5). The first draft of the study instrument illustrated by (Annex 3.6), while the final copy of the study instrument illustrated by (Annexes 3.7.1 in Arabic and 3.7.2 in English)

3.12.2.3. Construct validity:

Construct validity examines the fitness between the conceptual definitions and operational definitions of variables (Burns and Groves, 1997). In other words, construct validity describes how will the instrument be operationalized and quantified (Fagerestom, 2000; Al-Hindi, 2002). The researcher used the Correlation Coefficient test (Person Correlation test) to evaluate the construct validity of each domain of the study and total degree of the instrument. All the coefficients were positive and significant at the 0.05 level**,** and all correlation coefficients ranged between (0.543 -0.828), that means a content validity for what it is supposed to be measured (Annex 3.8). After that, the researcher used the Correlation Coefficient test (Person Correlation test) to evaluate the construct validity of each item and total degree of its domain. Six items were deleted from the initial draft of the instrument as following:

Access to care dimension: The coefficients of this domain are positive and significant at level lower than (0.05), all correlation coefficients ranged between (0.323-0.652), that means a content validity for what it is supposed to be measured, but item No. (30) is not significant and deleted from the final instrument (Annex 3.9).

Physical environment dimension: The coefficients of this domain are positive and significant at level lower than (0.05), all correlation coefficients ranged between (0.348-0.767), that means a content validity for what it is supposed to be measured, but items no.(32, 34,36, 40) is not significant and deleted from the final instrument (Annex 3.10).

Patients' expectations dimension: The coefficients of this domain are positive and significant at level lower than (0.05), all correlation coefficients ranged between (0.402-0.699), that means a content validity for what it is supposed to be measured (Annex 3.11).

Waiting time dimension: The coefficients of this domain are positive and significant at level lower than (0.05), all correlation coefficients ranged between (0.316-0.676), that means a content validity for what it is suppose to be measured, but item No. (60) is not significant and deleted from the instrument (Annex 3.12).

Information & Interaction dimension: The coefficients of this domain are positive and significant at level lower than (0.05), all correlation coefficients ranged between (0.427-0.847), that means a content validity for what it is suppose to be measured (Annex 3.13).

Therefore, the final copy of the study instrument consists of two parts included 79 items, as the following:

The first part included the patient's demographic, socio-economic, patients' health status, and organizational characteristics. This part included 21 items (Annexes 3.7.1 and 3.7.2). While, the second part included the items that reflected the study dimensions of patient's satisfaction as illustrated by (Table 3.1).

3.13 Eligibility criteria

3.13.1. Inclusion criteria:

All the patients who arrived to the OPsD at ASH at the time of data collection (July and August, 2009), were received health care, able and accept participation, conscious and oriented to time, place and persons.

3.13.2. Exclusion criteria:

All the patients who arrived to the OPsD of ASH at the time of the study and weren't meet the above criteria have been excluded from the study.

3.14 Response rate for the questionnaire

The total number of the study sample is 450 patients. 13 patients did not meet the inclusion criteria and 32 refused to complete the questionnaires. Therefore, 405 questionnaires were deserved to encompass in this study analysis. So, the response rate was 90%. This excellence rate may attribute to the approach utilized by the researcher and to the appropriate communication and interviewing skills. The interviewing questionnaires usually results in higher response rate (Burns and Grove, 1997).

3.15 Limitations of the study

1- Time factor, the time was determined by Al-Quds University to complete the study.
2- Limited resources, the studies concerning patient's satisfaction in and the scientific library for modern resources and references in GS are few.
3- Socio-economic status may affect the satisfaction level of the patients.
4- Budget, the study is self financing.

3.16 Period of the study

The study started in February 2009, by preparing the research proposal and designing the questionnaire. Approvals from Al-Quds University, Helsinki Committee and from MOH were getting in June 2009. Pilot study and data collection were completed in July and August 2009. Data entry, analysis and writing the final report continued till the end of November 2009.

Chapter 4

Results and Discussion

Results and Discussion

4.1 Introduction

This chapter presented the results, interpretation and discussion of statistical analysis of the data including descriptive analysis that presented the respondents' demographic, socio-economic, patient's health status and organizational characteristics. Furthermore, the differences between the selected variables and overall satisfaction scores were explored by using different analytical statistical tests as detailed below. In addition, it discussed the dimensions of patients' satisfaction with health services provided at OPsD at ASH.

4.2 Descriptive analysis

4.2.1. Demographic characteristics:

Table (4.1) summarizes the demographic characteristics of the study population that were selected in this study: age, gender and residency place.

Table 4.1: Selected demographic characteristics of the study population

Variables	Frequency	Percent
Gender		
Male	208	51.4
Female	197	48.6
Total	**405**	**100**
Age group		
Less than 24 years	106	26.2
From 25-34 years	99	24.4
From 35-46 years	99	24.4
More than 46 years	101	24.9
Total	**405**	**100**
Residency place		
North Governorate	62	15.3
Gaza Governorate	292	72.1
Others Governorate	51	12.6
Total	**405**	**100**

a. Gender

Fig. (4.1) and Table (4.1) presented the ratio between males and females of the study population as the following: males represented 51.4% and females represented 48.6% of the study sample.

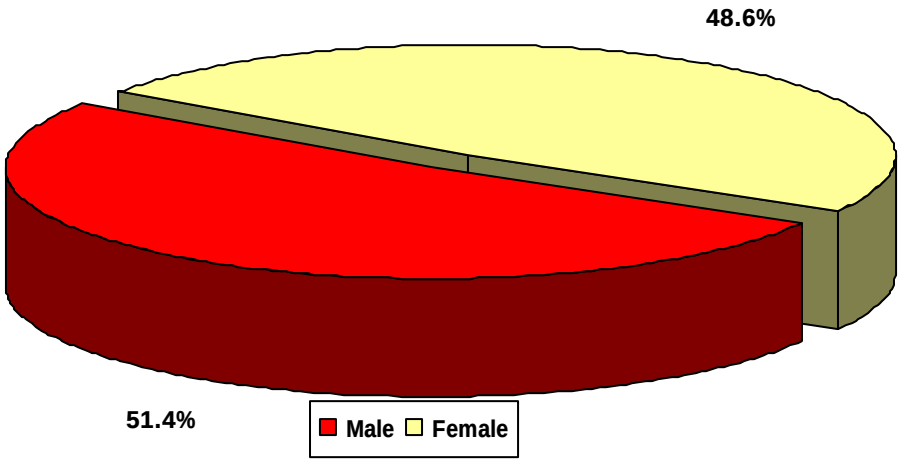

Figure 4.1: Distribution of study population by gender

b. Age

Fig. (4.2) and Table (4.1) illustrated the four nearly equal number of respondents groups, the first group is, less than 24 years, the second group is between 25 and 34 years, the third group is between 35 and 46 years, and the forth group is more than 46 years, which composed 26.2%, 24.4%, 24.4% and 24.9% from the respondents respectively. The mean age of the study population was 30.2988 years and the standard deviation was 4.43681 years.

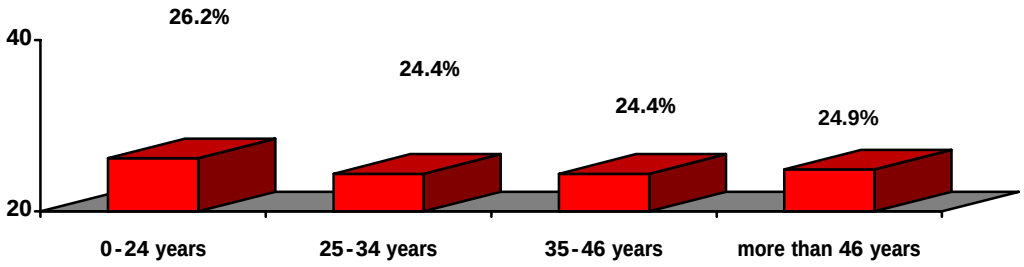

Figure 4.2: Distribution of study population by age group

c. Residency place

Fig. (4.3) and Table (4.1) illustrated that, the majority of the subjects were from Gaza governorate 72.1%, 15.3% were from North governorate and 12.6% were from others governorates (Mid-Zone, Khan-Younis and Rafah governorates).

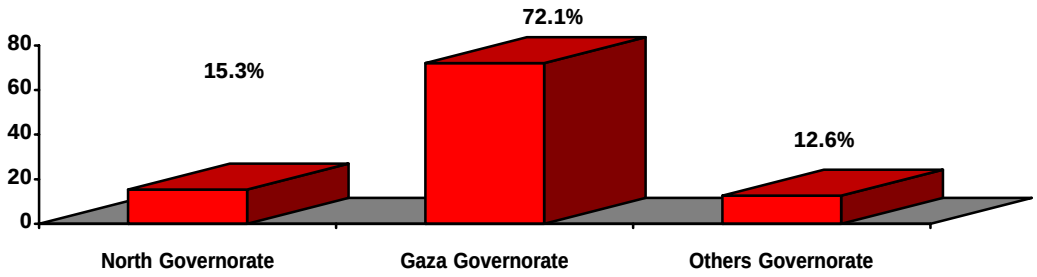

Figure 4.3: Distribution of study population by residency place

4.2.2. Socio-economic characteristics:

Table (4.2) summarized the important socio-economic characteristics of the study population that were selected in this study, marital status, educational level and monthly income.

Table 4.2: Selected socio-economic characteristics of the study population

Variables	Frequency	Percent
Marital status		
Married	274	67.7
Unmarried	108	26.7
Divorced	3	0.7
Widow	20	4.9
Total	**405**	**100**
Educational level		
Elementary	90	22.2
Preparatory	105	25.9
Secondary	130	32.1
University and more	80	19.8
Total	**405**	**100**
Monthly income		
Less than 1000 NIS	278	68.6
From 1000 to 2000 NIS	84	20.7
More than 2000 NIS	43	10.6
Total	**405**	**100**

a. Marital status

Fig. (4.4) and Table (4.2) described the marital status of the study's respondents, the respondents who are married showed higher percentage, which represented 67.7%, while the unmarried represented 26.7%, the widow subjects represented 4.9 and the divorced subjects represented 0.7% of the study sample.

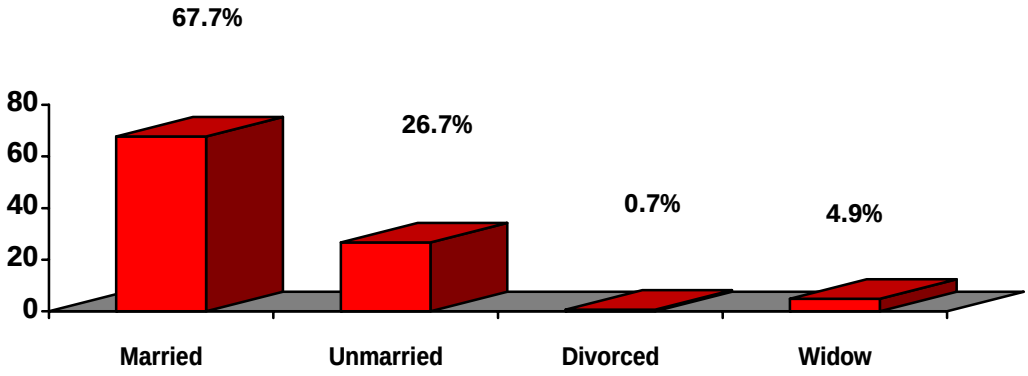

Figure 4.4: Distribution of study population by marital status

b. Educational level

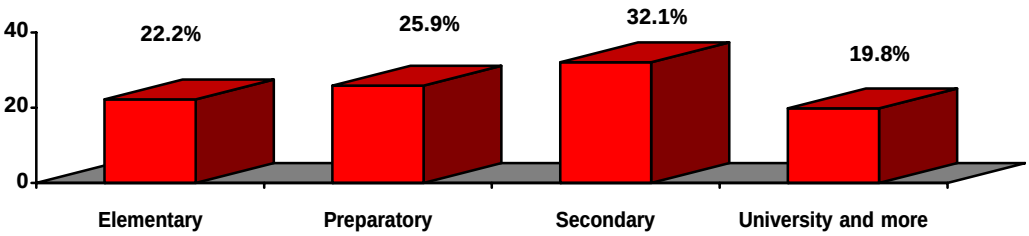

Figure 4.5: Distribution of study population by educational level

Fig. (4.5) and Table (4.2) showed that, 32.1% of the study population have had attained secondary education, 25.9% of the study population had preparatory education, 22.2 % of the study population had elementary education and 19.8% of the study population had university and more.

c. Monthly income

Fig. (4.6) and Table (4.2) showed monthly income of the respondents, whereas, 68.6% of the study population have had income lower than 1000 New Israeli Sheqalim (NIS), 20.7% of the population have had monthly income between 1000 and 2000 NIS and 10.6% of the study population have had income more than 2000 NIS. The mean of monthly income is 994.12 NIS and the standard deviation is 937.244 NIS.

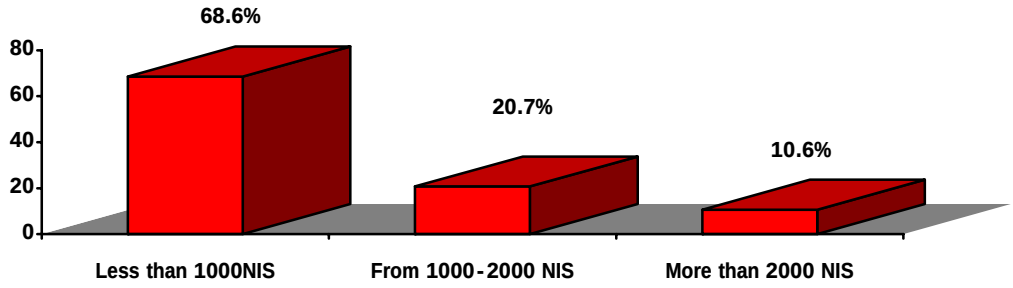

Figure 4.6: Distribution of study population by monthly income

4.2.3. Patient's health status characteristics:

Table (4.3) summarized the selected health status characteristics of the study population that were found in this study: number of visits (since two months), type of the disease and disability.

Table 4.3: Selected health status characteristics of the study population

Variables	Frequency	Percent
Number of visits (since two month)		
The first visit	133	32.8
More than one visit	272	67.2
Total	**405**	**100**
Type of the disease		
Chronic	119	29.4
Acute	219	54.1
Casualty	67	16.5
Total	**405**	**100**
Disability		
present	54	13.3
Not present	351	86.7
Total	**405**	**100**

a. Number of visits (since two months)

Fig (4.7) and Table (4.3) showed the number of visits of the study population for two months, 32.8% of the study population have the first visit, while 67.2% of the study population have more than one visit.

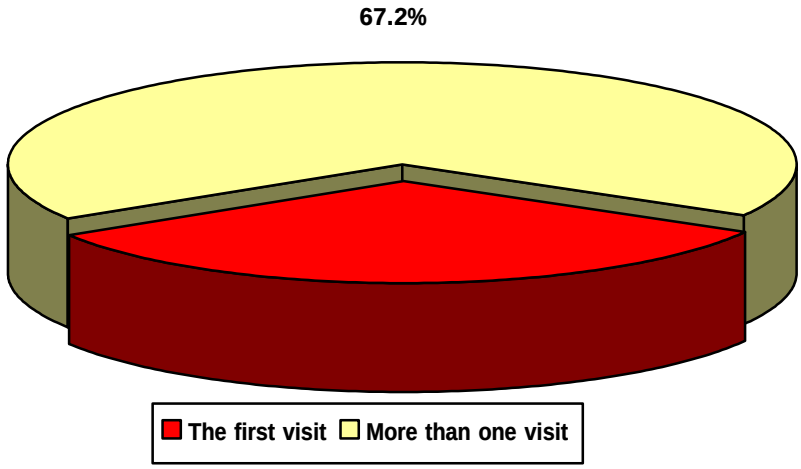

Figure 4.7: Distribution of study population by number of visits

b. Type of the disease

Fig. (4.8) and Table (4.3) and showed the different types of disease among the study population, whereas, 54.1% of the study population have acute disease, 29.4% of the study population have chronic disease (Hypertension, Diabetes Mellitus, Asthma, Cardiac diseases) and 16.5% of the study population have casualty.

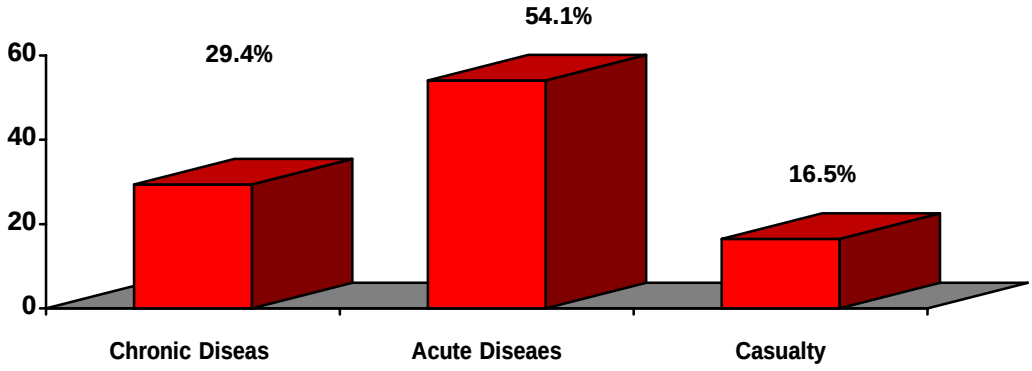

Figure 4.8: Distribution of study population by type of the disease

c. Disability

Fig. (4.9) and Table (4.3) illustrated that 13.3% of the study population have disability while 86.7% were free.

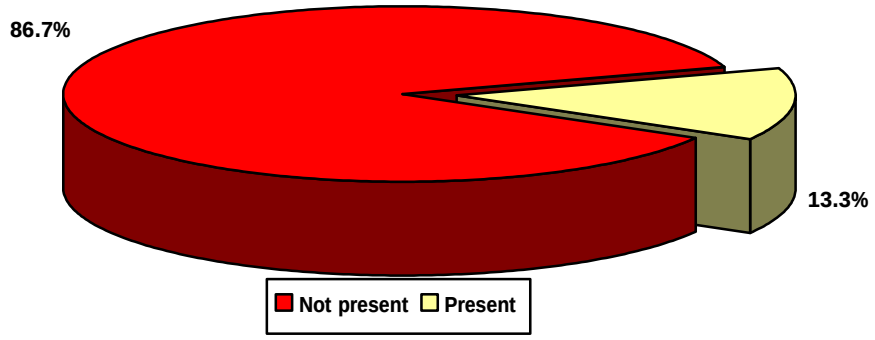

Figure 4.9: Distribution of study population by disability

4.2.4. Organizational characteristics:

Table (4.4) summarized selected organizational characteristics that were founded in this study: types of the clinic, the time consumed in the clinic, the area that consumed more time.

Table 4.4: Distribution of respondents by organizational factors

Variables	Frequency	Percent
Types of the clinic		
Surgical clinics	129	31.9
Medical clinics	241	59.5
Others	35	8.6
Total	**405**	**100**
The consumed time		
Less than 60 min	194	47.9
From 60-120 min	127	31.4
More than 120 min	84	20.7
Total	**405**	**100**
Area that consumed more time		
At registration office	20	4.9
At Doctors' room	328	81
At X-ray room	42	10.4
At Lab room	15	3.7
Total	**405**	**100**

a. Type of the clinic

Fig. (4.10) and Table (4.4) illustrates that, 59.5% of study population that visited medical clinics in the OPsD, 31.9% of study population visited surgical clinics in the OPsD and 8.6% of study population visited other clinics

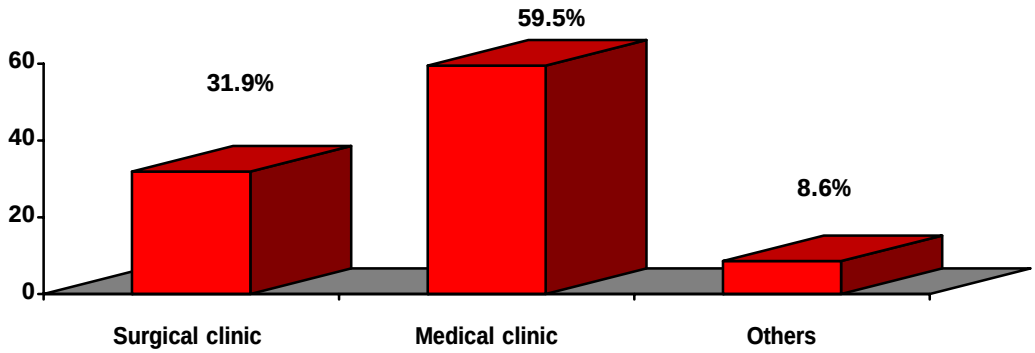

Figure 4.10: Distribution of study population by the recipient clinics

b. The consumed time

Fig. (4.11) and Table (4.4) reported the amount of time that consumed in the visit, where 47.9% of study population were spent time less than 60 min, 31.4% of study population were spent time between 60 to 120 min and 20.7% of study population were spent time more than 120 min.

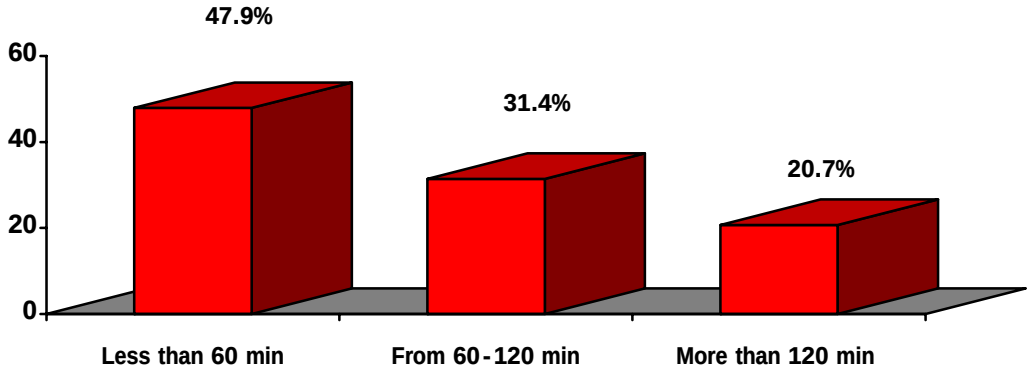

Figure 4.11: Distribution of study population by the amount of consumed time

c. Areas consumed more of time

Fig. (4.12) and Table (4.4) revealed that 81.4% of study population were consumed most of the time at doctors' room, while, 10.4% were consumed most of the time at X-Ray room, also, 4.9% were consumed most of the time at registration office and 3.7% were consumed most of the time at Lab. room.

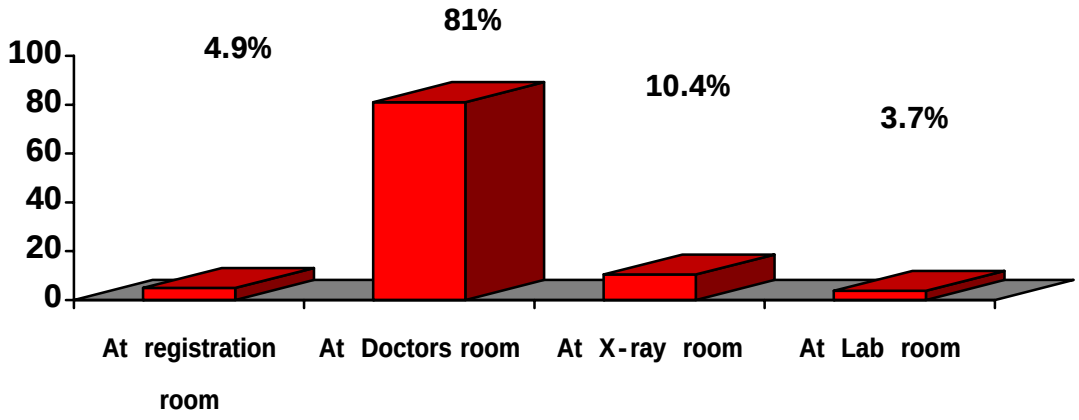

Figure 4.12: Distribution of study population by the area that consumed most time

4.3. Differences in patient's satisfaction and characteristics of the study population

4.3.1. Differences in patient's satisfaction and selected demographic characteristics of the study population:

4.3.1.1. Gender of the study population:

Table 4.5: Differences in patient's satisfaction by gender

Dep. var. "Patient Satisfaction"	Indep. var. " Sex"	N	Mean	T	P-Value
Access to care	Male	208	29.9856	-1.462	.145
	Female	197	30.6294		
physical environment	Male	208	33.2548	-1.802	.072
	Female	197	34.1726		
Patients' expectations	Male	208	42.7981	-4.133	.001*
	Female	197	45.8376		
Waiting time	Male	208	37.4808	-1.822	.069
	Female	197	38.6041		
Information & Interaction	Male	208	41.0529	-2.493	.013*
	Female	197	43.1269		
Overall satisfaction	Male	208	184.5721	-3.295	.001*
	Female	197	192.3706		

* P- value statistically significant at level equal or less than 0.05

An independent t-test to compare the means of the satisfaction scores in regard to gender, table (4.6) revealed that there were statistically significant in patients' expectations, overall satisfaction and information and interaction (P-value 0.001, 0.001 and 0.13 respectively). However, females elicited higher scores in all domains and overall satisfaction than males. This result may attribute to the good orientation and awareness of the females regarding their health and/or to find health services meeting their expectations. This result was approved by Baker (1996) who examined the characteristics of practices, general practitioners and patients related to levels of patients' satisfaction with consultations, the results indicated that women having higher satisfaction scores than men. Other study conducted Abdelrhman and Saeed (2000) who assessed patients' satisfaction with primary health care centers services in Kuwait city, the results indicated that females are usually more satisfied than males. Furthermore, this result consistent with El-Haj (2008) who found that females were more satisfied in information and communication domain and their mean scores were higher than the males mean scores in general subscales dimensions.

El-Haj (2008) attributed this findings to that females may not know their health rights and to low expectation level. Further, another study conducted by Uzun (2001) who measured patient satisfaction with nursing care in Ataturk University Hospital at Erzurm City in Turkey. The finding revealed that there was statistically significant relationship between satisfaction level and gender and gave higher scores than males. Weisman et al. (2001) who assessed gender and patient satisfaction in managed care plans in the united state, the findings determined that there was a small but significant means differences by gender. While, other studies pointed that there were no significant differences between males and females regarding satisfaction level with radiology services in GS (Al-Hindi, 2002). Also, this result was not endorsed by Abu-Saileek (2004) who examined the patients' satisfaction with nursing care provided at selected hospitals in GS. Otherwise, Tucker and Kelly (2000) study reported that there is a strong link between male patients and higher satisfaction.

4.3.1.2. Age of the study population:

Table 4.6: Differences in patient's satisfaction by age groups

Dep. var. "Patient Satisfaction"	Age groups	No.	Mean	Indep.var. Age groups	DF	F	p-value
Access to Care	Less than 24 years	106	30.2075	Between Groups	3 401	.476	.699
	From 25-34 years	99	29.9293				
	From 35-46 years	99	30.4040				
	More than 46 years	101	30.6535				
Physical environment	Less than 24 years	106	32.9623	Between Groups	3 401	3.498	.016*
	From 25-34 years	99	32.9293				
	From 35-46 years	99	34.0505				
	More than 46 years	101	34.8911				
Patients' Expectations	Less than 24 years	106	43.8113	Between Groups	3 401	2.524	.057
	From 25-34 years	99	43.6768				
	From 35-46 years	99	43.5657				
	More than 46 years	101	46.0495				
Waiting time	Less than 24 years	106	37.5000	Between Groups	3 401	2.502	.059
	From 25-34 years	99	37.1515				
	From 35-46 years	99	38.1010				
	More than 46 years	101	39.3663				
Information & Interaction	Less than 24 years	106	40.0377	Between Groups	3 401	5.907	.001*
	From 25-34 years	99	41.6869				
	From 35-46 years	99	41.8081				
	More than 46 years	101	44.8020				
Overall satisfaction	Less than 24 years	106	184.5189	Between Groups	3 401	4.721	.003*
	From 25-34 years	99	185.3737				
	From 35-46 years	99	187.9293				
	More than 46 years	101	195.7624				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to age groups. The results according to table (4.5) show that the differences were statistically significant in information and interaction, overall satisfaction and physical environment (P-value 0.001, 0.003 and 0.016 respectively). However, the table test shows that those patients who were more than 46 years reported highest mean scores of satisfaction, while the patients who were less than 24 years reported lowest scores of satisfaction. The results revealed that the older age patients more satisfied with the services provided at ASH than the younger one, this may attributed to the experience of the older patients and increase the health awareness among these patients represented in seeking to health information concerning their diseases, and the need to more comfortable environment during their visit. The results also may attribute to the low level of expectations among older age patients. Also, this indicates that concern is needed to be directed to the younger ages. This result is consistent with the study conducted by Abu-Saileek (2004) who found statistical significant differences between age groups regarding the satisfaction level, also older age reported higher level of satisfaction. This result goes with Uzun (2001) study who found that patients between the ages of 18 to 34 gave the lowest rating of satisfaction level and patients aged between 50 to 64 years and more than 65 gave the highest rating. As discussed in previous chapter studies found the same results as (Hall and Dornan, 1990; Wilde, et al., 1994; Cohen, 1996; Pope and Mays, 1993; and Owens and Batchelor, 1996). While, other studies found that the level of satisfaction was decreased as the age was increased in Palestinian people (Mousa, 2000). On the other hand, Al-Hindi (2002) found that no real differences between age groups regarding the satisfaction level. The researcher attributed the inconsistent relationship between satisfaction and age to the fact that patients' satisfaction is influenced by other variables rather than age of the patients.

4.3.1.3. The residency place of the study population:

Table 4.7: Patient's satisfaction and residency place

Dep. var. "Patient Satisfaction"	Residency place	No	Mean	Indep. var. Residency place	DF	F	p-value
Access to Care	North	62	30.0806	Between Groups	2 402	.119	.888
	Gaza	292	30.3630				
	Others	51	30.1961				
Physical environment	North	62	34.1935	Between Groups	2 402	.369	.692
	Gaza	292	33.5822				
	Others	51	33.7843				
Patients' expectations	North	62	44.5323	Between Groups	2 402	.353	.703
	Gaza	292	44.0959				
	Others	51	45.0000				
Waiting Time	North	62	38.3710	Between Groups	2 402	.401	.670
	Gaza	292	38.0719				
	Others	51	37.3529				
Information & Interaction	North	62	42.9032	Between Groups	2 402	.462	.630
	Gaza	292	41.8253				
	Others	51	42.3922				
Overall satisfaction	North	62	190.0806	Between Groups	2 402	.208	.812
	Gaza	292	187.9384				
	Others	51	188.7255				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to residency place. The results according to table (4.7) show that the differences were not significant between the satisfaction domains and the residency place of the study population. The results revealed that the patients who were living in the north governorate have had mean scores higher than those who live in Gaza and others governorates, but this difference was not reach the statistically significant level. This result may attribute to that patients who live in the North governorate find higher quality of health services than the health services that present in North governorate.

4.3.2. Differences in patient's satisfaction and selected socio-economic characteristics of the study population:

4.3.2.1. The marital status of the study population:

Table 4.8: Differences in patients' satisfaction by marital status

Dep. var. "Patient Satisfaction"	Marital status	No	Mean	Indep. var. Marital status	DF	F	p-value
Access to care	Married	274	29.9015	Between Groups	3 401	3.277	.021*
	Unmarried	108	30.8333				
	Divorced	3	31.6667				
	widow	20	32.6500				
Physical environment	Married	274	33.7336	Between Groups	3 401	.417	.741
	Unmarried	108	33.4167				
	Divorced	3	33.6667				
	widow	20	34.8000				
Patients' expectations	Married	274	43.9854	Between Groups	3 401	1.825	.142
	Unmarried	108	44.2963				
	Divorced	3	45.0000				
	widow	20	48.0500				
Waiting Time	Married	274	37.9380	Between Groups	3 401	1.309	.271
	Unmarried	108	37.7407				
	Divorced	3	39.0000				
	widow	20	40.6500				
Information & Interaction	Married	274	42.1168	Between Groups	3 401	1.669	.173
	Unmarried	108	41.2130				
	Divorced	3	43.0000				
	widow	20	45.7500				
Overall Satisfaction	Married	274	187.6752	Between Groups	3 401	2.274	.079
	Unmarried	108	187.5000				
	Divorced	3	192.3333				
	widow	20	201.9000				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to marital status. The results according to table (4.8) which illustrated that the differences were statistically not significant except in access to care (P-value 0.021). Also, the results revealed that the widow group has had highest scores of satisfaction. The researcher attributed this result to that the married patients seek to treatment more than unmarried and they facilitated the means to attend to the health center. Regarding the widow patients, who have had the highest mean scores of satisfaction, this may be attributed to pay attention by the widow patients regarding their health and

facilitate means to access to the care they need. Married patients have had higher mean scores of overall satisfaction than unmarried patients, this means that patients who were married satisfied more than unmarried patients, and may indicated that married patients have a previous experience about the services provided at ASH. This result consistent with (El-Haj, 2008; Abu-Saileek, 2004; Al-Doghaither, 2004) who revealed that married patients were more satisfied than unmarried patients, while the result was inconsistent with Hillis (2008) study that conducted in ASH to assess the satisfaction level among patients who need physiotherapy treatment that revealed there is no significant statistical differences in marital status.

4.3.2.2. Educational level of the stud population:

Table 4.9: Differences in patient's satisfaction by level of education

Dep. var. "Patient Satisfaction"	Education level	No	Mean	Indep. var. Education level	DF	F	p- value
Access to Care	Elementary	90	30.3667	Between Groups	3 401	2.363	.071
	Preparatory	105	31.1714				
	Secondary	130	30.0231				
	University and more	80	29.5250				
Physical environment	Elementary	90	34.5444	Between Groups	3 401	4.632	.003*
	Preparatory	105	34.2952				
	Secondary	130	33.7385				
	University and more	80	31.9125				
Patients' expectations	Elementary	90	44.4333	Between Groups	3 401	2.662	.048*
	Preparatory	105	45.3810				
	Secondary	130	44.4923				
	University and more	80	42.3000				
Waiting Time	Elementary	90	38.6889	Between Groups	3 401	2.307	.076
	Preparatory	105	38.9524				
	Secondary	130	37.5154				
	University and more	80	36.9000				
Information & Interaction	Elementary	90	43.7889	Between Groups	3 401	1.949	.121
	Preparatory	105	42.2190				
	Secondary	130	41.2462				
	University and more	80	41.2375				
Overall satisfaction	Elementary	90	191.8222	Between Groups	3 401	3.561	.014*
	Preparatory	105	192.0190				
	Secondary	130	187.0154				
	University and more	80	181.8750				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to educational level. The results according to table (4.9) revealed that the differences were reach statistical significant in physical environment, overall satisfaction and patients' expectation (P-value 0.003, 0.014 and 0.048 respectively). The results revealed that the patients who were attained to elementary and preparatory education have had higher scores of satisfaction. This result was consistent with Hillis (2008) study who found that the illiteracy and primary educated patients were satisfied more than the patients with university and more**.** El-Haj (2008) study was conducted in EGH in GS to assess the patients' perception level regarding the health services provided at EGH. The result illustrated that there were statistical analysis identified that the illiterate and preparatory patients reported higher scores of perception. Shaqura (2008) study that conducted in Jablia women's Health Center indicated that the illiteracy clients reported higher scores of perception, while the university level of education reported the lowest scores of perception. Another study conducted by Abu-Saileek (2004) to evaluate patients' level of satisfaction with nursing care in selected hospitals in south of GS found that there are significant differences within educational level regarding satisfaction level, the client' who had lower educational level were more satisfied with nursing care than the clients' who had higher educational level. The result was consistent also with Abdelkariem et al. (1996) study showed that the patients with lower level of education showed higher of satisfaction with availability of services and facilities, and those with higher of education tended to be more satisfied with the quality of care. Mousa (2000) study revealed that the least satisfied group is the highly educated one. On the other hand, Al-Hindi (2002) study conducted in GS to evaluate satisfaction level with radiology services indicated that higher level of education reported higher satisfaction level and concluded that because those with higher educational level might be more informed about the services. While, Abu-Harbeid (2004) findings revealed that there was no significant statistical difference between educational level and satisfaction's dimensions regarding overall satisfaction. Furthermore, the findings of this study were not consistent with Abu-Shuaib (2005) study the findings revealed that, there were no significant statistical differences between educational level and overall perception. Also, the study revealed that illiterate women reported positive experience more than educated ones.

There is inconsistency between the studies results regarding level of education and satisfaction level. This may attribute to differences in expectations and needs between patients, and also may attribute to other factors rather than educational level of the patients.

4.3.2.3. Monthly income of the study population:

Table 4.10: Differences in patient's satisfaction by monthly income

Dep. var. "Patient Satisfaction"	Monthly income	No	Mean	Indep. Var. Monthly income	DF	F	p- value
Access to Care	Less than 1000 NIS	278	30.6367	Between Groups	2 402	2.684	.070
	From 1000 to 2000 NIS	84	29.6786				
	More than 2000 NIS	43	29.3256				
physical environment	Less than 1000 NIS	278	34.0252	Between Groups	2 402	1.805	.166
	From 1000 to 2000 NIS	84	32.9048				
	More than 2000 NIS	43	33.1628				
Patients' expectations	Less than 1000 NIS	278	45.0468	Between Groups	2 402	4.853	.008*
	From 1000 to 2000 NIS	84	42.8452				
	More than 2000 NIS	43	42.0930				
Waiting Time	Less than 1000 NIS	278	38.4676	Between Groups	2 402	2.410	.091
	From 1000 to 2000 NIS	84	36.8333				
	More than 2000 NIS	43	37.5116				
Information & Interaction	Less than 1000 NIS	278	42.6007	Between Groups	2 402	2.224	.110
	From 1000 to 2000 NIS	84	41.3571				
	More than 2000 NIS	43	39.9535				
Overall satisfaction	Less than 1000 NIS	278	190.7770	Between Groups	2 402	4.582	.011*
	From 1000 to 2000 NIS	84	183.6190				
	More than 2000 NIS	43	182.0465				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to income. The results according to table (4.10) revealed that the differences were reach statistical significant in patients' expectations and overall satisfaction (P-value 0.008, and 0.011 respectively). The result means that there was a real relationship between the income variable and the patients' level of satisfaction. It may indicate that the patients who have income more than 2000 NIS were less satisfied. The patients with income less than 1000 NIS have had mean scores more than other group that means this group was more satisfied. Also, it revealed that there was statistical significant between patients' monthly income and overall satisfaction, this result was inconsistent with (Shaqura, 2008; Mousa, 2000; Al-Hindi, 2002) satisfaction studies. The researcher attributed this result to the low expectation level of the group with income less than 1000

NIS. Also, it may attribute to the ability of the high income group to compare between health services they received in different health centers. Further, it may attribute to the dominant impression regarding governmental health organization that is not satisfied for all population.

4.3.3. Differences in patient's satisfaction and selected health status characteristics of the study population:

4.3.3.1. Number of visits (since tow months) of the stud population:

Table 4.11: Differences in patient's satisfaction by number of visits

Dep. var. "Patient Satisfaction"	Indep. var. "No. of visits "	N	Mean	S.D	T	P-value
Access to Care	The first visit	133	30.1429	4.4707	-.494	.622
	More than one visit	272	30.3750	4.4264		
Physical environment	The first visit	133	33.5113	4.9888	-.520	.603
	More than one visit	272	33.7941	5.2158		
Patients' expectations	The first visit	133	44.1880	7.2719	-.165	.869
	More than one visit	272	44.3199	7.6860		
Waiting Time	The first visit	133	38.1880	6.0229	.364	.716
	More than one visit	272	37.9485	6.3208		
Information & Interaction	The first visit	133	41.5489	7.9320	-.857	.392
	More than one visit	272	42.3125	8.6550		
Overall satisfaction	The first visit	133	187.5789	22.8928	-.459	.647
	More than one visit	272	188.7500	24.6887		

* P-value statistically significant at level equal or less than 0.05

An independent t-test to compare the means of the satisfaction scores in regard to number of visits, table (4.11) revealed that the differences were not reached the statistically significant in all domains and overall satisfaction. The results revealed that the patients who have had more than one visit have higher satisfaction scores than the patients who have one visit. El-Haj (2008) study revealed that patients who were admitted for more than one admission elicited higher level of the overall perception scores, while the patient who were admitted for the first time have lowest scores of perception. In contrast result, Hillis (2008) study found that the patients who had the first experience of physiotherapy services were higher level of overall satisfaction scores than the patients who had previous experiences of physiotherapy services. The result of this study could be attributed to the last experience and knowledge receiving during the last visit that help the patient to

understand the hospital staff and to accomplish his visit with stress level less than patients who have the first one.

4.3.3.2. Type of the diseases of the study population:

Table 4.12: Differences in patient's satisfaction by type of the disease

Dep. var. "Patient Satisfaction"	Disease Type	No	Mean	Indep.var Disease type	DF	F	p-value
Access to Care	Chronic	119	30.8824	Between Groups	2 402	1.577	.208
	Acute	219	29.9863				
	Casualty	67	30.2836				
Physical environment	Chronic	119	34.4622	Between Groups	2 402	3.913	.021*
	Acute	219	33.7215				
	Casualty	67	32.2836				
Patients' Expectations	Chronic	119	44.8151	Between Groups	2 402	2.035	.132
	Acute	219	44.4932				
	Casualty	67	42.6119				
Waiting Time	Chronic	119	39.6555	Between Groups	2 402	6.468	.002*
	Acute	219	37.5571				
	Casualty	67	36.6716				
Information & Interaction	Chronic	119	44.2773	Between Groups	2 402	6.373	.002*
	Acute	219	41.3790				
	Casualty	67	40.3582				
Overall Satisfaction	Chronic	119	194.094	Between Groups	2 402	5.978	.003*
	Acute	219	187.130				
	Casualty	67	182.200				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to type of disease. The results according to table (4.12) showed that the differences were reach the statistically significant in physical environment, waiting time, information and interaction and overall satisfaction (P-value, 0.021, 0.002, 0.002 and 0.003 respectively). The results revealed that the patients who have chronic disease have highest satisfaction scores, while patients with casualty have lowest satisfaction scores. As shown in table (4.12) patients with chronic diseases reported high scores of satisfaction that means they were satisfied by the physical environment that exist in the clinic, time spent in the clinic, the information they received and the interaction way between them and the health staff. While, patients who have injures or casualty were less satisfied by these dimensions of health care. This result could be attributed to the high expectations level,

the less experience, the adaptation process with the disease and to misunderstanding of the health staff by the casualty patients. The differences between patients health status reach the significant level, that means there is a real relationship between the chronic patients and satisfaction level. This result was consistent with Abu-Saileek (2004) study who found that the clients who had chronic illness were more satisfied with nursing care than others, while the clients with injuries were less satisfied. Patients with chronic illness were more satisfied (Zapka, et al., 1995). The researcher concluded that the patient's health status considered as important factor that could affect patient's level of satisfaction. In disparity result Hsieh and kagle (1991) study found that health status was not a strong predictor for patient's satisfaction.

4.3.3.3. Disability of the study population:

Table 4.13: Differences in patient's satisfaction by present of disability

Dep. var. "Patient Satisfaction"	Indep. var. "Disability "	N	Mean	T	P-value
Access to Care	Present	54	28.9630	-2.390	.017*
	Not present	351	30.5043		
physical Environment	Present	54	33.9074	.316	.752
	Not present	351	33.6695		
Patients' expectations	Present	54	42.6111	-1.747	.081
	Not present	351	44.5328		
Waiting Time	Present	54	39.0370	1.283	.200
	Not present	351	37.8718		
Information & Interaction	Present	54	42.8889	.775	.439
	Not present	351	41.9345		
Overall Satisfaction	Present	54	187.4074	-.314	.754
	Not present	351	188.512		

* P-value statistically significant at level equal or less than 0.05

An independent t-test to compare the means of the satisfaction scores in regard to disability table (4.13) revealed that there were differences were statistically not significant except in access to care (P-value 0.017). Although, there were differences between two means, the differences were not reaching the statistically significant level in others satisfaction domains. The disabled patients interested in the access to care domain more than other domains. That may attributed to the help they received from their relatives that decreased their suffering. Also, the disabled patients were interested on their health situation rather

than other dimensions of health. Disabled patients report satisfaction mean scores in the rest of domains and overall satisfaction less than free patients that means the infrastructure of the OPsD needs modification and changes in the structure to be more comfortable to those patients than the existed structure. Also, they have had high expectation level and they look to the health providers to meet their expectation. Further, they were dissatisfied with the time they spent in the clinic, this means that they suffered from the long time they spent in the clinic. This problem needs to take actions to decrease their suffering in the clinic. Also, the disabled patients look for improving the communication way with them and need more information about their health situation.

4.3.4. Differences in patient's satisfaction and selected organizational characteristics:

4.3.4.1. Type of visited clinic of the stud population:

Table 4.14: Differences in patient's satisfaction type of the visited clinic

Dep. var. "Patient Satisfaction"	Visited clinic	No	Mean	Indep.var. Visited clinic	DF	F	p-value
Access to care	Surg. clinics	129	30.0698	Between Groups	2 402	.526	.591
	Med. clinics	241	30.4813				
	Others	35	29.8857				
Physical Environment	Surg. clinics	129	33.4496	Between Groups	2 402	.272	.762
	Med. clinics	241	33.8548				
	Others	35	33.5714				
Patients' expectations	Surg. clinics	129	43.7132	Between Groups	2 402	1.108	.331
	Med. clinics	241	44.7261				
	Others	35	43.2571				
Waiting time	Surg. clinics	129	37.3256	Between Groups	2 402	1.551	.213
	Med. clinics	241	38.4730				
	Others	35	37.5429				
Information & Interaction	Surg. clinics	129	41.7597	Between Groups	2 402	.469	.626
	Med. clinics	241	42.0415				
	Others	35	43.3143				
Overall Satisfaction	Surg. clinics	129	186.3178	Between Groups	2 402	.789	.455
	Med. clinics	241	189.5768				
	Others	35	187.5714				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to types of visited clinic. The results according to table (4.14) showed that the differences were statistically not significant in all domains of patients'

satisfaction. The patients who visited medical clinics were had highest means of satisfaction scores. Although, there were differences between the means but they were not reach statistically significant level. This result was consistent with the result of (El-Haj, 2008; Uzun, 2001) studies that found the patients who admitted to the medical wards elicited higher level of the overall perception scores, while the patients who admitted to the surgical wards reported lower level. This result is in contrast with a study conducted by Abu-Saileek (2004) who revealed that the client's from surgical wards and medical wards were in the same level of satisfaction. This result may attributed to the frequently of patients visiting the medical clinics rather than the surgical ones, this makes the patients who have medical diseases to be more cooperative and understanding the treatment process than surgical patients.

4.3.4.2. The consumed time:

Table 4.15: Differences in patient's satisfaction by the time consumed in the visit

Dep. var. "Patient Satisfaction"	"The consumed time"	No	Mean	Indep. var. "The consumed time"	DF	F	p-value
Access to Care	Less than 60 min.	194	31.1546	Between Groups	2 402	10.281	.001*
	From 60-120 min.	127	30.1102				
	More than 120 min.	84	28.6071				
Physical Environment	Less than 60 min.	194	34.2990	Between Groups	2 402	2.834	.060
	From 60-120 min.	127	33.3701				
	More than 120 min.	84	32.8214				
Patients' expectations	Less than 60 min.	194	45.4845	Between Groups	2 402	7.290	.001*
	From 60-120 min.	127	44.0709				
	More than 120 min.	84	41.7976				
Waiting Time	Less than 60 min.	194	39.2320	Between Groups	2 402	8.134	.001*
	From 60-120 min.	127	37.3780				
	More than 120 min.	84	36.2262				
Information & Interaction	Less than 60 min.	194	42.9742	Between Groups	2 402	3.150	.044*
	From 60-120 min.	127	41.8661				
	More than 120 min.	84	40.2500				
Overall Satisfaction	Less than 60 min.	194	193.1443	Between Groups	2 402	9.938	.001*
	From 60-120 min.	127	186.7953				
	More than 120 min.	84	179.7024				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to the time consumed in the visit. The results according to table (4.14) showed that the differences were statistically significant in all domains of patients'

satisfaction except in physical environment domain**.** Patients who spent time less than 60 minutes have had highest satisfaction scores and patients who spent time more than 120 minutes have had lowest satisfaction scores. The mean of spent time in the clinic was 92 min and stander deviation was 66.36 min. The result revealed that patients who waited shorter time tend to be more satisfied than patients who waited longer time. This result is consistent with the study conducted by Al-Hindi (2000) who indicated that the clients who waited the shortest time tend to be more satisfied than the others who waited long time. Furthermore, Bialor et al. (1997) found that the patients who waited shorter waiting time reported a higher satisfaction score than the patients who waited longer waiting time. Hillis (2008) in her study that conducted in ASH and AL-Wafa hospital to assess patients satisfaction with physiotherapy found that there were no significant statistical differences between waiting time and patients' satisfaction. Other study, found that the mixed results of the relationship between waiting time and patient satisfaction is unclear manner Gadallah et al. (2003). Several researchers like (El-Sabrawy and Mahamoud, 1993; Mansour and Al-Osimy, 1993) urged that long waiting time is major item of patients' dissatisfaction. This result could be attributed to the huge number of patients who attend daily to the clinic, overload in the OPsD for three or four hours and to the appointment system that present in the OPsD.

4.3.4.3. The area that consumed most of the time:

Table 4.16: Patient's satisfaction by the area that consumed most of the time

Dep. var. "Patient Satisfaction"	Area consumed most time	No	Mean	Indep. Var. Area consumed most time	DF	F	p-value
Access to Care	At registration office	20	31.3000	Between Groups	3 401	.687	.561
	At Doctor's room	328	30.3262				
	At X-ray room	42	29.9762				
	At Lab room	15	29.2667				
Physical environment	At registration office	20	35.4500	Between Groups	3 401	.875	.454
	At Doctor's room	328	33.5854				
	At X-ray room	42	33.9048				
	At Lab room	15	33.3333				
Patients' expectations	At registration office	20	45.6000	Between Groups	3 401	1.147	.330
	At Doctor's room	328	44.4665				
	At X-ray room	42	42.9762				
	At Lab room	15	42.0000				
Waiting time	At registration office	20	37.9000	Between Groups	3 401	.036	.991
	At Doctor's room	328	37.9939				
	At X-ray room	42	38.3095				
	At Lab room	15	38.1333				
Information & Interaction	At registration office	20	42.6000	Between Groups	3 401	.245	.865
	At Doctor's room	328	41.9085				
	At X-ray room	42	43.0238				
	At Lab room	15	42.0000				
Overall satisfaction	At registration office	20	192.8500	Between Groups	3 401	.345	.793
	At Doctor's room	328	188.2805				
	At X-ray room	42	188.1905				
	At Lab room	15	184.7333				

* P-value statistically significant at level equal or less than 0.05

One Way ANOVA statistical test was used to determine the differences in patients' satisfaction with regard to the areas that consumed most of the patient's time. The results according to table (4.15) showed that the differences were statistically not significant in all domains of patients' satisfaction dimensions and in overall satisfaction. The patients who consumed most of their time at registration office have had mean scores of satisfaction higher than others groups. That means those patients more satisfied in overall satisfaction than others groups, while the lowest satisfied group were the patients who waited at Lab. room for long time.

4.4 Dimensions of patient's satisfaction

Findings of this study showed that outpatients' level of satisfaction with health services provided at ASH is (63.9%). The findings revealed that the patients had moderate level of satisfaction towards these services. This result may be affected by high expectation regarding the services they received, and unmet patients' needs. Political situation also affects the patients' level of satisfaction by increased the work-load of the OPsD staff either the physicians or the nurses. The existed infrastructure also affects the patients' level of satisfaction (crowded area, small lab. And x-ray rooms and bad ventilation). Some studies showed satisfaction level with health services in GS higher than this result. Shaqura (2009) study revealed level of satisfaction higher than this study's level of satisfaction, it was 84.6%. Al-Hindi (2002) study revealed high level of satisfaction with radiology services, it was 82.5%, the researcher attributed this high level of satisfaction to the political and socio-economical situation of the Palestinian people. Hillis (2008) study revealed that the overall satisfaction with physiotherapy services in ASH and Al-Wafa hospital was 87.4%. The results that revealed by (Mousa, 2000; Abu-Harbeid, 2004; El-Haj, 2008) were slightly higher than this result that were 72%, 78%, 79.3% respectively. El-Haj (2008) attributed that the patients' expectations were low due to the closure of GS. While Abu-Harbeid (2004) attributed the client's satisfaction doesn't depend only on services but also on client's expectations, the researcher added that clients satisfy when services meet or exceed their expectations. Also, Mousa (2000) referred the result to lack of knowledge and the work-load of the family planning staff. In contrast result, Ahmad (2009) study that conducted to assess patients' level of satisfaction with delivery services provided at ASH revealed that, patient's level of satisfaction is 61.8%, which considered the lowest figure among the recently carried out studies in GS.

Domains of satisfaction that were extracted from the study after review of literature reflected the meaningful dimensions of patients' satisfaction with the health services provided at ASH. The percentage of overall satisfaction was 63.9%., also the scores' percentage of all satisfaction domains ranged between 58.5% to 68.1%, the highest percentage reflects the highest level of satisfaction and vice versa. The highest level of satisfaction was pointed to patients' expectations domain 68.1%, while, the lowest level of satisfaction was pointed to waiting time domain 58.5% (table 4.17).

Table 4.17: Dimensions' labels, means, standard deviation and percentage

Dimension	Mean	S.D	%
Access to care	3.37	0.493	67.3
Physical environment	3.06	0.467	61.3
Patients' expectations	3.41	0.580	68.1
Waiting time	2.93	0.478	58.5
Information & Interaction	3.24	0.648	64.7
Overall satisfaction	3.19	0.408	63.9

This study was conducted to assess the level of outpatients' satisfaction with health services provided at ASH and to explore the factors that may affect the level of outpatients' satisfaction. In addition, this study aimed to identify the positive and negative areas that affect patients' level of satisfaction with health services provided at ASH. The researcher attempts to interpret and discuss the results of these domains as follow.

4.4.1. Access to care:

Access to care is the first domain consisted the study's dimensions of patient's satisfaction and includes nine items (Annex 4.1). The domain refers to the availability and willing of the medical team, offering the most of services the patients need, facilitate the process of getting the services, getting the results of examinations on the time, availability of diagnostic procedures, comfortable dealing with Para-medical departments and presents of informative employee for all patients. The study findings showed that access to care domain reported 67.3%of satisfaction level with the health services provided at the OPsD at ASH (Table 4.17).

Regarding the interpretation of degrees of satisfaction of the Access to care domain items (Annex 4.1), the researcher found that the satisfaction level was between 55.6% and 73.5% and the highest satisfied item was "you can pay suitable medical fees" 73.5%, while the lowest satisfied item was "informative employee available for all patients" 55.6%. That means, the patient is ready to pay the cost of health services if received in appropriate way, also patients need some one to inform them and facilitate the visit to the department. Patients were moderately satisfied (68.8%) regarding the availability and willing the medical team to work at the beginning of the time.

The researcher hopes that, the low patients' level of satisfaction will encourage the ASH administration and staff to identify the causes which lead to this level of satisfaction and to find the appropriate methods to change or improve the quality of health services provided at ASH.

4.4.2. Physical environment:

Physical environment is the second domain consisted the study's dimensions of patient's satisfaction and includes eleven items (Annex 4.2). The domain refers to the infrastructure of the OPsD and some environmental factors that may affect the patients' level of satisfaction with health services provided at OPsD such as, the space inside the department, conditioning and lighting inside both the hall of the department and the diagnostic rooms, clean and fresh drinking water, cleaning, the bath rooms, suitable roads and moves chair needed by disabled patients and lastly the presence of enough direction charts in department. The study findings showed that physical environment domain reported (61.3%) of satisfaction level with the health services provided at the OPsD at ASH (Table4.17).

Regarding the interpretation of degrees of satisfaction of the physical environment domain items (Annex 4.2). The researcher found that the satisfaction level was between (39.3% and 77.9%), where the highest satisfied item was "lightning in the diagnostic room is adequate to work" (77.9%), and the lowest satisfied item was "there is clean water for drinking" (39.3%). Other item which report low satisfaction level and can easily to be solute is "conditioning inside the clinic is good" (45.8%). It's worthwhile to remember that the data was collected in July and August where the temperature was high and no conditioning inside neither the hall of OPsD nor the diagnostic rooms. Another important concern is "wheel chairs in the clinic are enough" (56.5%). The patients did not know the place that these wheel chair were present and they can't see them. The researcher suggests putting a direction chart to inform patients about the place of wheel chairs. The follow item is "the roads for the disabled are comfortable" (58.4%), that means the patients have had very low satisfaction level with this item too. The special roads for disabled patients were not founded in the OPsD, this make the movement is very difficult and the patients' level of satisfaction is low. Regarding the spaces and the patients' movement in the OPsD

item number 31, "There is enough space for patients to move easily", report 60% of satisfaction level, that means there were some difficulties in patients' movement inside the department. The researcher attributed that to the huge number of patients that attained at the same time. This is the main problem faced the administration of the ASH and seek to solve it by new appointment system and coordination between PHC and other centers that referred patient to the OPsD. Item 39, "Direction charts in the clinic are enough" report 71.4% of satisfaction level. The researcher considers this result is faire, direction charts were present but they need to be modified and to be easily seen by the patients. Another important item was number 36, "The administration takes care of the clinic cleaning" and report 75.3% of satisfaction level. The researcher attributed that to the continuous cleaning and to the present of small barrels to the discarded things.

The researcher concluded that the physical environment is an important aspect to evaluate the patients' level of satisfaction, and it could be considered as an indicator of patients' satisfaction.

4.4.3. Patients' expectations:

Patients' expectations are the third domain consisted the study's dimensions of patient's satisfaction and includes thirteen items (Annex 4.3). It refers to predetermined ideas regarding the OPsD and represent the main concerns of outpatients to be satisfied such as finding some one to provide information needed to the patients, find guidance, fairness, respect, cooperation, confidentiality, dealing with same degree, afford needed medical examinations in the OPsD. The study findings showed that patients' expectations domain reported the highest level of satisfaction (68.1%) with the health services provided at the OPsD at ASH (Table 4.17).

Regarding the interpretation of degrees of satisfaction of the patients' expectations domain items (Annex 4.3), the researcher found that the satisfaction level was between (55.2% and 79%), the highest satisfied item was 49, "Your confidentiality was respected during examination" (79%), while the lowest satisfied item was 53, "You find that all patients were dealing with same degree" (55.2%). Regarding the confidentiality, the medical team was respect the patients during the visit with accepted level, inspite of the big number of patients that increases the work load over the medical team makes the patient to feel of

disrespect and to the previous ideas about the medical team. It's very important to look carefully to the lowest satisfied item that tells us about the dealing way with patients. The patient has high degree of sensitivity regarding the speaking and face impression of the medical team. Also, this may attributed to the appointment system that may appears to the patient as unfair. One of the important items is number 43, "You felt that there is some one helping the patients", 65.3% of satisfaction level, that means there is a bad need to initiate informative station in the OPsD. Item number (48), "You find that the medical team is a cooperative", 72.6% of satisfaction level, means that there was cooperation from the medical team but it needs to be improved.

The researcher concluded that the medical team spent efforts to meet the high level of patients' expectation. Patents' expectation can't be met as all, but the medical team and the responsible persons should strive to meet the patients' needs not the patients' wants.

4.4.4. Waiting time:

Waiting time is the forth domain consisted the study's dimensions of patient's satisfaction and includes thirteen items (Annex 4.4). It refers to early going to clinic, time spent at registration office, doctor's room, Lab. room and at the x-ray room, it refers also to the discipline and ordering the patients in these places. Also, it refers to effect of the big number on the specific time of the patient. The study findings showed that waiting time domain reported the lowest level of satisfaction (58.5%) with the health services provided at the OPsD at ASH (Table 4.17).

Regarding the interpretation of degrees of satisfaction of the waiting time domain items (Annex 4.4). The researcher found that the satisfaction level was between (35% and 77%), the highest satisfied item was 57, "The registration office releases the patents' name quickly" (77%), while the lowest satisfied items were 61 and 65, "The big number of patients doesn’t hold back the doctor's work" and "The big number of patients doesn’t hold back the doctor's work" (35%). The low satisfaction level depends on attained number of patient to the OPsD, the huge number affected the physician's work and the patient's time. The highest satisfied item is with registration office that releases names quickly.

In general, the waiting time domain achieved the lowest level of satisfaction (58.5%). This result consistent with the mean of the time spent in the OPsD that was (92 min). The researcher concluded that the patient's waiting time considers as a crucial aspect of satisfaction and hope to take this results into consideration from the administration and the health planners.

4.4.5. Information and Interaction:

Information and interaction is the fifth domain consisted the study's dimensions of patient's satisfaction and it includes thirteen items (Annex 4.5). It refers to the components of communication between medical team and the patients such as, the medical team introduced to the patients, explaining to the patient in meaningful way, taking with medical them while the patient setting on the chair, satisfied answers for patients' questions, and priority of patient's care, getting adequate information about the disease, respect patient as a human, reduce patient's stress, good impression and gives enough time to the patients to give their opinions. The researcher found that the satisfaction level was between (39.4% and 73.1%). The highest satisfied item was 70, "You received a satisfied answers for your acquisitions" while the lowest satisfied item was 67, "The medical team introduce themselves to the patient" (39.4%). The lowest satisfied item reflects that the medical team needs to introduce themselves to the patients, this will remove the barriers between medical team and the patients that may lead to increase the patients' level of satisfaction. Regarding the item which reports high satisfied level, that means the medical team gives a good answers, but this is not for all patients. Item number 78, "The impression of the medical team when offering the medical services for you is good" reports satisfaction level of 68.4%, that means the patients need to be valued in addition to treatment, the satisfaction level is not high that requires more attention to the non-verbal communication. Item number 77, "You are satisfied with the communication way with the medical team", 67.6%, that means the patients satisfied with the communication as all only of 67.6%.

The researcher found that the communication and the interaction between professionals and patients considered as an important aspect of patients' satisfaction.

4.5 Overall satisfaction

The total satisfaction score (overall satisfaction) reflects all the subscales scores. Dimensions of patients' satisfaction with the health services were access to care (67.3%), physical environment (61.3%), patients' expectations (68.1%), waiting time (58.5%) and information and interaction (64.7%) of satisfaction level. The overall mean of satisfaction score was 3.19 and the overall satisfaction level was 63.9%. These results call for putting anew plans and strategies to improve these dimensions that lead to improve and elevate patients' satisfaction level with health services provided at OPsD at ASH (Fig. 4.13) and (Table 4.17)

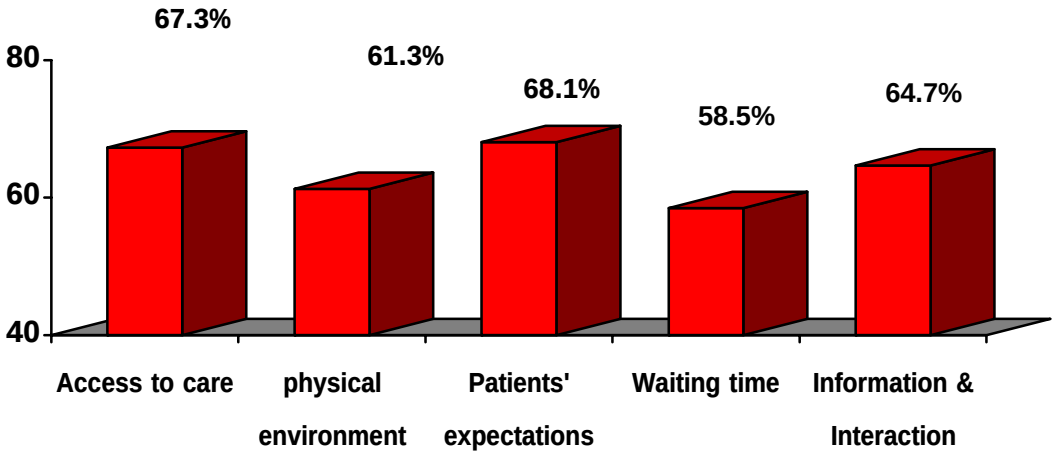

Figure 4.13: Percentages of patients' satisfaction dimensions

Chapter (5)

Conclusions and Recommendations

Conclusions and Recommendations

5.1 Conclusions

The health care production has become extremely competitive since the recent past. Only those organizations that have information about their clients have strategies to meet their expectations. Therefore, there has been an extraordinary demand for feedback from patients and their employers about their health care plans or their individual providers or health care organizations (WHO, 2004). Research in health outcomes takes into consideration patients' functional status, well-being, and satisfaction with care (Arnold, et al., 2004). Although, the literature contains a number of contradictions on the subject of patient satisfaction, it also offers a number of persuasive reasons for working to improve satisfaction among our patients (Carolyn, 2007). Ratings of different dimensions of satisfaction have been greatly correlated in some studies, and scores on these dimensions have been added to give up overall satisfaction ratings. However, responses to particular items are of interest to service providers who want to find out how a particular aspect of the service could be improved (WHO, 2000).

This study was conducted to assess the patients' satisfaction level with the quality of health services provided at the OPsD at ASH. The study's results could help in improving the dimensions of health care that provided at the OPsD at ASH. The OPsD is the biggest department in the ASH that considered the biggest health center in Palestine, it serves more than half million of Palestinian people in GS. The number of patients who arrive to the OPsD is a huge. According to the ASHR (2009) the total number of patients served in year 2007 was 98028, and in year 2008 was 81891, with average numbers are 90000 patients per year, 7500 patients per month and 341 patients per day.

The literature suggested that, the dimensions of patient's satisfaction that may indicate of the quality of care are different. This study conducted to assess five of these dimensions that are access to care, physical environment, patients' expectations, waiting time in addition to information and interaction. Also, to identify the differences between selected demographic, socio-economic, health status characteristics of the patients and selected

organizational factors that may affect the patients' level of satisfaction. The response rate was high 90%, and the reliability coefficient of the study instrument was high 0.91.

In general, the study revealed moderate scores for the overall satisfaction and for all study's satisfaction domains, that ranged between (58.5% and 68.1%), the overall satisfaction was 63.9%.

The highest level of satisfaction was expressed towards patients' expectations (68.1%), which reflect that the patients moderately meeting their expectation or they have had high level of expectation and they moderately meet them. On the other hand it may reflect that the medical teem spends efforts towards meeting the patients' expectations or at least to meet the needs of the patients'. The second highest domain was access to care with satisfaction scores of 67.3%, which reflects that the patients were moderately satisfied with the accessibility to the services provided at OPsD at ASH, such as continuity of the care and the degree of achievement the patient's goals from his visit to the department. The third domain was the information and interaction 64.7%, which reflects the needs for improving the communication way between health care providers and the patients and also, reflects that the patients need more information about their health status. In addition, it may reflect that the health team needs to improve their communication skills and to decrease the distance between the health care providers and the patients. The forth domain was the physical environment of the OPsD 61.3%, which reflects the needs for induced many improvement to the existed infrastructure such as, the wideness, present of clean water, waiting area, ventilation and improvement the Para-medical services. The lowest satisfied domain was the waiting time 58.5% which reflects real problem that inhibits patients' satisfaction level with health services. Also, it reflects that waiting time is very important to the patients.

Depending on the study's results, the selected demographic factors that may affect the level of satisfaction were the age, sex and residency place. The mean age of the study respondents was 30.3 years, the big number of respondents was the less of 34 years that consists more than half of the study respondents (50.6%), the older respondents were more satisfied than the younger. Also, females reported satisfaction scores more than male and they were consist of 48.6% of the study population. While, 72.1% of the study respondents were from Gaza governorate and reported the low satisfaction scores and

patient who were from the north governorate consist of 15.3% from the study respondents and reported the high satisfaction scores.

In addition, the socio-economic factors that affected the level of satisfaction were the marital status, educational level and income. Married patients were 67.7% of the study and reported the lowest satisfaction scores, while the widow patients consist of 4.9% and reported the highest satisfaction scores. Also, the patients attained preparatory educational level consist of 25.9% of the respondents and reported high satisfaction scores, while the patient who attained university education and more consist of 19.8% of the respondents and reported lowest satisfaction scores. The patients who attained secondary education consist of 32.1% of the study population and there was not statistically significant in satisfaction scores between them and other groups. Furthermore, the patients who have had income less than 1000 NIS consist of 68.6% of the respondents and reported the highest satisfaction scores , while the patients who have had income more than 3000 NIS consist of 10.6% and reported the lowest satisfaction level.

Regarding the patients' health status and satisfaction scores. The result showed that the patients who have had more than one visit to the department consist of 67.2% of the respondents and reported satisfaction scores more than patients who have had one visit. Also, patients with chronic diseases consist of 29.4% of the respondents and reported high satisfaction scores, while patients with casualty consist of 16.5% of the respondents and reported low satisfaction scores. The last group was patients with acute diseases consist of 54.1% of the respondents and reported not significant differences between them and other groups. In concerning of present of disability, the result showed that patients with disability consist of 13.3% of the respondents and reported satisfaction scores higher than patients who were free of disability and consist of 86.7% of the study respondents.

The last factors that have been assessed in this study were the organizational factors. The first factor was the type of recipient clinic reported that 59.5% of the respondents were received in medical clinics and reported high satisfaction scores than patients who were received in surgical clinics and consist of 31.9% of the study respondents. The second factor was the time consumed in the current visit and illustrated that 47.9% spent time less than one hour and reported satisfaction scores higher than other groups. The last factor specified the area that consumed most of the visit time, the result showed that 81% of the

study respondents spent most of their time at doctors' room, but the differences between means were not reach statistically significant level. In addition, patients who spent most of their time at Lab. room consist of 3.7% of the respondents and reported the lowest satisfaction scores, while patients who spent most of their time at registration office consists 4.9% of the respondents and reported the highest scores of satisfaction.

It's worthwhile, to describe the items which reported the highest and the lowest satisfaction scores. The item 49, "Your confidentiality was respected during examination" reported the highest satisfaction scores 79%, while item 61, "The big number of patients doesn't hold back the doctor's work" and item 65, "The big number of patients doesn't affect your own time" were reported 35% of satisfaction scores, and considered as the lowest scores of satisfaction among the items of this study.

5.2 Recommendations

This study was conducted to assess the outpatients' level of satisfaction with the quality dimensions of health care provided at OPsD at ASH. Access to care, physical environment, patients' expectations, waiting time in addition to information and interaction domains, were assessed in this study as dimensions of health care quality. The results showed that the outpatients have moderate level of satisfaction with these dimensions. Moreover, the findings illustrated different areas that need to be improved. So, the researcher will provides some recommendations that may help in improvement the current situation in the OPsD and therefore improve the patients' level of satisfaction

a- Recommendation for the administration

- The administration should pay more attention to the dimensions of health care that were assessed in this study and spend efforts to improve the patients' level of satisfaction by: Decrease waiting time at the investigation room by better use of resources and facilities, and by induce improvement on the appointment system.
- Induce some changes in the registration process by adding special card contains all patient information, improving the record searching process, displaying information of facilities and improving working environment will facilitate the registration process.

- Coordination between ASH and the primary health centers, this may achieve by inform these centers about daily schedule, physicians who have specific health specialties should work in these centers and the referral system should be modified.
- Increases the patient's consultation time by reducing number of patients who assigned to one physician. Therefore, this may help physicians to provide more information about the illness and the treatment to the patient that leads to increase patient's compliance to the treatment.
- Hospital administration should generate some policies and work regulations that help to facilitate the work.
- Induced some structural changes to the current building such as, separate the big clinics as orthopedic and ENT clinics, informative station for all patients, widen the Lab. and the x-ray rooms and separate the entrance and the exit doors of them, generate anew roads to the disabled patients, modernization of the furniture of the waiting hall and of the investigation rooms and induced modifications to the ventilation system to meet weather changes.
- Increase patient's awareness regarding their health status and management of their illnesses by providing disease related information in language that patient can understand and good follow up process.
- Modernization of the documentation procedures by using computer's programs in the hospital archive.
- Improve professionals' skills of communication and interaction with the patients.
- Appreciate self-monitoring approach and supervision.
- Induce motivations and rewards system for the employees to create ownership commitment to quality improvement.

b- Recommendation for health providers

- Improve their scientific knowledge and practical skills.
- Follow the organization roles and regulations.
- Training to work as a team member and accept constructive criticism.
- Help the patients to meet their needs and keep client's rights.

c- Recommendation for patients

- Follow the organization roles and regulation
- Respect health care providers and appreciate their works.
- Express their opinions regarding the quality of health services.

d- General recommendations

- Appreciate in-service education.
- Continuous evaluation for all performances that take place in the OPsD.
- Take thoughts and feelings of the patients and health providers into consideration.
- Pay more attention to the chronic and disability patients.

5.3 Areas for more research

- Comparing studies between patients' satisfaction with the quality of health services provided at governmental and non-governmental health organization.
- Evaluative studies that may be conduct after induces improvement on the dimensions that may need to be improved as this study revealed.
- Qualitative studies that may be conducted by in-depth interview focus group and public conferences.
- Comparing studies between patients' satisfaction regarding health services in both of GS and WB, or may be with neighbors Arab countries.
- Analytic study for all satisfaction studies that had been conducted in GS to generate real and creditable theories that may help decision makers to understand the real health situation in GS.

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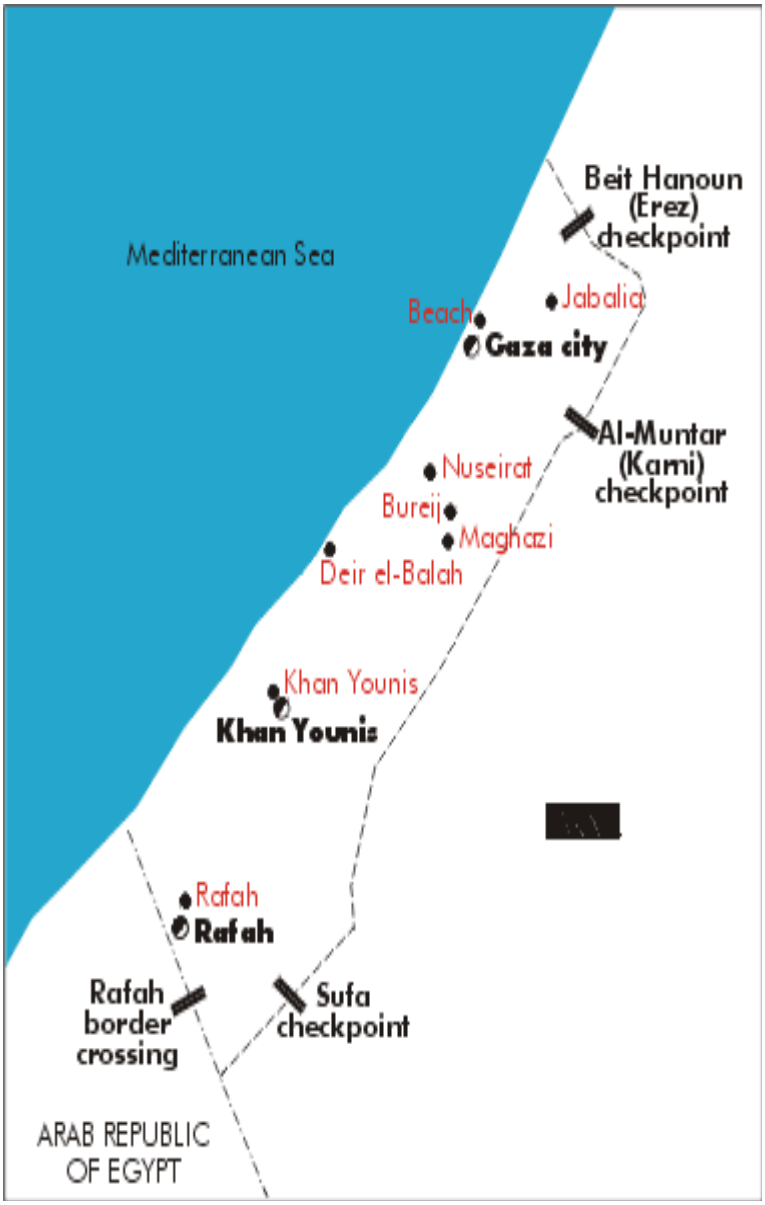
Annexes

Annex: (1.1)


الجهاز المركزي للإحصاء الفلسطيني
PALESTINIAN CENTRAL BUREAU OF STATISTICS
فلسطين
PALESTINE
LEBANON
SYRIA
SAFAD
ACRE
HAIFA
TABARIYA
NAZARETH
BEISAN
JENIN
TULKARM
TUBAS
QALQILYA
SALFIT
JAFFA
LOD
RAMALLAH & AL-BIREH
JERICHO
ER RAMLE
JERUSALEM (AL QUDS)
BETHLEHEM
HEBRON (AL KHALIL)
NORTH GAZA
GAZA
DEIR EL-BALAH
KHAN YUNIS
RAFAH
BEERSHEBA
MEDITERRANEAN SEA
JORDAN RIVER
DEAD SEA
JORDAN
EGYPT

Annex (1.2)



Source: Palestinian Central Bureau of Statistics (PCBS).

Annex 3.1: the Helsinki committee approval

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ2009/6/3

Name:

الاسم: نعيم شعبان محمد الكريري

I would like to inform you that the committee has discussed your application about:
Quality of Outpatients' Services Provided at Shifa Hospital: Patient's Satisfaction

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

In its meeting on June 2009
and decided the Following:-
To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر 6 2009
و قد قررت ما يلي:-
الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Conditions:-
- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Annex 3.2: Ethical letter of the school of public health sent to the responsible persons in MOH

بسم الله الرحمن الرحيم

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ: ٢٠٠٩/٧/١٢

جضرة الاخ/ د. ناصر أبو شعبان المحترم
مدير عام تنمية القوى البشرية – وزارة الصحة
تحية طيبة و بعد ،،،،

الموضوع: مساعدة الطالب/ نعيم شعبان الكريري

يقوم الطالب المذكور بعاليه باجراء بحث بعنوان :

Patients' Satisfaction with the Quality of Services Provided at the Outpatient Department at Al-Shifa Hospital.

كمتطلب للحصول على درجة الماجستير في الصحة العامة – مساراادارة صحية وعليه نرجو التكرم بالايعاز لمن ترونه مناسب لتسهيل مهمة الطالب في جمع البيانات اللازمة من مستشفى دار الشفاء التابع لوزارة الصحة.
علما بانّ المعلومات ستكون لغرض البحث العلمي لدى الطالب و الجامعة فقط وسنطلعكم على النتائج في حينها...

شاكرين لكم حسن التعاون
و اقبلوا فائق الاحترام و التقدير

د. بسام أبو حمد
منسق عام برامج الصحة العامة

نسخة :
للملف

Jerusalem Branch/Telefax 02-2799234
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فرع غزة / تلفاكس 08-2884422- 2884411
ص.ب. ٥١٠٠٠ القدس

Annex 3.3: Ethical letter of the responsible persons of the MOH to start data collection

Palestinian National Authority
Ministry of Health
Gen.Dir.of Human Resources Development

السلطة الوطنية الفلسطينية
وزارة الصحة
الإدارة العامة لتنمية القوى البشرية

الرقم :.....
التاريخ: 2009/07/13

الأخ /د. حسين عاشور المحترم،،،
مدير مجمع الشفاء الطبي

تحية طيبة وبعد،،،

الموضوع/تسهيل مهمة باحث

بالإشارة إلي الموضوع أعلاه، نرجو تسهيل مهمة الطالب/ نعيم شعبان الكر يري والـذي يعمـل حكيم بمستشفى الأطفال التخصصي في جمع المعلومات الخاصة بإجراء بحث التخـرج كمتطلـب للحصول على درجة الماجستير في الصحة العامة – مسار إدارة صحية بعنوان :

Patient's satisfaction with the quality of services provided at the outpatient department at alshifa hospital

قياس درجة رضي المريض عن الخدمات الصحية المقدمة في قسم العيادة الخارجية التابع لمجمـع الشفاء الطبي ، وتشمل الدراسة جمع المعلومات من المترددين للعيادة الخارجيـة بمجمـع الـشفاء الطبي بحيث لا يتعارض مع مصلحة العمل وضمن ضوابط منهجية البحث الصحي.

وتفضلوا بقبول التحية والتقدير ،،،

د. ناصر رأفت أبو شعبان
مدير عام تنمية القوى البشرية

وزارة الصحة
تنمية القوى البشرية
صادرا 1586
التاريخ 13/7/2009

دكتور
حسين مصيطف عاشور
مدير مجمع الشفاء الطبي

صورة لـــ/
- مدير عام المستشفيات
- كلية الصحة العامة
- الملف

E-Mail : Gdhrd@moh.gov.ps

FROM : FAX NO. : Jul. 13 2009 03:47PM P1

Annex 3.4.1: Patient's consent form in Arabic

بسم الله الرحمن الرحيم

رسالة توضيحية للمرضى المشاركين في الدراسة

الإستبانة

قياس درجة رضا المريض عن الخدمات الصحية المقدمة في قسم العيادة الخارجية التابع لمستشفى الشفاء- بغزة.

عزيزي المشارك/ة.....

إنني أقدر مشاركتك في تقييم مشروع البحث هذا، الذي يعتبر جزأ من دراستي لماجستير الصحة العامة – برنامج الإدارة الصحية – التابع لجامعة القدس. حيث تهدف الدراسة إلى قياس درجة رضا المريض عن الخدمات الصحية المقدمة في قسم العيادة الخارجية التابع لمستشفى الشفاء. كما أن نتائج هذه الدراسة قد تؤدي إلى تحسين جودة الخدمات الصحية المقدمة في العيادة الخارجية وتعود بالنفع على المرضى.

إنني أهتم في هذه الدراسة برأيك وانطباعك حول مدى رضاك عن جودة الخدمات والعناية الصحية المقدمة لك داخل العيادة الخارجية.

إن مقابلتي لك وتعبئة الإستبانة يستغرق من 15- 20 دقيقة، وإذا شعرت بعدم الارتياح في أي وقت فإنه بإمكانك أن تطلب وقف المقابلة. علماً بأن الإستبانة تحتوي على (خمسة) خيارات للإجابة، فحاول اختيار مدى الرضا الذي يصف شعورك بدقة، كما أنه لا يوجد إجابات صحيحة و إجابات خاطئة، فإذا وافقت على المشاركة يبقى لك الحق في الانسحاب متى تشاء دون الأثير على تلقيك الخدمة والعناية مستقبلاً .

كما أنه لا داعي لكتابة اسمك، وإجابتك ستحترم وتحفظ بسرية تامة. وستستخدم لأغراض البحث العلمي فقط.

الباحث

نعيم شعبان الكريري

كلية الصحة العامة_جامعة القدس

Annex 3.4.2: Patient's consent form in English

Serial No…….

Code No……

Explanatory Letter

Patients' Satisfaction with the Quality of Services Provided at the Outpatient Department at Al-Shifa Hospital

Dear client:

* Thank you for your participation, you were selected because you met the selection criteria of participation in this research

* This research is a part of my study at School of Public Health Al-Quds University.

* The aim of this study is to evaluate the quality of outpatients' health services provided at Shifa hospital from the patient's satisfaction aspect.

* This tool will reflect your opinion that will help in improving the quality of health care provided in the Outpatients' Clinic of Shifa hospital

* Confidentiality will be provided and maintained, no need to write down your name. Please answer all questions according to your feeling. There is no right or wrong answers. Filling this questionnaire takes 15 minutes and your participation is voluntary. You have the right to withdraw at any time during data collection.

* The researcher will facilitate the filling of the questionnaire.

The researcher

Naeem Shaban Al-Kariri

School of Public Health_ Al-Quds University

Annex 3.5: Experts panel names

No.	Member	College	University
1-	Dr. Yehia Abed	Public Health	Al-Quds University-Gaza
2-	Dr. Abdalazeez Thabet	Public Health	Al-Quds University-Gaza
3	Dr. Bassam Abu-Hamad	Public Health	Al-Quds University-Gaza
4-	Dr. Ashraf Al-Jedy	Education/Psychology	Islamic University-Gaza
5-	Dr. Atef Al-Agha	Education/Psychology	Islamic University-Gaza
6-	Dr. Sanaa Abu-Dagga	Quality Unit	Islamic University-Gaza
7-	Dr. Samir Qouta	Education/Psychology	Islamic University-Gaza
8-	Dr. Nabeel Dokhan	Education/Psychology	Islamic University-Gaza

Annex 3.6: The first draft of the study instrument

فقرات إستبانة قياس رضا المرضى عن جودة الخدمات الصحية المقدمة للمرضي في العيادة الخارجية في مستشفى الشفاء في صورتها الأولية (قبل التحكيم).

السيد الدكتور/ة.....حفظه/ها الله
السلام عليكم ورحمة الله وبركاته.

يقوم الباحث بإعداد بحث لنيل درجة الماجستير في الصحة العامة (إدارة صحية) بعنوان جودة الخدمات الصحية المقدمة للمرضي الخارجيين في مستشفى الشفاء من وجهـة نظـر المرضي، بإشراف الدكتور/ يوسف الجيش، وقد قام الباحث بإعداد استبانة سيقوم بتطبيقهـا علي عينة من المرضي الذين يتلقون الخدمات الصحية في العيادة الخارجية التابعة لمستشفى الشفاء بغزة، لذا أرجو التكرم بإبداء آرائكم في الإستبانة المرفقة من حيث ملائمتها في قياس جودة الخدمات الصحية من وجهة نظر المرضي عن هذه الخدمات، وتعديل العبارات التـي ترون أنها بحاجة إلى تعديل.

التعريفات الإجرائية:

- **الجودة** (من وجهة نظر المريض): هي الحصول علي الخدمة الـصحية الجيـدة فـي العيادة الخارجية لمجمع الشفاء الطبي في الوقت الذي يحتاج إليها عن طريق طاقم صـحي مؤهل وذو خبرة.
- **المريض الخارجي**: هو الشخص الذي يبحث عن العلاج أو التشخيص أو المتابعـة فـي العيادة الخارجية لمجمع الشفاء الطبي أثناء وقت الدراسة من كلا الجنسيين.
- **مدي رضا المريض**: هي درجة رضا المريض عن الخدمات الصحية المقدمة في العيادة الخارجية لمجمع الشفاء الطبي. ولقياس درجة الرضا تم إعداد هذه الإستبانة الخاصة لهـذا الغرض، وتم ترتيب درجات الرضا علي محتوي كل فقرة تبعا لقياس ليكـرت الخماسـي (موافق بقوة، موافق، لا أدري، غير موافق، غير موافق بقوة).

شاكرين حسن تعاونكم وتفضلوا بقبول فائق الاحترام والتقدير

الباحث: نعيم شعبان الكريري
كلية الصحة العامة-جامعة القدس

الإستبانة

الجزء الأول

معلومات المريض الشخصية:

1- اليوم_____

2 - العمر_____سنة

3- الجنس □ ذكر □ أنثى

4- الحالة الاجتماعية □ أعزب □ متزوج □ مطلق □ أرمل

5- مكان الإقامة □ محافظة الشمال □ محافظة غزة □ محافظة الوسطى
□ محافظة خان يونس □ محافظة رفح

6- نوع المواطنة □ مواطن □ لأجيء

7- مستوى التعليم □ ابتدائي □ إعدادي □ ثانوي جامعي فما فوق

8- المهنة الأساسية. □ موظف حكومي □ موظف وكالة □عمل حر لا يعمل
□ سيدة منزل □ طالب

9- الدخل الشهري_____ دولار أمريكي

10- عدد مرات الزيارة (منذ شهر) _____

11- الهدف من هذه الزيارة □ للمراجعة □للعلاج □ للتشخيص

12- المركز المحول منه □ حكومي □ وكالة الغوث □ موعد مسبق من العيادة الخارجية
□ أخرى

13- نوع التأمين الصحي □ حكومي □ عمال □ خاص □ غير مؤمن

14- نوع المرض □ مزمن □ حاد □ إصابة

15- وجود إعاقة □ يوجد □ لا يوجد

16- الحاجة للمرافق أثناء هذه الزيارة □ يحتاج □ لا يحتاج

17- محول إلى عيادة □ الجراحة □الباطنية

18- اسم العيادة بالتخصيص_____

الجزء الثاني

الرجاء اختيارا لمدى الذي يصف شعورك بدقة

5 = موافق بقوة، 4 = موافق، 3 = لا أدري، 2 = غير موافق، 1 = غير موافق بقوة

1- المحور الأول الأسئلة من (19 -31)

الوصول والاستفادة من الخدمة: وتعني سهولة الوصول للعيادة الخارجية، جاهزية الطاقم الصحي، وجاهزية الأقسام المساندة، ومقدرة المريض علي الاستفادة ودفع تكاليف الخدمة الصحية.

الرقم	السؤال	مدى ملائمة الفقرة للمحور			الملائمة اللغوية	التعديلات
		بدرجة كبيرة	بدرجة متوسطة	لا تنتمي		
19-	تكاليف وصولك إلي المستشفي محتملة					
20-	تصل إلي المستشفي بسهولة					
21-	الطاقم الصحي موجود وجاهز للعمل					
22-	الخدمات الصحية اللازمة لك متوفرة					
23-	تستطيع دفع رسوم الخدمات الصحية التي تناسبك					
24-	تعاملك مع الأقسام المساندة مريح					
25-	تظهر نتائج الفحوصات بالوقت المطلوب					
26-	إجراءات التشخيص اللازمة لك متوفرة					
27-	وجود صيدلية لصرف العلاج اللازم داخل العيادة يسهل الخدمة للمريض					
28-	تستفيد في كل زيارة للعيادة					
29-	نظام العمل في العيادة مريح للمريض					
30-	تستطيع الوصول للعيادة في نفس اليوم من تحويلك إليها					
31-	يوجد تسهيلات لعلاج غير المؤمنين صحيا					

2- المحور الثاني الأسئلة من (32-43)

- البيئة الداخلية في العيادة: وتعني الظروف الطبيعية داخل العيادة الخارجية مثل الضوضاء، تغيرات الطقس، المكان الفسيح، الماء النظيف، الإضاءة، التهوية، الروائح وحرية الحركة.

الرقم	السؤال	مدى ملائمة الفقرة للمحور			الملائمة اللغوية	التعديلات
		بدرجة كبيرة	بدرجة متوسطة	لا تنتمي		
32-	العيادة بعيدة عن الضوضاء الخارجية					
33-	يوجد في العيادة متسع لحركة المرضي بحرية					
34-	يوجد مكان مريح للمرضي في قاعة الانتظار					
35-	التهوية داخل العيادة جيدة					
36-	الإضاءة في العيادة كافية ومريحة للنظر					
37-	غرفة الكشف واسعة ومريحة					
38-	الإضاءة داخل غرف الكشف كافية للعمل بكفاءة					
39-	تتوفر مياه نظيفة للشرب					
40-	لا يوجد روائح غير مرغوب بها في العيادة					
41-	تهتم الإدارة بنظافة العيادة					
42-	تتوفر الحمامات بصورة كافية للجميع					
43-	الحمامات نظيفة والتعامل معها سهل					

3- المحور الثالث الأسئلة من (44-56)

- توقعات المريض: وتعني الاحتياجات والرغبات والأفكار المسبقة المأخوذة عن العيادة الخارجية، حيث يتوقع المريض إن يجد الكفاءة، الجاهزية للمساعدة، الثقة والدعم في الطاقم الصحي.

الرقم	السؤال	مدى ملائمة الفقرة للمحور			الملائمة اللغوية	التعديلات
		بدرجة كبيرة	بدرجة متوسطة	لا تنتمي		
44-	حصلت علي إرشادات كافية للمكان الذي تريده					
45-	رأيت أنه يوجد من يساعد المرضي ذوي الاحتياجات الخاصة					
46-	شعرت أن المواعيد والتسجيل يتم بعدالة					
47-	رأيت أن العاملين يحترمون الوقت					
48-	شعرت أن العاملين يحترمون المرضي أثناء الزيارة للعيادة					
49-	حصلت علي الخدمة الصحية بهدوء					
50-	وجدت أن الطاقم الصحي متعاون وذو خبرة					
51-	تم فحصك بصورة منفصلة عن باقي المرضى					
52-	شعرت أن نظام العمل يسير بشكل مريح للمريض					
53-	شعرت أن الجميع يحترم حاجاتك					
54-	أتممت الفحوصات المطلوبة لك بطريقة معقولة					
55-	وجدت أن جميع المرضى يتم معاملتهم بدرجة واحدة					
56-	بشكل إجمالي أنت راضي عن جودة الخدمات الصحية المقدمة في العيادة					

4- **المحور الرابع الأسئلة من** (57-67)

- **وقت الانتظار**: ويعني مقدار الوقت الذي يستغرقه المريض منذ ذهابه للعيادة، والحصول علي التسجيل، ومقابلة الطبيب، والحصول علي الخدمة الصحية اللازمة وحتى خروجه من العيادة.

الرقم	السؤال	مدى ملائمة الفقرة للمحور			الملائمة اللغوية	التعديلات
		بدرجة كبيرة	بدرجة متوسطة	لا تنتمي		
57-	أنت لم تخرج مبكرا من بيتك بسبب كثرة المراجعين					
58-	لم تنتظر طويلا أمام مكتب التسجيل					
59-	هناك ترتيب ونظام أمام مكتب التسجيل					
60-	يصدر مكتب التسجيل أسماء المرضي بسرعة					
61-	هناك ترتيب ونظام في صالة الانتظار					
62-	يتم ترتيب المرضي بهدوء					
63-	لم تنتظر طويلا أمام غرفة الطبيب					
64-	عدد المرضي الكبير لا يعيق عمل الطبيب					
65-	العمل يسير حسب نظام زمني محدد وعادل بين الجميع					
66-	الخدمات الصحية تنجز بوقت معقول					
67-	الوقت الذي مكثته في العيادة لانجاز خدمتك مناسب لك					

5- المحور الخامس الأسئلة من (68-80)

التفاعل والمعلومات: وتعني عملية التواصل وتبادل المعلومات بين مقدم الخدمة الصحية والمريض لتحقيق أهدافهم المشتركة.

الرقم	السؤال	مدى ملائمة الفقرة للمحور			الملائمة اللغوية	التعديلات
		بدرجة كبيرة	بدرجة متوسطة	لا تنتمي		
68-	يقدم الطاقم الطبي نفسه إليك					
69-	يشرح العاملون لك بطريقة مفهومة					
70-	تلقيت إجابات مرضية عن أسئلتك					
71-	يعطيك العاملون انطباعا أن خدمتك من أولوياتهم					
72-	تلقيت معلومات كافية عن مرضك وعن علاجك					
73-	الطاقم الطبي يحترمك كانسان					
74-	تشعر بأنك قريب من العاملين					
75-	يعمل العاملون علي تخفيف قلقك وتوترك					
76-	عدد المرضى الكبير لا يؤثر على وقتك الخاص					
77-	يشرح العاملون لك ما يريدون فعله قبل التنفيذ					
78-	أنت راض عن طريقة التواصل التي تلقيتها من الطاقم الطبي					
79-	انطباع العاملين عند تقديم الخدمة الصحية لك جيد					
80-	يمنحك الطاقم الطبي الوقت الكافي لإبداء رأيك					

Annex 3.7.1: The final copy of the study instrument in Arabic

بسم الله الرحمن الرحيم

الجزء الأول **رقم مسلسل_____**

الرقم الرمزي_____

معلومات المريض الشخصية:

1- اليوم_____

2 - العمر_____سنة

3- الجنس □ ذكر □ أنثى

4- الحالة الاجتماعية □ متزوج □ أعزب □ مطلق □ أرمل

5- مكان الإقامة □ محافظة الشمال □ محافظة غزة □ محافظة الوسطى
□ محافظة خان يونس □ محافظة رفح

6- نوع المواطنة □ مواطن □ لأجيء

7- مستوى التعليم □ ابتدائي □ إعدادي □ ثانوي □جامعي فما فوق

8- المهنة الأساسية. □ موظف حكومي □ موظف وكالة □عمل حر □لا يعمل □ طالب
□ سيدة منزل

9- الدخل الشهري_____ شيكل

10- عدد مرات الزيارة للمستشفى (منذ شهرين) _____

11- الهدف من هذه الزيارة □ للمراجعة □للعلاج □ للتشخيص

12- المركز المحول منه □ حكومي □ وكالة الغوث □ موعد مسبق من العيادة الخارجية
□عيادة الطبيب الخاصة □ أخرى

13- نوع التأمين الصحي □ حكومي □ نقابي □ خاص □ غير مؤمن

14- نوع المرض □ مزمن □ حاد □ إصابة

15- وجود إعاقة □ يوجد □ لا يوجد

16- الحاجة للمرافق أثناء هذه الزيارة □ يحتاج □ لا يحتاج

17- محول إلى العيادات □ الجراحية □الباطنية □ أخرى

18- اسم العيادة بالتخصيص_____

19-كم قضيت وقت في العيادة حتى أنهيت علاجك_____دقيقة

20- أين قضيت أكثر وقت قبل الحصول على الخدمة_____

21- رأيك في الوقت الذي يقضيه المريض في العيادة الخارجية هو □طويل □ مناسب □قصير

الجزء الثاني

الرجاء اختيار المدى الذي يصف شعورك

(1= غير موافق بشدة، 2= غير موافق، 3 = لا أدري، 4= موافق، 5= موافق بشدة)

الرقم	الفقرة	موافق بشدة	موافق	لا أدري	غير موافق	غير موافق بشدة
22-	الطاقم الطبي متواجد من بداية الوقت					
23-	نظام العمل في العيادة يساعد المريض لإتمام زيارته بسهولة					
24-	الطاقم الطبي جاهز للعمل من بداية الوقت					
25-	الخدمات الصحية اللازمة لك متوفرة					
26-	تستطيع دفع رسوم الخدمات الصحية التي تناسبك					
27-	تعاملك مع الأقسام المساندة (أشعة، مختبر، علاج طبيعي) مريح					
28-	تظهر نتائج الفحوصات بالوقت المناسب					
29-	إجراءات التشخيص اللازمة لك متوفرة					
30-	يوجد موظف استعلامات للمرضى					
31-	يوجد في العيادة متسع لحركة المرضي بحرية					
32-	التهوية داخل العيادة جيدة					
33-	غرفة الكشف مريحة للمرضى					
34-	الإضاءة داخل غرف الكشف كافية للعمل بصورة جيدة					
35-	تتوفر مياه نظيفة للشرب					
36-	تهتم الإدارة بنظافة العيادة					
37-	تتوفر الحمامات بصورة كافية للجميع					
38-	الحمامات نظيفة والتعامل معها سهل					
39-	اللوحات الإرشادية في العيادة كافية					
40-	الكراسي المتحركة للمعاقين كافية					
41-	الممرات الخاصة للمعاقين مريحة					
42-	حصلت علي إرشادات كافية للمكان الذي تقصده					
43-	شعرت أنه يوجد من يساعد المرضي					
44-	شعرت أن المواعيد تتم بعدالة					
45-	رأيت أن الطاقم الطبي يحترمون الوقت					
46-	شعرت أن الطاقم الطبي يحترم المرضي أثناء الزيارة للعيادة					
47-	حصلت علي الخدمة الصحية بسهولة					
48-	وجدت أن الطاقم الطبي متعاون					

49-	تم احترام خصوصيتك عند الفحص					
50-	شعرت أن نظام العمل يسير بشكل مريح للمريض					
51-	شعرت أن الجميع يحترم حاجاتك					
52-	أتممت الفحوصات المطلوبة لك بطريقة معقولة					
53-	وجدت أن جميع المرضى يتم معاملتهم بدرجة واحدة					
54-	بشكل إجمالي أنت راضٍ عن جودة الخدمات الصحية المقدمة في العيادة					
55-	لم تنتظر طويلا أمام مكتب التسجيل					
56-	هناك ترتيب ونظام أمام مكتب التسجيل					
57-	يصدر مكتب التسجيل أسماء المرضي بسرعة					
58-	هناك ترتيب ونظام في صالة الانتظار					
59-	يتم ترتيب المرضي بهدوء					
60-	الانتظار أمام غرفة الطبيب مناسب					
61-	عدد المرضي الكبير لا يعيق عمل الطبيب					
62-	يسير العمل حسب نظام زمني عادل بين الجميع					
63-	يصدر المختبر الفحوصات بوقت مناسب					
64-	تصدر صور الأشعة بوقت مناسب					
65-	عدد المرضى الكبير لا يؤثر على وقتك الخاص					
66-	الوقت الذي مكثه في العيادة لانجاز خدمتك مناسب لك					
67-	يقدم الطاقم الطبي نفسه للمريض					
68-	يشرح الطاقم الطبي الخدمة للمريض بطريقة مفهومة					
69-	تحدثت مع الطاقم الطبي وأنت تجلس علي كرسي					
70-	تلقيت إجابات مرضية عن استفساراتك					
71-	يعطيك الطاقم الطبي انطباعا أن خدمتك من أولوياتهم					
72-	تلقيت معلومات كافية عن مرضك وعن علاجك					
73-	الطاقم الطبي يحترمك كانسان					
74-	تشعر بأنك قريب من الطاقم الطبي					
75-	يعمل الطاقم الطبي علي تخفيف قلقك وتوترك					
76-	يشرح الطاقم الطبي لك ما يريدون فعله قبل التنفيذ					
77-	أنت راض عن طريقة التواصل التي تلقيتها من الطاقم الطبي					
78-	انطباع الطاقم الطبي عند تقديم الخدمة الصحية لك جيد					
79-	يمنحك الطاقم الطبي الوقت الكافي لإبداء رأيك					

Annex 3.7.2: The final copy of the study instrument in English

Patient's Questionnaire

Part One

Personal Information

1- Day_____,

2- Age_____ years,

3- Sex □ male □ female

4- Marital status □ married □ unmarried □ divorced □ widow

5- Residency place □North Governorate □ Gaza Governorate

□ Mid-Zone Governorate □ Khan Younis Governorate □ Rafah Governorate

6- Nationality □ refugee □ not-refugee

7- Educational level □ elementary □ preparatory □ secondary □ university and more

8- Main job □ governmental employee □ UNRWA employee □ free work

□ not working □ student □ home lady

9- Monthly income_____ Sheqalim.

10- Number of visits (since one month) _____

11- The aim from this visit □ follows up □ treatment □ diagnosis

12- Referred center □ governmental □ UNRWA □ appointment

□ Special doctors' clinic □ others

13- Health insurance □ governmental □ syndicate □ special □ not insured

14- Type of the disease □ chronic □ acute □ casualty

15- Disability □ present □ not present

16- Need for assistant during this visit □ yes □ no

17- Referred to □ surgical clinics □ medical clinics □ others

18- Name of the specified treatment clinic_____ .

19- How much time you consumed in the clinic_____ minute.

20- Where the long time was consumed _____

21- The time was consumed in the clinic is □ long □ short □suitable

Part two

Dear client:

You have five answers for each question, please choose the answer that describe your feeling more than others by using Likert Scale with five answers as following:

(1- strongly disagree, 2- disagree, 3-uncertain, 4-agree, 5- strongly agree)

No.	item	1- strongly disagree	2- disagree	3- un- certain	4- agree	5- strongly agree
22-	The medical staff is available at the beginning of the time					
23-	Work system in the clinic help the patients to finish his visit easy					
24-	The medical staff is willing to work at the beginning of the time					
25-	your needed medical services are available					
26-	you can pay suitable medical services fees					
27-	Dealing with the Para-medical departments is comfortable					
28-	The experiments results are on time					
29-	Your needed diagnostic procedures are available					
30-	Informative employee available for all patients					
31-	There is enough space for patients to move easily					
32-	Conditioning inside the clinic is good					
33-	The diagnostic room is comfortable to the patients					
34-	Lighting in the diagnostic room is adequate to work well					
35-	There is clean water for drinking					
36-	The administration takes care of the clinic cleaning					
37-	There are enough WC for all					

38-	The WC are clean and easily managed					
39-	Direction charts in the clinic are enough					
40-	Wheel chairs for disabled are enough					
41-	The roads for disabled are comfortable					
42-	You get adequate information to the intended place					
43-	You felt that there is some one helping the patients					
44-	You felt that the appointment are fair					
45-	You see that the medical team were respect timing					
46-	You felt that the medical team were respect the patients during the visit to the clinic					
47-	Getting the medical service quietly					
48-	You find that the medical team is a co-operative					
49-	Your confidentiality was respected during examination					
50-	You felt that the works goes smoothly for the patients					
51-	You felt that the medical team were respect your needs					
52-	Your needed medical examinations were accomplished in a reasonable way					
53-	You find that all patients were dealing with same degree					
54-	In general you are satisfied by the health services in the clinic					
55-	I don’t too long by the registration office					
56-	There is discipline by the registration office					
57-	The registration office releases the patents' name quickly					
58-	There is discipline in the waiting hall					
59-	Ordering the patients goes quietly					
60-	I don’t too long by the doctor's room					
61-	The big number of patients doesn’t hold back the doctor's work					
62-	Work goes according to a fair schedule for all					
63-	The lab produce tests in a suitable time					

64-	The x-ray reports are produced in a suitable time					
65-	The big number of patients doesn't affect your own time					
66-	The time spent in the clinic to get your services is suitable					
67-	The medical team introduce themselves to the patient					
68-	medical team explains to the patient in a meaningful way					
69-	You are talking with the medical team while you are setting on the chair					
70-	You received a satisfied answers for your acquisitions					
71-	Medical team makes you feel that your service takes their priority					
72-	you get adequate information about your illness and the your medicine					
73-	Medical team respect you as a human					
74-	you felt that you are close to the Medical team					
75-	Medical team work to reduce your stress					
76-	Medical team explains what they are going to do					
77-	You are satisfied with the communication way with the medical team					
78-	The impression of the medical team when offering the medical services for you is good					
79-	Medical team gives you enough time to give your opinion					

Annex 3.8: Correlation coefficient between each satisfaction domains and total degree of instrument

No.	Factor name	R Pearson correlation	Significant level
1-	Access to care	0.543**	0.01
2-	Physical environment	0.828**	0.01
3-	Patients' expectations	0.808**	0.01
4-	Waiting time	0.794**	0.01
5-	Communication and Interaction	0.802**	0.01

** Correlation is significant at 0.01 level

Annex 3.9: Correlation coefficient between each item of Access to care domain and total degree of domain

No.	1-Access to care	Person correlation	Sig. level
22-	The medical staff is available at the beginning of the time	0.425*	0.05
23-	Work system in the clinic help the patients to finish his visit easy	0.435*	0.05
24-	The medical staff is willing to work at the beginning of the time	0.388*	0.05
25-	your needed medical services are available	0.652*	0.05
26-	you can pay suitable medical services fees	0.487*	0.05
27-	Dealing with the Para-medical departments is comfortable	0.462*	0.05
28-	The experiments results are on time	0.323*	0.05
29-	Your needed diagnostic procedures are available	0.453*	0.05
30-	You appreciate presence pharmacy for needed medicine inside the clinic	0.135 \\\	0.376
31-	Informative employee available for all patients	0.494*	0.05

* Correlation is Significant at level of 0.05 \\\ not significant

Annex 3.10: Correlation coefficient between each item of Physical environment domain and total degree of domain

No.	2-Physical environment	Person correlation	Sig. level
32-	The clinic is far away from outside chaos	.167 \\\	.272
33-	There is enough space for patients to move easily	0.676*	0.05
34-	There are a comfortable chairs for patients in waiting place	.224 \\\	.140
35-	Conditioning inside the clinic is good	0.767*	0.05
36-	Lighting in the clinic is adequate and eyes fit	.205 \\\	.177
37-	The diagnostic room is comfortable to the patients	0.759*	0.05
38-	Lighting in the diagnostic room is adequate to work well	0.507*	0.05
39-	There is clean water for drinking	0.680*	0.05
40-	No bad smile in the clinic	.145 \\\	.341
41-	The administration takes care of the clinic cleaning	0.449*	0.05
42-	There are enough WC for all	0.400*	0.05
43-	The WC are clean and easily managed	0.348*	0.05
44-	Direction charts in the clinic are enough	0.404*	0.05
45-	Wheel chairs for disabled are enough	0.563*	0.05
46-	The roads for disabled are comfortable	0.547*	0.05

* Correlation is significant at level of 0.05 \\\ not significant

Annex 3.11: Correlation coefficient between each item of patient's expectations domain and total degree of domain

No.	3- patient's expectations	Person correlation	Sig. level
47-	You get adequate information to the intended place	0.475*	0.05
48-	You felt that there is some one helping the patients	0.518*	0.05
49-	You felt that the appointment are fair	0.699*	0.05
50-	You see that the medical team were respect timing	0.557*	0.05
51-	You felt that the medical team were respect the patients during the visit to the clinic	0.402*	0.05
52-	Getting the medical service quietly	0.599*	0.05
53-	You find that the medical team is a co-operative	0.500*	0.05
54-	Your confidentiality was respected during examination	0.512*	0.05
55-	You felt that the works goes smoothly for the patients	0.645*	0.05
56-	You felt that the medical team were respect your needs	0.619*	0.05
57-	Your needed medical examinations were accomplished in a reasonable way	0.478*	0.05
58-	You find that all patients were deal by same degree	0.431*	0.05
59-	In general you are satisfied by the health services in the clinic	0.638*	0.05

* Correlation is significant at level of 0.005

Annex 3.12: Correlation coefficient between each item of waiting time domain and total degree of domain

No.	4- Waiting time	Person correlation	Sig. level
60-	I don’t get out of my home too early due to the big number of patients	0.282\\\	0.06
61-	I don’t too long by the registration office	0.577*	0.05
62-	There is discipline by the registration office	0.548*	0.05
63-	The registration office releases the patents' name quickly	0.316*	0.05
64-	There is discipline in the waiting hall	0.610*	0.05
65-	Ordering the patients goes quietly	0.676*	0.05
66-	I don’t too long by the doctor's room	0.660*	0.05
67-	The big number of patients doesn’t hold back the doctor's work	0.430*	0.05
68-	Work goes according to a fair schedule for all	0.564*	0.05
69-	The lab produce tests in a suitable time	0.564*	0.05
70-	The x-ray reports are produced in a suitable time	0.637*	0.05
71-	The big number of patients doesn’t affect your own time	0.448*	0.05
72-	The time spent in the clinic to get your services is suitable	0.610*	0.05

* Correlation is significant at level of 0.05 \\\ not significant

Annex 3.13 Correlation coefficient between each item of Information and Interaction domain and total degree of domain

No.	5- Information and Interaction	Person correlation	Sig. level
73-	The medical team introduce themselves to the patient	0.501*	0.05
74-	medical team explains to the patient in a meaningful way	0.756*	0.05
75-	You are talking with the medical team while you are setting on the chair	0.427*	0.05
76-	You received a satisfied answers for your acquisitions	0.603*	0.05
77-	you felt that you are close to the Medical team	0.757*	0.05
78-	Medical team explains what they are going to do	0.739*	0.05
79-	Medical team makes you feel that your service takes their priority	0.571*	0.05
80-	you get adequate information about your illness and the your medicine	0.794*	0.05
81-	Medical team respect you as a human	0.745*	0.05
82-	Medical team work to reduce your stress	0.504*	0.05
83-	You are satisfied with the communication way with the medical team	0.847*	0.05
84-	The impression of the medical team when offering the medical services for you is good	0.567*	0.05
85-	Medical team gives you enough time to give your opinion	0.800*	0.05

* Correlation is significant at level of 0.05

Annex 4.1: Access to care items and degree of satisfaction

1-Access to care	strongly disagree	disagree	uncertain	agree	strongly agree	S.D	Mean	%
	Number	Number	Number	Number	Number			
	%	%	%	%	%			
22- The medical staff is available at the beginning of the time	6	86	71	208	34	.9644	3.439	68.8
	1.5	21.2	17.5	51.4	8.4			
23- Work system in the clinic help the patients to finish his visit easy	11	108	25	246	15	1.0016	3.360	67.2
	2.7	26.7	6.2	60.7	3.7			
24- The medical staff is willing to work at the beginning of the time	8	76	77	221	23	.9246	3.432	68.6
	2	18.8	19	54.6	5.7			
25- Your needed medical services are available	11	93	22	265	12	.9656	3.431	68.6
	2.7	23	5.4	65.4	3			
26- You can pay suitable medical services fees	17	73	18	212	84	1.1188	3.675	73.5
	4.2	18	4.4	52.3	20.7			
27- Dealing with the Para-medical departments is comfortable	6	57	66	260	16	.8357	3.550	71
	1.5	14.1	16.3	64.2	4			
28- The experiments results are on time	12	87	57	240	9	.9408	3.363	67.3
	3	21.5	14.1	59.3	2.2			
29- Your needed diagnostic procedures are available	8	89	93	202	12	.9114	3.299	66
	2	22	23	49.9	3			
30- Informative employee available for all patients	51	117	112	120	5	1.0453	2.780	55.6
	12.6	28.9	27.7	29.6	1.2			

Annex 4.2: Physical environment items and degree of satisfaction

2-Physical environment	strongly disagree	disagree	Un certain	agree	strongly agree	S.D	Mean	%
	Number	Number	Number	Number	Number			
	%	%	%	%	%			
31- There is enough space for patients to move easily	31	157	4	206	7	1.1290	3.002	60
	7.7	38.8	1	50.9	1.7			
32- Conditioning inside the clinic is good	153	116	6	126	4	1.2831	2.288	45.8
	37.8	28.6	1.5	31.1	1			
33- The diagnostic room is comfortable to the patients	13	96	9	271	16	.9976	3.446	68.9
	3.2	23.7	2.2	66.9	4			
34- Lighting in the diagnostic room is adequate to work well	4	23	9	344	25	.6246	3.896	77.9
	1	5.7	2.2	84.9	6.2			
35- There is clean water for drinking	171	97	116	18	2	.9666	1.967	39.3
	42.2	24	28.6	4.4	0.5			
36- The administration takes care of the clinic cleaning	5	45	10	324	21	.7613	3.767	75.3
	1.2	11.1	2.5	80	5.2			
37- There are enough WC for all	20	67	203	105	10	.8489	3.044	60.9
	4.9	16.5	50.1	25.9	2.5			
38- The WC are clean and easily managed	25	64	217	92	7	.8382	2.980	59.6
	6.2	51.8	53.6	22.7	1.7			
39- Direction charts in the clinic are enough	7	74	20	287	16	.8923	3.571	71.4
	1.7	18.3	4.9	70.9	4			
40- Wheel chairs for disabled are enough	19	90	242	50	4	.7377	2.827	56.5
	4.7	22.2	59.8	12.3	1			
41- The roads for disabled are comfortable	20	102	175	106	2	.8523	2.921	58.4
	4.9	25.2	43.2	26.2	0.5			

Annex 4.3: Patient's expectations items and degree of satisfaction

3- patient's expectations	strongly disagree	Dis agree	Un certain	agree	strongly agree	S.D	Mean	%
	Number	Number	Number	Number	Number			
	%	%	%	%	%			
42- You get adequate information to the intended place	14	141	2	235	12	1.0683	3.222	64.4
	3.5	34.8	0.5	58	3			
43- You felt that there is some one helping the patients	23	106	19	254	3	1.0379	3.266	65.3
	5.7	26.2	4.7	62.7	0.7			
44- You felt that the appointment are fair	27	155	36	179	8	1.0826	2.965	59.3
	6.7	38.3	8.9	44.2	2			
45- You see that the medical team were respect timing	12	127	25	230	11	1.0242	3.249	65
	3	31.4	6.2	56.8	2.7			
46- You felt that the medical team were respect the patients during the visit to the clinic	6	49	6	326	18	.7823	3.743	74.9
	1.5	2.1	1.5	80.5	4.4			
47- Getting the medical service quietly	21	102	5	266	11	1.0492	3.355	67.1
	5.2	25.2	1.2	65.7	2.7			
48- You find that the medical team is a co-operative	6	66	13	307	13	.8449	3.629	72.6
	1.5	16.3	3.2	75.8	3.2			
49- Your confidentiality was respected during examination	7	46	5	248	98	.9306	3.950	79
	1.7	11.4	1.2	61.2	24.2			
50- You felt that the works goes smoothly for the patients	8	83	20	270	23	.9457	3.537	70.7
	2	20.5	4.9	66.7	5.7			
51- You felt that the medical team were respect your needs	7	63	31	231	71	.9831	3.734	74.7
	1.7	15.6	7.7	57	17.5			
52- Your needed medical examinations were accomplished in a reasonable way	7	62	11	298	26	.8716	3.678	73.6
	1.7	15.3	2.7	73.6	6.4			
53- You find that all patients were deal by same degree	62	144	30	167	2	1.1601	2.760	55.2
	15.3	35.6	7.4	41.2	0.5			
54- In general you are satisfied by the health services in the clinic	30	110	12	240	13	1.1116	3.237	64.7
	7.4	27.2	3	59.3	3.2			

Annex 4.4: Waiting time items and degree of satisfaction

4- Waiting time	strongly disagree	disagree	Un certain	agree	strongly agree	S.D	Mean	%
	Number	Number	Number	Number	Number			
	%	%	%	%	%			
55- I don't too long by the registration office	13	64	6	275	45	.9765	3.682	73.6
	3.2	15.8	1.5	67.9	11.1			
66- There is discipline by the registration office	10	76	8	280	30	.9564	3.604	72.1
	2.5	18.8	2	69.1	7.4			
57- The registration office releases the patents' name quickly	4	42	15	292	51	.8049	3.851	77
	1	10.4	3.7	72.1	12.6			
58- There is discipline in the waiting hall	34	189	3	170	9	1.1336	2.829	56.6
	8.4	46.7	0.7	42	2.2			
59- Ordering the patients goes quietly	57	184	23	135	6	1.1287	2.627	52.5
	14.1	45.4	5.7	33.3	1.5			
60- I don't too long by the doctor's room	46	186	4	161	8	1.1537	2.750	55
	11.4	45.9	1	39.8	2			
61- The big number of patients doesn't hold back the doctor's work	240	99	6	47	13	1.1408	1.750	35
	59.3	24.4	1.5	11.6	3.2			
62- Work goes according to a fair schedule for all	13	164	17	207	4	1.0405	3.061	61.2
	3.2	40.5	4.2	51.1	1			
63- The lab produce tests in a suitable time	13	87	93	204	7	.9235	3.259	65.2
	3.2	21.5	23	50.4	1.7			
64- The x-ray reports are produced in a suitable time	11	53	82	246	13	.8605	3.486	69.7
	2.7	13.1	20.2	60.7	3.2			
65- The big number of patients doesn't affect your own time	213	139	2	39	11	1.0511	1.752	35
	52.6	34.3	0.5	9.6	2.7			
66- The time spent in the clinic to get your services is suitable	44	146	2	204	9	1.1790	2.970	59.4
	10.9	36	0.5	50.4	2.2			

Annex 4.5: Information and Interaction items and degree of satisfaction

5- information and interaction	strongly disagree	disagree	un certain	agree	strongly agree	S.D	Mean	%
	Number	Number	Number	Number	Number			
	%	%	%	%	%			
67- The medical team introduce themselves to the patient	149	186	6	61	3	1.0264	1.970	39.4
	36.8	45.9	1.5	15.1	0.7			
68- Medical team explains to the patient in a meaningful way	22	103	12	258	9	1.0494	3.319	66.4
	5.4	25.4	3	63.7	2.2			
69- You are talking with the medical team while you are setting on the chair	29	107	2	239	28	1.1478	3.321	66.4
	7.2	26.4	0.5	59	6.9			
70- You received a satisfied answers for your acquisitions	12	50	17	312	14	.8491	3.656	73.1
	3	12.3	4.2	77	3.5			
71- You felt that you are close to the Medical team	11	85	93	205	10	.9178	3.292	65.8
	2.7	21	23	50.6	2.5			
72- Medical team explains what they are going to do	18	89	8	278	15	.9935	3.466	69.3
	3.7	22	2	68.6	3.7			
73- Medical team makes you feel that your service takes their priority	6	138	12	233	16	1.0272	3.284	65.7
	1.5	34.1	3	57.5	4			
74- You get adequate information about your illness and the your medicine	30	109	18	241	6	1.0874	3.207	64.1
	7.4	26.9	4.4	59.5	1.5			
75- Medical team respect you as a human	20	103	13	257	12	1.0447	3.340	66.8
	4.9	25.4	3.2	63.5	3			
76- Medical team work to reduce your stress	24	124	16	223	17	1.1061	3.210	64.2
	5.9	30.6	4	55.1	4.2			
77- You are satisfied with the communication way with the medical team	15	106	13	252	19	1.0381	3.380	67.6
	3.7	26.2	3.2	62.2	4.7			
78- The impression of the medical team when offering the medical services for you is good	14	95	18	263	15	.9983	3.419	68.4
	3.5	23.5	4.4	64.9	3.7			
79- Medical team gives you enough time to give your opinion	33	107	15	236	14	1.1241	3.224	64.5
	8.1	26.4	3.7	58.3	3.5			

وكذلك أظهرت الدراسة أنه لا يوجد دلالة إحصائية بين المرضى في الحالة الاجتماعيـة، أو عدد الزيارات للعيادة، وفي وجود إعاقة أو عدم وجود إعاقة، وفي نوع العيـادة المقـصودة وأخيراً في المكان الذي استغرق فيه المريض أكثر الوقت في أثناء زيارته للعيادة.

وقد أوصت الدراسة أن تقليل وقت انتظار المرضى في العيادة، وإدخال بعض التحـسينات على تركيبة العيادة الطبيعية، وكذلك تحسين طريقة التواصل والتفاعل مع المرضى، تعتبـر عوامل مهمة لتحسين معدل رضا المرضى عن جودة الخدمات الصحية المقدمة لهم في قسم العيادة الخارجية التابع لمستشفى الشفاء.

رضا المرضى عن جودة الخدمات المقدمة في قسم العيادة الخارجية في مستشفى الشفاء.

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إشراف: الدكتور يوسف الجيش

ملخص:

يعتبر رضا المريض عن الخدمات الصحية مؤشرا جيدا على جودة هذه الخـدمات. ولقـد أصبح رضا المريض في هذا الوقت الحاضر مجالا للتحدي لكثير من المؤسسات الـصحية. تهدف هذه الدراسة إلى تقييم مستوى رضا المرضى الذين حصلوا على الخدمات الـصحية في قسم العيادة الخارجية التابع لمستشفى الشفاء، وتهدف الدراسة أيضاً إلى تقديم توصـيات لتحسين جودة هذه الخدمات.

وقد صممت هذه الدراسة كدراسة تحليلية مقطعية، واستخدم الباحث مقياساً مصمماً ومركزاً لمقابلة المرضى بطريقة منتقاة، وذلك بعد تلقيهم الخدمات الصحية في قسم العيادة الخارجية. وقد اختار الباحث عينة الدراسة وعددها 450 مريضاً بطريقة منتظمة، حيث بلغـت نـسبة تجاوب المرضى مع الدراسة 90%. ولقد تمتع مقيـاس الدراسـة بدرجـة ثبـات عاليـة بلغت0.91 حسب مقياس (Cronbach's Alpha).

وقد اهتمت الدراسة بإيضاح الفروق بين المرضى من حيث الصفات الشخصية والاجتماعية والاقتصادية وحالة المريض الصحية، وكذلك ببعض خصائص المؤسسة بالنسبة لرضـاهم عن جودة الخدمات الصحية المقدمة لهم. وقد اشتمل مقياس الدراسة على خمسة أبعاد للخدمة الصحية وهي: الوصول والاستفادة من الخدمة، والبيئة الطبيعية، وتوقعات المريض، ووقت الانتظار وأخيراً التواصل والتفاعل مع المريض. وقد بلغ مستوى الرضا العام عن الخدمات 63.9%. وسجل بعد توقعات المريض أعلى معدلات الرضا % 68.8. بينما سـجل بعـد الوصول والاستفادة من الخدمة أقل معدلات الرضا وبلغ % 58.5.

ولقد أظهرت الدراسة أن المرضى الإناث، والمرضى كبار السن، والمرضى ذوى التعلـيم الإعدادي، والمرضى ذوي الدخل الشهري لأقل من 1000 شـيكل، والمرضـى أصـحاب الأمراض المزمنة، والمرضى الذين مكثوا أقل من ساعة في العيادة، قد سجلوا فـروق ذات دلالة إحصائية في معدل الرضا عن الخدمات الصحية أعلى من باقي فئات المرضى.