The quality of health care and patient satisfaction

Introduction

Good quality of care is considered to be the right of all patients and the responsibility of all staff within the hospital. The health care industry has to cope with environmental pressures such as demographic changes and ageing of populations as well as emergence of new treatments and technologies and increased insistence on greater quality of medical and health care services

Purpose – To examine the major factors affecting patients' perception of cumulative satisfaction and to address the question whether different patients of different demography and cultures evaluate quality of health care similarly or differently.

Design/methodology/approach – The course based on conceptual and evidence based empirical model including behavioural dimensions of patient-physician relationships and patient satisfaction. This course is problem solving oriented base on real cases in different hospitals.

Practical implications – The outcomes of the course can be used by the hospitals to reengineer and redesign creatively their quality management processes and the future direction of their more effective health-care quality strategies.

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

Why there is a need to improve the quality in developing countries?

Still, there is a need to find a way to achieve better health care quality that is appropriate. It is important to start with an understanding of the real situation. Some common features of the health care challenges in many developing countries are:

- a low level of basic primary and hospital care, with few preventative services;
- lack of transport and resources for supervision;
- the low use of these services by the public, due to poor treatment and high user charges for many items;
- an increasing use of private care: private hospitals and clinics in some cities, pharmacies and individual doctors and other practitioners working privately, with no effective regulation;
- lack of knowledge about quality ideas, methods and results. Lack of skills in using the methods or in implementing programmes;

- lack of standards which are credible, agreed, and authorized by the ministry and professions, and which can be applied flexibly in different situations; many personnel are low paid and de-motivated and see no personal or other advantages to spending extra time working on quality improvements: the benefits for them are not clear; a history of a centralized system of administration, with the health ministry allowing little discretion for regions, districts and facilities, and few financial incentives to improve quality (and in some countries, financing under the control of the ministry of finance);
- a low level of training and professionalism for most health practitioners, who are not supervised, are low-paid and rely on patient fees and other sources of private income; and
- the lack of management training and a culture with a power structure which would be threatened by lower levels making changes and taking more control of their services, or by the establishment of a strong line management structure and process.