

Patient Satisfaction in Outpatient Healthcare Services at Secondary Level vs. Tertiary Level

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SUMMARY

Introduction Patients satisfaction is a very important part of any clinical practice both for evaluation and improvement of healthcare services.

Objective The aim of this study was to determine patient satisfaction with public outpatient healthcare services at secondary and tertiary level and to assess possible differences between the two levels.

Methods In a quantitative cross-sectional study, a convenient sample of 646 patients who experienced public outpatient healthcare services at the secondary and tertiary level during the last two months were interviewed. Patient satisfaction questionnaires, with statements regarding various aspects of satisfaction, were completed during face-to-face interviews (response rate 84.6%). The research instrument was tested for internal consistency using the Cronbach's coefficient alpha estimate.

Results The patients were significantly more satisfied in tertiary than in secondary outpatient healthcare facilities in almost all aspects of assessment related to general settings, nurse/administrative staff performance and physician performance ($p < 0.001$). The patients in the secondary healthcare services (SHCS) were more satisfied than in the tertiary healthcare services (THCS) but only regarding the information on location (83.9% vs. 78.3%) and possibilities to enter and move inside the department (88.8% vs. 83.3%). Analysis of data for SHCS and THCS showed that there was no significant difference between the mean overall satisfaction scores with regard to patients' gender, age, marital status, educational level, employment and number of visits.

Conclusion There is a need to improve the current level of patient-provider relationship and communication, as well as that of hospital environment, while special efforts should be made to address the problem of patient waiting time and hospital bureaucracy.

Keywords: outpatient healthcare services; personal satisfaction; health; tertiary healthcare; secondary healthcare

INTRODUCTION

Healthcare has evolved over the years in accordance to requirements of society and the availability of resources and technology. Increased focus was put on the development and investment in health to be human-centered and quality-delivered [1]. Patient satisfaction in healthcare and treatment has become increasingly important as an indicator of the quality of care [2]. The importance of measuring patient satisfaction has become well articulated; patient satisfaction has been extensively studied and measured as a stand-alone construct and as a component of outcome quality [3, 4]. Defining the patient satisfaction as multi-dimensional evaluation of various aspects of healthcare received in a specific episode, proposes that the processes by which patient experiences were transformed into "evaluations" of the service were complex [4, 5]. The literature review indicates that the assessment of patient satisfaction needs to be a continuously repeated action, therefore helping service providers learn about deficiencies in the health delivery system thus enabling them to undertake timely and appropriate alternative steps [2, 6].

Some developed countries, such as France and Great Britain, labeled patient satisfaction studies as "priority" or even "legal obligations", as early as at the end of the last century [7]. Nevertheless, as low- and middle-income countries (LMICs) experience economic development, calls for improved quality of care within primary and secondary care settings have emerged. Unfortunately, however some authors, in many of these countries quality improvement may be at the "end of the beginning" [8, 9]. Experience suggests that scientists from LMICs around the globe, although producing important insights, face barriers to publication [8]. However, healthcare in LMICs has traditionally focused more on the understanding patients' perceptions of the quality of hospital inpatients care than that of outpatient clinics [10]. Reports of this specific issue from LMICs remain scarce in the scientific literature [9]. However outpatient healthcare services at the secondary and tertiary level can make an important contribution to early diagnoses and treatment, nevertheless, a greater attention is needed within this realm. Research has showed that both specialty and subspecialty outpatient clinics are the key point of contact with the

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patient and if satisfied with their services patients are more likely to follow specific medical regimens and treatment plans [10, 11].

Health system in the Republic of Macedonia is set up as an insurance-based system aiming to provide universal coverage and a comprehensive healthcare to the population. The main providers of health services are public and private health organizations. With health reforms in 2005, the public primary healthcare (PHC) organizations were privatized. In addition, the growth of the private hospital sector resulted in an outflow of qualified medical personnel from the public to the private sector. For the time being, privatization has not brought significant changes to patients regarding services of PHC which is contrary to services from private hospitals and outpatient clinics where costs for users are significant unless there is a contract with the Health Insurance Fund. For public specialist outpatient care, patients with health insurance have to pay a small co-payment for services. Since 2011, with the amendments to the Law on Healthcare, a regulatory framework to ensure the proper gate keeping and referral practices from the secondary to tertiary care has been introduced. Patients, except in special circumstances, can use tertiary care services only if transferred from secondary healthcare departments.

OBJECTIVE

The objective of this study was to determine patient satisfaction towards public outpatient healthcare services at secondary and tertiary level and to assess possible differences between the two.

METHODS

Setting

The survey was performed in outpatient facilities for internal diseases at the University Clinical Center, Skopje, R.Macedonia. Maternity, cardiology and psychiatric outpatient facilities were not included. The setting was chosen for three reasons. First, it is the only place with public tertiary outpatient facilities in the country. Second, based on the present healthcare law, while looking for solution of their medical problem, the patients transferred to tertiary care outpatient facilities had already experienced outpatient healthcare services at secondary level. Third, patients from all over the country gravitated toward this center. Operational definitions used were as: a) tertiary healthcare outpatient facilities (THCOF) referred to a university public hospital daily department attended usually for specialist/subspecialist treatment or consultation; b) secondary healthcare outpatient facilities (SHOF) referred to a hospital or polyclinic daily unit usually for specialist treatment or consultation and c) patient satisfaction referred to a patients feelings and contentment with utilizing outpatient services.

Study design and sample

In a quantitative cross-sectional survey, a convenient sample of 646 patients attending public tertiary outpatient facilities affiliated to the University Clinical Center in Skopje was surveyed during the time period from April 1st to June 1st 2012. The information was collected by face-to-face interviews following a simple random sampling method. The respondents were asked by trained social workers to be interviewed right before they leave the tertiary healthcare outpatient facilities. Any health insured patient aged 18 or older, who experienced outpatient healthcare services for internal diseases at the secondary and tertiary level during the last two months, and was willing to complete all sections of the questionnaires was eligible to participate in the survey. Patients who either refused participation or were hospitalized were never interviewed. The required information was not obtained from the family members in cases when the patient was too sick and/or unable to answer. Out of 764 eligible patients for the study, 646 accepted to participate and their questionnaires were considered for final processing. The response rate of participation in the study was 84.6%.

Questionnaire

A structured questionnaire was developed by combining questions from relevant published literature with newly designed questions concerning patient satisfaction [12, 13, 14]. An initial version of the questionnaire was pretested in a pilot study and an amended questionnaire was prepared. The questionnaire consisted of 33 items each related to the secondary as well as to tertiary outpatient facilities. In addition to the demographic information of participants, the questionnaire covered three main domains of outpatient services i.e. satisfaction from general settings (environment, facilities, and organization), satisfaction from nurse/administrative staff performance (communication, efficacy, confidence, trust etc) and satisfaction from performance of attending physician (communication, time, treatment, trust and confidence etc). Each item was scored using a four-point Likert scale: 1 – very satisfied, 2 – satisfied, 3 – dissatisfied, and 4 – very dissatisfied. The total satisfaction score for each respondent ranged between 27 (very satisfied) and 108 (very dissatisfied). The lower mean score indicated a higher level of satisfaction.

Ethical consideration

Prior to conducting the study, approval from the Medical Faculty, University “St. Kiril and Metodij”, Skopje has been obtained following the evaluation of its relevant internal body that all measures were utilized to protect the patient's rights. During the study duration leaflets with comprehensive information were distributed to all outpatient waiting rooms for internal diseases.

The patients were given information about the purpose, possible benefits and anonymity of the study. Before involvement each participant was asked for oral informed consent. The information about the nature of the research was also available in an introductory letter attached to each questionnaire. No identifying marks were printed on the questionnaires.

Statistical analysis

Data entry and statistical analysis was performed using Statistics version 7 and Statistical Package for Social Sciences (SPSS) program version 17.0 for Windows. The research instrument was tested for internal consistency using the Cronbach's coefficient alpha estimate. The values of the Cronbach's coefficient alpha for all three dimensions of the questionnaire were: 0.881 (general settings – 10 items), 0.868 (nurse/administrative staff performance – 7 items) and 0.954 (performance of attending physician – 10 items), thus the constructs measures were deemed reliable [15]. Descriptive statistics were presented for demographic data and general opinion. Categorical variables were expressed as numbers and percentage. Some ordinary categorical variables were crosstabulated with multiple response variables/dichotomies. The Chi-square test was used for comparison between patient satisfaction at the secondary and tertiary level. Mean satisfaction scores of the study group with regard to independent variables were analyzed by Student t test and ANOVA test. The level of statistical significance was set at p -values ≤ 0.05 .

RESULTS

A total of 646 questionnaires related to satisfaction towards outpatient healthcare services at the secondary and tertiary level were analyzed. The information regarding demographic characteristics of the study respondents is provided in Table 1.

The analysis of data revealed a highly significant difference in the levels of patient satisfaction between outpatient healthcare services at the secondary and tertiary level in almost all aspects of assessment related to general settings, nurse/administrative staff performance as well as physician performance ($p < 0.001$).

The satisfaction rate with general settings was 72.7% vs.79.3% for secondary and tertiary care outpatients' facilities (Table 2). In TCOF patients were more satisfied than in SCOF with the system for setting the appointment (79.5% vs. 58.8%), patient waiting time (76.5% vs.56.9%), hygiene in outpatient department (74.3% vs.53.3%), privacy during consultation and examination (88% vs.80.8%), adequacy of drugs supplies/medical equipment (79.5% vs.53.9%), information about required documents/expenses (77.1% vs.71.5%) and hygiene of toilets (55.1% vs.25.4%). The patients in SCOF were more satisfied than in TCOF about the information regarding location of outpatient services

Table 1. Demographic characteristics of the study respondents

Characteristic	Value	
Age (years)	Mean	49
	SD	15.122
	Range	18–80
Gender	Female	252 (39.0%)
	Male	394 (61.0%)
Marital status	Single	168 (17.0%)
	Married	478 (83.0%)
Education	Undergraduate	40 (6.2%)
	Graduate	338 (52.3%)
	Postgraduate	268 (41.5%)
Employment	Student	42 (6.5%)
	Unemployed	328 (50.8%)
	Employed	120 (18.6%)
	Retired	156 (24.1%)
Visit	First	144 (22.3%)
	Second	62 (9.6%)
	Follow-up	440 (68.1%)

(83.9% vs.78.3%) and possibilities to enter and move around the department (88.8% vs.83.3%).

Table 2 summarizes the satisfaction levels related to nurse/administrative staff performance. The satisfaction rate for staff performance was 80.2% for SCOF and 85.8% for TCOF. The patients were found to be more satisfied in TCOF than in SCOF regarding kindness of administrative staff (82% vs. 61%), respect of patients rights (73.7% vs.73.3%), efficacy of administration (75.6% vs.61.3%) and trust and confidence in nurses (89.5% vs.86.4%). The patients in SCOF were more satisfied than in TCOF about nurses providing easily understood answers to important questions.

Satisfaction levels related to performance of attending physician is shown in Table 2 and they were found higher for TCOF in all areas of interest. The patients were found to be more satisfied in TCOF than in SCOF about the kindness of physicians' behavior (94.7% vs.90.7%), opportunities to describe the medical problem (91.3% vs.83.9%), time spend on consultation (76.5% vs.72.9%), given attention (88.9% vs.78.3%), physician's explanation about the disease (88.9% vs.80.2%), clarity of recommendations (87.6% vs.85.1%), physical examination (91.3% vs.74.4%), adequately answered questions (91.3% vs.80.8%), trust and confidence in physician (93.5% vs.88.2%) and possibilities for active participation in the treatment (80.2% vs.76.5%).

The comparison of mean satisfaction scores between SCOF and TCOF related to general settings, nurse/administrative staff performance, physician performance and overall satisfaction from all three dimensions, showed high significant differences ($p < 0.001$). The analysis found general settings in outpatient facilities as the main domain of dissatisfaction (Table 3).

Bivariate analysis of the data for SCOF and TCOF showed that there was no significant difference between the mean overall satisfaction scores with regard to patients' gender, age, marital status, educational level, employment and number of visits (Table 4).

Table 2. Differences in patient satisfaction according to level of health care

Questionnaire	Items	SCOF vs. TCOF		
		χ^2	df	p
General settings	System for setting the appointment	87.297	3	0.0001*
	Info for location of outpatients' facilities	94.833	3	0.0001*
	Waiting after stated appointment time	50.759	3	0.0001*
	Easy to enter and move around	32.088	3	0.0001*
	Hygiene in outpatient department	89.001	3	0.0001*
	Privacy during consultation/examination	63.607	3	0.0001*
	Adequacy of drugs supplies/equipment	102.58	3	0.0001*
	Info about required documents/expenses	28.605	3	0.0001*
	Hygiene of the toilets	132.08	3	0.0001*
	Satisfaction with general settings	62.146	3	0.0001*
Nurse/ administrative staff performance	Kindness of the nurses	2.2879	3	0.516
	Kindness of the administrative staff	50.507	3	0.0001*
	Respect of patients rights	44.72	3	0.0001*
	Efficacy of administration	62.294	3	0.0001*
	Trust and confidence in nurse	22.989	3	0.0001*
	Nurse – giving easy to understand answers	43.023	3	0.0001*
	Satisfaction with staff performance	24.551	3	0.0001*
Physician performance	Kindness of the physician	82.258	3	0.0001*
	Opportunities to describe the problem	93.571	3	0.0001*
	Time spend on consultation	77.326	3	0.0001*
	Attention given by the physician	113.86	3	0.0001*
	Explanation of symptoms or disease	91.383	3	0.0001*
	Clarity of recommendations	116.76	3	0.0001*
	Physical examination	128.61	3	0.0001*
	Active participation in treatment	79.547	3	0.0001*
	Questions have been answered	115.67	3	0.0001*
	Trust and confidence	123.06	3	0.0001*

* p significant at <0.001

TCOF – tertiary care outpatient facilities; SCOF – secondary care outpatient facilities

Table 3. Comparison of mean satisfaction scores according to the level of health care (n=646)

Item		Total satisfaction score		SCOF vs. TCOF		
		Mean	SD	t-test	df	p
General settings in outpatients facilities	SCOF	26.3	4.1	-9.718	1290	0.0001*
	TCOF	23.8	5.0			
Nurse/administrative staff performance	SCOF	22.1	3.5	-6.132	1290	0.0001*
	TCOF	20.8	4.1			
Physician performance	SCOF	23.3	4.5	-11.001	1290	0.0001*
	TCOF	20.2	5.6			
Overall satisfaction	SCOF	71.6	10.2	-10.848	1290	0.0001*
	TCOF	64.7	12.5			

* p significant at <0.001

DISCUSSION

Almost forty years after patient satisfaction has emerged as an area of special interest for researchers, it became obvious that the assessment of patients' views on healthcare services is a valuable tool to evaluate and improve the healthcare services since it is based on direct experiences of users [16]. Patients' expectations from health services have increased and priorities changed due to advancements in information technology. Over the time, the concept of patient satisfaction has moved from a more theoretical essence to a more technical and operational approach with its components being summarized as "the quality and accessibility of medical care, availability of health services and structures, af-

fordability of costs, information and participation of the patient" [17]. However, most of these latter factors are under the direct control of health managers and medical staff, which makes it possible for patient satisfaction to be improved with appropriate efforts [16].

Our study, like similar studies, indicates that the general satisfaction of patients is quite high, although there are many unmet needs. Comparison of our findings on the satisfaction score for overall quality of services received with the results in the literature showed that they are higher than levels reported in the surveys on overall quality of dermatology services (65.6%) [12] or emergency care (66.1%) [18], but lower than the satisfaction with outpatient hysteroscopy in gynecology services which were 95%

Table 4. Comparison of mean satisfaction scores according to the demographic characteristics of patients

Item		Overall satisfaction score											
		SCOF						TCOF					
		Mean	SD	t	F	df	p	Mean	SD	t	F	df	p
Gender	Male	67.9	11.6	0.569		644	0.569	65.3	12.0	-0.944		644	0.345
	Female	68.4	12.1					64.4	12.8				
Age (years)	≤45	68.2	12.2	1.447		644	0.148	63.9	12.5	1.332		644	0.183
	>45	68.2	11.7					65.2	12.4				
Marital status	Single	67.6	10.8	0.749		644	0.454	64.6	11.1	0.168		644	0.867
	Married	68.4	12.3					64.8	12.9				
Education	Undergraduate	68.4	10.2	0.374	2		0.688	65.8	12.4	0.296	2	0.7440	
	Graduate	67.8	12.1					64.4	12.7				
	Postgraduate	68.6	12.0					65.0	12.2				
Employment	Student	68.2	13.4	0.648	3		0.585	64.2	10.2	1.162	3	0.323	
	Unemployed	68.0	12.3					64.1	13.0				
	Employed	69.5	12.7					66.6	13.1				
	Retired	67.5	10.0					64.8	11.4				
Visit	First	66.9	12.2	1.095	2		0.335	62.8	11.5	2.318	2	0.099	
	Second	68.0	11.2					64.7	10.3				
	Follow-up	68.6	11.9					65.4	12.9				

* p significant at <0.001

in 2005 compared with 94% in 2000 [19]. However, Lebow noted that the satisfaction level has never been fixed nor had a consistent score. It changes with circumstances and quality and quantity of service provided. Several studies reported that the satisfaction rate appeared to be as high as 91-100% and as low as 51-60% [20]. Some studies from Western countries have also claimed very high satisfaction rates [8, 9]. Although surveys reported high levels of overall satisfaction, often there is some disparity between the patients' overall satisfaction ratings and their opinion regarding specific aspects of their care process [4, 21]. The results of this study showed varying levels of satisfaction with various dimensions of healthcare. For both, SCOF and TCOF, high levels of satisfaction were expressed about the possibilities to enter and move around the department, and privacy during consultation and examination. The patients indicated their dissatisfaction regarding waiting time (43.1% for SCOF and 23.5% for TCOF), hygiene of department (46.7% for SCOF and 25.7% for TCOF) and toilets (74.6% for SCOF and 44.9% for TCOF). Also, a high level of dissatisfaction for SCOF was expressed about the adequacy of drugs supplies/medical equipment (46.1%) and system for setting the appointment (41.2%). Our results supported other studies which report a high dissatisfaction rate with the waiting time at the clinic and inadequate cleaning [12, 22]. In a study about satisfaction in 30 hospitals, it was determined that the areas of dissatisfaction were long waiting time, poor cleaning and hospital settings, and weak doctor-patient relationship [23]. Another study found that patients were not satisfied due to a low quality of care and inadequate supply of medications [24]. The longer waiting time in SCOF could be attributed to the poorly developed secondary care network, lack of providers, transferred patients who could be attended at the primary care level and regulatory framework for referral patients to tertiary healthcare only through the secondary healthcare departments. All of these also influenced a

growing number of patients in TCOF and could explain the long waiting time there. Unsatisfactory hygiene in public healthcare outpatient facilities is due to the insufficient annual limited budget, under-staffing and need for capacity building and modernization of old buildings.

This study showed that the patients were dissatisfied with the lack of kindness and efficacy of the administrative staff in SCOF. This is attributed to the untrained personnel assigned to work on this position, formalism involved in obtaining services and bureaucratic procedures. Patients expected that they should spend least possible time on administration since long bureaucratic procedures resulted in their dissatisfaction. Although bureaucracy is universally required by every complex organization and is the basis of organizational order, if not carefully applied it might produce service delay and dissatisfaction [25]. The survey also identified over 26% of patients dissatisfied about respect of patients' rights by nurse/administrative staff in both SCOF and TCOF, which indicates a need for improvement of this very important aspect of healthcare. These results were expected, taking into account patients' awareness about their rights and high expectations after intensive national campaigns following the introduction of the patients' rights law in 2008.

International comparisons originating from various countries suggest that the aspects of doctor-patient communication are crucial from the patients' perspective [26]. Good doctor-patient communication has the potential to help regulate patients' emotions, facilitate comprehension of medical information, and allow for better identification of patients' needs, perceptions, and expectations [26, 27, 28]. Different authors have stated that the three most important aspects of doctor-patient communication, as reported by patients, were good interpersonal relationship, facilitating exchange of information, and including patients in decision making [27, 29]. This study found that patient satisfaction rates with physician performance in

both SCOF and TCOF were high, which is in line with the results of Strutt et al. [30] who found that the majority of patients were satisfied with treatment, the explanations they received and their perceived health outcomes. These findings are inconsistent with the results of another study where 40% of the patients were less satisfied about the information they received and 36.7% felt that they were not allowed to express their symptoms in detail [12]. The patients in our study were critical, significantly more for SCOF than for TCOF, about consultation time, attention given by the physician, and possibilities for active participation in the treatment. Same patients' concerns and perceptions have been highlighted in many other studies, but with dissatisfaction rates much higher than in this study [12]. In practice, the examination time could vary corresponding to the nature of the disease or behavior of the patient, but spending longer time with the patient may pose a problem to physicians in busy clinics. Nevertheless, more effective and frequent use of written information is clearly indicated as having the potential to address some of the patients' information needs [12, 24, 25].

In the process of decision-making, the patient centered healthcare with co-partners' treatment, is strongly associated with the recovery and has been repeatedly emphasized as an important patient's right [17, 26]. A more patient centered system results in increased patient as well as doctor satisfaction [26, 31]. Satisfied patients are less likely to initiate complaints and they should be perceived as advantageous for doctors in terms of greater job satisfaction, less work-related stress, and reduced burnout [24, 25, 26]. Demographic characteristics of patients did not seem to be significant predictors of patient satisfaction in our study group which is in line with findings from other studies [6].

The limitations of this study are recognized by the authors. First and foremost, the sample of the study was drawn from patients accessing healthcare from outpatient

facilities for internal diseases at the University Clinical Center, Skopje, R.Macedonia. The findings of this study may not be generalized to other patients attending TCOF, in-patients facility, and emergency rooms of the hospital. However, this study gave some useful insight into the magnitude of patient satisfaction since other patients utilize the same general, sensitive, and supporting hospital services. This study, therefore, provides useful baseline information for consultation and comparative purposes. Furthermore, the questionnaire was pretested internally for clarity and acceptability. Although, the language used in the questionnaire was Macedonian language, other languages such as Albanian, Romani, and Serbian were used to explain verbally to the patients who could not adequately understand Macedonian language. This limitation of misinterpreting the questionnaire was recognized by the researchers, though pre-testing of the questionnaire did not reveal a language bias. However, their effects were minimized by involving social workers who speak certain languages and trained them on the exact translation of the questionnaire.

CONCLUSION

The majority of patients were satisfied with overall healthcare, significantly more in TCOF than in SCOF. However, specific questioning has exposed certain areas that need to be improved. There is a need to sustain and improve the current level of patient-provider relationship, patient-provider communication, and hospital environment while effort should be made to address patient's waiting time, and hospital bureaucracy. The areas with dissatisfaction rates should be the focal areas which the hospital management and relevant authorities should address so that quality improvement processes would be initiated, as they reflect directly what patients feel.

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Задовољство пацијената амбулантним здравственим службама на секундарном нивоу у односу на терцијарни ниво

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КРАТАК САДРЖАЈ

Увод Задовољство пацијената је важан део сваке клиничке праксе за оцену и унапређење здравствених услуга.

Циљ рада Циљ рада је био да се утврди задовољство пацијената јавним амбулантним здравственим услугама на секундарном и терцијарном нивоу и процене могуће разлике међу тим нивоима.

Методе рада У квантитативној студији пресека интервјуиран је погодан узорак од 646 корисника амбулантне здравствене услуге на секундарном и терцијарном нивоу током два месеца. За време интервјуа „лицем у лице“ попуњавани су упитници о задовољству пацијента, с изјавама у вези с разним аспектима задовољства пруженим услугама (стопа одзива била је 84,6%). Инструмент истраживања био је тестиран за унутрашњу конзистентност помоћу алфа процене Кронбаховог (*Cronbach*) коефицијента.

Резултати Пацијенти су били значајно задовољнији у амбулантима установа терцијарног нивоа здравствене заштите у односу на амбуланте секундарне заштите, готово у свим

аспектима процене: у погледу општих услова, помоћи медицинских сестара и административног особља, као и помоћи лекара ($p < 0,001$). Пацијенти у амбулантама установа секундарног нивоа здравствене заштите били су задовољнији од оних у амбулантама терцијарне заштите само у погледу информација о локацији (83,9% према 78,3%) и могућностима уласка и кретања унутар одељења (88,8% према 83,3%). Анализа добијених података показала је да не постоји значајна разлика међу просечним укупним скоровима задовољства у односу на пол, старосно доба, брачно стање, ниво образовања, запосленост и број посета пацијената.

Закључак Потребно је побољшање постојећег нивоа односа и комуникације између лекара и пацијента, како и побољшање услова болничке средине. Посебне интервенције су потребне у погледу времена чекања пацијената и болничке бирократије.

Кључне речи: установе амбулантне заштите; услуга; лично задовољство; здравље; терцијарни ниво здравствене заштите; секундарни ниво здравствене заштите