CHAPTER II

LITERATURE REVIEW

As a background to the study questions this review of literature starts with the definition, concept and theory on users satisfaction, definition of maternity care, scope of university hospitals in health service delivery, factors determining the satisfaction and dissatisfaction and the users opinions on health services are being explored. Finally general methodological issues and relevant literature from Nepal are discussed.

2.1 Definition and concept of user's satisfaction

Any effort to define satisfaction is not a simple task. One of the World Bank documents states that satisfaction can be only partly explained by objective criteria and subjective criteria matters. People can be satisfied with their own health care and dissatisfied with their countries health system as a whole. A comparison of 10 OECD countries with different health system found that in 8 countries public satisfaction was related to the level of health expenditure of each countries. [12]

In much literature satisfaction to health care has been defined differently but of course having some common consensus in general. "Satisfaction is hereafter defined as the degree to which expectations of health care perceived by the patient as being fulfilled". Social, sub culture and idiosyncratic experience of the individual may affect satisfaction. It is imperative to observe general feelings of satisfaction with and expectation of care. [13]

Dhakal R. in his study on user's satisfaction with health care services argue that the measurement of satisfaction is a very complex task. In fact there is no single yardstick, which can correctly measure the satisfaction status of the users. 'The complexity is due to its vast nature and number of different factors associated to it. The service provider, health services facilities, the various nature of illness and belief systems, the cultural social and economical background of the users. In fact the study on patient satisfaction highly demand more multi-disciplinary anthropological approaches. [14]

Different people in different perspectives have viewed the concept of user's in health care. It may indicate public interest in the control of prices, services and the quality of care related to cost, outcome and efficiency. [15] Within the human rights movements 'users' emphasize the participation of individuals in health policy, self-determination and a decrease in the influence of the professionals and technology. [16]

There has been a debate on active and passive role of the users in different settings. As Wim writes the user is not only a passive receiver/ recipient of services, he is an active participator in the consumption process (decides to see a doctor etc.). At the same time, however he often has no choice in case of, for example acute symptoms and when there is insufficient knowledge of his bodily system as well as the complex health system. [17] Similarly, Gilson on her findings in community satisfaction with PHC services in Tanzania writes that "the community is not a passive receiver of allopathic health care but judges its value and relevance against their needs and the alternative health providers". [18]

The meaning of satisfaction as in dictionary is multifaceted as a noun, adjective and verb as well. As a noun satisfaction is defined as anything that offers contentment, fulfillment, pleasure, relief or gratification. [19] It cantos the idea of marketing something right such as payment of debt or obligation.

Swan, Sawyer, Van Matre and Mc Gae propose definition of satisfaction in their studies of patient's satisfaction with medical care and nursing care in a hospital. They viewed the patient's satisfaction as a positive emotional response that is from a cognitive process in which patients compare their individual experiences to a set of subjective phenomena. The use of term positive delimits the word satisfaction from dissatisfaction. (20)

Satisfaction with medical care is frequently measured in health research for different reasons. We contend that aspects of an agency's relationship with its environment exerts their major influence by determining an organization's internal structure and processes and treat environmental conditions. These internal agency characteristic influence performance level and assessed by the clients in terms of satisfaction as depicted below. [21] Decision regarding continuity of health care depends on client's satisfaction with it. Medical care providers agree that consumer satisfaction is as legitimate and relevant health care concept and should be a standard component of any services provided. [22]

2.2 Theory of satisfaction

Satisfaction is intrinsically related to need fulfillment. Patients who come to seek or obtain services at health care facility are in the way to meet their needs related to alter health. Abraham Maslow of Brandeis University fashioned a dynamic and realistic explanation of human needs. He stated that a human is complex and changing being, and he felt that motivation must reflect this nature. Needs are powerful determinants of our behavior when these are not satisfied for sufficiently length of time our lives are threatened. [23]

2.3. Definition of Maternity Care

The world Health Organization Expert Committee on maternity care has defined maternity care as follows. "The objective of maternity care is to ensure that every expectant and nursing mothers maintains good health and learns the art of child care, has a normal delivery and bears healthy children". Maternity care in a narrower sense consists in the care of the pregnant women, her safe delivery, her postnatal examination, the care of the newborn infant, and the maintenance of lactation. In the wider sense it begins much earlier in measures aimed to promote the health and well being of the young people who are potential parents, and to help them develop the right approach to family life and to the place of the family in the community. It should be included in guidance in parent craft and in problems associated with infertility and family planning. [24] The delivery service is most important component of the maternity care. The delivery service begins with the entering of the expectant mother into labor (process of childbirth).

2.4. The Scope of University Hospitals in Health Service Delivery

To enhance the fundamental goal of entirely personal compassionate patient care, teaching hospitals needs to initiate research at bedside. As teaching learning activities UHs strives to provide superlative patient care, considered to be the requisite model for learning. The educational process aims to graduate individuals who will be committed to a life time of continuing education while they are contributing in many and varied ways to the health needs of people. To respond to the circumstances they are facing UH's services should not be seen as an end in themselves, but must justify their existence based in how well they meet the social and political needs of their various stakeholders. UH strategic planning must be rooted in both missions and in public needs. [5]

Hospital stakeholders can be categorized into three groups internal, interface and external. Internal stakeholders for example, include staff employees as well as clinic managers; external stakeholders include suppliers, patients and financial community. The relationship between the organization and these external stakeholders is a symbolic one because the organization depends on these stakeholders for its survival. Interface stakeholders are those who function both internally and externally to the organization that is, those who are on the interface between the organization and its environment. [25]

Three traditional commitments of UHs are patient care, teaching and research. However it is important to point out that many of the strategies examined by previous researchers have as their goal making UHs more competitive as centers for patient care. There are two reasons why UHs are especially concerned with patient care, although it is an only one part of their mission. First, there is a high degree of interdependence among the three goals of UHs. Without an adequate mix of patient's care, teaching and research activities suffer. Thus UHs sees their whole mission threatened by increased competition in patient care. Second revenues from research are difficult to increase and financial support for medical education has decreased. As a result, UHs seems to be relying increasingly on patient care as an important source of revenue. [26] Although the circumstances of each UHs are to some extent unique, certain future trends appears to be widely agreed upon. A model developed by Porter and adapted to hospital industry by Auty and Thomas assures that the health care industry will become more competitive in the future and that UHs will need to compete in order to meet their missions effectively.

For analyzing an organization's overall situation in order to find out strategies for improvement of service SWOT analysis is a useful tool. SWOT stands for strengths, weaknesses, opportunities, and threats. This approach attempts to balance the internal strengths and weaknesses of organization with the opportunities and threats that their

external environment present. This approach suggests that the major issues facing an organization can be isolated through careful analysis of each of these four elements. Strategies can be then formulated to address these issues. [27] The components of analysis should include organizational structure, planning, coordinating, staffing, supervision, training, management information, and finally commodity management, which all influence the service delivery and affect satisfaction of patients. [28]

Consumer satisfaction refers to the attitude towards the medical or therapeutic care of those who experienced a contact with it. It is different from the medical belief component of the predisposing variable in that it measures user satisfaction with the quality of care actually received. Study on patient satisfaction is an important aspect of health management. Consumer satisfaction is best evaluated in the context of specific, recent, and identifiable episode of medical care attending. Dimensions of satisfaction relevant to consider in eliciting subjective perceptions of access are satisfaction with the convenience of care, its coordination, and cost, the courtesy shown by provider, and his judgment as to the quality of care he received. Aday and Anderson explained the concept on access to medical care. In the theory they have described the main components of the whole framework of medical care. [29]

2.5 Factors Determining Satisfaction and Dissatisfaction

Helevi UK, Malin M and Hemminki E. studied on women's satisfaction with maternity health care services in Finland. They reported about information collected in interview (n=63) and questionnaire (n=408) of mothers who had taken maternity care during pregnancy in hospital clinics and maternity care centers. The women in this study are satisfied in general with the content of maternity care services and regard them necessary for their well being during pregnancy, data also indicated that women are more

satisfied with visits to maternity care centers than with visits to hospital clinics. Women felt they received sufficient advice and support (91%). The topic that women most often complained was unsatisfactory communication between doctor and patient. Satisfaction of service users is an important criterion for successful care and should be valued as such. Satisfaction has an effect on the use of services and compliance with their use. The importance of social and psychological support is another evident of care. [30].

Taylor CC, Sanders D, Basset M, Goings S. written about the maternal health care, which recently has been reorganized as one of the important challenges for primary health care and family health in Zimbabwe. It was considered as a lesson for approach to surveillance for equity. They stressed on standard approach in efforts to reduce mortality and morbidity from pregnancy related problems as high risk monitoring. All women should be encouraged to start a series of visits to health facilities early in pregnancy to identify complications or indicators of potential risk. Early detection of potential problems should initiate preventive measures, including making sure that the women reaches a health facility which can provide whatever level of health care her condition requires at the appropriate time. This report also gives information about the different level of care needed to provide in equitable manner. [31]

Kazmj S. conducted a large study to improve knowledge base for decision -making in maternal health policy. With the multidimensional objectives to assess the types of maternal and child health care services mothers usually prefers, evaluate basic maternal and child heath care, obtain consumers view point from mothers on maternal and child health services, awareness about accessibility of maternal health services, investigate reluctance to lady doctors and indicate areas for improvement. Both quantitative and qualitative (focus group discussion) methods were employed to collect data. The results in socio-demographic data showed that majority of women interviewed were 21-34 years

(76.1%), more than half is illiterate (58.8). 1%), only (7%) of women had access to income in the urban setting and (11%) in the rural, but the income earned was low. The vast majority of women had experienced pregnancy for the six times (804/1200). Traditional Dais (57%) attended most deliveries, but a large urban rural difference was evident (90% and39%). Satisfaction with service rendered by different kinds of providers was consistently high (93%-98%). In the opinion of women on the perceived safety of home versus hospital delivery, the urban/rural differences was confirmed; (63.5%) of the urban women said hospital as the safest place, but only (29.5%) of the rural women thought so. Poor distribution of trained care provider at work place lacked to provide appropriate antenatal care, delivery care and postpartum care. Changes to increase their availability and services were proposed. (32)

Williams LR and Cooper MK reported in a study of new paradigm for post partum care. They evaluated the short stay maternity programs developed by Nurse associates in conjunction with Kaiser permanent of Ohio since 1989. The program consisted of three phases: prenatal preparation, referral process, and postnatal home visit program. The program outcomes were measured in terms of time and frequency of nursing diagnosis, readmission, and consumer satisfaction and cost effectiveness. Which had reliable outcomes in terms of patient care and cost effectiveness and saved $1 million a year. The rate of consumer satisfaction had been measured by mailed questionnaire with nine items of one page. Return rate was 75% and 99% are satisfied. (33)

Margrane D, Gannon J and Miller CT. studied attitudes and expectations of student doctors and women in labor. They found responses of medical students and patients were significantly different in all attitudes and expectations studied. All patients felt that student's participation in the care should be requested rather than assigned. Although student's expectations of participation in care were high, fairly low levels of students

involved in communication, examination, labor support and procedures. Of the 222 patients studied 136(61%) indicated that the most important reason for their acceptance of student's involvement was to contribute to student education. Only 27 (40%) students surveyed identified this as the most important reason. Twenty-six (12%) patients and 17 (27%) students thought the reason patients accepted student participation was that patients generally defer to their provider's wishes. This concludes students have high expectations to involve in intrapartum care and tends to underestimate the sense of altruism that motivates student's participation. [34]

August B, Morgan BM, Bulpit CJ, Cliflon P and Lewis PJ. studied the consumer's attitude to obstetric care with focus on dimensions of pain in labor, medical attention in labor, mother and child bonding, child care, hospital accommodation which were scaled in thirteen statement questionnaire (n=632). They found that majority of women did not consider that medical care was excessive and 63% found fetal monitoring was reassuring attitudes to pain in labor is an emotional experience and necessary part of it 45% agreed, 38% disagreed and 17% neither agreed nor disagreed. Questions on mother and child bonding showed that only few mothers (19%) thought that this was influenced by events during labor and delivery. Significant association between maternal opinion on epidural anesthesia and characteristic of respondent was found. [35]

Seguin L, Therrien R Champagne F, and Lorouche D. studied the components of women's satisfaction with maternity care, for the better understanding of how women's satisfaction with maternity care is affected. A representative sample of 1790 women from the Montreal area who had delivered earlier was selected. Only 938 subjects responded the postal questionnaire. The questionnaire content were divided in five dimensions of women's satisfaction; (a) the delivery itself, (b) medical care, (c) nursing care, (d) information received and participation in decision making process, (e) physical aspects of

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the labor and delivery rooms. Multiple regression analysis was done to determine expletive factors for each of these dimensions of satisfaction. Items relative to the delivery process such as pain intensity, complications, and length of labor were the most important for the delivery experience itself. Participation in the decision making process was the first component of satisfaction with medical care. Information received appeared to be the major component of their satisfaction with nursing care. The physical environment did not affect women's satisfaction with obstetric care. [36]

Light HK, Solheim-JS, and Hunter GW. studied satisfaction with medical care during pregnancy and delivery, in the context of recent changing concern of patient's attitudes towards medical care and procedures. They developed four categories of medical care for investigation: as doctors care during pregnancy, doctor care during labor and delivery, hospital care during labor and following delivery. Areas studied within these categories were specific medical procedures, personal relationships with medical staff, affective and instrumental communication. The instrument designed in a likert scale and open-ended questionnaires, which were administered in 291 maternity patients during their confinement period in mid western hospitals of North Dakota. The result of study showed 88.8% of the subject were satisfied with doctor's professional competency. Eighty two percent reported feeling that they could trust their doctor's judgment in matters of dealing with pregnancy and delivery. Eighty one percent felt comfortable with their doctors, 80% satisfied that they could ask questions to doctors, related to pregnancy and delivery, but only 68.8 % reported believing that their doctors understand their feelings. Less than three fourth of the subjects expressed satisfaction with any aspects of doctor care during labor process. Women of higher educational level express less satisfaction with doctor's explanation on medication than did women of lower educational levels ($p<0.01$chi-squire).

Satisfaction of each of four categories indicates that greatest percentage of women (92.2%) expressed satisfaction with the individualized attention they received. [37]

Hinshaw AD and Atwood JR. studied a Patient Satisfaction Instrument, precision by replication, which was defined as the stability of psychometric estimates for instrument reliability and validity over multiple studies. The purpose of this instrument was to measure patient satisfaction with nurses and nursing care in primary settings. It is important to understand the perspective from their evaluations. The patient satisfaction with nurses and nursing care were conceptualized in following three dimensions: (1) Technical professional factors- 2) Trusting relationship (3) Education relationship. The PSI was assessed in terms of internal consistency. To address the first question, four estimates were used; i.e. coefficient alpha, inter item, item subscale, and subscale-subscale correlations. The technical professional subscale, coefficient alpha met the new scale criterion of alpha=. 70 for all. For the educational subscale all of the coefficient alpha not only met the new scale but exceeded the mature scale criterion (alpha=.83 to .95). This instrument was used in many studies within 8 years time by various researchers in different settings. Such as care comfort study in which an empirical model was constructed and tested to estimate the relationship of care comfort standards to staff and patient outcomes. Operative trajectory study was another, which documented the operation room nurse's effectiveness of their preoperative education, and a clinical theoretical modeling. [38]

Pitaktepsombati P and Wongboonsin K. studied the maternal health care and recent trends, differentials and correlates. Based on 1987 Thai Demographic and health survey data an approximately 3900 birth since January 1982 to the time of survey. It was found that majority of mothers received prenatal care from health professionals, received tetanus injections, received assistance at birth from health professionals and delivered at health facility. However, in-depth analysis indicated substantial variations in utilizing these

services on the basis of differences in place of residence, number of years since last birth occurred, age of mothers at the time of child's birth, region of residence, religion-linguistic ethnicity, case of access to health facilities, levels of education and family wealth. For example, 73% of mothers who lived in the most rural areas received prenatal care from health professionals compared to 96% of those who live in Bangkok. The results suggest that rural mothers did not fully use the nearest health personnel and facilities but rather chose to utilize health facilities in semi urban or urban areas or to follow traditional practices. Thus some strategies should be made to persuade rural women to fully utilize the nearest health facility, the health center which will be beneficial to both government programs and the mothers. [(39)]

King PM, Cameron S and Shiella A. reported in the study of satisfaction with post natal care-the choice of home or hospital. Consumer's perceptions of their postnatal care were examined at the end of the period of care. Women could choose one of two forms of care; either domicilliary care following early discharge, or hospital care until discharge. Women assessed the midwives interest and caring, education and information provided, their own progress with feeding and baby care, and their expectations of and gains from postnatal care. The findings indicated that women choosing domiciliary care and women choosing hospital care had different expectations of their care they choose. The women who chose domiciliary care rated their postnatal care more highly than the women who stayed in the hospital did. The findings reinforce the importance of providing women with choices for the maternity care, which best suits, their needs and satisfaction. [(40)]

WaldenstromU and Nilsson CA studied women's satisfaction with birth center care by a randomized controlled study. They compared women's satisfaction with care at in-hospital birth center with standard obstetric care in Stockholm. Subjects were 1230 women with an expected date of birth between October 1989 and February 1992, who

expressed interest in birth center care and who were medically low risk. The intervention was the random allocation of maternity care at the birth center or standard obstetric care. Women at the birth center expressed greater satisfaction with antenatal, intrapartum, and postpartum care specifically the psychological aspects of care. Of these women, 63% thought that the antenatal care had raised their self-esteem, versus 18% of the control groups. Eighty-nine percent of the experimental group would prefer birth center care for any future birth, and 46% of the control group would prefer standard care. Birth center care successfully meets the needs of women who are interested in natural child birth and active involvement in their own care, and are concerned about the psychological aspects of birth. (41)

Likun P. stressed in his study that waiting time and patient dissatisfaction with some aspects of service problems exists in OPD of 1st affiliated Kuming Medical College Hospital. The results confirmed that patient waiting time and the relationship between patient and medical staff have important impact on patients overall opinion of hospital services. (42)

Clark CA, Pokorney ME and Brown ST. described in a study undertaken to assess patient satisfaction with nursing care in a rural hospital emergency department with respect to psychological safety, discharge teaching, information giving and technical competence. Davi's consumer emergency care satisfaction scale was used to determine the degree to which 52 patients perceived overall satisfaction with nursing care. Findings indicated that patients were satisfied with nursing care. No statistical significant effect of gender or education level on consumer satisfaction or on any subscale was detected. But African American consumers were less satisfied with discharge teaching, which may suggest that discharge teaching should reflect the cultural diversity of consumers presenting to the emergency department. Nursing staff may need to spend more time with rural African

American consumers. Staff may need to be inserviced to meet the cultural and educational needs of African Americans.[43]

Hart J and Malinarski Y. assessed the satisfaction with the department and hospital services provided by a medium sized community hospital of the Golda medical center, affiliated with Aviv University in two months period (April-May 1995). The principal points of the survey concerned the general perception regarding the services in the department and sanitary conditions, an evaluation of the physicians' and nurses' skill and attitude, as well as their compliance to patient's needs. Overall satisfaction with the medical care was very high. The physicians' attitude and nurse's compliance are the two most important determinants. The role of this type of questionnaire as an instrument for improving health services is emphasized.[44]

2.6 User's Opinions in Developing Health Services

Ware advice that " if satisfaction data are used in planning programmatic interventions evidence that specific nature of problems with care and services can be detected with patient satisfaction scores it must be demonstrated and well understood before they are used to make judgements about specific characteristics of providers and services. Findings published to date do not justify the use of patient satisfaction rating for this purpose".[45]

A consumer perspective can contribute to an evaluation of the structure, and outcome of the health services. Patient satisfaction survey data have been used as dependent variable to evaluate provider service and facilities, the assumption that patient satisfaction is an indicator of the structure, process, and outcome of care.[46]

2.7 Evidence from the Literature on User's Satisfaction from Nepal

During the process of literature review it was almost impossible to find relevant literature from Nepal on users status and their level of satisfaction from the health care services. However an attempt has been made here to present some general literature on user's satisfaction in different settings.

A study on family health services delivery, health care utilization and quality of services in three rural areas of Nepal looked at the health facility, reason for visiting health facility, time spent on travel, waiting time at the health facility, the client's satisfaction with the behavior of health workers and the available health facilities were studied. The reasons the clients showed their dissatisfaction with the service delivery included non-availability of appropriate medicines for particular health problems, poor behavior of the health workers, absence of health personnel at the facility, improper and inefficient management of health facilities. However, clients felt that the facilities under study cater to their needs adequately and they only need some improvement.[(47)]

A survey done by Save the Children US in Siraha district on utilization of health services showed that the distance to the hospital appear to be a major impending factor for low level of hospital service utilization. It was reported that 60% of the married men would prefer to visit a health post if he/she had fallen ill. Another about 1/3rd each would visit private doctors and less than 5% married women of reproductive ages and men preferred to visit hospital. [(48)]

Sirajulhaq M. found in his study on assessment of user's satisfaction from the district level hospital and health facilities that overall satisfaction status was low among the Nepalese respondents. The major contributing factors which influenced the majority of users satisfaction were older age, low caste, chronicity of disease and non fulfillment of expectations. Among the respondents many of the older patients were found dissatisfied

because they were in need of extra care, empathetic behavior, free medicines and more information. Low caste people were dissatisfied because of discrimination while chronic patients were found dissatisfied due to lack of confidence on doctor, high cost of treatment and improper curing of diseases. Factors that contributed to the majority of respondents regarding organization of services were long waiting time to reach the doctor, improper working hours and lack of effective emergency services. Similarly, with respect to health staff point of view, the main influencing factors as perceived were lack of proper communication and medical skills of doctors.(49)

Dulal R. studied on factors affecting the satisfaction of tuberculosis patients at the National tuberculosis center, Thimi, Nepal. He found that all variables related to the characteristics of the health service provider were significantly associated with satisfaction. They were quality of care, thoroughness, personality traits and informativeness. Out of 153 patients 88.8% were found to be satisfied and 11.2% dissatisfied with quality care. The association between satisfaction and quality of care was found statistically significant.(50)

2.8 Literature on General Methodological Issues on Assessing User's Satisfaction

The concern about the development of theory emphasizes the fact that qualitative methods themselves are certainly necessary to gain a deeper understanding of local knowledge, attitudes and beliefs about diseases but are not sufficient, even combined with qualitative method, if any are inappropriately derived using models and theories developed outside of the setting in which they will be used.(51) Similarly satisfaction studies can function to give providers of care some idea of how they would have to modify their provision of services in order to make patients more satisfied. In order to be used in this way, studies need to be service specific, based on users actual experiences with those

services and be sufficiently detailed to provide clear guides as to which patients require modifications in service delivery.[52]

2.8 The Methods of Qualitative Research Approach

One of the major strengths of qualitative methods is the possibility to describe a process rather than a state. Miles and Hubermann call qualitative data to be attractive because they describe process occurring in local context. This however requires a great deal of openness and the capability to communicate.[53] Regarding the qualitative design the opinion of Patton is worthwhile to mention here. "Qualitative inquiry designs can not be completely specified in advance of field work. While the design will specify an initial focus, plans for observations an interview, and primary questions to be explored, the naturalistic and inductive nature of the inquiry makes it both impossible and inappropriate to specify operational variables, state testable hypothesis and finalize either instrumentation of sampling schemes. A qualitative design unfolds as field work unfolds.[54]

2.9 Focus Group Discussion

Focus group discussions (FGD) are helpful especially on gaining insight into people's perception, attitudes, opinions, behavior and experiences. They are special type of interviews in which a small group of about 6-10 participants discusses freely and spontaneously, guided by a facilitator who has the theme (the focus) considered important in mind. Principally the group participants should have a reasonably homogenous, social and cultural background, they should be willing to participate and the environment should be conducive for discussions. In focus group discussion, the interaction between several informants highlights common experience and important issues as well as conflicts between community sub groups.[55]