

Deanship of Graduate Studies

Al- Quds University

**Perception of Hospitalized Patients about the Services
Provided at the European Gaza Hospital (EGH)**

Mohammad Abed El-Hafez El-Haj

MPH Thesis

Jerusalem - Palestine

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Thesis Approval

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إهداء

أهدى هذا العمل إلى روح والدي الطاهرة التي تضيء لي الطريق، وإلى والدتي العزيزة،
وزوجتي و أبنائي وبناتي الذين كانت محبتهم الدعم والتشجيع لأعمالي.

Dedication

To the spirit of my father, which enlightens my way.

To my mother, wife and kids, whose love has always supportive to
my efforts.

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-----

Mohammad Abed El-Hafez El-Haj

Date:

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Abstract

Patients' perceptions about health services have gained increasing attention over the past 30 years. Such perceptions, especially about services quality, might affect confidence and subsequent behaviors with regard to the choice and the usage of the available health care facilities. This study aims to examine patients' perception about the hospital services at the adult medical and surgical wards in the European Gaza Hospital and to provide recommendations for improving the quality of the offered services.

This study is a cross sectional design for eligible patients who discharged from the hospital after three or more admission days and his/her age 18 years old and over. An exit interviewed questionnaire was developed which concentrated on perspectives about hospital services provided at the EGH. A sum of 375 patients chosen according to the eligibility criteria were requested to complete interviewed questionnaire. The response rate was 88.8%. The total instrument reliability test (Cronbach's Alpha) was 0.8564 and the Principal Component Extraction Varimax Rotation with Kaiser Normalization with a substantially above chance level variance (48.68%) were used to assess the validity of this study using a factor loading of more than 0.4 as a cut off point.

The study extracted six factors that constituted a frame for patients' perceptions about the EGH services. Meanwhile, the study revealed that the EGH patients were moderately satisfied which ranged from 73% to 83% in general, there were variations regarding the perception level with the various domains. Whilst, high perception levels were found with respect and privacy, approach of care and meeting expectations, lower level of perceptions were recognized with information and communication and hotel services. The least perception level was found with hospital culture

Findings revealed that, females, older age, married, patients living in Khanyunis Governorate, non-refugee, patients living outside camps, low education level and being un-employed have had more positive perceptions (statistically significant) about EGH than their counterparts. Also, the study revealed that patients who had previous admissions to the hospital, admitted for short period, medical admission and admitted from the emergency department have had more positive perception than their counterparts. The study concluding that the hospitalization factors including number of admission days and admission ward showed a statistically significant impact on the level of patients' perception about the hospital services. However, residency place, health insurance scheme, number of admissions and type of admission showed no statistically significant impact on the level of patients' perception.

The study revealed that improvement in hotel services and hospital culture are considered important factors to improve the patients' perception. Furthermore, health managers could use the study findings to target patient groups at risk of having lower perception about the hospital services.

وجهات نظر المرضى الذين مكثوا في مستشفى غزة الأوروبي حول الخدمات المقدمة

وجهات نظر المرضى بخصوص الخدمات الصحية بدأت تأخذ اهتماما متزايدا على مدار الثلاثون عاما الماضية. إن وجهات نظر المرضى وخاصة حول جودة الخدمات، يؤثر لاحقا في الثقة والسلوك فيما يتعلق باختيار واستخدام المتاح من مرافق الرعاية الصحية. هذه الدراسة تهدف إلى دراسة تصور المرضى عن خدمات المستشفى في أقسام الباطنة والجراحة للبالغين في مستشفى غزة الأوروبي وتقديم التوصيات لتحسين جودة الرعاية.

الدراسة مقطعية التصميم و أعدت للمرضى المستوفين للشروط و الذين تم تخريجهم من المستشفى بعد ثلاثة أيام أو أكثر من دخولهم المستشفى و أعمارهم 18 عاما وأكثر. لقد تم إعداد إستبانة ركزت على وجهات نظر المرضى حول الخدمات المقدمة في مستشفى غزة الأوروبي. لقد تم اختيار 375 مريضا وفقا لمعايير الأهلية وطلب منهم تعبئة إستبانة. وكان معدل الاستجابة %88.8. ودرجة ثبات الاستبيان ككل كانت حسب عامل اختبار كرنينج (Cronbach 's) تساوي 0.8564 وكان العنصر الرئيسي في استخراج *Varimax Rotation with Kaiser Normalization* مع فرصة كبيرة فوق مستوى الفرق (%68.48) المقررة في مصداقية هذه الدراسة باستخدام عامل ارتباط 0.4 وما فوق باعتبارها نقطة الحسم.

الدراسة استخلصت ستة عوامل التي شكلت إطارا لوجهة نظر المرضى حول خدمات المستشفى. في غضون ذلك، كشفت الدراسة أن المرضى في مستشفى غزة الأوروبي كانوا يشعرون بدرجة متوسطة بالرضا تراوحت بين %73 و %83 بشكل عام، كانت هناك اختلافات فيما يتعلق بمستوى تصور عوامل وجهات النظر والرضا. حيث وجد أن التصور كان عاليا بخصوص الاحترام والخصوصية و أسلوب الرعاية وتلبية التوقعات، تصور أقل كان مع المعلومات والاتصالات، والخدمات الفندقية. أقل التصور وجد مع نمط العمل في المستشفى.

أظهرت النتائج أن الإناث، وكبار السن، والمتزوجين، والمرضى من محافظة خان يونس، والمرضى المواطنين، والمرضى الذين يسكنون خارج المخيمات، والمرضى ذوا التعليم المنخفض، و الغير عاملين لديهم وجهات نظر أكثر ايجابية عن الخدمة المقدمة لهم في المستشفى الأوروبي. أيضا أظهرت النتائج أن المرضى الذين سبق لهم أن عولجوا في هذا المستشفى، و المرضى الذين قضاوا ثلاثة أيام في المستشفى، والمرضى الذين ادخلوا إلى قسم الباطنة، و المرضى الذين ادخلوا عن طريق قسم الطوارئ كان لديهم وجهات نظر أكثر ايجابية من نظرائهم حول الخدمة في المستشفى. كذلك

أظهرت الدراسة أن العوامل المتعلقة بالمستشفى بما في ذلك عدد أيام دخول المستشفى، وقسم الدخول لها دلالات إحصائية واثراً على مستوى تصور المرضى عن خدمات المستشفيات. ومن ناحية أخرى أظهرت الإحصائية أن مكان الإقامة ونوع التأمين الصحي ليس مهماً من الناحية الإحصائية في التأثير على مستوى تصور المرضى. كذلك أظهرت الدراسة أن عدد مرات دخول المستشفى ونوعية الدخول ليس له تأثير إحصائي على وجهة نظر المرضى.

استخلصت الدراسة، أن تحسين الخدمات الفندقية، و ثقافة وتقاليد المستشفى خصوصاً في مجال التعامل و الاتصال والتواصل من العوامل المهمة في تحسين وجهة نظر المرضى، لذلك من الضروري مراعاتهما من قبل المسؤولين وصناع القرار. فضلاً عن ذلك، يستطيع المسؤولون استخدام نتائج الدراسة والاهتمام بالفئات التي كان لديها انطباع ووجهات نظر أقل عن الخدمات المقدمة في المستشفى.

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apter One

Introduction

Chapter 1

Introduction

1.1 Background

Patients perceptions about health care have gained an increasing attention over the past 20 years (Sitzia and Wood, 1997). Patients perceptions can contribute through providing important information to quality of care assessment that is not gained by monitoring more

traditional measures of performance alone. From the hospital's perspective, there are various reasons for assessing patient perception (Donabedian, 1988). Firstly, patient satisfaction is considered to be a desired outcome of care, at a time when the technical aspects of medicine are overtaking humanistic factors. Secondly, patient's perception is predictive of future behavior (compliance with recommended treatments). Thirdly, patient perception is related to the quality of care, in interpersonal and organizational areas as well as in technical and physiological domains.

The fact that quality perceptions have a strong influence on one's desire to avail health services is beyond dispute. Thus, expanding access or holding the line on costs is not enough if one's confidence in the quality of health care services is low. Perceptions of poor quality of health care may, in fact, dissuade patients from using the available services because health concerns are among the most salient of human concerns. If the system cannot be trusted to guarantee a threshold level of quality, it will remain underutilized, be bypassed, or used as a measure of last resort (Andaleeb, 2001).

Assessing patients' perception may therefore be an important source of information for screening problems and developing an acceptable plan of action (Labarere and Francois, 1999). The patient's perspective on what constitutes high quality in health care is increasingly recognized as essential in quality assessment and improvement efforts. Attempts to define and measure this perspective are now being made at both the provider and system level.

Many Governments have developed performance framework that include indicators of responsiveness to patients. Recently, international agencies, such as the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD), have stressed its importance as a key component of system performance (Murray

and Frenk, 2001). WHO included an index of responsiveness to the expectations of consumers in its recent report on health systems around the world (WHO, 2000). This measure ranked countries' health systems according to their performance on two paradigms: respect for persons (including dignity, confidentiality and autonomy) and client orientation (including prompt attention, quality of amenities, access to social support and freedom of choice of providers) (WHO, 2000).

There are several ways of incorporating the patient's voice in the audit process (Rosenthal and Shannon, 1997). Surveying patient satisfaction is the most common method for obtaining patient's views on their hospital stay. Patient satisfaction is, however, deemed to be an ungrounded concept by several authors (Sitzia and Wood, 1997).

Satisfaction is an abstract concept, which cannot be directly observed or measured. Despite the growing literature devoted to the patient satisfaction, no unified approach has been devised for its measurement and there is disagreement as to whether patient satisfaction exists and what it means. Some authors have criticized the notion that patient satisfaction is directly supported by the discrepancies between expectations and perception (Avis, Bond and Arther, 1995).

In the field of marketing research, the majority of the consumer satisfaction on the disconfirmation paradigm (Oliver, 1980). This paradigm encompasses four constructs: expectations, perceived performance, disconfirmation and satisfaction. Disconfirmation is an intermediate variable that arises from discrepancies between expectations and perceived performance (Conway and Willcocks, 1997).

Interest has therefore grown not only in the assessment of treatment interventions by patients, but in the systematic evaluation of the delivery of that care. Patient satisfaction

has become an established outcome indicator of the quality and the efficiency of the health care systems (Johansson, Oleni and Fridlund, 2002).

By understanding what is most important to their patients, hospital staff can modify their care to improve satisfaction. Also, to provide high quality of hospital services in Gaza Strip, hospital staff may need to be constantly a ware of what is most important to their clients' and hospital staff may need to modify services to meet needs that have been defined by the clients'.

With careful analysis, this study can be used effectively to provide hospital staff with greater understanding of their clients' and how they express their needs. Hospital staff can then use the provided information to identify areas for improvement, develop interventions and monitor change. Therefore, this study may be considered important to improve the quality of hospital services and to increase clients' satisfaction.

1.2 Research problem

Investigations on the quality of health services were focused on client satisfaction. Responses indicated wide variation of satisfaction among health facilities and among different aspects. It was evident however those patients were expecting more from professional and health institutions both in term of physical accessibility and quality of the assistance (Abed, March 2007).

Palestinian Human Rights Monitoring Group who analyzed the quality of health care system in Palestine pointed to the quality defect, which is reflected in the inefficiency of health care system to deliver quality health care. Although the national inputs into health care in Palestine seem to be high in comparable to those nations with similar economic

status, they reported that there is general dissatisfaction among public and professionals regarding quality of health care in Palestine (Palestinian Human Rights, 2000).

Therefore, improvement in the quality of hospital services is essential to achieve energy of the services offered. To start with improvement, a base line scientific studies are required.

Although there is no much data available regarding patients perception about the health services provided at the European Gaza Hospital, however, this study aims to address the issue, therefore the purpose of the study is to examine patients perception regarding the health services at the adult medical and surgical departments in EGH from the patients' perspectives and to make recommendations for improving the quality of care.

1.3 Justification of the study

Patients' perception is considered one of the indicators for the quality of health care in Palestine. In general, there appears to be an over investment in the health care system in Palestine in spite of the limited resources and a noticeable clients' dissatisfaction with the quality of care in the different health care setting. The health conditions in the Palestinian areas still require more attention to certain problems and difficulties which prevent giving appropriate medical care (Palestinian Human Rights, 2000).

Moreover, Palestine Research Unit (PRU) who study the conditions of the civilian population in the Occupied Palestinian Territories reported that, 39% of the population enforced to find an alternative health facility, which added additional costs, delay in the needed care, and more suffering. Also, Palestine Research Unit reported that 71% of the population was satisfied with hospital services (Palestine Research Unit, 2004).

The decision to develop a study on patient's perception was based on the fact that patient satisfaction is becoming an established outcome indicator of the quality and efficiency of the health care system (Johansson, Oleni and Fridlund, 2002).

The health providers have wanted patients who attended hospital departments to be satisfied, but they were uncertain of the accuracy or the usefulness of the patients view. A related reason for interest in patient perception is the idea that improved patient perception may lead to increased patient adherence to the care and treatment, which in turn affects the whole health outcome.

There are many ways of getting information about the patient perception of health care services provided and practices, sometimes the belief that services are good or bad is based on an informal impression, gained from patients experience or experience of others and because individual experience is haphazard and sometime misleading, it must be supplemented by the result of formal research studies.

The administration of the European Gaza Hospital (EGH) in 2000 put a mission to be carried out in the hospital, which is "Patient First." It could be present as a nice mission and it has to be followed by good care for the clients to be satisfied at the end. So, assessing patients' perception level is considered to be a key indicator in evaluating the quality of hospital health services.

Furthermore, making services and care more evidence based will improve quality and will improve health outcomes of the population. Since the EGH was established, a lot of studies have been made that dealt with professional issues and didn't cover all aspects. But this study includes additional aspects such as hotel services and patient-centered care that other studies haven't mentioned.

The researcher will conduct this study to make this information available for Palestinian ministry of health, decision makers, administration of EGH, health providers to improve the services to the best.

1.4 Aim of the study

To assess patients' perceptions about the services provided in EGH. Moreover, the study aims to provide policymakers with recent evidence-based information about patient experiences and views in order to improve the hospital services.

1.5 Study objectives

1. To assess patients' perceptions about the hospital services provided in the EGH.
2. To explore the main constructs of patients perceptions about the hospital services in the EGH.
3. To identify factors that affect patients' perceptions about the hospital services.
4. To identify the relationship between demographic, socio-economic and hospitalization factors with respect to patients' perception.
5. To provide suggestions and recommendations for future possible interventions.

1.6 Research questions

1. Do clients have positive perceptions about the hospital services provided at the EGH?
2. What are the main domains of patients' perception about the hospital service provided at the EGH?
3. Are there significant differences in the level of patients' perception about hospital services in relation to demographic characteristics, such as gender, age, marital status, family members, citizenship and place of residency?

4. Are there significant differences in the level of patients' perception about hospital service in relation to socio-economic characteristics, such as educational level, employment status, health insurance scheme?
5. Are there significant differences in the level of patients' perception about hospital service in relation to hospitalization variables, such as number of admissions, type of admissions, number of admission days and ward of admission?
6. Are there significant differences in the level of patients' perceptions about the hospital services in relation to their evaluation of the health status?
7. What are the patients views about the health care services offered at EGH?
8. What are the suggestions and recommendations for future possible interventions?

1.7 Context of the study

The information that describes the health care services and the population who received that care are considered very important for proper planning and development of health care services. This study was conducted in the Gaza Strip which has its unique culture, therefore in the following paragraphs some information about the Palestinian population and their health status, health care system and services delivery in Palestine are provided.

1.8 Demographic context

Palestine is situated on the Eastern Coast of the Mediterranean Sea. It is of an ancient and of strategic important location. Now, Palestine comprises two areas separated geographically; the West Bank and Gaza Strip, the total area is 6,020 sq. Km. with total population living in is 3,761,646 individuals in 2007 (PCBS, 2007). Gaza Strip is a narrow piece of land lying on the eastern coast of the Mediterranean sea. Its position on the

crossroads between Africa and Asia made it a target for invaders and conquerors over the centuries. The last of these was the Israeli occupation of the Gaza Strip from Egyptians in 1967 (PCBS, 2007).

Gaza Strip is very crowded place with an area of 365 sq. Km and constitutes 6.1% of the total area of the Palestinian Territories. In 2007 the population number was 1,416,539 mainly concentrated in the cities, small villages and eight refugee camps that contain two thirds of the population of Gaza Governorates with a population density of 3,808 inhabitants/km² that comprises the following main five governorates: North of Gaza, Gaza City, Mide-Zone, Khan-younis and Rafah. (PCBS, 2007).

The Palestinian Centre Bureau of Statistic (PCBS) reported that the current natural increase rate in Palestine was 3.3% (3.0% in WB and 3.8% in GS), the percentage of population under 15 years old was 46.3% of the total population (44.2% in WB and 49.1% in GS).

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. The Palestinian Ministry of Health has reported that, the crude birth rate (CBR) in Palestine was 27.5/1000 population in 2005 (33.7 GS and 23.9 WB). MOH has reported that, the crude death rate (CDR) in Palestine was 2.7/1000 population in 2005 (3.1 GS and 2.5 WB) (MOH, 2006).

1.9 Socio-economic context

The World Bank stated that the Gross National Product (GNP) in Palestine has been subjected to high fluctuations during the last five years. GNP was 5,454 million US\$ in 1999 and decreased to 4,169 million US\$ in 2005. Gross Domestic Product (GDP) was 4,517 million US\$ in 1999 and decreased to 3,832 million US\$ in 2005. Gross National product per capita (GNP/capita) was 1,806 US\$ in 1999 and decreased to 1,039 US\$ in

2005. Gross Domestic Product per capita (GDP/capita) was 1,496 US\$ in 1999 and decreased to 955 US\$ in 2005 (World Bank, 2005).

The number of workers in Israel decreased from 135,000 in 1999 to 36,000 in 2005. And completely stopped from 1999 to 2005. The workers in Palestine also decreased from 453,000 in 1999 to 135,000 in 2005 (World Bank, 2005). The World Bank reported that the unemployment rate was 32%. This revealed sharply increasing of the unemployment rate from 11.8% in 1999 to 32% and the poverty rate in Palestine was 44% in 2005. This situation is a result of Israeli enforced restriction on the Palestinian movement, military operations, land confiscation and leveling and the construction of Barrier in addition to other escalating activities imposed on Palestinian people (World Bank, 2005).

The latest development after the Palestinian elections and the winning of Hamas have had a great impact on health situation as the Quartet has imposed a comprehensive siege on the government depriving Palestinians from the financial support that used to come from international donors for the government, the fact that deepened the socioeconomic crises in the country. Realities on the ground are getting so complicated as the cohesion of the Palestinian society has been greatly damaged and the socio economic conditions have been deteriorating constantly leaving two third of the population living under poverty line and the unemployment rate is more than 40%.

1.10 Health care system context

MOH is the main health care provider in Palestine with other health care providers, UNRWA, Medical Services for Police and General Security, health services of National and International Non Governmental Organizations (NGOs) and private health sector.

MOH is the health authority responsible for supervision, regulation, licensure and control of the whole health services (MOH, 2006).

The Primary Health Care sector (PHC) is a major component of the Palestinian health care system; which provides health care to all Palestinian people especially for children. Primary health care centers in Palestine provide primary, secondary and tertiary health care services. In the last five years and after the uprising of second Intifada (Al Aqsua), PHC centers in Palestine have been developed in a dynamic way to face instability of Palestinian situation. PHC centers try to offer accessible and affordable health services for all Palestinians regardless the geographical locations (MOH, 2006).

Also, MOH is responsible for a significant portion of the secondary healthcare delivery system (60-70% of general and specialized hospital beds) and more than this proportion in hospital services (about 70% of hospital services). In 2005, there were 43 general hospitals with 3,726 beds, 10 specialized hospitals with a total bed capacity of 812 beds, 19 maternity hospitals at a total bed capacity of 322 beds and four rehabilitation centers with a total bed capacity of 165 beds (MOH, 2006). There is only one obstetric and gynecology hospital for the MOH in Rafah city despite the availability of maternal departments in the general hospitals and all of the rehabilitation hospitals are owned and operated by the NGOs (MOH, 2006).

The Palestinian MOH hospitals offer the following main specialties:

- Internal medicine and medical subspecialties
- General surgery and surgical subspecialties
- Pediatric medicine
- Obstetrics and gynecology

- Special care: general intensive care units, coronary care units, neonatal intensive care units, burns unit, pediatric intensive care unit and general medical intensive care unit.

The Palestinian MOH hospitals do also provide services for non-admitted patients through outpatient departments (orthopedic, ophthalmology, physiotherapy, gynecology and obstetric, surgery, internal medicine, ENT, psychiatry, oncology and uro-surgery) emergency departments, day care beds in haemodialysis, oncology and blood diseases treatment centers (MOH, 2006).

Despite the fact that the Palestinian MOH has developed advanced diagnosis and treatment facilities in West Bank and Gaza Strip, it is necessary to refer patients who are in need of special diagnosis and care which are not available in MOH institutions to institutions outside the Palestinian MOH. The patients who are in need of particular diagnosis or treatment outside MOH institutions are referred for consultations or hospitalization at NGO/private health providers in West Bank, Gaza Strip and East Jerusalem or to public/private health providers in Israel, Jordan and Egypt. These patients are labeled “treatment abroad patients” and managed through the Special Treatment Department, Palestinian Ministry of Health in West Bank or in Gaza Strip (MOH, 2006).

It is important to stress that the term “treatment abroad” embraces all patients who receive treatment consultation (outpatient) or hospitalization (inpatient)) outside the Palestinian MOH institutions, either in health facilities in West Bank, Gaza Strip, East Jerusalem, or in hospitals in Israel, Jordan and Egypt or elsewhere.

In Palestine, the total number of patients referred for hospitalization and consultation increased from 6,200 in 2000 to 31,744 in 2004 and 31,721 in 2005 with an increasing percentage of 412% in comparison with the year 2000 (MOH, 2006). For 2004 the total

cost of treatment abroad was NIS 261,356,601 (USD 58,079,245), which represented 46% of the actual expenditure for 2004. For 2005 the total cost of treatment abroad was NIS 268,044,025 (USD 59,565,339), the running cost MOH budget in 2005 was USD 139,584,400. The treatment abroad represented 42.7% of the actual running expenditure for 2005 (MOH, 2006).

It is imperative, therefore, for healthcare providers to focus on and deliver quality services to regain patient confidence. It should be possible to introduce patient-driven quality standards to enable service providers to better address patients' needs. In turn, such measures should bring patients back to a system that is designed to serve their needs as well or better than the services abroad. When the quality of services improves, patients will feel reassured to seek curative services within the country. An indirect benefit to the country would be to preserve its foreign exchange that can be deployed in other important sectors.

1.11 European Gaza Hospital:

EGH is a MOH hospital built in 1993, located in Khanyounis Governorate at the southern area of the Gaza Strip. An International Management Team (IMT) took the responsibility to commission the hospital. The hospital services started on 15 July 2000 according to scheduled program, the hospital provides services to 400,000 catchments population. On the fifteenth of October 2000, the management authority transferred to the Palestinian staff. The EGH is considered one of the biggest health investments in the area, with total cost around \$60 million. The EGH was conceived by UNRWA and funded by European

countries to be a center of excellence providing much needed secondary plus care services to the southern area of Gaza Strip (European Gaza Hospital Records, 2007).

EGH played a very important role in health services development process through introducing new system, such as appointment system and computerized networking system. Today, the EGH provides a major portion of medical services for Palestinians through a full range of diagnostic and management facilities for patients ranging in age from the neonate to elderly. The EGH is the referral center for medical services. An average 1115 patients per month were admitted to different hospital departments and 350 patients per month were admitted to medical and surgical departments. In general, the bed occupancy rate in the hospital during 2007 was 86% and the average length of stay was 4.55 days (European Gaza Hospital Records, 2007).

The staff of EGH have a diverse experience of the different countries. The total number of physicians in the hospital was 140 physicians and the total number of nursing staff who is working in different departments in the hospital was 205 nurses. In adult medical and surgical departments there are 70 nurses and 123 beds. The hospital contains facilities for a full range of secondary and planned tertiary patients care services for both inpatients and out patients. The administration requires that the quality of the services rendered and general operating standards of the center meet the standards of European hospitals. In addition to providing excellent care for patients, professional and technical position, there are continuing in service education programs and specific training programs (European Gaza Hospital Records, 2007).

1.12 Definition of terms

Hospital services

Hospital services in this study, these services, which the patients received inside the adult medical and surgical wards at the EGH, starting from the admission until the discharge from the hospital including all the aspect of care.

Patients' perception

Patients' perception is operationally defined in this study, as patients' experience, views, attitudes, opinions, satisfaction, or perspective about the hospital services they received.

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).

Level of satisfaction

Level of satisfaction is the extent to which patients are happy and have positive attitudes about the hospital services they received.

1.13 Layout of the study

Chapter one: Introduction:

As of mentioned at this chapter, the researcher gave a background about the study, justification of the study, aim of the study. Also, the researcher mentioned the objectives and the questions of the study. Moreover, the researcher gave in some details the context of the study. In the next chapters the researcher will discuss in detail the following things:

Chapter two: Literature review:

The review aims to identify a theoretical framework within which the concepts of perception/satisfaction can be analyzed and discussed. It also aims to explore the origins of perception/satisfaction measurement in the health service and identify methods that can be employed to measure perceptions/satisfaction in the health services field.

Chapter three: Conceptual framework:

A set of concepts, terms and relationships within which the problem is formulated and solved. It is the foundation on which the research was done.

Chapter four: Methodology of the study:

The Methodology chapter explains the methodology used in this study. The researcher explains the selected design of the study, sample, sample process and ethical considerations. After that the instrument, method of validation, pilot study and data collection were discussed, then illustrated the psychometric properties of the questionnaire. In this chapter the researcher depicts the methods of analyses, eligibility criteria and the limitations of the study.

Chapter five: Results and discussion:

At this chapter the researcher presents the findings of the data analysis. Next, the researcher discusses the aspects of the findings that are consistent with previous researchers and theoretical explanations and those that are not in agreement. The researcher reports the limitation of the study that occurs during the study that may influence the results.

Chapter six: Conclusion and recommendations:

The study conclusions are the researcher's attempt to show what knowledge has been gained by the study and are also an attempt to generalize the findings.

Recommendations concerning extension of the research study should answer the question, "What comes next". The researcher proposes the next steps that need to be taken.

Chapter Two

Literature Review

Chapter 2

Literature Review

2.1 Concepts of Perceptions versus Patient Satisfaction

The terms perceptions and satisfaction have often been used interchangeably. This can lead to considerable conceptual confusion. Satisfaction is an example of a perception, but it is by no means the only example. Satisfaction can be defined as fulfilling expectations, needs, or desires (Sitzia, and Wood, 1997).

In their comprehensive review of the literature on patient satisfaction, Crow, Gage, and Hampson (2002) stated that two conclusions follow from this definition: (a) Satisfaction does not imply superior service, only adequate or acceptable service; and (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 its use since there is rarely any theoretical or conceptual development of patient satisfaction, little standardization, low reliability, and uncertain validity of measures (Crow, Gage, and Hampson, 2002; Morales, 2001).

Crow identifies three bases for the conceptual development of patient satisfaction and its measurement: expectation theories; evaluations of health services attributes; and economics utility. Crow, Gage, and Hampson (2002) also point to a fourth possibility, a holistic approach that incorporates a wide range of determinants of satisfaction and emphasizes feedback loops between expectations and experiences (Crow, Gage, and Hampson, 2002).

Expectation theories: Satisfaction is based on the difference between what one expects and what occurs. Within the disconfirmation paradigm (Gottlieb, Grewal, and Brown, 1994), satisfaction is determined by the difference between a patient's standard of expectancies, ideals, or norms and the same patient's perceptions of their experiences of care, with satisfaction arising from either confirming positive expectation or disconfirming negative

expectations. A fourth type of expectation is labeled an uninformed expectation, in which patients are not capable or are reluctant to communicate their expectations, either because they may not have any expectations or because they do not wish to substantiate their feelings or cannot express them (Morales, 2001).

Given the potential for uninformed expectations, Crow notes that patients should be educated about appropriate expectations for care (particularly technical features) and motivated to judge the quality of care they are receiving (Crow, Gage, and Hampson, 2002).

Many studies of satisfaction subdivide their measures (or items) according to Donabedian's classic differentiation of structure, process, and outcome (Donabedian, 1980). Structure is the patient/consumer's rating of the physical environment and physical facilities in which the service occurs. Process measures address, for example, the patient's rating of interpersonal interactions with service personnel and of personnel with each other. Specific attributes include, for example, responsiveness, friendliness, empathy, courtesy, competence, and availability. Outcome-related measures or items ask about the patient's perception of the results of process, including symptom reduction or resolution, improvement in functioning, or resolution of underlying problems. It is with noting that Donabedian was attempting to subdivide criteria for assessing the quality of health care. His categorization has been very useful to various kinds of health professionals.

In economic terms, satisfaction is defined by the utility of a product or service that a person purchases for its utility-generating attributes (Rice, 1998). As in expectation theories, satisfaction depends on the difference between the experience of the actual utility and the utility the consumer expected. Different consumers have different preferences and therefore will purchase different products defined by a variety of characteristics.

Studies of patient satisfaction have contributed to our understanding of how patient perceptions affect the patient's own behavior. For example, studies have shown that patients who report being more satisfied with their care are more positive, more compliant and cooperative, and are more likely to participate in their treatment procedures (Bartlett, 2002; Brown, 2001).

However, there have also been critiques of the use of 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 an experience 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' perceptions either to identify better performers or to identify where improvements in quality are needed.

Furthermore, if satisfaction is, as Crow, Gage, and Hampson, (2002) state, an indicator simply of "acceptable" care, then how much do we learn about the quality of an enterprise when we find out that its customers are merely "satisfied" with it? As many have noted, patient satisfaction surveys are frequently prone to ceiling effects, which have the unfortunate consequence of making it difficult to distinguish those providing simply adequate services from those providing superior care (Rosenthal, and Shannon, 1997). In this context, it may be more important to know about the level of dissatisfaction (Coyle, and Williams, 1999).

In addition, many satisfaction surveys include global ratings of their patients' overall satisfaction with an experience of care, a health plan, or a provider. It appears to be cognitively difficult for some patients to give global ratings of satisfaction because their

experiences of care vary over time and across different providers. This has led many survey developers to shift their attention from ratings of satisfaction to reports of experiences.

As Epstein, Laine, Farber, Nelson, and Davidoff, (1996) note it may be more useful to ask patients about specific time periods and experiences with their care, documenting both reports of their care and the rating, or value that patients placed on that experience.

In studies of potential users of the patient survey results, lay people have reported that they prefer to know specific aspects of other patients' experiences, instead of their overall ratings of satisfaction, when they are choosing health care providers. For instance, they want to know how long patients waited to see their doctors, rather than "how satisfied" they were with the waiting times, since their need or expectation of care may differ from another patient's need (Edgman, and Cleary, 1996). Asking very specific questions may also minimize the subjectivity and the confounding of patient expectations and their ratings (Rosenthal, and Shannon, 1997).

The focus on patients as important evaluators of care has led to a burgeoning of studies and surveys examining patient satisfaction or experiences (Edwards, and Staniszevska, 2000; Aspinal, Addington-Hall, Hughes, and Higginson, 2003; Edwards, Staniszevska, and Crichton, 2003). However, the key limitation in this area has been the poor conceptual and theoretical development of the concept of patient satisfaction. While there have been some attempts to develop a theoretical understanding of what we are trying to measure in satisfaction (Strasser, Aharony, and Greenberger, 1993).

Concepts thought to have a key role in evaluation, such as 'expectations', 'needs' and 'wants', have not been explored in depth and are generally poorly developed and partially

understood (Staniszewska and Ahmed, 1999). This has hampered conceptual development because the basic building blocks of the evaluative process are not clear. In addition, as satisfaction surveys became more common, there has been increasing concern about the concept of satisfaction as accurately representing the process of evaluation (Staniszewska and Ahmed 1999, Edwards and Staniszewska 2000; Edwards, Staniszewska, and Crichton, 2003).

Some of these concerns have emerged because of the positive evaluations that satisfaction questions regularly produce; despite the reality that health care is unlikely to be quite so consistently perfect as suggested by many surveys. This has prompted the suggestion that some form of normative effect may be operating which appears to inhibit criticism, although this has not been extensively explored (Fitzpatrick, 1993). Despite these concerns, many 'first generation' satisfaction studies did not explore these areas of difficulty, but rather focused on establishing correlation relationships between expectations and satisfaction, tending to produce inconsistent findings (Staniszewska and Ahmed 1999).

Second generation of patient evaluation studies in response to growing concerns about satisfaction and our understanding of evaluation, a 'second generation' of studies has emerged that has started to explore patient evaluation in more depth (Williams and Coyle 1998; Coyle, 1999; Coyle, and Williams, 2000; Edwards, Staniszewska, and Crichton, 2003). This second generation of studies is characterized by work such as that by Edwards, Staniszewska, and Crichton, 2003, who explored the way in which patients construct their expressions of satisfaction using the phenomenological sociology of Alfred Schutz because of its emphasis on appreciating the 'natural attitude' of individuals, within which they interpret their experiences.

Individualized care, as seen from a patient point of view, can be evaluated from two different perspectives: by exploring patients' views on how they thought their individuality was supported through health caring interventions (Capezuti, Talerico, Cochran, Strumpf, and Evans, 1999; Suhonen, Valimaki, Leino-Kilpi, and Katajisto, 2004) and by examining how they perceived individuality in their own care (Radwin 2000; Suhonen, Valimaki, and Leino-Kilpi, 2004). Individualized care involves allowing the individuality of a patient to determine interpersonal approaches and staff interventions (Lauver, Ward, Heidrich, Keller, Bowers, Brennan, Kirchhoff, and Wells, 2002).

Because patients are different, a variety of interventions may promote individualized care (Radwin, 2000). Common themes in the individualized care have included the recognition of a patient's clinical situation, personal life situation, and decisional control over care (Suhonen, Valimaki, and Leino-Kilpi, 2000b).

Individualized care has a positive impact on patient outcomes (Stewart, Brown, Donner, McWhinney, Oates, Weston, and Jordan, 2000; Tate, Wing, and Winett, 2001, Frich, 2003) and has been found to increase patient satisfaction with nursing care (Dana, and Wambach, 2003; Frich, 2003; Ruggeri, Lasalvia, Bisoffi, Thornicroft, Vasquez, Becker, Knapp, Schene, and Tansella, 2003) and to improve patients' quality of life (Ward, Donovan, Owen, Grosen, and Serlin, 2000; Patti, Ciancio, Cacopardo, Reggio, Fiorilla, Palermo, Reggio, and Thompson, 2003). High levels of satisfaction have been reported among patients experiencing high levels of individualized care (Walsh, and Walsh, 1999; Frich, 2003; Ruggeri, Lasalvia, Bioffi, Thornicroft, Vasquez-Barquero, Becker, Knapp, and Schene, 2003).

Service satisfaction can be seen as a result of the perception of each patient that the care received has been tailored to their own problems (Ruggeri, Lasalvia, Bisoffi, Thornicroft,

Vasquez, Becker, Knapp, Schene, and Tansella, 2003). Among positive patient outcomes related to individualized interventions is improved quality of life related to health (Annells, Koch, and Brown, 2001).

Others have found an association between health related quality of life and perceptions of the severity of health problems showed that individually tailored information about pain management correlated with better overall quality of life. Health related quality of life measures a person's view of the meaning of health for their quality of life (Stewart, Brown, Donner, McWhinney, Oates, Weston, and Jordan, 2000), representing their individual responses to the physical, mental and social effects of illness on daily living (Bowling 1997).

Patient satisfaction is a concept partially driven by consumer demands for quality health care and accountability of health care services (O'Connell, Young, and Twigg, 1999; Oermann, Masserang, Maxey, and Lange, 2002). Its utility is based on the notion that, if patients are satisfied, they have in fact received good care. However, problematic this notion may be, a search of the health care literature reveals a multitude of references confirming that the concept is in common use. Interestingly, it is not often defined (Williams, Coyle, and Healy, 1998), but a notable exception is a paper by Strasser, and Aharony, (1993), who describe a comprehensive model of patient satisfaction that is organized around a theory of human judgment. They emphasize that patient satisfaction is a perceptual, multidimensional, relativistic, dynamic, patient-centered, attitudinal and individual process (Strasser, and Aharony, 1993).

In contrast, when a conceptual definition is not given, patient satisfaction is usually treated as a product. A health care institution strives to 'achieve' patient satisfaction, usually through responding to concerns raised by individual patient (Ashe, and Manzo, 2002).

Patient satisfaction is seen to have both practical and political relevance. Practically speaking, long waiting times and/or unsatisfactory relationships with health care professionals are potential barriers to seeking treatment and/or to individual treatment choices. Conversely, researchers have linked high levels of satisfaction with patient loyalty, treatment adherence and positive health outcome (Raper, Davis, and Scott, 1999).

In addition, patient satisfaction is used as a proxy measure of health care quality. Politically speaking, patient satisfaction – with an apparent emphasis on the viewpoint of individual patients – is a way to be responsive to the public, and the concept of patient satisfaction is often seen by health care professionals as a suitable vehicle for addressing the issues of both ‘people centered care’ and ‘doing the best that they can’ (Edwards & Staniszewska 2000, Nystrom, Dahlberg, and Carlsson, 2003) rather than from actual experiences of the care provided.

Also, patient satisfaction research is often non-specific. It can be difficult to separate the influence of nurse–patient interaction, physician–patient interaction, and the physical environment from each other when interpreting results. The most obvious result of lack of conceptual clarity and unresolved measurement challenges is that studies about patient satisfaction levels tend to generate lists of criteria/ items which administrators then take up and pass on to staff.

For example, in the case of, quality of nurse–patient relationships, which are thought to be a reliable predictor of high levels of patient satisfaction (Gotlieb 2002), nurses, may be told that these need improvement. This feedback focuses on individual behavior and may ignore systemic constraints on nursing practice such as workloads that do not allow sufficient time to develop relationships. This symptom-based approach falls short of dealing with the source of problems.

Humphrey, (1998) said under the title of consumer-driven health care: the world turned upside down, consumer-driven health care implies that consumers will have real power to make decisions that were previously made for them. It also implies that these will not be mindless decisions, that consumers will have access to, and take advantage of, useful information to make informed choices (Humphrey, 1998).

2.2 Definition of satisfaction

Disagreements about satisfaction not only surround the origins of satisfaction measurement and conceptual clarity, but also the meaning of satisfaction. Despite this lack of clarity and consensus, however, there is often assumed to be an underlying unity of the definition. This is evident in studies that do not define satisfaction or make reference to its conceptual uncertainty (Walsh and Walsh, 1998; Shipman, Payne, Hooper, and Dale, 2000).

Pascoe (1983) defined patient satisfaction as a general reaction of the recipient of health care in significant areas of structure, processes and outcome of his experiences with health services. This reaction is internal, singular and is expressed through observational changes in patient behavior.

According to Guzman, Sliepcevich and Lacey (1988), patient satisfaction is the result of their interactions with health care which, in part, determines the future use of health services they will make, as well as their compliance with their therapeutic treatment.

Petersen (1988) maintained that satisfaction is a general concept the patient has of the way is provided without the patient considering the result or the appropriateness of the care. According to Smith (1992), patient satisfaction is a combination of perceived needs, expectations and experiences of health care.

In the field of hospital health services, the most widely accepted definition is that, patient satisfaction with care is the degree of convergence between the expectations patients have of ideal care and their perception of the care they get. Robbins (1993) wrote that attitude is the (positive or negative) evaluation of facts, objects or people and it includes three elements; the cognitive, the emotional and the behavioral in contradiction to perception, which refers to the process of organization and interpretation of external stimuli with the aim to give purpose to the environment and which can be influenced by the attitudes of each individual.

Macran and Ross (1999) define client perspective as the following (1) a recognition that clients are individuals with their beliefs and values who make an active contribution to the therapeutic process; (2) this recognition is translated into action by allowing the individual nature of client experiences to be expressed in a way, which is unhindered by researchers' own beliefs and values; (3) this doesn't mean having clients complete rating scales or checklists about their feelings or expectations, but to undertake a collaborative approach, which allow clients to set the agenda for what is important and meaningful for them personally in therapy (Macran and Rose, 1999).

The concept of satisfaction can be categorized into several categories. It is all one agreed that, clients' satisfaction demonstrates that satisfaction judgments are influenced by both emotional responses and cognitive disconfirmation (Oliver, 1993).

Oliver (1993) defined satisfaction as "a summary of psychological state that results from the confirmation or non confirmation of expectations when compared to perceptions of a discrete episode of contact with an organization. Another approach to define the concept of satisfaction derives from two factors; outcome and process. The former approach emphasizes the results from consuming experience. The later one extended to the nation

that satisfaction involves states that not limited to mere satisfaction and can be described as a process (Oliver, 1993).

For these several points of view, client satisfaction with a retail establishment may be viewed as an individual's emotional and cognitive reaction to his or her evaluation of the total set of experiences realized from patronizing the retailer. Thus, the feeling of satisfaction arises when clients compare their perceptions of the performance of a product or service to both their desires and expectations (Kim, Kols and Muccheke, 1998).

No one standard definition of satisfaction was observed in the literature due to the fact that patient satisfaction is a multidimensional concept that is difficult to be accurately defined and measured (Anderson Maloney and Bread, 1998; Schomer and Kucukarslan, 1997; Staniszewska and Ahmed, 1999).

Staniszewska and Ahmed (1999) emphasized this saying that firstly, it is important to define and understand satisfaction and expectation, then theoretical modeling and valid instrument can be established. They added that few studies have defined and measured satisfaction within a theoretical model.

Satisfaction has been associated with need fulfillment (Wright, 1998); for example, should a patient need pain relief, yet not receive it, both the patient and their family may express dissatisfaction. This may also be the case where relatives' needs are unmet. The problem arises when there are disagreements between patients and their relatives regarding levels of satisfaction. This is especially so in hospital care, where families may be asked to act as representatives or proxies for patients in assessing satisfaction.

Proxy responses may, understandably, be biased towards the relative's perception of the care rather than the patient's, or indeed of the relative's views on their own experiences of

care. The use of retrospective proxy measures of satisfaction after bereavement may affect the type of information given and influence whether the information accurately reflects patient experience and service quality.

It has often been assumed that there is a relationship between satisfaction and the fulfillment of expectations. 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 refute the proposed link between expectations and satisfaction (Medigovich, Porock, Kristjanson, and Smith, 1999).

Staniszewska and Ahmed (1999) suggest that this inconsistency can be explained, at least in part, by the varied methodological approaches adopted to study the relationship between satisfaction and expectation fulfillment, and also by the different dimensions of expectations that have been used (Staniszewska and Ahmed, 1999).

Compounding these problems is the fact that expectation, like the concept of satisfaction, is difficult to define (Williams, Weinman, Dale, and Newman, 1995). It is, perhaps, unsurprising that findings of studies that attempt to establish the relationship between expectations and levels of satisfaction provide very different pictures.

Some have found that satisfaction levels were not affected by unmet expectations, while others have found that levels of satisfaction are directly related to meet expectations (Williams, Weinman, Dale, and Newman, 1995). If it is indeed the case that satisfaction levels are determined by fulfillment of expectations, then it is questionable whether satisfaction surveys actually highlight good quality care or whether they simply indicate a better experience than was expected. This may be the case, for example, when patients are moved between organizations that have different standards or philosophies of care.

Further, various factors may play a part, many of them external to the health care area, for example, ease of access to the hospital by public transport (Lecouturier, Jacoby, Bradshaw, Lovel, and Eccles, 1999).

Satisfaction surveys may, therefore, not measure satisfaction with services or care, but something else entirely. Until satisfaction has been defined and clarified, there can be no assurance that measurement tools and the studies using them are measuring satisfaction. It is difficult, therefore, legitimately to claim that these tools are satisfaction measures.

2.3 Theoretical Perspective

Very few attempts have been made to test out older theories or to develop new ones and proper attention has not been paid to the meaning of patient satisfaction (Linder-Pelz, 1982). Most theories which have been put forth to explain patient satisfaction come from or are based on motivation theories which have been developed and mainly used in the workplace.

Maslow's Hierarchy of needs: Maslow was the first theorist who connects the creation of the existence of people's perception with the maintenance of the classified needs (Maslow, 1943). He suggests that human needs are arranged in a series of levels, a hierarchy of important. Maslow identified eight innate needs, including the need to know and understand aesthetic needs and the need for transcendence. However, the hierarchy is usually shown as ranging through five main levels, from the lowest level physiological needs, through safety needs, love needs, and esteem needs to the need for self actualization at the highest level (Maslow, 1987).

The hierarchy is shown in form of a pyramid that explains the following needs; physiological needs, such as satisfaction of hunger, thirst, sex, and shelter. Security needs

include safety and security, freedom from pain or threat of physical attack, protection from danger or deprivation. Love needs refer to social needs; these include good relations with the environment, friendship, and fellowship, to love and to be loved. Esteem needs these include both self-respect involves the desire for self-confidence, strength, independence and freedom and achievement. Esteem of others involves reputation or prestige, status, recognition, attention and appreciation. Self-actualization needs, this is the development and realization of one's full potential (Mullin, 1999).

These needs vary from one individual to another; these are not considered as a rigid framework. The individuals' willingness to get a result and expectation of maintaining the result will push him to show the highest performance. Maslow's (1943) Hierarchy of needs expresses that all individuals have innate needs, which they will seek to satisfy according to priority system.

The two factor theory presented by Herzberg, Mausner and Snyderman, 1959 can, according to certain scientists, give a possible interpretation to the factors which lead patients to satisfaction or dissatisfaction (Altschul 1983; Bond and Thomas 1992).

Bond and Thomas (1992), applying Herzberg's theory to explain patient satisfaction with nursing services, contended that patients are satisfied when internal needs are met, such as the need for interpersonal relations, recognition and participation in decision making, while they become dissatisfied when the environmental factors and amenities which are not the right ones.

La Monica, Oberst, Madea and Wolf (1986), making a factor analysis with one of the classic patient satisfaction instruments, the Risser Scale (1975), identified a dissatisfaction

factor and drew the conclusion that satisfaction and dissatisfaction are not exact opposites of the same straight line, thus verifying in part Herzberg's theory.

The double meaning which Herzberg gave to satisfaction is found to be consistent with Juran's definition (1984) regarding quality as the lack of faults or errors (which lead to dissatisfaction) and responding to patient-client needs (which lead to satisfaction).

Oberst (1984) has also suggested that patients form two groups of expectations, the ideal ones, which one rarely finds in every day conditions, and one group of more realistic expectations which are taken into greater consideration the more the limitations increase. Also significant is the fact that almost all the researchers recognize that expectations are an important factor in the shaping of patient satisfaction.

Frequently, the concepts of patient satisfaction and patients' perceptions of quality are used alternatively while according to Oberst (1984), there is a difference between the two concepts. The term satisfaction has a different meaning for each individual, such as pleasure, trust, happiness, thus making any evaluation quite subjective. In the first research carried out, patient satisfaction was defined according to the omissions in care as perceived by the patients (Abdellah and Levine, 1957).

Donabedian (1980) urged that patient satisfaction is an opinion of the quality of care and represents specific elements of quality, which are mainly related to the expectations and values of the patient. According to Donabedian, Quality is simply an attribute that the technical and interpersonal aspects of medical care manifest in varying degrees. He provided criteria for what constitutes "good care", using the framework of structure (related to physical environment and facilities), process (related to interaction with service

personnel) and outcome (the result of the interaction). Donabedian developed seven attributes of health care quality:

- Efficacy, (the best result or benchmark for a particular diagnosis).
- Effectiveness, (ordinary medicine, or the industry average).
- Efficiency, (a measure of cost, or the less costly of two identically effective treatments).
- Optimality, (cost-benefit evaluation, or the point at which further resources do not add benefit).
- Acceptability, (adaptation of care to the wishes, expectations and values of patients and their families).
- Legitimacy, (the community's view of care).
- Equity, (the principle by which one determines what is just or fair in the distribution of care and its benefits among the members of a population).

The theme continues regarding the relationship between expectations and perception of service. Lytle and Mokwa 1992, maintain that service quality depends on two variables: expected service and perceived service. They further state that “A health care service product is a “bundle” of tangible and intangible benefits that satisfy patients' needs and wants.” Two research groups linked perceived service quality on the part of consumers to the level of employee satisfaction with work roles. Both groups maintain that such factors as job design, role clarity, and autonomy affect employee attitudes, which in turn affect patient experience in the institution. These observations emphasize the need to look beyond the immediate and obvious aspects of satisfaction and to consider other aspects, which affect patient perception of their experience (Lytle and Mokwa, 1992).

2.4 Quality of services and satisfaction

Providers consider increasing quality in health care to be “the right thing to do”. The revival of customer service occurred, in part, because service quality, as opposed to cost, distinguishes among health care institutions (Hudson, 1998). Secondly, involvement and satisfaction of the customer affect behavior.

Legnick-Hall (1996) developed a conceptual model of the consumer contribution to quality, which includes a description of the relationship of perceived quality to satisfaction, and the motivation to change behavior. This is of considerable importance if you consider the relationship between patient satisfaction and compliance with medical treatment plans. Researchers found a positive relationship between the patients’ feeling of satisfaction and compliance with respective medical regimes (Salimbene, 1999).

Third, as quality improves, expectations increase. According to Moore, and Schlegelmilch, (1994), as consumers become more quality conscious, service firms not only need to satisfy their expectations, but to exceed them (Moore, and Schlegelmilch, 1994).

The consequence of NOT meeting expectations received some attention. Researchers identify managing negative reactions, which come from unmet expectations, as a strategic method for ensuring patient satisfaction. Not to do so, is to lose market share and customer loyalty (Mittal, Vikas, and Baldasare, 1996).

Dube and Menon (1998) conducted further research on the relationships of negative emotions to reduced satisfaction. Leaders in the health care industry, therefore, need to anticipate patient expectations, and then develop health care services that will exceed them. The more pragmatic argument relates quality to increased market share and a stronger competitive edge.

Although different, satisfaction and service quality relate closely. Parsuraman, Zeithaml, and Berry (1988), suggest that service quality is similar in nature to an attitude. It is related, but not equivalent, to satisfaction. Cronin, Joseph and Taylor (1992), ask whether a provider's objective should be to have consumers who are merely "satisfied" or who consider the experience of their encounter as one which has achieved maximum levels of quality (Cronin, Joseph and Taylor, 1992). They suggest that:

- Service quality perceptions should be considered as long-term consumer attitudes.
- Satisfaction should be referred to as short-term, encounter-specific consumer judgments.

The literature indicates a positive relationship between service quality and patient satisfaction with hospital care and a willingness to return to the hospital, or even to recommend it to family or friends. According to Oswald, Sharon, Douglas, Turner Robin and Butler (1998), consumers cannot evaluate medical treatment per se, but must rely on attitudes toward caregivers and the facility itself in order to evaluate their experience. They maintain that there is a strong connection between health service quality perceptions and customer satisfaction (Oswald, Sharon, Douglas, Turner Robin and Butler, 1998).

2.5 Stability of patient definitions and ratings of quality

Patient ratings of the quality of the visit went up over time: 52% rated their overall care as excellent immediately post visit, 59% gave an excellent rating two weeks later, and 63% gave this rating three months later. Of greater interest, there was some change in the determinants of satisfaction, and of dissatisfaction, over these three points in time (Jackson, Chamberlin and Kroenke, 2001).

If patient definitions of quality are not stable over time, it will be difficult both to develop a health care system that patients perceive as high quality and to provide comparative quality information that is meaningful. However, we could find only one study that examined issues related to this. Jackson, Chamberlin and Kroenke (2001), studied 500 retired military patients who were walk-in patients seeing new physicians because of a symptom.

The researchers began by identifying the expectations and concerns of the patients prior to the visit; 98% articulated at least one specific pre-visit expectation, including a desire for an explanation of the cause of their symptoms (80%), a prescription (66%), information about the anticipated time for recovery (62%), a diagnostic test (56%), or a subspecialty referral (47%). Sixty-four percent were concerned that their symptom might represent a serious illness (Jackson, Chamberlin and Kroenke, 2001).

Multi-variate analysis revealed that 26% of the variance in immediate post visit satisfaction was determined by age (older patients were more likely to give a high satisfaction rating), better functional status, having no unmet expectations, and getting an explanation of symptom cause and likely duration. Two weeks later, predictors of satisfaction shifted. Those with a shorter symptom duration, whose symptoms had improved, who were less worried about having a serious illness, who felt the symptom had not lasted longer than expected and had not required another physician visit, and who reported having no unmet expectations, were more satisfied. These predictors were stable from two weeks to three months. Thus, initial satisfaction is linked to patient-physician interaction, whereas over time and distance from the interaction itself satisfaction shifts to the course and impact of the patient's symptoms (Jackson, Chamberlin and Kroenke, 2001).

2.6 Qualitative versus quantitative assessment methods?

A debate also surrounds whether qualitative or quantitative methods should be used to assess satisfaction. The methods adopted have to be determined by the research questions asked, but satisfaction data have been collected using a variety of methods ranging from interviews to self-administered questionnaires. However, the most common method of measuring satisfaction is with a closed-question format questionnaire (Dougall, Russell, Rubin, and Ling, 2000).

Questionnaires are relatively cheap and can be short and administered anonymously, but they must consider the topics under study and the participant group. In hospital care, where patients are often very frail and ill and families are emotionally distressed, patients may feel too ill and family members too upset to complete a questionnaire. Surveys can sometimes overlook the really important aspects of people's lives. This poses particular difficulties for serious cases and their relatives, who may wish to express feelings and thoughts about service provision from a holistic viewpoint. In order to avoid the reductionism associated with quantitative methods, qualitative methods have been proposed (Coyle and Williams, 2000; Dougall, Russell, Rubin, and Ling, 2000).

Adopting a qualitative approach can enable understanding of patients' frames of reference and ensure that their views are adequately represented. Qualitative methods can situate people's views on satisfaction within a wider context, but also have limitations. Face-to-face interviewing, for example, may inhibit honesty by patients or families for fear of repercussions, and may be time-consuming and draining for frail patients. To get the best from each approach and to avoid its limitations, it may be better to use a combination of methods.

There is little agreement on the choice of tools. Most studies use more than one satisfaction tool, and numerous assessment tools were identified in the papers reviewed.

Commonly, these tools are used as a basis upon which service- or study-specific tools can be built. Most satisfaction assessment tools are amended from the original to take account of the participant group and study setting (Dougall, Russell, Rubin, and Ling, 2000).

Other studies have developed satisfaction questionnaires based on pilot studies as part of a wider project. Many of the tools used were not satisfaction scales but symptom or quality of life scales, although the results were often discussed in terms of satisfaction. This may reflect the notion that satisfaction is Multidimensional and therefore their measurements have to be multifaceted.

Alternatively, it may show that those using the tools have not thought thoroughly about the issues surrounding measuring satisfaction. This highlights the need for further research to identify factors that influence satisfaction level and what individuals perceive satisfaction as meaning. It may also indicate the need for a systematic review of satisfaction measures and for a standardized measurement tool to be developed to allow cross-study comparisons.

The literature shows several approaches and different examples of instruments, which reflect the wide variety of dimensions of perception/satisfaction that were adopted by researchers who attempted to study and measure clients' perception in different health care settings. Approaches to measure satisfaction vary from short standardized questionnaire to structured and semi-structured interviews resulting in qualitative information. Questionnaire was preferred by several researchers as it saved time, and limited the interviewer effect. The use of administered questionnaire helps to achieve high response rate, and to facilitate the process of filling the questionnaire to illiterate respondents. Exit-interview questionnaire is known by its social desirability. It has no recall bias, in addition for being easy in administration and saving time.

Several studies have used previously tested instruments, while other researchers developed new ones for estimating the optimal level of care and service features. Validation of an instrument is an 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 (Fagerstrom, 2000).

A valid research instrument was developed by Gilleard and Reed (1998) to assess patients' satisfaction with nursing care. The researchers in their study described their attempt to validate and measure patients' satisfaction with nursing services in London. The instrument was derived from an earlier North American questionnaire, which assessed satisfaction with hospital nursing services. A sample of 269 elderly people who received the services and met the eligibility criteria, were interviewed by using four standard questionnaires. Researchers measured how valid was this interview based questionnaire in their assessment of satisfaction with the community nursing care, and also they measured how significant was the nurse-patient relationship in determining satisfaction with community nursing care (Gilleard and Reed, 1998).

The results of the study indicated that it is insensitive to assess the impact of services by using homogenous measures, due to several features, which might affect some patients but not the others. A multidimensional structure that emerged from the factor analysis supports the significance of patients' responses to the questionnaire. The results that assessed the role of nurse-patient relationship in determining patients' satisfaction showed that the personal domains of satisfaction, including concern, empathy, and neglect were

associated with personal knowledge, while this seems to have no influence in their judgment on professional aspect of care (Gilleard and Reed, 1998).

The relationship between satisfaction and expectation and the influence of this mixed relation on the content validity of the study is considered an important issue, which have been discussed in a qualitative study conducted by Staniszewska and Ahmad (1999) who urged that the expectation studies do not always rationalize the use of expectation items. They added that there are different types of patients who show different expectations, which hindering their content validity and lead to limitation of many expectation studies (Staniszewska and Ahmad, 1999).

Therefore to achieve the content validity, studies should provide rationale for using the expectation and to identify the special group of the patients. Staniszewska and Ahmed attempted in their study to explore the concepts of expectations and satisfaction by using in depth interviews to achieve detailed information and description from patient about their expectations before receiving the care and their experience after receiving the care. Also, they selected a particular patient group to achieve validity of data. A sample of 33 daycare cardiac patients were selected and interviewed twice, before and after receiving the care (Staniszewska and Ahmad, 1999).

Results of the first interview showed that cardiac patients were found to have specific expectations of their care, therefore, four main groups of expectations identified including: expectation of the nurse, the doctors, the patients own participating in care and of the outcomes of health care. During the second interview, patients evaluated their health care experience; they tended to describe their care by comparing what happened against their initial expectations.

Several satisfaction instruments were reported in the literature, but few were approved their validity as Hill (1997) mentioned. He denoted that the already developed instruments were used to measure satisfaction with care provided by either the physicians or by the nurses. Hill in his study mentioned that it is more appropriate to develop a new specific instrument to measure patient satisfaction in nurse-led rheumatology clinics, and to be used in both the medical and nursing clinics. Therefore, the Leed Satisfaction Questionnaire (LSQ) was developed to fulfill important criteria including easy completion, no too time consuming, sensitive to change, valid and reliable. LSQ shown to be both reliable (Chronbach's Alpha, 0.96) and stable (Test-re-test $r = 0.83$). Seventy patients were randomly assigned to either rheumatologist's or a nurse's clinic, and completed the LSQ on entry and on completion of the study. The results showed that at the start of the study both groups were satisfied with their care with no significance differences between them, while at week 48 there were significant increased satisfaction with access and continuity, but no change in overall satisfaction, also at week 48, nurse's patients showed to be significantly more satisfied than those of rheumatologist's (Hill, 1997).

A study conducted by Oltedal, Garratt, Bjertnaes, and Sachs (2007) to describe the development of a questionnaire designed for comparisons of patient experiences of hospital care within the Nordic countries. The results of testing for data quality, reliability, and validity are presented following a Norwegian survey. Methods: Following a literature review and consultation within an expert group six items were developed measuring patient experiences together with two items assessing global satisfaction and perception of incorrect treatment. The questions were included in a questionnaire that was mailed to 500 patients randomly selected from patients receiving inpatient treatment at a large university hospital in Norway. Principal component analysis was used to assess dimensionality. Reliability was assessed by the internal consistency and test-retest methods. Construct

validity was assessed by the scale's correlation with variables known to be related to patient experiences.

The six items in the questionnaire that measured important aspects of patient experiences with the services contributed to a single scale with item-total correlations in the range 0.59–0.71 and a Cronbach's alpha of 0.85. The test–retest interclass correlation was 0.88. The Nordic Patient Experience Questionnaire (NORPEQ) is a brief measure of patient experiences that covers important aspects of the healthcare encounter. It shows good evidence of reliability and validity and is relatively easy to apply alongside existing national surveys (Oltedal, Garratt, Bjertnaes, and Sachs, 2007).

2.7 Constructs of Perception/Satisfaction (dimensions)

Abu Shuaib (2005) conducted a study to assess women perception and experience of childbirth services at governmental hospitals in the Gaza Strip. A descriptive cross sectional design with a proportional random sample of women who had gave birth in the governmental hospitals at the time of the study was taken. An exit interview questionnaire was developed which concentrated on perspectives with childbirth services provided by health providers. The total sample was 450 women, 223 from the Shifa Hospital, 152 from Naser Hospital, 49 from the European Gaza Hospital, and 53 from Al-Aqsa Hospital. The researcher identified these dimensions of satisfaction, approach of women care, approach of baby care, counseling, attitude and respect, information and communication, decision participation, privacy and ward environment.

Jenkinson, Coulter, Bruster, Richards and Chandola (2002) conducted a study to determine what aspects of health care provision are most likely to influence satisfaction with care willingness to recommend hospital services to others and secondly, to explore the extent to

which satisfaction is a meaningful indicator of patient experience of healthcare services. The researchers identified these dimensions of satisfaction; information and education, coordination of care, physical comfort, emotional support, respect patient preferences, involvement of family/friends, and continuity of care.

Al-Doghaither (2004) conducted a study to assess inpatient satisfaction with physician services at King Khalid University Hospital in Saudi Arabia. The researcher identified these dimensions: admission and diagnosis, communication, and care of the patient.

Abu Salleek, (2004) conducted a study to assess the level of clients' satisfaction with nursing care provided at selected hospitals in Gaza Strip, and identified the major organizational and demographic variables. The researcher explored six dimensions of satisfaction with nursing care; information and interaction, availability/attentiveness and openness, Comfort and environment, nurses' skills and professionalism, organizational culture, counseling and advising.

Margolis, Al-Marzouqi, Revel and Reed (2003) conducted a study to evaluate the suitability of a patient satisfaction questionnaire to survey care consumers of traditional Arabic background in the United Arab Emirates. The researchers identifies these dimensions; accessibility, continuity, humaneness, comprehensiveness, health education, effectiveness of services.

Alasad and Ahmad (2003) conducted a study to examine patients' satisfaction with nursing care at a major teaching hospital in Jordan. The researchers identified these dimensions; respect of patients' values, coordination, integration and information flow, information and education, physical comfort, emotional support, involvement of family and friends, transition and a continuity.

A study was conducted by Abu Dayah (2000) to assess the level of satisfaction of Palestinian people of health services provided by the MoH clinic through exit interviews of the clients who seek medical services over one week period to select the desired sample. The selected sample composed of 1555 patients distributed between Gaza strip and West Bank (42.8% and 57.2% of the sample size respectively).

The researcher used a questionnaire of 5 points scale to choose the suitable answer by the clients. The domains of satisfaction that studied were; patient involvement in the plan of health care, appropriateness of humanness and respect of medical staff, overall satisfaction of staff humanness and reception, overall satisfaction of diagnosis procedures, overall satisfaction of method of medical treatment, easiness of services, appropriate constellation of services, overall satisfaction of clients' privacy and staff interest.

Another study conducted by Mousa (2000) presented some results related to client's satisfaction with family planning services in Gaza Strip in Palestine conducted that domains of satisfaction among Gaza family planning recipients includes attitudes and expectations, information and counseling, communication and interaction, mechanism of care and delivery of care. Also a study done in Palestine by Al Hindi (2002) explored the client satisfaction with radiology services in Gaza Strip. The researcher identified these dimensions of satisfaction, organizational culture, continuity and affordability, availability, communication and interaction, attitude and perception, comfort and privacy and approach of care (AL Hindi). Abu Saileek (2004) conducted a study to assess clients' satisfaction with nursing care provided at selected hospital in Gaza Strip, the researcher identified these dimensions of satisfaction, information and interaction, availability/attentiveness, comfort and environment, nurses' skills and professionalism, organizational culture and lastly counseling and advising.

2.8 Factors affecting patients' perception/satisfaction

When assessing service quality, it is important to be as sure as possible that the service, rather than external factors, determine data and results. To this end, demographic, socio-economic, and hospitalization data on research and audit participants are usually collected. This allows the relationship between demographic, socio-economic, and hospitalization variables and satisfaction levels to be understood within the context of the study. A multitude of studies has attempted to show how demographic, socio-economic, and hospitalization factors impact on levels of satisfaction, irrespective of service quality.

Some authors suggest that there is little or no correlation between demographic and socio-economic factors and satisfaction levels (Fox and Storms, 1981). Others, however, propose that demographic factors such as sex, socio-economic status, and age impact on satisfaction levels (Malacrida, Bettelini, Degrate, Martinez, Badia, Piazza, Vizzardi, Wullschleger, and Rapin, 1998; Welk and Smith, 1999). Fakhoury, McCarthy, and Addington (1997) and Lecouturier Jacoby, Bradshaw, Lovel, and Eccles (1999) showed that age is the most influential socio-demographic factor in satisfaction, and that older patients express higher levels of satisfaction (Fakhoury, McCarthy, and Addington, 1997; Lecouturier Jacoby, Bradshaw, Lovel, and Eccles, 1999). It is possible that this has less to do with characteristics of age per se, but that older people are treated better when receiving health care services than other age groups, or indeed that older people have lower expectations. Further research is needed to determine whether demographic variables influence levels of satisfaction.

The enduring difficulty of these studies is that it is rarely possible to determine if such systematic differences should be attributed to differences in patient expectations,

perceptions, or the actual care received. Further, the results of the research have often been inconsistent and contradictory.

These studies showed different results regarding the relation of patient perception to these variables (Abu Shuaib, 2005). One study was conducted by Jenkinson, Coulter, Bruster, Chandola, and Richards (2002) to determine what aspects of health care provision are most likely to influence satisfaction with care and willingness to recommend hospital services to others in five hospitals in Scotland. Questionnaires were mailed within one month of discharge to their home of patients aged 18 and over.

The patients were randomly selected from hospital information system stratified by provider unit, age, and sex. The questionnaire comprises 40 items which measure seven core dimensions: information and education, coordination of care, physical comfort, emotional support, respect for patient preferences, and involvement of family/friends and continuity of care. They used the standardized 5 point likert scale. The result showed that age and self-reported health status were often cited as major determinants of satisfaction (Jenkinson, Coulter, Bruster, Richards, and Chandola, 2002).

Jaipaul and Rosenthal (2003) conducted a study on patient satisfaction at thirty one hospitals in a large Midwestern metropolitan area in Iowa. The study aimed to determine relationship between age, self-reported health, and satisfaction in a large cohort of hospitalized patients. Patients' overall ratings of hospital quality and satisfaction with 5 aspects of care (physician care, nursing care, information provided, discharge instructions, and coordination of care) were measured by a validated survey, which was mailed to patients after discharged.

Analysis compared satisfaction in 5 groups (18-35, 36-50, 51-65, 66-80, and >80 years). Scores for the 5 aspects of care initially increased with age ($P < .001$) and then declined. A similar relationship was found in analyses of the proportion of patients who rated overall quality as "excellent" or "very good". Satisfaction was higher in patients with better self-reported health ($P > .001$). In analyses of patients with poor to fair health, satisfaction scores peaked at age 65 before declining. However, declines in satisfaction in older patients were lower in patients with better health. These findings were consistent in multivariable analyses adjusting for potential confounders. The results suggest that age and health status should be taken into account when interpreting patient satisfaction data (Jaipaul and Rosenthal, 2003).

In a study to compare patient satisfaction of male and female users of Veterans health administration services, Steven and his colleagues used mail questionnaire to survey 107,995 out patients and 112,817 inpatients in FY USA. Patient's rating of overall quality and unique dimensions of satisfaction, courtesy, education, emotional support, physical comfort, patient preference, sociodemographic and health-related patient attributes. Significant differences between female and male reporting of satisfaction were found in the unadjusted analysis with males showing greater level of satisfaction than female ($p < 0.05$). These differences disappeared or became smaller for both outpatient and inpatient services, after adjusting for covariates, for six of the inpatient dimensions (Transitions, Physical comfort, Involvement family and friends, Courtesy, Coordination and access) males had higher satisfaction than females after statistical adjustment (Steven, Thomas, Stacey, Jim, and Charles, 2006).

Alasad, and Ahmad, (2003), conducted a study to examine patients' satisfaction with nursing care at a major teaching hospital in Jordan. The study aimed to compare patient's

satisfaction with nursing care at major areas within the hospital. Therefore, 267 inpatients were invited to participate and 266 agreed. All patients were recruited from the medical, surgical and gynecological wards. Gender, educational level, and having other diseases were significant predictors for patients' satisfaction with nursing care. 19-items were scored on a five point likert scale (Alasad, and Ahmad, 2003).

John, Anne, and Autin (2001) conducted a study to develop a methodology suitable for assessing patients' perception of quality of care received in Irish hospitals nationwide. Therefore, thirteen acute care hospitals throughout Ireland participated in the study. Data was collected using computer aided telephone interview to receive and collate patient feedback. Patients' perceptions in a wide range of areas were examined including admission procedures, pain management, adherence to the patient charter medication and overall satisfaction.

A total of 3276 patients were randomly selected for interview and 1950 respondents yielded a response rate of 59.5%. The results showed that the respondents believed that more printed information should have been offered to them at the time of their admission. The majority of respondents (95.9) felt that they received the right amount of pain relief medication during their hospital stay. However, 49.6% of the respondents experienced delay before pain medication was administered. Some respondents would have welcomed more detailed information at discharge on how to continue with their unaware of a complain procedure in the hospital they attended. The majority of respondent (92.6%) reported that they would prefer to return to the same hospital (John, Anne and Autin, 2001).

Margolis, Marzouqi, Revel, and Reed (2003) conducted a study on patient satisfaction with primary health care services in the United Arab Emirates. The study aimed to evaluate the

suitability of a patient satisfaction questionnaire to survey health care consumers of traditional Arabic background. A cross sectional random sample survey using an Arabic language questionnaire that drew upon concepts of patient satisfaction measurement in Western research literature.

All participants were interviewed once by experienced interviewers to ascertain their level of satisfaction with their health care service. Six domains of patient satisfaction were measured; accessibility to services, continuity of care, humaneness of staff, comprehensiveness of care, provision of health education, and effectiveness of services. 39 items were scored using a five likert scale (strongly agree- strongly disagree).

There was no statistically significant relationship between the sexes, marital status, and transport mode for any of the domains of satisfaction. Age and education were statistically significant for the domains of comprehensiveness and effectiveness, respectively. Older people felt that the clinic services were more comprehensive than younger people, and people with higher levels of education felt that the clinic service was less effective than those who were less educated (Margolis, Marzouqi, Revel and Reed, 2003).

Muntlin, Gunningberg, and Carlsson (2005) conducted a study to identify patient's perception of quality of care at an emergency department and identification of areas for quality improvement at a university hospital in the middle of Sweden. The quality of patient's perspective questionnaire was developed from a Swedish qualitative study with a grounded theory approach. The questionnaire contains of a number of questions designed to measure factors in the following four dimensions: medical-technical competence, physical-technical conditions, identity-oriented approach and socio-cultural atmosphere. 200 respondents showed that the patients estimated quality of care at the emergency department as fairly good, but there were areas in need of improvement.

A high percent of inadequate quality was related to the environment in the emergency department. About 20% of patients reported that they did not receive effective pain relief. More than 20% estimated that nurses did not show an interest in their life situation and patients did not receive useful information on self-care and about which physician was responsible for their medical care (Muntlin, Gunningberg, and Carlsson, 2005).

Al-Doghaither (2004) conducted a study on inpatient satisfaction with physician services at King Khalid University Hospital, Riyadh, Saudi Arabia. The study aimed to assess inpatient satisfaction with physician services at King Khalid University Hospital. Therefore, 400 patients selected at random from the different wards in the hospital with probability proportional to the number of patients in the ward.

Data were obtained for 350 patients, a response rate of 88%. Data was collected using structured interview questionnaire that included 83 questions about the hospital service. The questionnaire was based on the 5-point standardized likert scale of patient satisfaction. The questions addressed three main components: admission and diagnosis; communication; and care of the patient. The results showed that the highest mean satisfaction score was for admission and diagnosis and the lowest for communication.

For communication, the highest mean score was for patient conditions, opinions and preferences, and the lowest for physicians inquiring about patient opinions of the provided quality of care. Females were more satisfied than males. Education, marital status and age were significantly related to satisfaction with physician-led services. Those with more education were less satisfied than those with less education. Also, patients 50 years and more were more satisfied than younger patients. Married patients were more satisfied than single patients. The high income group was less satisfied than others (Al-Doghaither, 2004).

Anastasios, Elizabeth, and Chryssoula (2003) conducted a study on evaluation of patient satisfaction with nursing care: qualitative and quantitative approach. The study aimed to assess the results, along with the feasibility, applicability and relative merits of paradigm triangulation in the field of nursing care quality for that; a sample consisted of 200 randomly selected inpatient from two large Greek Metropolitan Hospitals.

Collection of quantitative and qualitative data was carried out sequentially by face to face interviews. The instrument was consisted from two part. The first part of the interview a valid likert scale questionnaire exploring six dimensions of patient satisfaction: technical aspect of care-response to patients' demands, delivery of information and education, interpersonal relationship, maintenance of restful atmosphere, cleanliness, and hospital meals.

This was followed by a structure interview with open ended questions to explore the same areas of patient satisfaction. The results showed that highest ratings of satisfaction were assigned to the technical aspects care and to nurses' response to patients' demands, whilst information delivery items were associated with the lowest ratings. Also, participants were more satisfied with the skillfulness, punctuality and continuity of care and less satisfied with patient education and orientation they received on admission (Anastasios, Elizabeth, and Chryssoula, 2003).

Nguyen Thi, Briancon, Empereur and Guillernin (2002) conducted a study on factors determining inpatient satisfaction with care at Nancy University Hospital center in France. The aim of the study was to identify factors associated with satisfaction among inpatients receiving medical or surgical care for cardiovascular, respiratory, urinary and locomotors system diseases.

Patients eligible for screening were adults aged 18-80 years old, stayed more than 3 days and were discharged to their home. Data were collected by using the Patient Judgment of Hospital Quality questionnaire of 106 items. The results showed that respondents with respiratory disease (31.3%), cardiovascular diseases (22.1%), urinary diseases (15.8%) and locomotor's system diseases (30.8%) and total of 77% were admitted to medical services. Mean age of subjects was 56.2 years, and 63% were male. Forty seven percent were educated to below high school level, 42% had a high school education and 11% had received college or graduate diplomas.

One third of patients chose their hospital, most commonly on the basis of its reputation. Patients who did not choose the hospital themselves complained almost twice as often about their hospital stay as those who did. Also, younger patients and those with poor self perceived health status at admission tended to complain more often (Nguyen Thi, Briancon, Empereur and Guillernin 2002).

Schmidt (2003) conducted a study on patients' perceptions of nursing care in the hospital setting. The aim of the study was to discover patients' perceptions of the nursing care they receive in the hospital sitting at academic medical center located in the south-eastern United States of America. Data was collected from eight participants during an interview.

Patients were asked to describe their most recent nursing care experience and subsequently probed about aspects of their nursing care that they found to be good and those they considered to need improvement. The results showed that patients entered the nursing care situation expecting to be treated as unique individuals. Patients expected to be known by more than their diagnosis and expected the nursing staff to treat them as a person (Schmidt, 2003).

2.9 Patients satisfaction in Palestine

The MOH had been, since the Oslo Agreement, the major provider of "free care" in the Territories. It carried also the major responsibility towards promoting and protecting the health and well being of the population. Despite the large aid assistance, the MOH and the entire sector was suffering from financial crisis. The deepening of the political crisis and subsequent economic recession meant a decrease in real term of the MOH budget. It was difficult to satisfy the raising demand for free health care services (Abed, March, 2007).

Palestinian population have a tendency to score their satisfaction regarding specific items favorably, despite the problems encountered, and the real situation inside the health facilities and they are always complain about the services provided for them. Many studies were done to assess the Palestinian level of satisfaction about the health services by international organizations and Palestinian researchers.

Palestine Research Unit (PRU) of the Graduate Institute of Development Studies of the University of Geneva since the outbreak of the second Intifada in September 2000, on the impact of local and international aid on the living conditions of the civilian population in the Occupied Palestinian Territories (OPT) conducted a study to be of use to the Palestinian Authority, many UN and other international agencies, as well as local NGOs as the findings provide a wider picture of Palestinian public perceptions on their living conditions. The results show that the main reason that The Palestinian respondents chose their health facility is because that facility is free or cheaper than others (42%).

The second reason influencing the choice of the health facility is distance or because it is the only one available (23%), followed by trust in the quality of services (18%) and the availability of drugs (6%). The remaining reasons for choosing a health facility, such as

the short waiting time (4%), the humanity of the caretakers (2%) or the gender of the physician (2%). Also the finding revealed that 66% of the respondents stated that they or their household members have benefited from hospital services in the past six months, 74% used medication, 44% made use of primary health care services, 8% benefited from physical rehabilitation, 13% from specialized care, and 20% from ambulances.

Moreover, the results revealed that the level of satisfaction among beneficiaries of hospital services was 71% of the respondents were satisfied, while 29% were dissatisfied. As for the providers of hospital services, in general, 71% of the respondents stated that this service had been provided to them by the Palestinian Authority (PA), 13% referred to UNRWA as their provider, while 6% specified that local NGOs were their providers of hospital services (Bocco, Brunner, Daneels, Al-Husseini, Lapeyre, And Rabah, 2004).

Another study was conducted by Al Hindi (2002) to assess the degree of satisfaction among clients seeking radiology services at Al-Shifa hospital and at Gaza Diagnostic Center, the researcher reported that the overall satisfaction level 82.5% as expressed by the clients who used radiology services (Al Hindi, 2002).

Abu Shuaib (2005) conducted a study in governmental hospitals in Gaza strip to examine women's perceptions of childbirth services, the result showed that the overall perception level was 70% at the governmental hospitals. Abu Shuaib attributed the high level of perception to the social and cultural factors of the Palestinian society which made the women appraise the services even they were not satisfied, also due to the economical and political situation which lowered the level of expectation of the Palestinian women (Abu Shuaib, 2005).

In his study to measure the level of clients' satisfaction with nursing care in the two major and biggest governmental hospitals in the south of Gaza Strip, EGH and Nasser Hospital in Khanyounis governorate, the result showed that the satisfaction level was 70.1% in both hospitals. Abu Saileek attributed the high level of satisfaction to the cultural and political factors, which might have an impact on their expectations and have resulted in the revealed the level of satisfaction (Abu Saileek, 2003).

Abu Dayya (2000) conducted a study in the GS and WB, which investigated the Palestinian's satisfaction with health services provided by MoH, the findings showed that 61.9% of the clients' showed high level of satisfaction with health services as overall. Abu Dayya attributed the high level of satisfaction of Palestinian people to the low expectations with regard to the difficult political and socioeconomic situation of the Palestinian National Authority in general and MoH specifically (Abu Dayya, 2000).

Mousa (2000) conducted a study in the Gaza Strip to assess the level of client's satisfaction with family planning services at UNRWA and MoH clinics, the researcher reported that overall satisfaction as expressed by the Palestinian women was 72% (Mousa, 2000).

Although, the researchers found moderate to high level of satisfaction, the available evidence suggests that patient satisfaction with Palestinian health care system is low. Patients generally regard health care services in Palestine as inferior and seek care in Egypt, Jordan, Israel, and elsewhere.

Chapter Three

Conceptual framework

Chapter 3

Conceptual Framework

To evaluate and improve the quality of services provided, it is of vital importance to investigate the quality of hospital service. Patient perception is a significant indicator of the quality of hospital service. Consequently, quality work includes investigations that map out patient perception with hospital services. To improve the quality of hospital services, the hospital staff needs to know what factors influence patient perception. The aim of this literature study was to describe the influences on patient perception with regard to hospital services in the context of services provided at the EGH. The review of the literature helps the researcher to take the following domains affecting client perception:

- **Respect and privacy:**

This refers to the standard of respect and concern about the patient and his family. Also, unit arrangement and preparation provides privacy and freedom. Patient's confidence on the hospital staff and how patients view the hospital staff.

- **Approach of care:**

Approach of care refers to the advice the health service provider gave and how they perform their work. The feeling of the patient towards the hospital staff, the standard of care, how the staff carry out the procedures, if medication were given on time. Also, it refers to the availability of the staff in the ward if needed.

- **Information and Communication**

Information and communication refers to information and explanation which were given to the patient about the procedures, tests, his/her condition and about the daily routine. Moreover, it refers to the degree of involvement of the patient in the decisions about his care.

- **Hotel services:**

Hotel services refer to the surrounding physical environment which include cleanliness, food, sound level, fellow patients and the comfort and aesthetics of the premises. Also it refers to patient's needs e.g. the need for clean clothes, good room temperature, a clean bed and tasty food.

- **Hospital culture:**

The way hospital staff acts with the patients and the time were taken to respond to patient call. Also, if the patients were treated equally and if there were delays during the admission process.

- **Meeting expectations:**

Meeting expectations refer to the respect of the patient's need for pain relief, if the patient receives the type of services which he expected and if the hospital staff respected the patient as a person.

Patients' perception was determined by their expectations regarding the hospital service they supposed to receive and by their perception about the service previously received. These two subjective factors were crucial for the patient's perception of being satisfied or dissatisfied. Also, there are several factors which will influence the patient expectations both before and during care. Moreover, these factors will affect on the dimensions of patients' perception. **These factors are:**

- 1. Demographic factors:**

Perception could be affected by age, gender, marital status, place of living, citizenship and educational level, all of these demographic factors could affect perception and life expectation.

- 2. Socio-economic factors:**

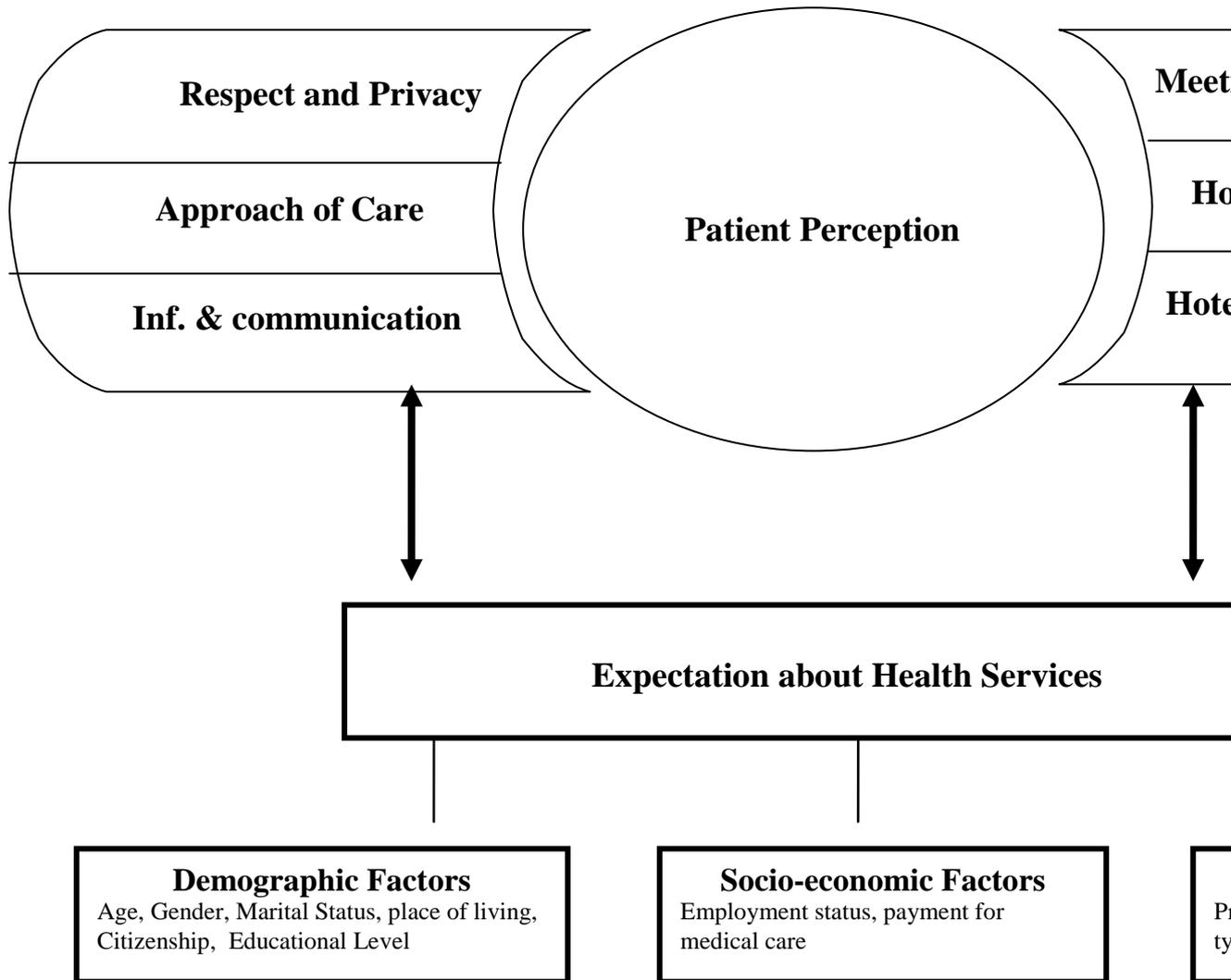
Current employment status and health insurance scheme could also affect perception.

- 3. Hospital admission related factors:**

Number of previous admissions, number of admission days and type of admission and ward of admission also affect client's expectation.

The patient makes a continuous subjective evaluation of these domains, resulting in a perception of hospital health services. This perception is then reflected in new expectations within the different domains. As diagram shows, it is the positive or negative perception with health services that forms the basis for the patient's expectations prior to the next hospitalization. This literature study primarily illuminates patients' perception about the health services provided at the EGH.

Diagram illustrate hospitalized patients' perception about the Health services provided at the EGH



Chapter Four

Methodology

Chapter 4

Methodology

4.1 Study design

The design of this study is cross sectional one. It has been selected because this method would be useful for descriptive and analytical analysis of study constructs, like perspectives, perceptions, experiences and satisfaction. It enables the researchers to meet the study objectives in a short time and low cost. This type of studies examines the association between cause and effect at a point of time. In general, cross sectional studies are economical, easy manage and quick (Polit and Hungler, 1999).

4.2 Study population

The study population in this research was the patients who were adults aged above 18 years, admitted to one of the medical or surgical wards of the EGH during the implementation of the study from October 15, 2007 to December 15, 2007, stayed more than 2 days and discharged to their home.

4.3 Setting of the study

The study was conducted at the EGH. It is a governmental hospital in the Gaza Strip, which provides secondary and tertiary medical and surgical services for pediatrics and adults of the GS population.

4.4 Period of the study

The study was conducted in the third quarter of the year 2007. Ethical letter was sent to the General Director of MOH in July 2007. Then, the pilot study was conducted in the

first half of October, 2007. Actual data were collected from October 15, 2007 till the December 15, 2007. Then, the questionnaires were checked out for completeness, then coding and entering onto the computer within the end of December. Data analysis was completed by the end of January. In general, the study took nine months from it starting date.

4.5 Study subjects

A total of 375 eligible patients were taken who were discharged from the medical and surgical wards after more than two nights of admission and this included all admitted patients who met the inclusion criteria.

4.6 Eligibility criteria

4.6.11 Inclusion criteria:

The target population consisted of:

- Patients who were discharged to home from the hospital after at least three days of admission.
- Patients who had received care on an adult medical and surgical ward at the EGH.
- Patients who were able to answer the questionnaire independently.
- Patients whose age were 18 years and older.
- Oriented to person, time and place.

4.6.2 Exclusion criteria:

- Patients, who transferred to the ICU or other hospital during the period of the study.
- Patient who died during the period of the study.

- Patient in bad condition, unconscious, mentally unstable and not capable of verbal communication.
- Patient who was receiving pharmaceutical agents potentially affecting their level of consciousness and younger than 18 years of age.

4.7 Ethical consideration

Participants in the study received a complete explanation about the research purposes, consent form was obtained from each participant in the study (Annex 1). The researcher maintained throughout the research an adherence and commitment to the ethical principles developed by Helsinki Declaration. Ethical approval to carry out the study was obtained from the Helsinki Committee in the Gaza Strip (Annex 2). Also an official letter of request was obtained from MOH the Director General to conduct the study in the EGH (Annex 3). To encourage maximum participation, confidentiality of the information was maintained at all times during the study.

4.8 Construction of the questionnaire

The instrument used in this study was a structured questionnaire (Annex 4 English and Annex 5 Arabic). The researcher constructed the questionnaire based on the review of the literature, his observations and personal experiences in health services provided at the hospital sector. The questionnaire consisted of two sections and took approximately 20 minutes to complete. The first section explored the patient perceptions and satisfaction with the health services, it consisted of 80 items that reflected all the services features, it was developed mainly using 5-point likert scale format, also it included open ended questions, in which the patients encouraged to expand on their answers and to give any additional comments. The second section, sixteen items explored the requested

information on demographic, socioeconomic profile of the patients and hospitalization variables.

4.9 Pilot study

A pilot study was conducted to determine whether the study was feasible or not and to identify possible problems in the design, examine the reliability, validity and suitability of the instrument (Burns and Grove, 1997). The instrument was piloted using a sample of 20 clients from EGH. In the piloting process, the researcher found some statements that needed rephrasing and some words needed corrections. Results from the pilot study pointed that the questionnaire would provide the needed data to meet the purpose of the study. The pilot subjects were excluded from the study.

4.10 Data collection

The data was collected by the researcher himself and an assistant. The assistant was graduated from a nursing collage, trained and prepared well on how to interview patients, filling questionnaire and clarification of the instrument item by item were provided. Collection of quantitative and qualitative data was carried out sequentially by face-to-face interviews. Obtaining of informed consent preceded the interviews. After proper introduction, the interviewer stated the research purpose; confirmed the anonymity and confidentiality of data, as well as the lack of risks and the benefits from the study; informed patients about their right to withdraw or to refuse participation; explained the procedures; and finally obtained a written informed consent.

4.11 Data entry

Over viewing of the questionnaires was the first step prior to data entry. This step followed by designing an entry model using the computer Software Statistical Package for Social Sciences (SPSS) version 12. Then the coded variables entered into the computer by the researcher. Data cleaning is done through checking out a number of the questionnaires and through exploring descriptive statistics frequencies for all variables. All suspected or missed values were checked by revising the available questionnaire.

4.12 Data analysis

In data analysis, many different statistical tests were used, through frequency of the study factors, description of the study population. Frequency Tabulation, Bar Chart and Pie Chart were used to disseminate the study factors. Then that was followed by testing reliability and validity of the instrument. After that, advanced statistical analyses were conducted to explore the potential relationships between variables. Therefore, an Independent t-test and One Way ANOVA (include scheffe- Post Hoc test) tests were carried out to investigate the relationships between the independent study variables with the total and sub-scores of the perception level.

4.13 Reliability

The technique of measuring variables must be reliable as this reflects the extent to which an operational definition, questionnaire, test, interview schedule or other instruments is stable and consistent (Mark, 1996). So, a measure is reliable if it gives the same results each time the situation or the factor is measured. The total instrument reliability test was high as 86%. Reliability is concerned with how consistently the measurement technique measures the concept of interest (Burns and Grove, 1997). A strong correlation among the items may imply strong links between the items and latent variables. The classic approach

is to generate such scales following an exploratory or confirmatory approach (Factor analysis) and then to determine the Cronbach Alpha reliability coefficient as a measure of internal consistency of a scale. In general, values more than 0.7 is considered acceptable (Table 4.1).

Table 4.1: Factors sub-scales reliability estimates

Factor No.	Factor name (Domain)	No. of cases	No. of items	Cronbach's Alpha
1.	Respect and privacy	333	10	0.8832
2.	Approach of care	333	14	0.9032
3.	Information and communication	333	14	0.9074
4.	Hotel services	333	10	0.8555
5.	Hospital culture	333	10	0.7243
6.	Meeting expectation	333	9	0.8650
7.	Overall perception	333	67	0.8564

4.14 Validity

Validity of an instrument is considered to be an important issue that have been discussed and stressed out by many researchers. Validity is defined as "the extent to which a measuring instrument measures what it is supposed to measure" (Mark, 1996). In fact, when instruments measure what they are designed for, this considered to be of great importance for their reliability and this start with conceptual relevance and simplicity of the instrument (Fagerstorm, Rainio, Rauhala, and Nojonen, 2000). Three types of validity evidence were frequently discussed in the literature. They are face validity content and construct related validity evidence.

4.15 Content validity

Content validity is defined as the extent to which a test reflects the variable it seeks to measure (Burns and Grove, 1997). So that content validity conducted before data collection and measured in the form of expert estimates of the relevance, clarity and completeness. Therefore, content validity is a subjective estimate of measurement rather than statistical analysis and applied to all relevant parts of the measured area. For that the researcher sent the instrument including items, dimensions and operational definitions, research questions to ten different experts including academics, researchers and managers in the field. They were asked to estimate the relevance, clarity completeness of each item. Criteria of 80% acceptance among experts were used. As a result, some questions were modified, others were deleted and the rest showed relevance and an adequacy.

4.16 Construct validity

Construct validity examines the fit between the conceptual definitions and operational definition of variables (Burns and Groves, 1997). In other words, construct validity describes how well the instrument is operationalized and quantified (Fagerstorm, 2000).

So from construct point of view, the valid instrument has the ability to measure the hypothetical construct. The researcher evaluated the construct validity of this study by using factor analysis. The scale items were subjected to a principal components factor analysis. The rotation method was Varimax with Kaiser Normalization and all factors possessed an Eigenvalue equal 1.0. Eigenvalue and factor loading of 0.4 was used as a cutoff point of elimination items. This method is the most accurate, common and suitable for attitudinal research study (Polit and Hungler, 1999).

As a result of factor analysis, six factors were emerged and included respect and privacy, approach of care, information and communication, hotel services, hospital culture and meeting expectation. These factors represented 48.68% of the total amount of variance. More detailed discussion about that will be presented in the next chapter.

4.17 Response rate

According to the eligibility criteria, the researcher selected 375 patients to participate in this study. The total number of 333 patients agree to participate in this study, which represented 88.8% of the study population and 42 patients refused to participate, which represented 11.2% of the population. The high response rate could be attributed to the approach utilized by the researcher. Furthermore, the interviewing questionnaires usually result in higher response rate (Burns and Grove, 1997).

4.18 Limitation of the study

The researcher abilities and position in the hospital gave him the chance to face minimal limitations. This has been reflected in the high response rate and the high validity and reliability of the study. However, the following limitations were met:

1. Lack of relevant resources as references.
2. Time limitation.
3. The political situation during the period of data collection.
4. The research deals with different group of clients especially the elderly.
5. The bad economical situation of the majority of the population during the implementation of the study might have effect on the expectation and perception level.
6. The frequent cutoff the electricity supply.

Chapter Five

Results

Chapter 5

Results

5.1 Introduction

This chapter presents the results of statistical analysis of the data. Descriptive analysis presents the demographic characteristics of the respondents in the EGH. In addition, findings of factor analysis identified the main dimensions of patients' perception with hospital health services at EGH. Moreover, the differences between the selected variables and general perception scores and with sub-scales were explored by using different analytical statistical tests and presented as detailed below.

5.2 Descriptive analysis

5.2.1 Demographic and socio-economic characteristics:

Table 5.1, summarizes important variables that were found in this study; gender, age, marital status, place of living, citizenship, residency, level of education and employment status. Regarding the gender, males represented 50.2% (167) of the respondents and females represented 49.8% (166).

The mean age was 42 years and the standard deviation was 17 years. The highest age group was lower than 31 years and represented 34.8%, while the second highest age group was 31-50 years, which represented 34% of the study population, while the third highest age group was more than 60 years, which represented 17% of the study population. The remaining percentage was that age group 51-60 years and represented 14% (Figure 5.1).

Table 5.1: Demographic and socioeconomic characteristics of the study population

	Variables	Frequency	%
Gender	Male	167	50.2
	Female	166	49.8
Age	18-30	116	34.8
	31-50	114	34.2
	51-60	47	14.1
	>60	56	16.8
Marital status	Married	222	66.7
	Unmarried	111	33.3
Place of living	Rafah Governorate	159	47.7
	Khanyounis Governorate	141	42.3
	Gaza, Mid zone and north Gov.	33	9.9
Citizenship	Refugee	230	69.1
	Not-refugee	103	30.9
Residency	Inside camp	199	59.8
	Outside camp	134	40.2
Education level	Illiterate	85	19.5
	Preparatory	46	13.8
	Prep	56	16.8
	Secondary	93	27.9
	University	73	21.9
Current employment status	Employed	84	25.2
	Not employed	249	74.8

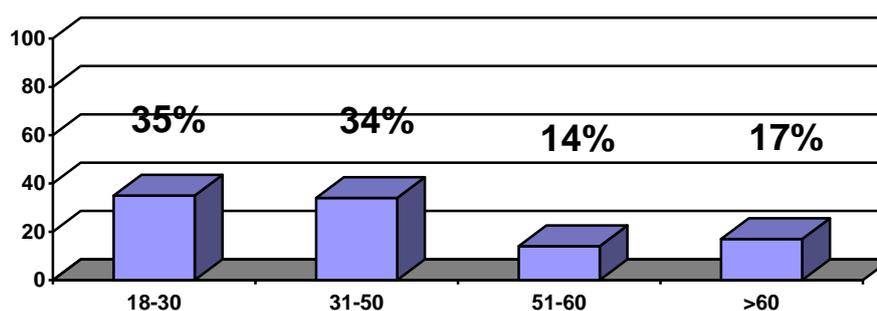


Figure 5.1: Distribution of study population by age group

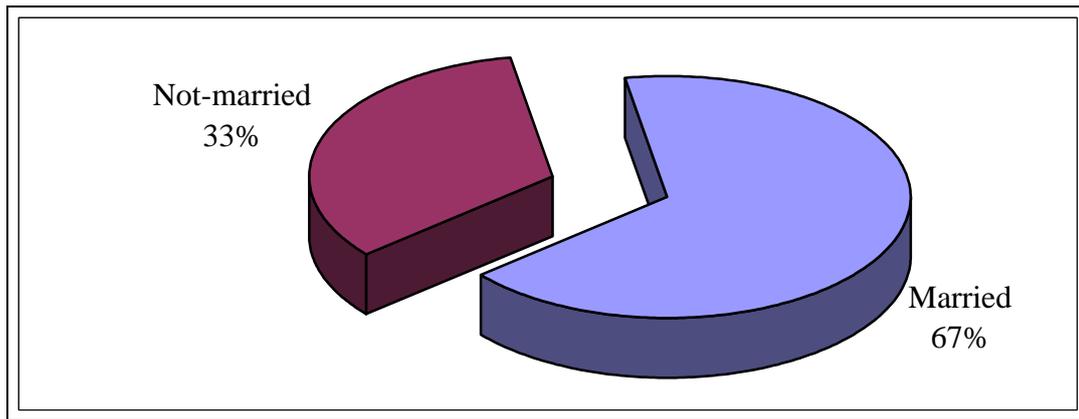
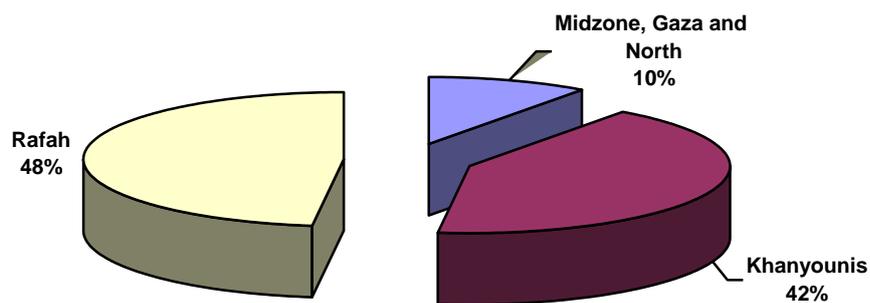


Figure 5.2: Distribution of study population by the marital status

Regarding the marital status, the respondents who were married showed higher percentage, which represented 66.7% of the subjects, while the unmarried represented 33.3% of the study population (Figure 5.2).

Figure 5.3 illustrates that, 47.7% were living in Rafah Governorate, 42.3% were living in Khanyounis Governorate and 9.9% were living in Mid zone, Gaza and north Governorates combined. The majority of the study population 90% from the south of Gaza strip (Figure 5.3).



Fig

ure 5.3: Distribution of study population by place of living

As shown in Table 5.1 the majority (69%) of the study population were refugees and 31% of the subjects were citizens. This goes with the PCBS normal distribution of the Palestinian population in Gaza Strip.

Gaza Strip has two types of residency; people who live inside camps and represented 59.8% of the study population and others who live outside camps such as cities, villages and represented 40.2% of the study population (Table 5.1).

As shown in Figure 5.4, 28% of the study population have had attained secondary education, 22% of the study population have received Diploma or University education, followed by illiterate which represented 20% of the population, followed by 17% of the population have received preparatory school, lastly, 14% of the study population have received elementary educational level. The mean years of education were 9 years and the SD. 5.6 years (Figure 5.4).

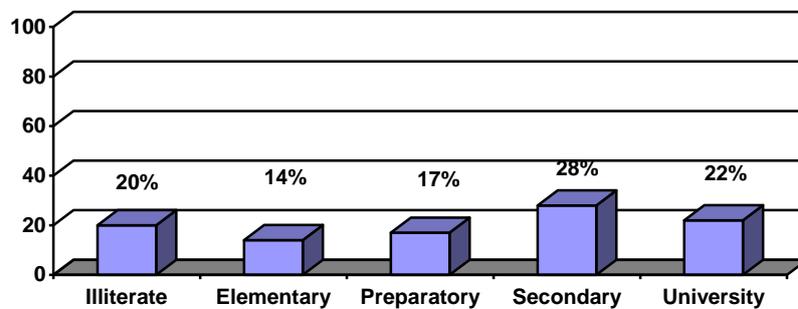


Figure 5.4: Distribution of study population by educational level

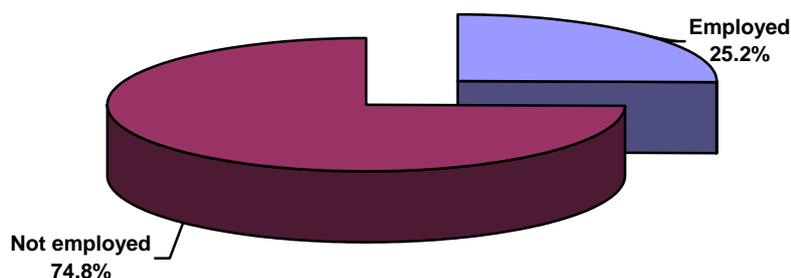


Figure 5.5:

Figure 5.5: Distribution of study population by employment status

Regarding the employment status, the majority of the study population was unemployed or students, which represented 74.8% and the remaining 25.2%, were employed (Figure 5.5).

5.2.2 Hospital admission related factors

Table 5.2: Distribution of subjects by hospital admission related factors and patient health status variables

Variables		Frequency	%
Health Insurance Scheme	Government H. Insurance	136	40.8
	Syndicate H. Insurance	114	34.2
	Private H. Insurance	83	25
Number of admission	First admission	184	55.3
	More than one admission	149	44.7
Admission days	3 days	156	46.8
	4-6	63	18.9
	7-9	60	18
	>9 days	54	16.2
Type of admission	Emergency	239	71.8
	Planned	94	28.2
Admission ward	Surgical ward	183	55
	Medical ward	150	45
Patients health status on discharge	Excellent	33	6.9
	Very good	134	40.2
	Good	158	47.4
	Fair/Poor	18	5.4
Rate of hospital services	Excellent	58	17.4
	Very good	117	35.1
	Good	147	44.1
	Fair/Poor	11	3.3

Regarding health insurance scheme for health services, the results showed high percentage of respondents who were government insured (40.8%), also, syndicate health insurance was 34.2%, while private health insurance were 25% (Figure 5.6).

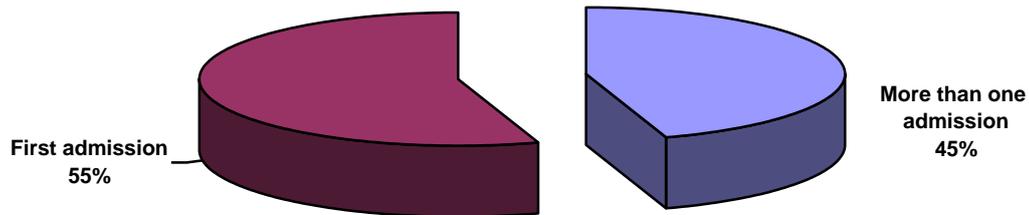


Figure (5.6): Distribution of study population by number of admissions

As shown in Figure 5.6, for 55.3% of the study population, it was the first admission at the EGH, while for 44.7% of the study population it was not the first admission.

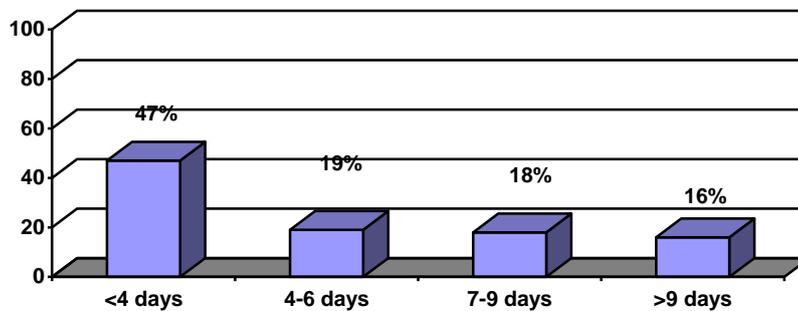


Figure 5.7: Distribution of study population by the number of admission's days

As shown in Figure 5.7, 47% of the subjects were admitted for three days, 19% of subjects were admitted for 4-6 days, while 18% of the study population was admitted for 7-9 days and lastly 16% were admitted for more than 9 days. The mean of admission's days was 6.3 and std. deviation was 4.8.

As shown in Table 5.2, the respondents who were admitted to the surgical ward represented 55%, while the respondents who were admitted to medical wards represented 45%. In regard to the health status of the study population, the study revealed that the majority of the population perceived their health status as good and very good (87.6%). Also, 6.9% of the study population perceived their health status as excellent, while the minority considered their health status as either fair or poor (5.4%) (Table 5.2).

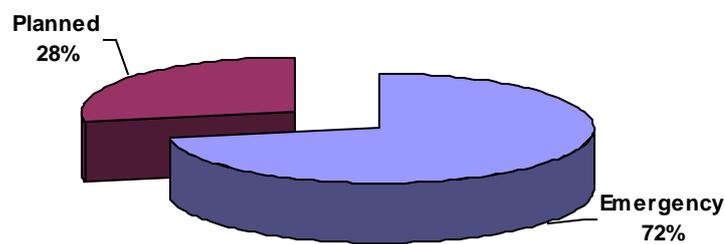


Figure 5.8: Distribution of study population according to the type of admission

As shown in Figure 5.8; the majority of the study population were admitted as emergency cases, which represented 71.8%. The rest of the subjects were admitted as planned (outpatient clinic) cases (Figure 5.8).

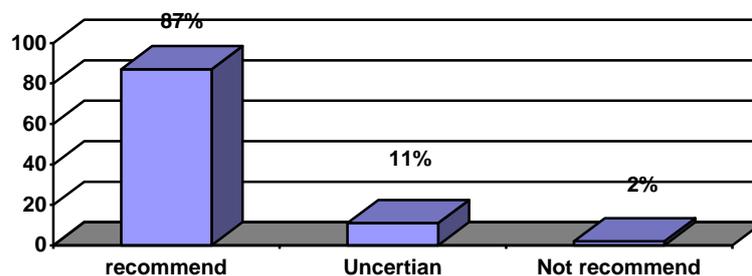


Figure 5.9: Distribution of study population by recommending the European hospital to others

As shown in Figure 5.9, 87.1% of the respondents will recommend this hospital to family and friends. Also, 11.2% of the respondents were uncertain about their decision, while 1.5% of the subject would not recommend the EGH for others.

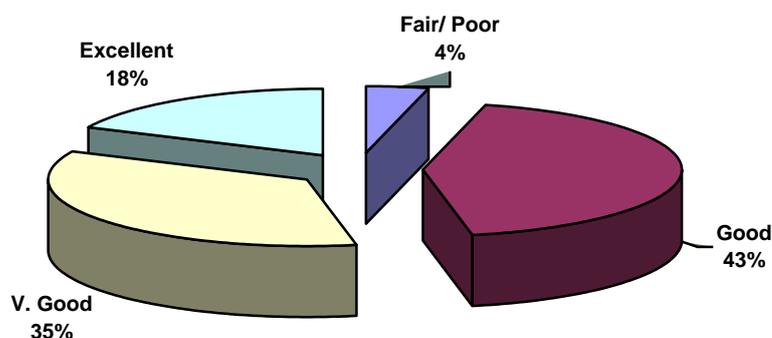


Figure 5.10: Distribution of study population according to their evaluation of health services provided at the EGH

As shown in Figure 5.10, In regard to the evaluation of the hospital health services provided to the study population at the EGH, the study revealed that the majority of the population perceived the hospital health services as excellent, very good and good (96.6%), this indicates the level of satisfaction reported by patients at their hospital visit. This finding is consistent with the results from the recommendation item in which 87.1% of respondents indicated that they would recommend the hospital to family and friends. While, 3.4% of the respondents considered the health services fair or poor.

5.3 Factor analysis and related sub-scale dimensions

Domains of perception that were extracted from the study as a result of the factor analysis reflected the meaningful dimensions of patients' perception about the health services provided at EGH. It is worth reminding the readers that, 67 scaled items were included (Annex 6). As a result of factor analysis, six factors were emerged and they were labeled by the researcher as following:

5.3.1 Respect and privacy:

Respect and privacy was the first factor and included ten items (Annex 6). This dimension reflects the concern of the hospital staff with the respect shown to the patients. Also, it refers to the patients' perceptions toward the confidence to the hospital staff. The highest level of perception in this study was reported a mean 4.1517 out of five with respect and privacy (83%) meaning that patients have positive perception about respect and privacy.

5.3.2 Approach of care:

Approach of care refers to the role of the hospital staff in facilitating and delivering the services (Annex 6). Also, it refers to the standard of services shown to the patient and his family. In this study the findings showed that the approach of care domain reported a mean 4.11 (82.2%) of perception level which mean that patients have also positive perception about the approach of care.

5.3.3 Information and communication:

Information and communication dimension included fourteen items (Annex 6). This refers to the interaction and communication between the hospital staff and the patients. Also, it refers to the degree of information and explanations given to the patients. In this study, the findings showed that the information and communication domain reported a mean 3.8567 (77.1%) of the perception level meaning that patients have a moderate positive perception about information and communication domain.

5.3.4 Hotel services:

Hotel services dimension included ten items (Annex 6). This refers to the meals services and the living arrangements for the patients. Also, it refers to the comfort and cleanliness

of the patient's bed. In this study the findings showed that the hotel services domain reported a mean 3.726 (74.5%) of perception level.

5.3.5 Hospital culture:

Hospital culture included ten items (Annex 6). It refers to the relationship between hospital staff themselves and the relation between hospital staff and the patients. In addition, it refers to the patients' impression toward the hospital staff. Also, perception with the length of waiting time and unreasonable delays of the services provided to the patients. The lowest level of perception was expressed by the patients toward the hospital culture domain with a mean 3.6679 (73.4%) of perception level.

5.3.6 Meeting expectation:

The last factor was the meeting expectation which included nine items (Annex 6). This dimension reflects the experience of the patients with the health care services. Also, it refers to the expectations of the patients about the health services at the EGH. In this study the findings showed that the meeting expectation domain reported a mean 4.11 (82.2%) of perception level. It means that the patients have positive perception about meeting expectation domain.

5.4 Overall perspective

The total perspective score (overall perspective) reflects all the subscales scores. Dimensions of patients' perspective of hospital health services were respect and privacy, approach of care, information and communication, hotel services, hospital culture lastly, meeting expectation. The overall mean of perspective score (maximum 5) was 3.9378 (78.7%). The mean perspective score for subscales range from 3.67 to 4.15 (73.4% -

83%), high mean scores indicate positive perception and vice versa (Table 5.3 and Figure 5.11). The highest level of perspective was expressed by the patients' toward the respect and privacy dimension (83%).The lowest level was reported with the hospital culture dimension (73.4%).

Table (5.3): Factor labels, mean, standard deviation and variance.

Factor name	Mean	%	Std. deviation	Variance
1. Respect and Privacy	4.1517	83%	.53608	.28738
2. Approach of care	4.1130	82%	.51231	.26246
3. Information and Communication	3.8567	77%	.60021	.36025
4. Hotel services	3.7267	75%	.68713	.47214
5. Hospital culture	3.6679	73%	.60849	.37026
6. Meeting expectation	4.1108	82%	.55806	.31143
7. Overall perspective	3.9378	78.8%	.45277	.20500

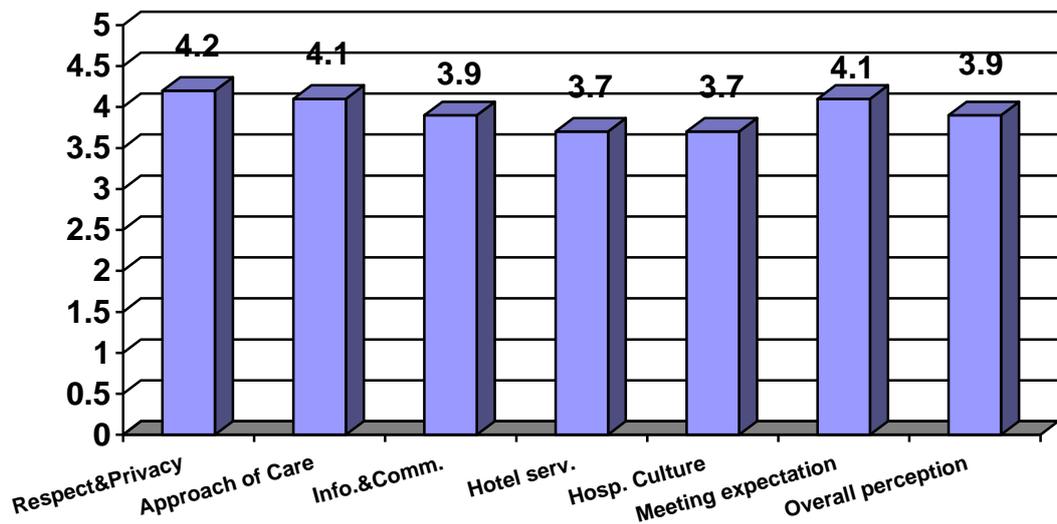


Figure 5.11: Means of patients' perception dimensions.

5.5 Patients' characteristics and perception

Table 5.4: Differences in patients' perception by gender

Dep. Var. Patient perception	Indep. Var. "Gender"	N	Mean	S.D.	t	Sig
Respect and privacy	male	167	4.1365	.56498	-.516	.606
	female	166	4.1669	.50661		
Approach of care	male	167	4.1048	.54937	-.295	.769
	female	166	4.1213	.47364		
Information and communication	male	167	3.8405	.63467	-.495	.621
	female	166	3.8731	.56486		
Hotel services	male	167	3.6335	.73874	-2.503	.013*
	female	166	3.8205	.61914		
Hospital culture	male	167	3.6425	.65615	-.762	.447
	female	166	3.6934	.55728		
Meeting expectation	male	167	4.1098	.55636	-.033	.974
	female	166	4.1118	.56145		
Overall perception	male	167	3.9113	.47867	-1.073	.284
	female	166	3.9645	.42490		

* Statistically significant

Table 5.4 shows that females elicited higher scores in the overall perception than males. Additionally, females have had more positive perception in all the domains constituting the concerned construct. However, although females have higher perception in the domains than males the differences between the two groups were statistically not significant except in the hotel service which was statistically significant (p-value 0.013).

Table 5.5, illustrates the differences between patients' perception and the age groups of study population. The result revealed a significant statistical differences between the age groups of patients and respect and privacy, approach of care, information and communication, hotel services and lastly, overall perception (P-value 0.017, 0.028, .001, .020 and .005 respectively). The table shows that those patients who were more than 60 years of age have higher scores of perceptions, while the age group 18-30 years reported the lowest scores of perceptions.

Table 5.5: Differences in patients' perceptions by age groups

Dep. Var. "Patients perception"	Indep. Var.		Age groups	Sum of squares	df	Mean square	F	P- value
	Age Groups	Mean						
Respect and privacy	18-30 yrs	4.0426	Between Groups	2.896	3	.965	3.433	.017*
	31-50 yrs	4.1844	Within Groups	92.515	329	.281		
	51-60 yrs	4.1255	Total	95.412	332			
	> 60 yrs	4.3125						
Approach of care	18-30 yrs	4.0020	Between Groups	2.382	3	.794	3.082	.028*
	31-50 yrs	4.1464	Within Groups	84.756	329	.258		
	51-60 yrs	4.1307	Total	87.138	332			
	> 60 yrs	4.2398						
Information and communication	18-30 yrs	3.6766	Between Groups	5.560	3	1.853	5.346	.001*
	31-50 yrs	3.9338	Within Groups	114.042	329	.347		
	51-60 yrs	3.8906	Total	119.602	332			
	> 60 yrs	4.0077						
Hotel services	18-30 yrs	3.5963	Between Groups	4.587	3	1.529	3.306	.020*
	31-50 yrs	3.7205	Within Groups	152.165	329	.463		
	51-60 yrs	3.7872	Total	156.752	332			
	> 60 yrs	3.9411						
Hospital culture	18-30 yrs	3.5630	Between Groups	2.288	3	.763	2.080	.103
	31-50 yrs	3.6836	Within Groups	120.638	329	.367		
	51-60 yrs	3.8085	Total	122.926	332			
	> 60 yrs	3.7179						
Meeting expectation	18-30 yrs	4.0586	Between Groups	1.274	3	.425	1.368	.253
	31-50 yrs	4.1093	Within Groups	102.122	329	.310		
	51-60 yrs	4.0804	Total	103.395	332			
	> 60 yrs	4.2401						
Overall perception	18-30 yrs	3.8232	Between Groups	2.624	3	.875	4.397	.005*
	31-50 yrs	3.9630	Within Groups	65.435	329	.199		
	51-60 yrs	3.9705	Total	68.059	332			
	> 60 yrs	4.0765						

- Statistically significant

Table (5.6): Differences in patients perceptions scores by marital status

Dep. Var. Patient perception	Indep. Var. "Gender"	N	Mean	S.D.	t	Sig
Respect and privacy	Unmarried	111	4.1045	.61988	-1.135	.257
	Married	222	4.1752	.48867		
Approach of care	Unmarried	111	4.0637	.57743	-1.244	.215
	Married	222	4.1377	.47591		
Information and communication	Unmarried	111	3.7619	.65828	-2.048	.041*
	Married	222	3.9041	.56456		
Hotel services	Unmarried	111	3.6775	.75483	-.925	.356
	Married	222	3.7514	.65105		
Hospital culture	Unmarried	111	3.6523	.62796	-.331	.741
	Married	222	3.6757	.59981		
Meeting expectation	Unmarried	111	4.0951	.55492	-.362	.717
	Married	222	4.1186	.56071		
Overall perception	Unmarried	111	3.8925	.50389	-1.293	.197
	Married	222	3.9604	.42430		

* Statistically significant

Table 5.6, illustrates the differences between patients' perception and marital status of study population, which revealed that the married clients' elicited higher overall scores (3.9604). Additionally, married patients have had more positive perceptions in the all dimensions. Although, married patients have higher perception in the dimensions than unmarried the differences between the two groups were statistically not significant except in information and communication which was statistically significant (P-value 0.041).

Table (5.7): Differences in patients' perceptions by place of living

Dep. Var. Patients perception	Ind. Variable place of living	Mean	Indep. Var. Place of living	Sum of squares	df	Mean square	F	P-value
Respect and privacy	Rafah govern.	4.0742	Between groups	1.875	2	.937	3.304	.038*
	Khanyounis govern.	4.2305	Within groups	93.537	330	.283		
	Mid zone, Gaza & North govern.	4.1879	Total	95.412	332			
Approach of care	Rafah govern.	4.0557	Between groups	1.077	2	.536	2.056	.130
	Khanyounis govern.	4.1753	Within groups	86.061	330	.261		
	Gaza & North govern. Mid zone governorate	4.1234	Total	87.138	332			
Information and communication	Rafah govern.	3.8068	Between groups	1.109	2	.338	1.498	.225
	Khanyounis govern.	3.9230	Within groups	118.493	330	.359		
	Gaza & North govern. Mid zone governorate	3.8139	Total	119.602	332			
Hotel services	Rafah governorate	3.6918	Between groups	1.378	2	.475	1.006	.367
	Khanyounis govern.	3.7865	Within groups	155.378	330	.472		
	Gaza & North govern. Mid zone governorate	3.6394	Total	156.752	332			
Hospital culture	Rafah govern.	3.6566	Between groups	.438	2	.213	.574	.564
	Khanyounis govern.	3.6553	Within groups	122.488	330	.371		
	Gaza & North govern. Mid zone governorate	3.7758	Total	122.926	332			
Meeting expectation	Rafah govern.	4.0839	Between groups	.333	2	.134	.430	.651
	Khanyounis govern.	4.1434	Within groups	103.062	330	.313		
	Gaza & North govern. Mid zone governorate	4.1010	Total	103.395	332			
Overall perception	Rafah govern.	3.8948	Between groups	.617	2	.308	1.503	.223
	Khanyounis govern.	3.9857	Within groups	67.442	330	.204		
	Gaza & North govern. Mid zone governorate	3.9402	Total	68.059	332			

* Statistically significant

Table 5.7, illustrates the comparison between patients' perception and place of living of study population and it shows that, there was statistically significant difference between the dependent variable respect and privacy and the place of living (P-value 0.038). On the other hand, there were no statistical significant differences between the place of living and all of the other dimensions. However, the findings revealed that patients who live in Khanyounis Governorate have higher scores of perceptions, while the patients who live in Mid zone, Gaza and north governorates have lowest scores of perceptions.

Table (5.8): Differences in patients' perception scores by citizenship

Dep. Var. Patient perception	Indep. Var. "Citizenship"	N	Mean	S.D.	t	P-value
Respect and privacy	Refugee	230	4.1209	.52100	-1.569	.118
	Not-refugee	103	4.2204	.56488		
Approach of care	Refugee	230	4.0820	.49960	-1.657	.098
	Not-refugee	103	4.1824	.53562		
Information and communication	Refugee	230	3.8078	.58904	-2.237	.026*
	Not-refugee	103	3.9660	.61330		
Hotel services	Refugee	230	3.7074	.66758	-.767	.444
	Not-refugee	103	3.7699	.73041		
Hospital culture	Refugee	230	3.6913	.58033	1.050	.294
	Not-refugee	103	3.6155	.66712		
Meeting expectation	Refugee	230	4.0850	.53309	-1.260	.209
	Not-refugee	103	4.1683	.60895		
Overall perception	Refugee	230	3.9157	.44976	-1.331	.184
	Not-refugee	103	3.9871	.45775		

* Statistically significant

Table 5.8, showed that refugees and not-refugees have closely similar mean scores in general all subscales dimensions and no statistical significant differences were recorded between refugees and non-refugees in most of the dimensions of patients' perception except between dependent variable information and communication (0.026) and the citizenship. This result identifies that refugees and non-refugees are in the same level of overall perspective and in most of dimensions of perception.

Table 5.9, shows that patients who were living in refugee camps and non-camps were closely similar mean scores in general all subscales dimensions and no statistical significant differences were recorded between refugee camps and non-camps (cities, villages, etc.). This result identifies that refugee camps and other places were in the same level of overall perspective and in all dimensions of perception.

Table (5.9): Differences in patient's perception by residency place

Dep. Var. "Patient perception"	Indep. Var. "Residency place"	N	Mean	S.D.	t	Sig
Respect and privacy	Refugee camp	199	4.1191	.53403	-1.352	.177
	Non-camp	134	4.2000	.53747		
Approach of care	Refugee camp	199	4.0808	.51218	-1.403	.161
	Non-camp	134	4.1610	.51064		
Information/ communication	Refugee camp	199	3.8248	.58390	-1.182	.238
	Non-camp	134	3.9041	.62283		
Hotel services	Refugee camp	199	3.7231	.66626	-.117	.907
	Non-camp	134	3.7321	.71950		
Hospital culture	Refugee camp	199	3.7080	.58537	1.1471	.142
	Non-camp	134	3.6082	.63885		
Meeting expectation	Refugee camp	199	4.1195	.51851	.347	.729
	Non-camp	134	4.0978	.61390		
Overall perception	Refugee camp	199	3.9292	.45203	-.421	.675
	Non-camp	134	3.9505	.45525		

The results according to Table (5.10), revealed that there is real difference between patient education level and information and communication, hotel services, meeting expectation and overall perception (P-value .005, .000, .001 and .001 respectively). However, there were no significance difference between educational level and the other patients' perception dimensions. The table indicates that the preparatory patients reported higher scores of perceptions, while the university level of education reported the lowest scores of perceptions (Table 5.10).

Table 5.10: Differences in patient's perception by level of education

Dep. Var. "Patients perception"	Ind. Variable "level of education"	Mean	Indep. Var. "Level of education"	Sum of squares	df	Mean square	F	P-value
Respect and privacy	Illiterate	4.2477	Between groups	2.453	4	.613	2.164	.073
	elementary	4.2957	Within groups	92.959	328	.283		
	Preparatory	4.1375	Total	95.412	332			
	Secondary	4.0720						
University	4.0877							
Approach of care	Illiterate	4.1846	Between groups	2.250	4	.563	2.174	.072
	elementary	4.2593	Within groups	84.887	328	.259		
	Preparatory	4.1301	Total	87.138	332			
	Secondary	4.0384						
University	4.0391							
Information and communication	Illiterate	3.9549	Between groups	5.311	4	1.328	3.811	.005*
	elementary	4.0093	Within groups	114.291	328	.348		
	Preparatory	3.9821	Total	119.602	332			
	Secondary	3.7657						
University	3.6928							
Hotel services	Illiterate	3.9108	Between groups	14.298	4	3.575	8.230	.001*
	elementary	3.9326	Within groups	142.454	328	.434		
	Preparatory	3.9036	Total	156.752	332			
	Secondary	3.6462						
University	3.4000							
Hospital culture	Illiterate	3.7723	Between groups	2.746	4	.687	1.874	.115
	elementary	3.7957	Within groups	120.180	328	.366		
	Preparatory	3.5250	Total	122.926	332			
	Secondary	3.6473						
University	3.6301							
Meeting expectation	Illiterate	4.1778	Between groups	5.647	4	1.412	4.737	.001*
	elementary	4.3647	Within groups	97.748	328	.298		
	Preparatory	4.1667	Total	103.395	332			
	Secondary	3.9940						
University	3.9970							
Overall perception	Illiterate	4.0414	Between groups	3.916	4	.979	5.006	.001*
	elementary	4.1095	Within groups	64.143	328	.196		
	Preparatory	3.9742	Total	68.059	332			
	Secondary	3.8606						
University	3.8078							

* Statistically significant

Using an independent t-test to compare the means of the perception scores in regard to the employment status (employed and un-employed), table 5.11, revealed that the un-employed patients elicited higher level of the overall perception scores (mean 3.9594), while the employed patients reported lower level (mean 3.8738). There were no statistical significance difference between the employment status and most of the perception dimensions, while there was statistical significant difference between employed patients

and un-employed with regard to hotel services. This result indicates that the un-employed patients have had more positive perception with health services than the employed patients.

Table 5.11: Differences in patients' perception scores by current employment status

Dep. Var. Patient perception	Indep. Var. "Employment status"	N	Mean	S.D.	t	Sig
Respect and privacy	Employed	84	4.1048	.59877	-.927	.355
	Not-employed	249	4.1675	.51355		
Approach of care	Employed	84	4.0791	.58954	-.702	.483
	Not-employed	249	4.1245	.48427		
Information and communication	Employed	84	3.7985	.64129	-1.029	.304
	Not-employed	249	3.8764	.58574		
Hotel services	Employed	84	3.5333	.75415	-3.019	.006*
	Not-employed	249	3.7920	.65175		
Hospital culture	Employed	84	3.6464	.68009	-.373	.709
	Not-employed	249	3.6751	.58367		
Meeting expectation	Employed	84	4.0807	.56848	-.571	.568
	Not-employed	249	4.1209	.55529		
Overall perception	Employed	84	3.8738	.50442	-1.501	.134
	Not-employed	249	3.9594	.43292		

* Statistically significant

Table 5.12, illustrates the comparison between patients' perception and payment for medical care of study population. The findings showed that, there were no statistical significant difference between dimensions of patients perceptions of health services and payment for medical care. However, the test revealed that patients who use syndicate health insurance have higher scores of perceptions, while the patients who use private health insurance have lowest scores of perceptions.

Table 5.12: Differences in dimensions of patient's perception and Health Insurance Scheme

Dep. Var. Patients perception	Ind. Variable "Insurance Scheme"	Mean	Indep. Var. "Insurance Scheme"	Sum of squares	df	Mean squar	F	P-value
Respect and privacy	Private H. insur.	4.1398	Between groups	.134	2	.067	.231	.794
	Govern. H. insur.	4.1356	Within groups	95.278	330	.289		
	Syndicate	4.1791	Total	95.412	332			
Approach of care	Private H. insur.	4.0800	Between groups	.173	2	.087	.329	.720
	Govern. H. insur.	4.1106	Within groups	86.964	330	.264		
	Syndicate	4.1398	Total	87.138	332			
Information and communication	Private H. insur.	3.7797	Between groups	.656	2	.328	.911	.403
	Govern. H. insur.	3.8810	Within groups	118.946	330	.360		
	Syndicate	3.8839	Total	119.602	332			
Hotel services	Private H. insur.	3.7759	Between groups	1.573	2	.786	1.672	.189
	Govern. H. insur.	3.6437	Within groups	155.179	330	.470		
	Syndicate	3.7887	Total	156.752	332			
Hospital culture	Private H. insur.	3.6542	Between groups	.173	2	.086	.232	.793
	Govern. H. insur.	3.6496	Within groups	122.753	330	.372		
	Syndicate	3.6991	Total	122.926	332			
Meeting expectation	Private H. insur.	4.0710	Between groups	.194	2	.097	.310	.734
	Govern. H. insur.	4.1160	Within groups	103.201	330	.313		
	Syndicate	4.1333	Total	103.395	332			
Overall perception	Private H. insur.	3.9168	Between groups	.191	2	.096	.465	.628
	Govern. H. insur.	3.9227	Within groups	67.867	330	.206		
	Syndicate	3.9706	Total	68.059	332			

Table 5.13, reveals that the patients who were admitted for more than one admission elicited higher level of the overall perception scores (mean 3.9776), while the patients who admitted for the first time reported lower level (mean 3.9056). There were no statistical significance difference between the number of admissions and all of the perception dimensions. This result indicates that the patients who were admitted more than one admission have had more positive with health services than the patients who were admitted for the first time.

Table 5.13: Differences in patients' perception scores by number of admissions

Dep. Var. Patient perception	Indep. Var. No. of admission	N	Mean	S.D.	t	Sig
Respect and privacy	1 st admission	184	4.1223	.55711	-1.111	.267
	More than one	149	4.1879	.50843		
Approach of care	1 st admission	184	4.0943	.53154	-.740	.460
	More than one	149	4.1361	.48830		
Information/ communication	1 st admission	184	3.8094	.63592	-1.603	.110
	More than one	149	3.9151	.54943		
Hotel services	1 st admission	184	3.6793	.73307	-1.400	.162
	More than one	194	3.7852	.62324		
Hospital culture	1 st admission	184	3.6636	.60429	-.142	.887
	More than one	149	3.6732	.61563		
Meeting expectation	1 st admission	184	4.0646	.59449	-1.682	.093
	More than one	149	4.1678	.40466		
Overall perception	1 st admission	184	3.9056	.47710	-1.445	.149
	More than one	149	3.9776	.41895		

Table 5.14, illustrates the comparison between patients' perception and number of admission's days of study population. There were no statistical significance difference between the number of admission's days and most of the perception dimensions, while there were statistical significant difference between the patients with regard to respect and privacy and approach of care. However, the test revealed that patients who were admitted for three days have higher scores of perceptions, while the patients who were admitted for more than 9 days have lowest scores of perceptions.

Table 5.14: Relationship between dimensions of patient's perception and number of admission's days

Dep. Var. "Patients perception"	Ind. Variable "number of admission's days"	Mean	Indep. Var. "Number of admission's days"	Sum of squares	df	Mean sq.	F	P-value
Respect and privacy	< 4 days	4.2103	Between groups	2.515	3	.838	2.969	.032*
	4-6 days	4.1175	Within groups	92.897	329	.282		
	7-9 days	4.1983	Total	95.412	332			
	> 9 days	3.9704						
Approach of care	< 4 days	4.1685	Between groups	2.320	3	.773	3.000	.031*
	4-6 days	4.0544	Within groups	84.817	329	.258		
	7-9 days	4.1750	Total	87.138	332			
	> 9 days	3.9524						
Information and communication	< 4 days	3.9066	Between groups	1.759	3	.586	1.637	.181
	4-6 days	3.8197	Within groups	117.843	329	.358		
	7-9 days	3.8988	Total	119.602	332			
	> 9 days	3.7090						
Hotel services	< 4 days	3.7712	Between groups	1.763	3	.588	1.247	.293
	4-6 days	3.7651	Within groups	154.989	329	.471		
	7-9 days	3.7133	Total	156.752	332			
	> 9 days	3.5685						
Hospital culture	< 4 days	3.7032	Between groups	1.249	3	.416	1.126	.339
	4-6 days	3.6698	Within groups	121.677	329	.370		
	7-9 days	3.6967	Total	122.926	332			
	> 9 days	3.5315						
Meeting expectation	< 4 days	4.1709	Between groups	1.168	3	.389	1.253	.291
	4-6 days	4.0882	Within groups	102.227	329	.311		
	7-9 days	4.0519	Total	103.395	332			
	> 9 days	4.0288						
Overall perception	< 4 days	3.9884	Between groups	1.567	3	.522	2.584	.053
	4-6 days	3.9191	Within groups	66.492	329	.202		
	7-9 days	3.9557	Total	68.059	332			
	> 9 days	3.7934						

* Statistically significant

Also, by using an independent t-test to compare the means of the perception scores in regard to the admission ward (medical and surgical). Table 5.15, revealed that the medical patients elicited higher level of the overall perception scores (mean 3.9652), while the surgical patients reported lower level (mean 3.9153). There were no statistical significance difference between the admission wards and most of the perception dimensions, while there was statistical significant differences between medical and surgical patients with regard to information and communication. This result indicates that the medical patients have had more positive perception scores with health services than the surgical patients.

Table 5.15: Differences in patients' perception scores by admission wards

Dep. Var. Patient perception	Indep. Var. "Admission ward"	N	Mean	S.D.	t	Sig
Respect and privacy	Medical	150	4.1893	.56913	1.162	.246
	Surgical	183	4.1208	.50688		
Approach of care	Medical	150	4.1367	.54322	.761	.447
	Surgical	183	4.0937	.48616		
Information and communication	Medical	150	3.9290	.59160	2.000	.046*
	Surgical	183	3.7974	.60231		
Hotel services	Medical	150	3.8040	.68717	1.865	.063
	Surgical	183	3.6634	.68245		
Hospital culture	Medical	150	3.6027	.62936	-1.776	.077
	Surgical	183	3.7213	.58717		
Meeting expectation	Medical	150	4.1296	.60083	.558	.578
	Surgical	183	4.0953	.52157		
Overall perception	Medical	150	3.9652	.45979	1.001	.318
	Surgical	183	3.9153	.44693		

* Statistically significant

Table 5.16, showed that the majority of the study population was admitted as emergency cases to the hospital wards. It also revealed that the mean of overall perception for emergency admission (3.9575) of the study population higher than for planned admission (3.8876). Additionally, it shows that emergency admitted patients have had more positive perception. No statistical significant differences between all the dimensions of perceptions and the type of admission for the study population.

Table 5.16: Differences in patients' perception scores by type of admission

Dep. Var. "Patients perception"	Indep. Var. "Type of admission"	N	Mean	S.D.	t	Sig
Respect and privacy	Emergency	239	4.1674	.56033	.852	.395
	(Outpatient clinic)	94	4.1117	.46924		
Approach of care	Emergency	239	4.1270	.53830	.793	.428
	(Outpatient clinic)	94	4.0775	.44002		
Information and communication	Emergency	239	3.8805	.62371	1.151	.250
	(Outpatient clinic)	94	3.7964	.53421		
Hotel services	Emergency	239	3.7665	.70619	1.690	.092
	(Outpatient clinic)	94	3.6255	.62835		
Hospital culture	Emergency	239	3.6607	.62427	-.344	.731
	(Outpatient clinic)	94	3.6862	.56921		
Meeting expectation	Emergency	239	4.1432	.55486	1.695	.091
	(Outpatient clinic)	94	4.0284	.56065		
Overall perception	Emergency	239	3.9575	.46902	1.270	.205
	(Outpatient clinic)	94	3.8876	.40659		

As shown in table 5.17, the results indicate that there were real differences between the patients rating of their health status and the overall perception (P-value .016) and all dimensions of patients perceptions. The table indicates that, patients who had excellent health status reported higher scores of perceptions, while the patients who had fair/poor health status reported lowest scores of perceptions.

Table 5.17: Differences in dimensions of patients' perception and the patient's evaluation of their health status

Dep. Var. "Patients perception"	Ind. Variable "rate of health status"	Mean	Indep. Var. "Rate of health status"	Sum of squares	df	Mean square	F	P-value
Respect and privacy	Excellent	4.4913	Between groups	3.837	3	.963	4.595	.004*
	Very good	4.1455	Within groups	91.575	329	.279		
	Good	4.1361	Total	95.412	332			
	Fair/Poor	3.9000						
Approach of care	Excellent	4.4658	Between groups	4.063	3	1.022	5.364	.001*
	Very good	4.1215	Within groups	83.074	329	.253		
	Good	4.0818	Total	87.138	332			
	Fair/Poor	3.8730						
Information and communication	Excellent	4.2267	Between groups	4.153	3	1.038	3.945	.009*
	Very good	3.8502	Within groups	115.449	329	.352		
	Good	3.8341	Total	119.602	332			
	Fair/Poor	3.6310						
Hotel services	Excellent	4.0913	Between groups	4.544	3	1.351	3.274	.021*
	Very good	3.7231	Within groups	152.209	329	.461		
	Good	3.7089	Total	156.752	332			
	Fair/Poor	3.4444						
Hospital culture	Excellent	3.3435	Between groups	2.910	3	.884	2.659	.048*
	Very good	3.7172	Within groups	120.016	329	.364		
	Good	3.6829	Total	122.926	332			
	Fair/Poor	3.5833						
Meeting expectation	Excellent	4.3671	Between groups	2.987	3	.782	3.263	.022*
	Very good	4.0829	Within groups	100.408	329	.306		
	Good	4.1280	Total	103.395	332			
	Fair/Poor	3.8395						
Overall perception	Excellent	4.1643	Between groups	2.113	3	.568	3.513	.016*
	Very good	3.9401	Within groups	65.947	329	.201		
	Good	3.9286	Total	68.059	332			
	Fair/Poor	3.7119						

* Statistically difference

As shown in table 5.18, patient's evaluation of the hospital services was categorized into four groups; excellent, very good, good and lastly, fair/poor. The results indicate that there were real differences between the rate of health status and the overall perception (P-value .001) and all dimensions of patients perceptions. The table indicates that, patients who evaluated the hospital services as excellent reported higher scores of perceptions, while the patients who had fair/poor health services evaluation reported lowest scores of perceptions.

Table 5.18: Differences in dimensions of patients' perception and patient's evaluation of the hospital services

Dep. Var. Patients perception	Ind. Variable rate of health status	Mean	Indep. Var. "Rate of health status"	Sum of squares	df	Mean square	F	P-value
Respect and privacy	Excellent	4.4397	Between groups	13.701	3	4.567	18.389	.001
	Very good	4.2026	Within groups	81.710	329	.248		
	Good Fair/Poor	4.0585 3.3364	Total	95.412	332			
Approach of care	Excellent	4.4347	Between groups	17.640	3	5.880	27.835	.001
	Very good	4.1880	Within groups	69.498	329	.211		
	Good Fair/Poor	3.9937 3.2143	Total	87.138	332			
Information and communication	Excellent	4.0973	Between groups	16.041	3	5.347	16.986	.001
	Very good	3.9756	Within groups	103.561	329	.315		
	Good Fair/Poor	3.7342 2.9610	Total	119.602	332			
Hotel services	Excellent	3.9379	Between groups	9.177	3	3.059	6.820	.001
	Very good	3.8188	Within groups	147.575	329	.449		
	Good Fair/Poor	3.6136 2.1455	Total	156.752	332			
Hospital culture	Excellent	3.4931	Between groups	6.367	3	2.122	5.991	.001
	Very good	3.6470	Within groups	116.559	329	.354		
	Good Fair/Poor	3.7884 3.2000	Total	122.926	332			
Meeting expectation	Excellent	4.2586	Between groups	9.850	3	3.283	11.548	.001
	Very good	4.1937	Within groups	93.545	329	.284		
	Good Fair/Poor	4.0469 3.3030	Total	103.395	332			
Overall perception	Excellent	4.1102	Between groups	8.963	3	2.988	16.634	.001
	Very good	4.0043	Within groups	59.095	329	.180		
	Good Fair/Poor	3.8725 3.1934	Total	68.059	332			

* Statistically significant

As shown in Table 5.19, patient's recommending the EGH to other friends or family members was categorized into three groups; yes to high extent, uncertain and not at all. The results indicate that there were real differences between recommending the hospital to others and the overall perception (P-value .000) and all dimensions of patients perceptions. The test indicates that, patients who will recommend this hospital reported higher scores of

perceptions, while the patients who will not recommend this hospital reported lower scores of perceptions.

Table 5.19: Differences between dimensions of patients' perception and patient's recommending the EGH for others

Dep. Var. Patients perception	Ind. Variable "recommend this hospital to others"	Mean	Indep. Var. " recommend this hospital to others "	Sum of squares	df	Mean square	F	Sig.
Respect and privacy	Yes	4.2638	Between groups	28.346	2	14.173	69.740	.001*
	Uncertain	3.4132	Within groups	67.065	330	.203		
	Not at all	3.2600	Total	95.412	332			
Approach of care	Yes	4.2113	Between groups	21.761	2	10.881	54.922	.001*
	Uncertain	3.4643	Within groups	65.377	330	.198		
	Not at all	3.3429	Total	87.138	332			
Information and communication	Yes	3.9643	Between groups	26.132	2	13.066	46.131	.001*
	Uncertain	3.1523	Within groups	93.470	330	.283		
	Not at all	2.9714	Total	119.602	332			
Hotel services	Yes	3.8366	Between groups	27.284	2	13.642	34.772	.001*
	Uncertain	3.0105	Within groups	129.468	330	.392		
	Not at all	2.8000	Total	156.752	332			
Hospital culture	Yes	3.7183	Between groups	5.720	2	2.860	8.052	.001*
	Uncertain	3.3342	Within groups	117.207	330	.355		
	Not at all	3.2800	Total	122.926	332			
Meeting expectation	Yes	4.1977	Between groups	17.130	2	8.565	32.766	.001*
	Uncertain	3.5468	Within groups	86.265	330	.261		
	Not at all	3.3556	Total	103.395	332			
Overall perception	Yes	4.0320	Between groups	20.028	2	10.014	68.800	.001*
	Uncertain	3.3202	Within groups	48.031	330	.146		
	Not at all	3.1683	Total	68.059	332			

* Statistically significant

5.6 Qualitative findings

As the focus of this study was the exploration of patients' perception about the service provided at the EGH. The patients were asked to describe their positive. Most respondents described their experience as good, very good or excellent (96%). This finding is consistent with the results from the recommendation of the EGH others, in which (87%) of the respondents indicated that they would recommend the hospital to family and

friends. However, there were others who said they would not recommend this hospital to other referring that to; poor response of hospital staff (physicians – nurses) to patients requests, unavailability of physicians in the evening and night shift in the ward, frequent postpone the dates of the operations and physicians don't give a full picture about the patients illness . Also, they said that there was discrimination between patients due to political commitment.

On responding to the question "what did you enjoy mostly about your stay in hospital? Most of the patient were pleased from the service and felt that the hospital different from other hospitals and in their points they said that; the ward was clean, organized and quite, no smoking in the wards, the hospital services and care were excellent. Also, they said that they enjoyed the external view of the hospital's garden which makes a comfortable atmosphere for the patients and their visitors, the staff have dealt with us in a human way and they have good communication with us.

On responding to the question "What do you think the hospital could do to improve the quality of the care and service it provides?" The patients gave too many ideas, most of these were concern on the hotel services and the hospital culture. We mentioned here the most frequent request of the patient which were: attention and maintenance of clean bathrooms; attention to food in terms of quality and type, taste and appearance; the patients in need for sheets, blankets, pillows clean and enough; the patients were asking for hot drink in the morning or evening time; having living hall in the ward for the patients and their visitors. Also, they said that: there is a need for wheel chairs in good condition, enough for the patients and suitable for service.

Regarding care, they asked for providing complete nursing care and not to leave that burden on the family, giving pain relief when needed and not to leave the patient suffering.

Moreover, they said that: physicians were not found in the ward most of the time and when the patient needs them, they took too long time to come.

Many surgical patients were worried from the fact that operation's date not respected and always there are postponed or canceled of the operations. The patients said that: the staff has to be patient and listen more to the patient and his complains.

Some of the patients said that: there is a need to have physician office hour to meet the patient's family and to give them clear and understandable information about the patient's condition.

On responding to the question "Are there any other services that you think could or should the hospital provide?" The patients pointed and focus on the need for other wards like dialysis, nephrology, burn unit, plastic surgery and MRI. Also, the patients want recreation programs and to expand the work in the operation room to the evening time.

Chapter Six

Discussion and Implications

Chapter 6

6.1 Discussion and Implications

The preliminary model of service quality and perception discussed in this study provides insights to both researchers and practitioners who might consider using the results to improve service quality and patient perception in the hospital environment in Palestine. Theoretically, the model identifies several dimensions that are important to hospitalized patients at the EGH. While these six dimensions are largely perceptual rather than objective in nature which given the intangibility of the service and the difficulty that patients may have in assessing its technical quality, they strongly explained patient perception about the hospital services.

These dimensions with perspective measurement properties represent patient-centered service quality indicators in the hospital setting; their use in evaluating hospital services should help provide better care to the often neglected patients. Additional research is needed, however, to replicate and refine the model. Over time and with further validation, or with the identification of additional service variables, it should be possible to introduce patient-driven quality standard to enable service providers to better address patients' needs.

When the quality of services improves, patients will feel reassured to seek curative services within the hospital. Also, an indirect benefit to the country would be to preserve its foreign exchange that can be deployed in other important sectors. Health care providers ought to view the results of this study as an overall evaluation of their performance and as reminder that patient-driven service standards are important for the production of quality care and must be better understood.

Patients are not merely bodies or ailments; they are human and have expectations. If their expectations are not met, they will undervalue the system or avoid it for better options. The researcher limited his focus to the EGH to explore the patients' views about the health services provided at the hospital after seven years of starting this hospital.

Patients' tendency to score their satisfaction regarding specific items favorably, despite the problems encountered, may be explained by the framework of expectations (Oberst, 1984), according to that, patients' expectations are formed by the interaction of their personal characteristics and attitudes and prior experiences with the attributes of the situation they encounter. Therefore, the standard against which care is judged may be based upon the efficacy and limitations of the health care system. Furthermore, no direct relationship may exist between one's descriptions of the care experienced and one's evaluation of care (Staniszewska and Ahmed, 1999; Williams, Coyle and Healy, 1998). Staniszewska and Ahmed (1999) found that patients form "predicted expectations", which are based on experience and information and "normative expectations", which refer to what is deserved in a certain situation.

The patients at Gaza Strip may enter the health care system with low expectations because of the information provided by the community, relatives, mass media and the generally unfavorable social attitude towards the governmental hospital's services. Furthermore, the high level of governmental health insurance coverage may create the illusion of receiving care for "free", thus moderating expectations.

Domains of perception were extracted from the study as a result of factor analysis reflected patients' perception about the hospital services provided at the EGH. The result showed that the patient's perception level about the hospital services at the European Gaza Hospital was 78%. Nevertheless, examining the items with low patients' perspective will enable

hospital staff to identify the defects in hospital services and to institute appropriate changes.

The result was consisted with Al Hindi (2002) study which was conducted in GS to assess the degree of satisfaction among clients seeking radiology services at Al-Shifa hospital and at Gaza Diagnostic Center, the researcher reported that the overall satisfaction level was 82.5% as expressed by the clients who used radiology services. Al-Hindi attributed this result of satisfaction to the difficult political and socio-economic situation of the Palestinian people which might lowered their expectations and have resulted in a high satisfaction level (Al Hindi, 2002).

The result was higher than the result revealed with Abu Shuaib (2005) study which was conducted in governmental hospitals in Gaza strip to examine women's perceptions of childbirth services, the result showed that the overall perception level was 70% at the governmental hospitals. Abu Shuaib attributed the high level of perception to the social and cultural factors of the Palestinian society which made the women appraise the services even when they were not satisfied, also due to the economical and political situation which lowered the level of expectation of the Palestinian women (Abu Shuaib, 2005).

Also, the result was higher than the result revealed with Abu Saileek (2003) study which was conducted in Gaza Strip to measure the level of clients' satisfaction with nursing care in the two major and biggest governmental hospitals in the south of Gaza Strip, EGH and Nasser Hospital in Khanyounis Governorate, the result showed that the satisfaction level was 70.1% in both hospitals. Abu Saileek attributed the high level of satisfaction to the cultural and political factors, which might have an impact on their expectations and have resulted in the revealed the level of satisfaction. (Abu Saileek, 2003).

Abu Dayah (2000) conducted a study in the GS and WB, which investigated the Palestinian's satisfaction with health services provided by MOH, the findings showed that 61.9% of the clients' showed high level of satisfaction with health services as overall (Abu Dayah, 2000). Abu Dayah attributed the high level of satisfaction of Palestinian people to the low expectations with regard to the difficult political and socioeconomic situation of the Palestinian National Authority in general and MoH specifically (Abu Dayah, 2000).

Mousa (2000) conducted a study in the Gaza Strip to assess the level of client's satisfaction with family planning services at UNRWA and MoH clinics, the researcher reported that overall satisfaction as expressed by the Palestinian women was 72%. Mousa attributed the result to the lack knowledge of the work-load of the family planning staff also, to the in-built bias, which predisposed some clients to express satisfaction with family planning they received (Mousa, 2000). Andaleeb (2001) conducted a study in Bangladesh to assess the service quality perceptions and patient satisfaction: a study of hospitals in a developing country, the researcher reported that the satisfaction level was 67% as expressed by the population of Dhaka who had utilized hospital services. Andaleeb (2001) attributed the low level of satisfaction to the lack of patient confidence.

Alasad and Ahmad (2003) conducted a study to examine patients' satisfaction with nursing care at a major teaching hospital in Jordan. Patients' satisfaction was examined in the medical, surgical and gynecological wards of the hospital in relation to patient's gender, age, class of admission, level of education, length of stay in the hospital, operation status, having other diseases and health insurance. The researcher reported that the satisfaction level as expressed by the patients was 77%. Al-Doghather (2004) conducted a study to evaluate inpatient satisfaction with physician services at King Khalid University Hospital in Riyadh, the result showed that the overall satisfaction was 66.2%. Al-Doghather

attributed the low level of satisfaction to the majority of doctors were from non-Arabic speaking countries and because of cultural and social differences, fluent communication with patients was sometimes difficult. Another study was conducted in Turkey with Yildiz and Erdogmus (2004) developed a reliable and valid instrument to measure patient satisfaction of the quality of health care in Turkey, the result revealed that the satisfaction level was 76.6%. They attributed the result to the low education and culture level.

Ricketts (1996) claimed that high level of satisfaction that is usually reported by many studies is considered meaningless when it is a result of a single measurement. Therefore, repeated measurements or comparisons with other health centers are necessary (Ricketts, 1996). In general and in spite of the quality concerns of the health care services as Massoud reported in his situational analysis about health care in Palestine (Massoud, 1994). The findings from this study indicate that patients reported high degree of perspective with hospital services 78%. This is consistent with other patients satisfaction studies discussed before. The political, economical and social factors of the population in Gaza Strip made the patients accept the health services even they were not satisfy with it. Furthermore, the expectations of the Palestinian patients were low due to the closure (siege) of Gaza Strip and the Israeli sanctions against the civil population living there. Moreover, the people want to support the elected government against the attacks of the Israeli occupational forces.

6.2 Domains of patients' perception

To identify the patterning of patient perception, the researcher analyzed the 80 items using principal components factor analysis with a Varimax Rotation Techniques. Items were then eliminated if they did not load at least 0.4 on any of those factors. Six interpretable

factors containing 76 items were identified (Annex 6). These six domains might reflect a frame of the Palestinian patients' perception with the health services provided at the EGH.

The level of positive perceptions about these dimensions varied as the following: respect and privacy (83%), Approach of care (82.2%), Meeting expectation (82.2%), Information and communication (77.1%), Hotel services (74.5%) and Hospital culture (73.4%). These evaluations could be used as a benchmark against which future assessments could be made to track the perceived quality of services that EGH in GS delivers. The following paragraphs present the interpretation of these domains and explain what behind scores.

6.2.1 Respect and privacy:

The highest level of perception was reported with respect and privacy (83%). The finding showed that hospital staff in this study were concerned with the respect of the patients and preserving their privacy at the hospitals' wards. Qualitative information that is obtained from the patients' comments support these facts. Also, analysis of the open-ended questions showed that no any complaint regarding respect and privacy during the period of hospitalization. Participants appeared, overall, very pleased regards physicians' and nurses' behavior towards them.

Qualitative data reflect patients' opinion with respect and privacy dimension, many patients said; *they are very good, they respect and treat us as human being and they do their best.* Another patient stated; *"They are all very well mannered and sweet, always with smile".* However, some patients were not satisfied and they said; *"Some of the female nurses don't respect patient."* Another respondent said that; *"There was poor response from the hospital staff (Physicians-Nurses) to patient's requests."*

Compared with Abu Shuaib (2005) study, which included privacy dimension, the finding showed that privacy dimension elicited that 78.6% perception level. Abu Saileek (2004) study showed that the client's reported lower level of satisfaction 69.7% with privacy. Al Hindi (2002) study showed that the client's reported higher level of satisfaction 90% with comfort and privacy. This result might be due to our Islamic/Arabic culture where the patient has to be respected. Anyhow, hospital staff has to do more in this issue by providing privacy when needed, respect patient privacy, dignity and confidentiality.

6.2.2 Approach of care:

The approach of care dimension is considered as an important quality dimension. Important factor for patient perception were the advice the health service providers gave and that they performed their work in a technically correct way. Patients felt that staff should skillfully assist each other in examinations and treatments and they should support and show patients how to carry out the procedures. Patients expected the hospital staff to work well together as a team. Medications were given on time would influence patient perception. Patients were satisfied with the way hospital staff treated them. Hospital staff was available if the patient needs them. The more attention the staff paid to the patient, the greater the perception of satisfaction. In addition, patient perception was influenced by the staff's behavior and qualities. Qualitative data reflect patient's opinion with approach of care dimension, many patients said; "*they were enjoyed the services and the care which were given to them.*" Another respondent said; "*They are very caring with patients who are unable to do much for them.*" Another respondent said; "*I cannot even begin to describe how much they have done for me.*" Respondents exhibited a high degree of agreement about nurses' dexterity regarding the technical aspects of care and their consistency in administering medications. One respondent said; "*They are excellent*

technicians." Another one said; *"Although, my veins are difficult, they do not seem to have problem in locating a new vein."*

The result revealed that patients' perceived approach of care reported level of perception as 82.2%, congruently with other studies conducted in Gaza Strip, Al Hindi's (2002) study and reported satisfaction level 80% with approach of care in radiology services. Abu Shuaib (2005) study, reported higher level of satisfaction 85.5% with the approach of mother care. The level of satisfaction 82.2% to the care which the patient received may related to the nature of the culture which looks for rationalization to any type of services provided to them. Furthermore, the majority of the patients don't know their health rights; this could be due to knowledge deficit and low educational level. Moreover, most of the patients are unemployed which make the economical situation very bad which leads to frustration, depression and low expectation.

6.2.3 Information and communication:

The information and communication reflected the extent of patients' perspective with the health services, hospital staff responses, listening carefully, answering and explanation of the needed information about health related issues clearly, knowing what to expect and understanding hospital routine was found to facilitate the retention of control by patients, thus reducing their vulnerability. Being prepared enabled the participants to deal with some of the aspects of being a patient; it reduced uncertainty and hence the stress caused by 'not knowing'. The perspective level of information and communication dimension in this study was 77.1%.

Qualitative data reflect patient's response with information and communication dimension, one patient said; "I had a good interaction and communication with the hospital staff."

Another respondent said that; "There was no discrimination between patients." A third respondent said that; "Physicians gave a full and clear picture about the patient's illness."

On the other hand some respondents expressed their dissatisfaction; one respondent said that; *"If you were had information about what will happen after the operation, you know there are certain things coming up, whether they are good or bad, it dose not really make a difference. Except that if you know, then you can prepare yourself."* One participant said on his hospital experience; *"Not enough information is given. There are a lot of things they could tell you beforehand. I had no idea what my operation was going to be like.....it would have been better to know....at least I would have known what I was for. You wonder what's going to happen...just wondering...I think the most important thing is knowledge of what's going to happen to you."* Another respondent said about his post operative period; *"I was told nothing at all,....I wasn't told not to do this, not to do that. I was just told to rest. But I wasn't told, that means not to walk."*

Similar findings revealed by Abu Shuaib (2005) study, which assess women perception and experience of childbirth services at governmental hospitals in Gaza Strip. The researcher reported that information and communication as expressed by Palestinian women was 78.1%. Another study conducted by Abu Saileek (2004), who examined the client's satisfaction with nursing care provided at selected hospitals in Gaza Strip showed that 67.4% of the clients were satisfied with information and interaction dimension. Al Hindi (2002) conducted a study, which investigated client's satisfaction with radiology services. The researcher reported that communication and interaction as expressed by Palestinian clients was 77.5% satisfied and 22.5% dissatisfied. Mousa (2000) conducted a study about clients' satisfaction with family planning services in GS and showed that communication and interaction were reported to have the lowest degree of satisfaction.

Only 54% of the respondents were satisfied with regard to the communication and the interaction part of service. Mousa pointed to the need for comprehensive and in-depth training courses in the counseling process among health providers (Mousa, 2000).

Andaleeb (2001) conducted a study, which evaluated the service quality perceptions and patient satisfaction in Bangladesh. Andaleeb reported that communication as expressed by Bangladesh clients was 69.1% satisfied. Coulter and Cleary (2001) conducted a study, which analysis the patients' experiences with hospital care in five countries. The researchers reported that information and education as expressed by the respondents were in Germany 79.6%, Sweden 76.6%, Switzerland 83.3%, United Kingdom 71.3% and United State 74.8%. Informing the patient about his care is an issue that has been stressed by several studies (Kaplan and Ware, 1995; Wilson, 1992). Kaplan and Ware (1995) urged that informed patients feel better than those who were less informed about their care.

Hospital staff must spend more time with the patients to listen and answer their questions, give them the information they need and encourage them to ask and explain every procedure or investigation they need by simple words to be understood by the patients and never avoid questions. On the other hand, to improve the relationship between the health provider and the patients, hospital staff has to deal with the patient as if he gives care only to the patient in order to encourage patient's health providers trust and avoid feeling that the patient felt the health provider deals with files more than with the patient.

6.2.4 Hotel services:

Hotel services mains including the surrounding physical environment and its influencing on patient satisfaction. The physical environment included room temperature, safety and security, cleanliness, food, sound level, fellow patients and the comfort and aesthetics of

the premises. Clean clothes, a clean bed and tasty food were considered to be tokens of good hospital service. In this study, the findings showed that hotel services dimension scores was 74.5%. Apparently, the respondents are not predisposed to give the hospital staff a high rating on this service dimension. The majority of the patient accept the hotel services and the environmental situation at the hospital, that's were clear from their responses in this study. For example, one respondent said: *"The rooms were cleaned and arranged."* Another respondent said that: *"The good thing, there was no smoking in the hospital's wards."* Another respondent said: *"The external view of the hospital's garden makes a comfortable atmosphere for the patients and their visitors."* But on the other hand, some patients complain from the hotel services during their stay in the hospital. Also, these findings are consistent with the qualitative data in this study. For example, one patient said: *"Bathrooms always dirty and the maintenance is very bad."* Another responder said: *"Taste, type, appearance and quality of food are bad and need to be improved."* Another patient said: *"There was not enough and clean sheets, blankets and pillows."* Another patient said: *"I didn't find a well functioning wheel chair, always they are broken."* Another respondent said: *"I afraid to fall from the bed, because their were not side rails for the bed."* Also, another patient said: *"I can't sleep well, always there is a noise and the lights were on during the night and the nurses didn't do any thing for that."* This result is in agreement with Abu Shuaib (2005), who assesses women perception and experience of childbirth services at governmental hospitals in Gaza Strip. Abu Shuaib reported 76.1% of perspective level. He attributed that to the unfamiliar place; cold, strange, frightening and full of surprises. Compared with Abu Saileek (2004) study, who reported 69.7% satisfaction level with comfort and environment domain. Also, the results showed that the EGH clients' reported higher satisfaction level 88.9%, while Nasser Hospital clients' reported only 58.2% of satisfaction level. Also, Anastasios (2003) in his

study for evaluation of patient satisfaction with nursing care; the patients expressed low satisfaction with the cleanliness of toilets, noise levels and the variety and temperature of meals. The environment provides a first impression of the health care experience and influences the customer's evaluation of services is often based on that first impression (Uzun, 2001). The patient's hospital room is likely to be one of the most pervasive elements of the physical environment affecting patient-nurse interactions, because most interactions between the patient and nurse occur in the patient's room (Gotlieb, 2002).

To increase patient satisfaction regarding the hotel services, hospital staff may need to improve the physical environment through follow up cleanliness and maintenance of the ward especially the bathrooms. Also, more attention to food in terms of quality and type, taste and appearance. Moreover, having breaking hall for the patients and their visitors in each ward. Support hospital system and policies through enhancing the visit policies and continue preventing smoking inside the hospital. Hospital staff are responsible for the hotel services and should do their best to transform the situation into one associated with the image of pleasure, comfort and happiness. Improve the hotel services will alleviate the suffering of the patient.

6.2.5 Hospital culture:

Hospital culture domain reflects the relation between the hospital staff and the patients, the time took to respond to the patients requests, discrimination between patients, also reflects the distance between the patient and the health provider, if the patients exposed to risk, the ability of the hospital staff and the time taken for the admission process.

The finding showed that the patients' were reported the lower scores 73.4% of perspective level with the hospital culture domain. This is consistent with Abu Saileek (2004) findings

which reported 73.5% of satisfaction level with organizational culture domain. In addition, the results identified real differences between EGH clients' and Nasser Hospital clients'. The EGH reported higher satisfaction level 81.9%. On the other hand, Nasser Hospital clients' reported only 68.5%. However, this study is not consistent with Al-Hindi (2002) study which reported that the clients' reported higher level of satisfaction 80% with organization culture domain.

The important relationship between the organizational culture and satisfaction also were revealed by a study conducted by Niedeze (1998), who supported two correlation hypothesis stated that "*Patients' satisfaction with nursing care and patients' perceptions of the organization climate for service were each positively related patients' perception of service quality*" (Niedeze, 1998).

Qualitative data reflect patients' opinion with hospital culture, one patient said; "*I have a good trust of my doctors and nurses.*" Another one said; "*Hospital staff treat us on the same way without and discrimination.*" Another patient stated; "*I feel safe and relax by the way hospital staff treated me.*" On the other hand, other patients find it differently. One patient said; "*Hospital staff makes discrimination between the patients.*" Another patient said; "*If you have to be treated in a good way and to be respected, you have to visit the private clinic of the doctor.*" Another patient said; "*I have doubt about the abilities of the hospital staff who treated me.*" Another patient said; "*My operation's date was postponed many time because of the situation in the GS.*"

Hospital culture determines how the hospital operates and how the hospital staff frames the work inside the hospital. The culture of the organization has a powerful influence and outcomes (Evans and Lindsay, 1999). Changing culture to be supportive to quality improvement effects is a must. Therefore, it is important to train the staff to improve their

communication skills and how to work cooperatively as a team. Additionally, to listen carefully to the customer as he/she is considered an integral partner in developing a quality culture (Evans and Lindsay, 1999). The study findings indicating activities or programs to initiate a cultural change and to create a caring, customer-focused atmosphere. The activities have to be designed to define the desired culture, train the hospital staff to improve their communication skills, especially between the patients and the staff and celebrate the uniqueness of EGH. The crews of the hospital staff their responsibility through paying their medical attention for the patient. There have to be equality in the provision of service to the patients. Hospital staff has to increase the trust and the confidentiality of the patients. Also, operations and medical tests have to be done in a timely manner and without delay. Moreover, the culture of the hospital should reflect a wide variety of aspects such as communication channels, employee behavior and attitude, organizational structure and policies, rules, procedures and the work group.

6.2.6 Meeting expectations:

Meeting expectation dimension reflects to what extent the patient's satisfaction with the desire to receive pain relief, to the type of services provided and the patient experience with the health care services. Also, it reflected the extent of patients' perspective with the health services; the patients were given sufficient assistance in the activity of daily living and the involvement of the patients in the process of their care. In this study, the findings showed that the majority of the respondents were satisfied (82.2%) with the services they received; minority of patients (17.8%) found that service did not meet their expectation.

This finding was consistent with qualitative data of this study, for example, one patient stated; *"I received the type of service I expected."* Another patient stated; *"I cannot even begin to describe how much they have done for me."* Another patient said; *"They are very*

caring with patients who are unable to do much for them." Another patient said; *"They always do the best they can, but how can they help when there are only two of them. We see them running from one patient to the next."* On the other hand, express about the unmet expectation. One patient said; *"The only thing that I found was the time it took them, from the time I pressed the button for help. Sometimes it took a long time for them to come if they come at all."* Another patient stated; *"Most of the time, there is no doctor available in the ward especially on the evening and night shifts."* Another patient said; *"They left me suffering without any pain relief."*

Satisfaction is based on the difference between what one expects and what occurs (Thompson and Sunol, 1995). Within the disconfirmation paradigm, satisfaction is determined by the difference between a patient's standard of expectancies, ideals, or norms and the same patient's perceptions of their experiences of care, with satisfaction arising from either confirming positive expectation or disconfirming negative expectations. A fourth type of expectation is labeled an uninformed expectation; in which patients are not able to communicate their expectations, either because they may not have any expectations or because they do not wish to substantiate their feelings or cannot express them (Morales, 2001). Given the potential for uninformed expectations, Crow, Gage, Hampson, Hart and Kimber (2002) note that patients should be educated about appropriate expectations for care (particularly technical features) and motivated to judge the quality of care they are receiving (Crow, Gage, Hampson, Hart and Kimber, 2002).

6.3 Demographic variables and patients perceptions

In this part of the discussion, the researcher illustrated the relationship between dimensions of patients' perspective and demographic factors.

The study results showed that females mean scores were higher than the males mean scores in general and in all subscales dimensions. This result identified that females were in a higher level of overall perspective and in all dimensions of perception and no statistical significant differences were recorded between males and females in most of the dimension except in hotel services (P-value .013) of dimension of patients perception , their were statistical significant between males and females. This result is not endorsed by Abu Saileek (2004) who examined the client's satisfaction with nursing care provided at selected hospitals in Gaza Strip and identified that females were represented higher percentage (52.2%), while males' percentage was 47.8%. Also the statistical analysis pointed that there are no differences between males and females in their level of satisfaction with nursing care.

Al Hindi (2002) who evaluated clients' satisfaction with radiology services in Gaza Strip identified that there were no differences between males and females regarding the satisfaction level. On the other hand, findings by Jacox, Bauell and Mahrenholz (2002) pointed that men showed difference from women with respect to their assessment of care. Further, another study conducted by Uzun (2001) who measured patient satisfaction with nursing care in Ataturk University Hospital at Erzurum City in Turkey. The findings determined that there was a statistically significant relationship between satisfaction level and gender; the females gave higher scores than males (Uzun, 2001). Cleary, Zaslavsky and Cioffi (2000) who identified sex differences in assessments of the quality of Medicare managed care in the United State and identified that there were minimal differences between males and females; women reported slightly more positive assessments than did men.

Weisman, Henderson, Schifrin, Romans and Clancy (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 mean difference by gender. Women reported higher satisfaction on the rating of all experiences in the health plan on composite scores of customer services, whereas men had higher scores on three measures: getting cares quickly, how well doctors communicate and courtesy and helpfulness of office staff.

Thi, Briancon, Empereur and Guillemin (2002) who identified the factors associated with satisfaction among inpatients receiving medical and surgical care for cardiovascular, respiratory, urinary and locomotor system diseases. The findings determined that men tended to be more satisfied than women and women tended to complain more often than men do. In this study the gender did not play any role regarding the level of satisfaction. This finding may indicate that females have low expectation and did not know their health rights.

In this study, the age of the respondents ranged from 18 to 80 years, the result revealed a significant statistical differences between the age of patients and respect and privacy, approach of care, information and communication, hotel services and lastly, overall perception (P-value 0.017, 0.028, .001, .020 and .005 respectively). The findings showed that those patients who were more than 60 years of age have higher scores of perceptions, while the age group 18-30 years reported the lowest scores of perceptions. This result could be attributed to the more experience of hospital services by the old ages who know the differences in other hospitals in Gaza Strip, so they were more satisfied with the quality of the services provided. Also, this indicates that concern is needed to be directed to the younger ages.

This result is consistent with another 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 and 34 gave the lowest ratings of satisfaction level and patients aged between 50 to 64 and more than 65 gave the highest ratings (Uzun, 2001). This result is not consistent with another study done in Gaza Strip by Abu Shuaib (2005), findings showed that there was a significant difference with women age, loyalty and approach of baby care. The results showed that those women who were less than 18 years had positive attitudes towards childbirth services more than those who were more than 24 years. Also, this result is not consistent with another study done in Gaza Strip by Mousa (2000), found that the level of overall satisfaction was decreased as the age was increased and he conducted that the old people in Palestinian context tended to be less satisfied than the young (Mousa, 2000). On the other hand, a study conducted by Al Hindi (2002) found that no real differences between age groups regarding the satisfaction level (Al Hindi, 2002). Al-Doghaither (2004), found that the oldest group of patients were more satisfied with physician care. The middle aged group (those aged 30-49 years) of patients were least satisfied with physician services. The researcher attributed that might because they have the most exposure to health services outside of the country.

With regard to the marital status, the results revealed married clients' elicited higher level of the overall perspective scores (3.9604). Also, the results revealed a significant statistical differences between the marital status of patients and information and communication, while, there was no statistical significant differences between patients' marital status and all the other dimensions. This finding might indicate that married patients have less expectation and might have a previous experience about the hospital services. Also,

married patients have more responsibilities and more patience especially when there is difficulty or they have to wait a long time.

This finding was consistent with Al-Doghaither (2004) study which revealed that married people were more satisfied than single people. Moreover, this result is consistent with Abu Saileek (2004) study which revealed that the respondents who were married showed higher percentage (65.3%), while unmarried percentage was 34.8%. The findings reported that there are significant differences in satisfaction level, between married and unmarried respondents, the married respondents reported higher level of satisfaction.

With regard to the place of living, the results indicated that, there was statistical significant difference between the dependent variable respect and privacy and place of living. On the other hand, there were no statistical significant differences between the place of living and all of the other dimensions. Also, patients who live in Khanyounnis governorate have higher scores of perceptions, while the patients who live in Mid zone, Gaza and north governorates have lowest scores of perceptions.

This might be attributed to the fact that the study was conducted at the EGH in Khanyounis Governorate. Given that, study settings are more feasible and accessible to the patients and their visitors who living in Khanyounis Governorate.

This result is consistent with another study done in Gaza Strip by Abu Shuaib (2005), found that there were significant differences between dimensions of women's perspectives and provinces, the women who were living in Rafah had more positive perspective than women who were living in other provinces, while the women who were living in the Gaza province reported the lowest score.

There was no statistical significant difference between patients' perspective and citizenship, except with the information and communication domain. Patients who were non-refugees reported higher scores of perception about the hospital services and patients who were refugees reported the lowest score of perception.

With regard to the residency place, the result indicated that the majority of the study population live in refugee camps and patients who live in refugee camps have a lower mean scores in general all subscales dimensions and no statistical significant differences were recorded between refugee camps and non-refugee places like (cities, villages, etc.). This result identified that refugee camps have a lower level of overall perspective and in all dimensions of perception. This is not consistent with Mousa (2000) findings which reported that people who lived in camps have a high level of satisfaction rather than who lived out of the camps.

This finding may indicate that respondents who live in camps are frustrated and looking for better health services because of their suffering. Also, the finding may indicates that the patients who were living in camps have different environment than the patients who were living in non camps and did not exposed to the same situations. Moreover, this might be attributed to the fact that refugee camps residents familiar to the UNRWA health services clinics.

This result is consistent with a study done in Gaza Strip by Abu Saileek (2004), the findings revealed that the respondents who were living in cities represented higher percentage (48%). The statistical analysis identified that the respondents who were living in cities reported higher satisfaction level than the respondents who were living in camps. This result is not consistent with a study done in Gaza Strip by Al Hindi (2002), the findings reported that the statistical analysis reveals that there are no differences between

city, village and camp residents regarding satisfaction level (Al Hindi, 2002). This result is not consistent with another study done in Gaza Strip by Abu Shuaib (2005), found that women who were living in villages reported higher score of perception with childbirth services and women who were living in cities reported the lowest score of perception.

Regarding to educational level, the results revealed that there is real difference between patient education level and information and communication, hotel services, meeting expectation and overall perception. However, there were no significance difference between educational level and the other patient's perception dimensions. The statistical analysis identified that the illiterate and preparatory patients reported higher scores of perceptions, while the university level of education reported the lowest scores of perceptions.

This finding was consistent with Carlson, Shaul, Eisen and Cleary (2002) study, who identified the influence of patient characteristics on ratings of managed behavioral health care in the USA. The findings revealed that the more educated patients in commercial plans and in publicly sponsored behavioral health plans, rate their health plans lower. Moreover, The findings with Roohan, Franko, Anarella, Dellehunt and Gesten (2003) study: Do commercial managed care members rate their health plans differently than Medicaid managed care members in the United State?. The findings revealed that patients in Medicaid with more than a college degree rated their health plans lower than did those with less education. This finding was not consistent with Abu Shuaib (2005) study; the findings revealed that, there were no significant statistical differences between educational level and overall perspectives. Also, the study revealed that illiterate women reported positive experience more than educated ones.

The same was found with Abu Harbid (2004) study which revealed no significant statistical relationship between educational levels and overall satisfaction. The result was inconsistent with other studies; Al Hindi (2002) study revealed that population of higher level of education reported a higher satisfaction level. Also Mousa (2000) study revealed that the least satisfied group is the highly educated one.

This result could be attributed either to differences in expectations of care or the reporting style of the respondents. Also, educated patients are capable of making comparison between the services they received before and services received recently.

6.4 Socio-economic variables and patients perceptions

Regarding to the employment status, the results revealed that the un-employed (75%) patients elicited higher level of the overall perception scores, while the employed (25%) patients reported lower level. There were no statistical significance difference between the employment status and most of the perception dimensions, while there was statistical significant difference between employed patients and un-employed with regard to hotel services. This result is consistent with Abu Shuaib (2005) study, who revealed that no statistical significant difference between employment with perspective's dimension regarding to overall perspective. Also, this result is consistent with Mousa (2000) study, which revealed no statistically significant between the economical statuses regarding to the satisfaction level.

Moreover, Al Hindi (2002) study, found that the respondents with higher financial status tend to be more satisfied than the respondents with lower financial status. In spite of no significant difference present, but the result indicates that the un-employed patients were more perspective with health services than the employed patients. The patients who have

higher income tend to have higher expectations, while patients who have lower income or un-employed tend to have lower expectation. Also, this is consistent with Hall and Dornan (1990) attempt to distinguish two possibilities; first that independent of the actual care received poor patients generally more accepting and more reluctant than rich patients to pass negative judgment, second that poor patients are treated in a less though and responsive manner.

Regarding to the health insurance scheme, the results showed that, there was no statistical significant difference between dimensions of patients' perceptions of health services and health insurance scheme. The statistical analysis revealed that patients who use syndicate payment have higher scores of perceptions, while the patients who use private health insurance have lowest scores of perceptions. This result is consistent with Abu Shuaib (2005) study, which revealed that the clients who were medically insured reported higher reported higher level of satisfaction, while the clients who are self paid care reported lower level of satisfaction.

This result could be attributed to the fact that the majority of the respondents have syndicate insurance which was given to the un-employed workers. Those workers have a low expectation and haven't another chance for medical services in private hospitals or clinics.

6.5 Hospital admission related variables and patients perceptions

Regarding the number of previous admissions, the findings showed higher percentage of the patients who have been hospitalized for the first time (55%), while the respondents who have been hospitalized previously represented only (45%). The study revealed patients who were admitted for more than one admission elicited higher level of the overall

perception scores, while the patients who were admitted for the first time have lowest scores of perceptions. This result is consistent with Abu Saileek (2004) findings that the clients who have been hospitalized previously in other hospitals were more satisfied than the clients who have not been hospitalized in other hospitals. This result could be attributed to experience and knowledge receiving during the past admissions will help the patients to understand the hospital staff.

With regard to the admission's days, the study revealed that, there were no statistical significance difference between the number of admission's days and most of the perception dimensions, while there were statistical significant difference between the patients with regard to respect and privacy and approach of care. The statistical analysis revealed that patients who were admitted for more than 9 days have lower scores of perceptions, while the patients who were admitted for less than 4 days have higher scores of perceptions.

This result is not consisted with Abu Saileek (2004) findings that the clients who spent 4 to 12 days in the hospital were more satisfied with nursing care than the clients who spent fewer days. This result is consistent with Abu Shuaib (2005) findings that the women who spent one day in the hospital were have higher positive perspectives with childbirth services than the women who spent more than 3 days. This result could be related to that, patients after a period started to know the defects and the problem to deal with the hospital staff. Gradually get used to the routine of the hospital services and make a real picture about what is going on.

Regarding to the admission ward (medical and surgical), distribution of the respondents showed that patients' from surgical wards were higher percentage (55%), while the respondents from medical ward represented (45%). Also, the findings revealed that the medical patients elicited higher level of the overall perception scores (mean 3.9652), while

the surgical patients reported lower level (mean 3.9153). this result is consistent with a study conducted by Uzun (2001) investigated patient satisfaction with nursing care in Hospital of Ataturk University in Turkey, found that the patients' in medical clinical treatment gave higher scores than did in surgical clinical treatment, there was a statistically high level of significant differences in mean in weighted scores for the dimensions between medical and surgical clinical patients (Uzun, 2001). This result contrast with a study conducted by Abu Saileek (2004), the findings revealed that the clients' from surgical wards and medical wards were in the same level of satisfaction.

This result might be related to; patients who were admitted to the medical wards have chronic disease, frequently admitted to get care and usually spend more days in the ward. Those patients usually have more perspective scores than other patients.

Regarding the type of admission, showed that the majority of the study population were admitted as an emergency cases to the hospital wards (72%). It also revealed that the mean of overall perception for emergency admission (3.9575) of the study population higher than for planned admission (3.8876). No statistical significant differences between all the dimensions of perceptions and the type of admission for the study population. This fact may give an alarm for the hospital director to find the cause of that.

6.6 Patient health status and patients perceptions

Regarding the patients evaluation of their health status, the findings showed that, there were real differences between the patient's evaluation of their health status and the overall perception (P-value .025) and all dimensions of patients perceptions. Statistical analysis revealed that, patients who had excellent and very good health status reported higher scores of perceptions, while the patients who had fair/poor health status reported lowest scores of

perceptions. In their review of 31 observational studies that examined the relationship between health status and satisfaction, Crow, Gage, Hampson, Hart and Kimber (2002) found that poorer physical health status, disability, low quality of life and psychological distress are related to lower reported satisfaction. This result is consistent with a study done by Haviland, Morales, Reise and Hays (2003); the findings revealed that ratings of health care were likely to be more positive among those in better health.

Another study conducted by Roohan, Franko, Anarella, Dellehunt and Gesten (2003): Do commercial managed care members rate their health plans differently than Medicaid managed care members? The finding revealed that health status had the largest effect on rating: respondents rating their health status as poor gave their health plan an average rating of 6.34 on a scale of 0 to 10, whereas those who rated their health status as excellent gave their health plan an average rating of 7.72. However, Wensing, Jung, Mainz, Olesen and Grol (1998) noted in their review that the meaning of the relationship between health status and patient perceptions is unclear. This result might be related to; patients who were evaluated their health status excellent and very good have better outcomes and report higher perspective scores and may be hospital staff respond more negatively to patients in poorer health.

6.7 Hospital services and patients perceptions

Regarding the patients evaluation of their hospital health services, the findings showed that, there were real differences between the patient's evaluation of their hospital health services and the overall perception (P-value .016) and all dimensions of patients perceptions. Statistical analysis revealed that, patients who had excellent and very good health status reported higher scores of perceptions, while the patients who had fair/poor health status reported lowest scores of perceptions. The results of this study indicate the

important of the hospital services provided to the patients on influencing patients' perspective. Also, continuous improvement in the services provided to the patients will lead to improve the patients' perception.

6.8 Recommending the European hospital to others

The results indicate that there were real differences between the recommendation item and the overall perception (P-value .000) and all dimensions of patients perceptions. The finding revealed that, the patients who will recommend this hospital reported higher scores of perceptions, while the patients who will not recommend this hospital reported lowest scores of perceptions.

The result is agree with a study conducted by Jenkinson, Coulter, Bruster, Richard and Chandola (2002) whose conducted a study to determine what aspects of healthcare and willingness to recommend hospital services to others at five hospitals within one National Health Service trust in Scotland. The results reported here similarly find high levels of perspective. Furthermore, perception is very highly associated with willingness to recommend to others the hospital in which they received treatment. However, many respondents who indicated that they were satisfied with their health care also indicated problems in aspects of their inpatient episode.

Chapter seven

Conclusions and Recommendations

Chapter 7

Conclusions and Recommendations

7.1 Conclusions

This study is carried out for understanding the patients' perception, experiences, concerns and views about the hospital services provided at the European Gaza Hospital. The study findings might help in improving the quality of hospital service at the EGH and furthermore, in Gaza Strip by providing some satisfaction indicators to start quality improvement process. The study explored the main domains of patients' perception; also it explored the differences within the demographics, socio-economic and hospitalization variables with respect to the patients' perception level. The response rate was high as 88.8%. The reliability coefficient of the study instrument was high 0.86.

The overall perspective level was reported 78.7%. The domains of perception about hospital services are extracted to include respect and privacy, approach of care, information and communication, hotel services, hospital culture and meeting expectation. The highest level of perception was expressed toward respect and privacy (83%). which reflects the extent of the patients' trust toward the hospital services provided to the patients to preserve their privacy at the hospital's wards. Still there is a room for more improvement. Also, patients reported high perception score towards meeting expectation (82.2%) and approach of care (82.2%). This positively affects patients' health status and encourages them to come back again in case of need to hospital service. Also, they will recommend the hospital to other relatives or friends.

Moderate perception scores were reported with information and communication (77.1%). Therefore to improve the information and communication. Hospital staff must spend more time with the patients to listen and answer their questions, give them the information they need and encourage them to ask and explain every procedure or investigation they need by simple words to be understood by the patients and never avoid questions.

On the other hand, the lowest level of perception was reported toward hospital culture (73.4%) and hotel services (74.5%). The activities have to be designed to define the desired culture, train the hospital staff to improve their communication skills, especially between the patients and the staff and celebrate the uniqueness of EGH. Also, hospital staff are responsible for the hotel services and should do their best to transform the situation into one associated with the image of pleasure, comfort and happiness. Improve the hotel services will alleviate the suffering of the patient There have to be equality in the provision of service to the patients. Hospital staff has to increase the trust and the confidentiality of the patients and their families. Also, operations and medical tests have to be done in a timely manner and without delay. Therefore, improving the quality of services encourages the patients to continue attending to the EGH.

The study showed significant differences within the demographics variables regarding the perception level. The older patients rated their care and health services more highly than did younger patients. More educated patients rate their hospital services lower than did those with less education. Males and females were nearly equally distributed with an average age of 42 years. Females reported higher perspective level about hospital services, while males reported lower level of perspective.

Married patients reported higher level of perspective, while unmarried patients reported lower level of perspective. Patients who live in Khanyunnis governorate have higher level

of perspective than the patients who live in the north of Khanyunnis governorate. Also, the majority of the respondents came from Khanyunnis and Rafah governorates because of the restriction on the patients who live on the other governorates in Gaza Strip. The hospital administration may need to encourage the northern population to come and benefited from the services on the EGH. Patients who live outside refugee camps have a higher level of perspective than those who live in refugee camps. The unemployed patients have a higher level of perception than the employee's patients. This reflects the difficult socioeconomic status that dominated Palestinian people in Gaza Strip at the time which the study was conducted. 75% of the respondents were not working at the time of data collection.

The patients who were used the syndicate health insurance to cover health services have a higher level of perception than those used governmental and private health insurance. This reflects that most of the unemployed people have syndicate health insurance and those patients have a difficult economic situation, so they might have low expectation.

The study pointed to the effects of the hospital services variables (number of admission, number of admission's days, type of admission and the admission ward) on the perception of the patients about the hospital services. Hospitalization factors showed a great impact on perception. The patients reported lower perspective scores in their first admission compared with those who had previous admissions. This might reflect that the patient is familiar with the hospital service. Also, this might reflect that patients who had previous admission are chronic, seriously ill, so they have low expectation.

Patients who were admitted for three days have a higher level of perception than patients who were admitted for more than four days. This might reflect that the patient is anxious at the first admission about the building and the arrangement system which is a little bit different from other governmental hospital. Patients who were admitted to the medical

ward have a higher level of perception than patients who were admitted to the surgical ward. This might be due to the type of patient, where most of the medical patients have chronic disease. The patients who were admitted from the emergency ward have a higher perception scores than the patients who were admitted from the outpatient clinic as planned admission. Attention to these points would bring a higher perspective scores and would improve patient's positive perception about the hospital services they received.

Evidence suggests that patients generally indicate that they are satisfied with care. The results reported here similarly find high level of reported satisfaction. Furthermore, satisfaction is very highly associated with willingness to recommend to others the hospital in which they received treatment. However, many respondents who indicated that they were satisfied with their health care also indicated problems in aspects of their admission. Indeed, on the related item of willingness to recommend the hospital to others, problems were indicated on all dimensions of the questionnaire for those patients who indicated they would be happy to do so. This seems to suggest that satisfaction with hospital services and willingness to recommend a hospital does not imply all aspects of that service were successfully delivered.

7.2 Recommendations

- The study extracted six important domains that constitute a framework for patients' perceptions. Health managers, professionals and policy maker need to consider these domains and deliberately work on improving them.
- The study concluded that respect and privacy, approach of care and meeting expectation are positively perceived domains; therefore, need to be reinforced.
- The study revealed that information and communication are weak points and conscious efforts need to be focused on improving them such as:
 - Provision of training on effective communication skills to the staff including physicians, nurses, technicians and administrative personnel.
 - Institutionalizing the informative approach when dealing with patients.
 - Reinforcing the role of the staff as a counselor and a coach to patients and their families.
 - Directing efforts at a wide-scale toward public awareness and education about their health rights.
- Hospital culture is a weak point that requires further attention. Being more responsive to patients needs, treating patients equally, considering the uniqueness of each patient-patient-centered approach and treating him/her in a humane way are important strategies that should be emphasized.
- Hotel services also scored low and it requires further attention. Hotel services could be promoted through providing sheets, blankets and pillows clean and enough, attention and maintenance of clean bathrooms. Also, attention to food in terms of quality and type, taste and appearance. Moreover, having rest halls in each ward and providing wheel chairs in good condition.

- The study showed that being un-married, young age group, living outside Khanyuois governorate, living in camps and being highly educated were associated with less positive perception, and those groups require more attention by health professionals and managers.
- More attention should be paid to employed patients; patients having private health insurance; patient who were admitted for the first time; Patient who stayed at the hospital for more than eight days; patient admitted to the surgical ward and patient who admitted from the outpatient clinic as planned admission.
- Policy maker and health manager could develop performance framework that include indicators of responsiveness to patients.

Chapter eight

References

Chapter 8

References

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Annexes

Annex 1

Consent Form

الرقم الرمزي:-----

طلب الموافقة

الأخوات والأخوة الأعزاء:

أرجو التكرم بالإجابة على أسئلة الاستبيان الذي تم إعداده لجمع المعلومات اللازمة لتقويم الخدمات الصحية المقدمة في مستشفى غزة الأوروبي

يتم هذا البحث بالتنسيق مع وزارة الصحة وجامعة القدس، وذلك كمتطلب تخرج لإنهاء درجة الماجستير في الإدارة الصحية، إن تعاونكم وموافقتكم على المشاركة والإجابة على أسئلة الاستبيان سيكون له أهمية بالغة لإنجاز هذا البحث، وكذلك للارتقاء بالخدمات الصحية في مستشفى غزة الأوروبي.

كما أن المعلومات الخاصة بكم وبناتج البحث ستكون في سرية تامة ولكم مطلق الحرية في المشاركة أو عدم المشاركة دون أن يكون هناك أي ضرر يلحق بكم في حال عدم المشاركة أو أي عائد مادي للمشاركة.

شاكرين تعاونكم

الباحث: محمد الحاج

Annex (2): Helsinki Committee Approval Letter

Palestinian National Authority
Ministry of Health
Helsinki Committee



السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

Date: 26/9/2006

التاريخ: 2006/9/26

Mr./ Mohammad El-Haj

السيد: محمد الحاج

I would like to inform you that the committee
has discussed your application about:

تفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم
حول:-

Perception of Hospitalized Patients
about the Service Provided
at the European Gaza Hospital (EGH)

In its meeting on September 2006
and decided the Following:-
To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر سبتمبر 2006
وقد قررت ما يلي:-
الموافقة على البحث المذكور اعلاه.

Signature

توقيع

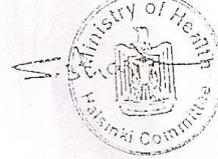
Member

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 appreciates receiving one copy of your final research when it is completed.

Annex (3): Ministry of Health Permission Letter

جامعة القدس



2007/7/2

كلية الصحة العامة

School of Public Health

القدس - فلسطين

وزارة الصحة



الرسالة رقم ٢٠٠٧/٧/٢
م. فتنحي الحاج
مدير عام الإدارة العامة للمستشفيات
نحية طيبة وبعد،،،

حضرة د. فتنحي الحاج المحترم
مدير عام الإدارة العامة للمستشفيات
نحية طيبة وبعد،،،

الموضوع: مساعدة الطالب محمد عبد الحافظ الحاج

يقوم الطالب المذكور أعلاه بإجراء بحث بعنوان:

"Perception of Hospitalized patients about the Health Services provided at European Gaza Hospital"

كمتطلب للحصول على درجة الماجستير في الصحة العامة-مسار إدارة صحية علماً بأن الطالب قد حصل على موافقة لجنة هلسنكي لأخلاقيات البحوث و ستكون المعلومات متوفرة لدى الباحث فقط. و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالب في جمع البيانات الخاصة.

موافقتكم دعياً للمسييرة الأكاديمية
و تفضلوا بقبول فائق الاحترام ،،،

د. سوزان شعشاعه
عمود كلية الصحة العامة المساعد

صناديق
وارب
٢٩٩٥
٩١٥٩

إرفاق
المدير الإداري
م. فتنحي الحاج

صناديق
وارب
٢٩٩٥
٩١٥٩

نسخة: الملف

Annex (4): Exit Interview Questionnaire

SECTION 1: YOUR EXPERIENCES OF THE HEALTH SERVICES

Please sign **one** response for **each** question

No.	Questions	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1	I had a good experience with the health care services in this hospital					
2	I received the type of services I expected					
3	Hospital staff respected me as a person					
4	Hospital Staff spent sufficient time with me					
5	Hospital staff made sure that patients had privacy when they needed it					
6	My choice of bath/shower were respected					
7	I was given sufficient assistance in the activities of daily living					
8	I was involved in the process of my care					
9	Hospital staff checked regularly to make sure that I am okay					
10	I am satisfied with the way the hospital staff treated me in general					
11	I had been given enough notice regarding my expected discharge date					
12	My date of discharge was appropriate to me					
13	I was involved in decisions affecting my care					
14	My desire regarding pain relief were respected					
15	I received adequate pain relief measures					
16	I was given enough information about my condition					
17	I was given enough information about my treatments, including possible alternatives and any associated side effects					
18	Hospital staff informed me about the daily routine care					
19	I had a difficulty in communicating with hospital staff					
20	Hospital staff provided me with clear explanations about the procedures which were done to me					
21	Hospital staff gave me clear explanations about my tests result					

No.	Questions	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
22	Hospital staff introduced themselves to me					
23	Hospital staff explained things in away I could understand					
24	I was given enough information about my care after discharge					
25	I was given enough assistance for my care after discharge					
26	The arrangements for my discharge handled in a good way					
27	I have a perception that I received satisfactory answers to my questions					
28	There were a adequate communications among the staff regarding my care					
29	Hospital staff treated me in a friendly and a courteous manner					
30	Hospital staff favored some patients over others					
31	It was easy to exchange smiles with the hospital staff					
32	There was a happy atmosphere in the ward (Thanks to the staff !!!)					
33	I felt ignored at the ward					
34	Hospital staff took enough notice of my views and wishes					
35	There was a distance between me and the health providers					
36	I felt that the staff were concerned about me as a person					
37	Hospital staff consistently demonstrated willingness to listen to me					
38	My admission was handled promptly					
39	There were unreasonable delays during the admission process					
40	Hospital staff took a long time to come when they were called					
41	Hospital staff were available around if I need them					
42	Hospital staff visited me regularly					
43	Hospital staff responded quickly to my requests					
44	Hospital staff were adequate in the ward					

No.	Questions	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
45	Hospital staff worked well together as a team					
46	My health care services were delivered in an appropriate manner					
47	My needs were considered and respected by all staff					
48	Hospital staff ignored what I told them sometimes					
49	I had confidence in the hospital staff					
50	Hospital staff acted too businesslike and impersonal toward me					
51	I viewed the hospital staff as friends					
52	I had doubt about the abilities of the Hospital staff who treated me					
53	I felt that my hospital staff were very competent					
54	Hospital staff exposed me to unnecessary risks					
55	The standards of personal care were high					
56	All the personal care (dressings, ??? exercises, etc.) delivered at appropriate times					
57	Medications were given on time					
58	The standard of care shown to me by hospital staff were excellent					
59	The standard of respect shown to me by hospital staff were excellent					
60	The standard of service shown to my family by hospital staff were excellent					
61	Hospital staff excused before entering my room					
62	Unit arrangement and preparation provided adequate privacy					
63	Visitors paid attention to my privacy					
64	Hospital staff made sure that patients had privacy when they examined them					
65	I the ward environment regarding privacy was excellent					

No.	Questions	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
66	It was easy for me to get to the hospital					
67	It was easy for my visitors to find my room in the hospital					
68	I was given enough freedom on the ward					
69	I think that the ward environment regarding the noise level during the day was tolerated					
70	The noise level in the night was tolerated					
71	The room temperature was fine					
72	The room cleanliness was acceptable					
73	Bathrooms cleanliness was good					
74	The meals provided were delicious					
75	I think that the meals with regard to appearance was nice					
76	I think that the meals with regard to choice was adequate					
77	I think that the meals with regard to amount of food was sufficient					
78	I felt concerns about safety or security whilst in hospital					
79	The ward was quiet					
80	The bedding was clean					

83- I will recommend this hospital to my family and friends if they need hospital care

1- Yes to high extent

2- Uncertain

3- Not at all

84- If not recommending this hospital, is there a particular reason?

85- What did you enjoy most about your stay in hospital?

86- What do you think the hospital could do to improve the quality of the care and service it provides? Are there any other services that you think could or should provide?

87- In general, how would you rate the health services provided to you during recent hospitalization?

1) Excellent 2) Very good 3) Good 4) fair 5) Poor

OK

Thank you for taking the time to fill in this questionnaire.

SECTION 2: QUESTIONS ABOUT YOURSELF

**These questions are about you. To help us understand your answers to the other sets of questions, we need some information about you.
This information is highly confidential and you will not be identified by providing this information**

Socio-demographic History

1- Gender: 1-Male 2-Female

2- Age:----- Years

3- Marital status:

a- Single b- Married c- Divorced d- Widows

4- Place of living:

1- Rafah governorate 2- Khanyonnis governorate 3- Gaza governorate
4- Mid-zone governorate 5- North governorate

5- Citizenship: 1-Refugee 2-Not-refugee

6- Residency Place: -----

7- Level of education completed: -----

8- Number of educational years-----

9- Occupation: -----

10- Payment for medical care at this hospital:

1- Private health insurance 2- Governmental health insurance
3- Self payment 4- Other

11- Is this your first admission to this hospital?: 1- Yes 2- No

12- If not, what are the number of previous admissions? -----

13- How many days you have stayed in the hospital (this admission)-----days

14- Admission department: 1- Medical 2- Surgical

15- In general, how would you rate your health?

1- Excellent 2- Very good 3- Good 4- Fair 5- Poor

16- My admission was: Emergency Outpatient Clinic

Annex (5): Arabic Language Questionnaire

الفصل الأول: خبراتك عن الخدمة الصحية في المستشفى:-

من فضلك ضع علامة على خيار واحد أمام كل سؤال

الرقم	الأسئلة	بشدة لا أوافق	لا أوافق	غير متأكد	أوافق	بشدة أوافق
1	تجربتي كانت جيدة بالنسبة للعناية و الخدمة الصحية في هذه المستشفى.					
2	تلقيت الخدمات التي كنت أتوقعها.					
3	موظفو المستشفى احترموني كإنسان.					
4	موظفو المستشفى امضوا وقتاً كافياً معي.					
5	موظفو المستشفى يحافظون / يوفرون الخصوصية للمريض عند الحاجة.					
6	اختياري بالنسبة للحمام كان يحترم " يؤخذ بالاعتبار "					
7	تلقيت مساعدة كافية للقيام بأنشطة الحياة اليومية.					
8	تم إشراكي في العناية المقدمة لي					
9	طاقم المستشفى كانوا يفحصونني باستمرار للتأكد من سلامتي.					
10	بشكل عام أنا راضي عن الطريقة التي عاملني بها موظفي المستشفى.					
11	أتلقي المعلومات الكافية حول تاريخ خروجي المتوقع من المستشفى.					
12	تاريخ خروجي من المستشفى كان مناسباً لي.					
13	تم إشراكي في اتخاذ القرارات ذات العلاقة بالعناية بحالتي.					
14	حاجتي للأدوية المخففة للألم أخذت بعين الاعتبار.					
15	تلقيت وسائل مختلفة لتخفيف الألم					
16	تلقيت معلومات كافية حول حالتي الصحية.					

الرقم	الأسئلة	لا بشدة	لا أوأفق	غير متأكد	أوأفق	أوأفق بشدة
17	تلقيت معلومات كافية حول العلاج، و احتمالات تغيير الخطة العلاجية، و أي أعراض جانبية قد تحدث.					
18	طاقم المستشفى أبلغوني عن الأعمال / العناية اليومية الروتينية					
19	أواجه صعوبات في التحدث/ التواصل مع طاقم المستشفى.					
20	طاقم المستشفى زودوني بشرح وافي بالنسبة للعمليات و العناية التي قدمت لي.					
21	طاقم المستشفى زودوني بشرح وافي حول نتائج التحاليل الطبية.					
22	طاقم المستشفى كان يقدم نفسه لي.					
23	طاقم المستشفى كان يشرح لي المعلومات بطريقة أفهمها.					
24	تم إعطائي معلومات كافية بخصوص العلاج المطلوب بعد الخروج من المستشفى.					
25	حصلت على مساعدة كافية بخصوص العلاج بعد الخروج من المستشفى.					
26	ترتيبات الخروج من المستشفى تمت بشكل جيد.					
27	من وجه نظري أنا تلقيت الإجابات المرضية لأسئلتني.					
28	كان هنالك حوارات و نقاشات كافية بين أفراد الطاقم الطبي بخصوص العناية المقدمة لي.					
29	طاقم المستشفى كان يتعامل معي بطريقة ودية.					
30	طاقم المستشفى يفضلوا بعض المرضى عن غيرهم.					
31	كان من السهل تبادل الابتسامات مع طاقم المستشفى.					
32	يسود جو من المرح و السعادة داخل القسم. (شكرا للموظفين)					

الرقم	الأسئلة	لا بشدة	لا أوافق	غير متأكد	أوافق	أوافق بشدة
33	كان لدي إحساس بعدم مبالاة الطاقم العامل في القسم بحالتي.					
34	طاقم المستشفى لديه معلومات كافية حول وجهات نظري ورغباتي. (تؤخذ على محمل الجد)					
35	هناك فجوة بيني وبين مقدمي الخدمة الصحية.					
36	شعرت أن طاقم المستشفى يبدي اهتماماً بي كإنسان.					
37	طاقم المستشفى يبدي الرغبة في الاستماع إلي بشكل جيد.					
38	دخولي المستشفى تم بشكل سلس وبدون تأخير.					
39	كان يوجد تأخير غير مبرر أثناء عملية دخولي للقسم.					
40	طاقم المستشفى يستغرق وقتاً طويلاً للرد على طلباتي "للرد على جهاز الاستدعاء".					
41	طاقم المستشفى موجود باستمرار وعند الحاجة.					
42	طاقم المستشفى يترددون على باستمرار وانتظام.					
43	طاقم المستشفى يلبي طلباتي بسرعة.					
44	الطاقم العامل في القسم كافي من الناحية العددية.					
45	طاقم المستشفى يعملون معا كفريق واحد.					
46	تم تقديم الخدمة الصحية لي بالشكل المناسب.					
47	طلباتي / حاجاتي أخذت بعين الاعتبار (تم تلبيةها) من طاقم المستشفى.					
48	طاقم المستشفى لا يبالي بما أقوله أحياناً.					
49	ثقتي عالية بطاقم المستشفى.					
50	طاقم المستشفى مستغل جدا ويعاملني بطريقة غير ودية.					
51	أتصور أنه يمكن اعتبار طاقم المستشفى أصدقاء.					

الرقم	الأسئلة	بشدة لا أوافق	بشدة لا أوافق	غير متأكد	أوافق	بشدة أوافق
52	لدي شك في قدرات الطاقم الذي يعالجني.					
53	أشعر أن طاقم المستشفى مؤهل وماهر في تقديم الخدمة.					
54	طاقم المستشفى عرضني لمخاطر غير مبررة.					
55	معايير تقديم العناية الصحية عالية.					
56	يتم تقديم العناية الشخصية (غيار- تمارين وغيرها) في مواعيدها المحددة.					
57	يتم إعطاء الدواء في مواعيد محددة.					
58	معايير تقديم الخدمة التي تعرفت عليها من خلال طاقم المستشفى كانت ممتازة.					
59	مستوى التقدير والاحترام الذي يظهره طاقم المستشفى كان ممتاز.					
60	مستوى الخدمة المقدمة لأسرتي بواسطة طاقم المستشفى كان ممتازا.					
61	يستأذن طاقم المستشفى قبل دخول الغرفة.					
62	ترتيبات وحدة المريض توفر الخصوصية الكافية له.					
63	الزائرين يراعوا ويهتموا بخصوصيتي.					
64	يحرص طاقم المستشفى على خصوصية المريض عند إجراء الفحوصات.					
65	بيئة القسم توفر خصوصية جيدة للمريض.					
66	كان من السهل علي الوصول للمستشفى.					
67	كان من السهل على الزائرين الوصول لغرفتي في المستشفى.					
68	أعطيت الحرية الكافية في القسم.					
69	أعتقد أن مستوى الضوضاء في القسم مقبولا ويمكن احتماله.					
70	مستوى الضوضاء في الليل مقبول.					

أوافق بشدة	أوافق	غير متأكد	لا أوافق	لا أوافق بشدة	الأسئلة	
					درجة حرارة الغرفة كانت مناسبة.	71
					مستوى النظافة في الغرفة كان مقبولاً.	72
					نظافة الحمامات جيدة.	73
					وجبات الطعام المقدمة شهية ولذيذة.	74
					أعتقد أن وجبات الطعام تقدم بشكل ومظهر جميل.	75
					أعتقد أنه توجد خيارات متاحة لاختيار وجبات الطعام.	76
					أعتقد أن كمية الطعام المقدمة في الوجبات كافية.	77
					يوجد اهتمام خاص بأمن المريض.	78
					القسم كان هادئ	79
					شرا شرف الأسرة دائماً نظيفة.	80

81- سوف أوصي أقربائي وأصدقائي للذهاب لهذه المستشفى عند الحاجة

1. نعم وبدرجة عالية

2. غير متأكد

3. إطلاقاً لا

82- إذا لم توصي بهذه المستشفى، حدد الأسباب ؟

الفصل الثاني: البيانات الشخصية

هذه الأسئلة هي عنك. لمساعدتنا على فهم إجاباتك على أسئلة أخرى، نحن نحتاج بعض المعلومات الشخصية عنك.
هذه المعلومات سوف تكون في غاية السرية وشخصيتك لن تكون معروفة عند تقديم هذه المعلومات.

- 1- الجنس: ذكر أنثى
- 2- العمر: -----
- 3- الحالة الاجتماعية:
أعزب متزوج مطلق أرمل
- 4- مكان الإقامة:
محافظة رفح محافظة خانونس محافظة غزة
محافظة الوسطى محافظة الشمال
- 5- المواطنة: لاجئ مواطن
- 6- مكان الإقامة: -----
- 7- المستوى التعليمي الذي أنهيت:
أمي ابتدائي إعدادي ثانوي جامعي
- 8- عدد سنوات التعليم: -----
- 9- المهنة: -----
- 10- تغطية مصروفات العلاج في هذه المستشفى من خلال:
تأمين صحي خاص تأمين صحي حكومي تأمين صحي عسكري
تأمين نقابي من حسابي الخاص آخر
- 11- هل هذه أول مرة تدخل فيها هذه المستشفى كمريض؟ نعم لا
- 12- إذا كانت الإجابة "لا" فما عدد مرات الدخول السابقة للمستشفى؟ -----
- 13- ما عدد الأيام التي مكنتها في المستشفى هذه المرة؟ -----
- 14- قسم الدخول: باطنه جراحة
- 15- بشكل عام، كيف تقيم صحتك:
ممتاز جيد جدا جيد مقبول سيئ
- 16- دخولي للمستشفى كان بشكل: طارئ العيادة الخارجية

Annex (6): Factor labels, items content, factor loading, mean and standard deviation

Factor name	Questions	Factor loading	Mean	S.D
Respect and privacy	59-The standard of respect shown to me by hospital staff were excellent	.643	4.2492	.65930
	36- I felt that the staff were concerned about me as a person	.612	4.2012	.68001
	64- Hospital staff made sure that patients had privacy when they examined them	.611	4.3093	.68798
	64- Hospital staff made sure that patients had privacy when they examined them	.593	4.1742	.83214
	47- My needs were considered and respected by all staff	.592	4.0541	.77814
	49- I had confidence in the hospital staff	.558	4.0961	.78565
	62- Unit arrangement and preparation provided adequate privacy	.533	4.0841	.80967
	68- I was given enough freedom on the ward	.515	4.1411	.73297
	65- The ward environment regarding privacy was excellent	.500	4.1772	.72922
	61- Hospital staff excused before entering my room	.487	4.0300	.94055
Approach of care	46- My health care services were delivered in an appropriate manner	.661	4.3093	.68798
	58- The standard of care shown to me by hospital staff were excellent	.631	4.1982	.71330
	45- Hospital staff worked well together as a team	.600	3.9940	.84309
	42- Hospital staff visited me regularly	.578	4.1021	.77718
	57- Medications were given on time	.563	4.3544	.56019
	53- I felt that my hospital staff were very competent	.562	4.0661	.69539
	60- The standard of service shown to my family by hospital staff were excellent	.537	4.0541	.88669
	55- The standards of personal care were high	.521	4.0210	.75819
	41- Hospital staff were available around if I need them	.519	4.1081	.74062
	56- All the personal care (dressings, ??? exercises, etc.) delivered at appropriate times	.453	3.9970	.93299
10- I am satisfied with the way the hospital staff treated me in general	.448	4.2913	.75399	

	38- My admission was handled promptly	.448	4.0210	.88979
	31- It was easy to exchange smiles with the hospital staff	.419	4.0931	.79931
	67- It was easy for my visitors to find my room in the hospital	.401	4.1171	.68202
Information and communication	13- I was involved in decisions affecting my care	.635	3.8559	.97109
	27- I have a perception that I received satisfactory answers to my questions	.624	3.9489	.67693
	43- Hospital staff responded quickly to my requests	.623	4.0000	.90181
	20- Hospital staff provided me with clear explanations about the procedures which were done to me	.618	3.7838	.83311
	22- Hospital staff introduced themselves to me	.571	3.5345	1.10428
	16- I was given enough information about my condition	.571	4.1742	.86759
	11- I had been given enough notice regarding my expected discharge date	.542	3.8619	1.00847
	18- Hospital staff informed me about the daily routine care	.524	3.6336	.96209
	44- Hospital staff were adequate in the ward	.504	3.8529	.96597
	26- The arrangements for my discharge handled in a good way	.493	4.0240	.68064
	34- Hospital staff took enough notice of my views and wishes	.486	3.5526	1.00949
	17- I was given enough information about my treatments, including possible alternatives and any associated side effects	.479	3.8408	.78496
	23- Hospital staff explained things in away I could understand	.444	3.8919	.81053
	24- I was given enough information about my care after discharge	.415	4.0390	.77711
Hotel services	74- The meals provided were delicious	.683	3.5556	1.19515
	75- I think that the meals with regard to appearance was nice	.672	3.6577	1.13935
	77- I think that the meals with regard to amount of food was sufficient	.656	3.6547	1.16071
	73- Bathrooms cleanliness was good	.629	3.7177	1.12671
	78- I felt concerns about safety or security whilst in hospital	.595	4.1562	.76023

	80- The bedding was clean	.545	3.7508	1.11441
	79- The ward was quiet	.524	4.0901	.91720
	72- The room cleanliness was acceptable	.522	4.1411	.67745
	71- The room temperature was fine	.506	4.1441	.67010
	76- I think that the meals with regard to choice was adequate	.408	2.3994	1.39694
Hospital culture	50- Hospital staff acted too businesslike and impersonal toward me	.776	4.2432	1.02865
	33- I felt ignored at the ward	.694	3.8529	1.06955
	48- Hospital staff ignored what I told them sometimes	.671	3.5826	1.17322
	35- There was a distance between me and the health providers	.647	3.8559	.95860
	40- Hospital staff took a long time to come when they were called	.633	3.7327	1.20643
	52- I had doubt about the abilities of the Hospital staff who treated me	.622	3.9550	1.06183
	30- Hospital staff favored some patients over others	-.616	2.2282	1.06230
	54- Hospital staff exposed me to unnecessary risks	.584	4.0420	.30748
	39- There were unreasonable delays during the admission process	.536	3.6907	1.06582
	19- I had a difficulty in communicating with hospital staff	.427	3.5826	1.24060
Meeting expectation	14- My desire regarding pain relief were respected	.697	4.1922	.68482
	15- I received adequate pain relief measures	.586	4.1321	.76084
	2- I received the type of services I expected	.554	4.2222	.69325
	1- I had a good experience with the health care services in this hospital	.546	4.2432	.66155
	9- Hospital staff checked regularly to make sure that I am okay	.460	4.3303	.70880
	21- Hospital staff gave me clear explanations about my tests result	.454	3.8438	.86408
	3- Hospital staff respected me as a person	.431	4.4384	.67661
	7- I was given sufficient assistance in the activities of daily living	.428	3.7688	1.0687
	8- I was involved in the process of my care	.420	3.8258	.94410

Annex (7): Map of Gaza Strip

