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**Patients' satisfaction with the health care
services provided by Ambulatory Care Units**

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LIST OF ACRONYMS USED

ALPHA – Access to Learning Public Health Agenda

CHI - Commission for health improvement

CQI – continuous quality improvement

HCQI Health Care Quality indicators

MoH - Ministry of Health

QA - Quality assurance

UEMS - European Union of medical specialist

1. INTRODUCTION

The good health of nations is a key to human development and economic growth and it is important to analyze health systems' performance and to share what we knew with governments and the international community (Brundtland G.H., 2001).

The health care industry is undergoing a rapid transformation to meet the ever-increasing needs and demands of its patient population. Hospitals are shifting from viewing patients as uneducated and with little health care choice, to recognizing that the educated consumer has many service demands and health care choices available (Howard J.E., 2000). Within all systems there are many highly skilled, dedicated people working at all levels to improve the health of their communities. To move towards higher quality care, more and better information is commonly required on existing provision, on the interventions offered and on major constraints on service implementation. Consumers need to be better informed about what is good and bad for their health, why not all of their expectations can be met, and that they have rights which all providers should respect (WHO, 2000). The challenge is to develop health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair. Recent research indicates that the way health systems are designed, managed and financed seriously affects people's lives and equitable health outcomes are essential for global prosperity and the well-being of societies.

There is growing interest in improving the performance of health systems in many countries. It is a major preoccupation, reflecting common pressures for cost containment on the one hand and rising consumer expectations on the other. This has led to a number of recent initiatives both to measure and to improve performance against quality, efficiency and equity goals. Many countries are developing initiatives to measure performance to guide and inform the improvement process. Indeed, measurement and improvement are increasingly linked, as is indicated by familiar phrases such as 'evidence-based medicine' and 'evidence-based policy' (Zeynep Or., 2002). Equally important, if action is to be taken to improve performance, it is the need to understand the roles and motivation of different actors and available instruments in each health system. "Performance" is defined as the extent to which the health system is meeting a set of key objectives. The key objectives for the health system are suggested as being: improving health outcomes and responsiveness to consumers, economic efficiency and equity of health (or access to care). The success or failure of any initiative to improve health performance will depend on the political and institutional context in which it is placed.

Many countries face similar problems in assuring and improving the performance of their health care system. Some of the main topics that are increasingly being raised on the health policy agenda in most countries include the following:

Improving health status and outcomes for the entire population;

Raising clinical effectiveness -ensuring that clinical decisions are based on the best current practice (avoiding over-use and under-use);

Improving safety or reducing medical errors - developing health care organizations that are capable of detecting medical errors or adverse events to patients, and which are then able to effectively act on them to avoid future occurrences;

Raising responsiveness of the system - providing timely services (reducing wasteful delays) which are patient-centered and respectful of individuals' preferences, needs, and values;

Improving efficiency/containing costs - providing the right incentives to providers, funders and consumers to get better value for money; and,

Ensuring the equity - ensuring that the same quality of care is provided to all, regardless of race, gender, geographic location, or ability to pay, and reducing the gaps in health outcomes across different regions and socio-economic or ethnic groups.

In all health systems, regulation plays an important role in determining the availability, accessibility, and cost and, increasingly, the quality of services provided. The major values and objectives of each health system are often secured *via* regulation. Regulation has been used to serve quite different functions in each country. It can have an extensive control function by defining and checking on unacceptable medical practices, or it can encourage good practice by providing positive principles according to which the medical profession should operate. Regulation also plays an important role in facilitating the accountability of the system and protecting patient's rights.

Health care quality is a global issue. Despite differences in the levels and methods of health care funding the challenges and solutions in quality are remarkably similar between countries. There are defined such common national concerns over quality: unsafe health systems; unequal access to health care services, waiting lists; dissatisfaction on the part of users and the wider public; unacceptable levels of variations in performance, practice and outcome; overuse, misuse or under-use of health care technologies; ineffectual or inefficient delivery; unaffordable waste from poor quality and unaffordable costs to society (Shaw Ch., 2002). Technological innovations, particularly in the fields of biotechnology, genetics, and information and communication technologies, are bringing substantial benefits in the prevention, diagnosis and treatment of disease, as well as access to care (Cotis J.P., 2003). Such innovation is costly and is predominantly carried out in the private sector, although

drawing on knowledge created in the public sector science base. Innovation is also a risky process with many promising leads failing at successive hurdles before a safe, efficacious and high quality product is brought to the market. Meanwhile, many countries are seeking to establish health priorities. Such priorities should take account of, and help guide, the direction of innovation – so a better match is delivered between innovation and a society's health needs.

Patient empowerment can cut health care costs and improve quality (Leatherman S., 2001). There is now a body of literature showing that better-informed patients have better outcomes, choose less risky procedures and avoid equivocal treatments. This should increase confidence that patients can not only make constructive use of performance data designed for them, but can also be reliable informants for performance assessment. The role of the health care professionals are of the great importance in order to assure high quality services which should be provided to the patients with dignity and respect. The general notion of responsiveness can be decomposed in many ways. One basic distinction is between elements related to respect for human beings as persons – which are largely subjective and judged primarily by the patient – and more objective elements related to how a system meets certain commonly expressed concerns of patients and their families as clients of health systems, some of which can be directly observed at health facilities (WHO, 2000). Respect for persons includes: 1) respect for the dignity of the person; 2) confidentiality or the right to determine who has access to one's personal health information; 3) autonomy to participate in choices about one's own health. This includes helping choose what treatment to receive or not to receive.

All people are consumers of health services. What are their expectations with the health services? Users of health services want safe, appropriate interventions, treatment and care. They want to be treated with dignity and respect. They want information that is accurate, timely and relevant. Consumers believe that if this is to happen then consumers of the health services must be involved and consulted, not only in relation to their own healthcare, but also about service planning and delivery, health evaluation and research (Graham J.D., 2001). Many errors could be avoided because of intervention or questioning by a consumer or career. Errors increase when the consumers are not heard.

The closest most health services come to measuring consumers' experiences is the occasional satisfaction survey. But only targeting a reduction in complaints is not a sign of improvement. What is needed is an effective evaluation of the accessibility of complaints procedures and the introduction of incentives, such as feedback and proof of real action, to encourage and support complaints. To participate as equal partners, health services

consumers need to be able to consult, to develop policy and strategies and to train for their advocacy role.

Considerable attention has been given to the literature on the value of measuring patient satisfaction with medical care. Measuring and improving levels of satisfaction is important for a number of reasons. For one, patient satisfaction can be viewed as a positive outcome of the medical care provided; patients, as consumers, deserve to be satisfied with the product. Also, patient satisfaction measures provide health care managers with useful information about the structure, process, and outcomes of care. They alert administrators to the positive and negative aspects of their institutions. Patients increasingly expect choice as well as quality in healthcare. But in order to make informed choices, they need to know how well different hospitals or doctors are performing compared with their colleagues elsewhere. Patient satisfactions assessments help maximize an organization's quality and the value of the care it provides (Bell R. et al., 1997, Kelsey T., 2001).

The following dimensions of care that patients' value was established (Edgman-Levitan S., Cleary P., 1996): respecting a patient's values, preferences and expressed needs; information and education; access to care; emotional support; involvement of family and friends; continuity and transition; physical comfort; coordination of care.

Researchers have reported that patients' judgments of quality care rely on the responsiveness of healthcare providers to patients' unique needs (Atkins P.M. et al., 1996). To patients, the "appearance of environment and employees, reliability, dependability of service delivery, responsiveness, and competence, understanding the patient, access, courtesy, communication, credibility, and security" indicate quality care. Patient satisfaction also hinges on whether the "service experience meets consumer expectations". Consequently, assessing patient satisfaction and quality care depends on the way in which quality care is defined. Data from patient satisfaction surveys are used to identify particular patient needs and develop interventions addressing those needs and priorities, thus enabling hospital administrators and clinicians to evaluate the services they provide. Although the literature pertaining to patient satisfaction in the inpatient setting is extensive, there is a paucity of data on patient satisfaction pertaining to outpatient clinical services.

2. THE AIM OF THE STUDY

The study addresses the issue of quality in health care sector. Patients' satisfaction was chosen as the indicator of service quality provided by ambulatory care units. The study is focused on searching for main sources of satisfaction versus dissatisfaction with health care services and their relation to socio-demographic characteristics of ambulatory care units' patients.

3. LITERATURE ANALYSIS

3.1. CORE CONCEPTS OF HEALTH CARE QUALITY

3.1.1. QUALITY VALUES IN HEALTH CARE

Openness, confidence, motivation and commitment are the foundations of a quality culture. But often, traditional practices and attitudes towards authority, mutual support and individual responsibility actively resist improvement. These create a culture of low expectations (from public and professions), vertical command structures, restricted information and a negative view of accountability and responsibility. This is still a major problem in central and Eastern Europe.

Quality design involves service providers, clients, and managers in a structured process to explicitly identify client needs and design service processes with key features to meet those needs. In the context of quality design, features are concrete, practical expressions of clients' needs, desires, and expectations. While quality design is often applied to develop an entirely new process or service where a comparable one does not exist, it may also be used to substantially redesign an existing process or service.

3.1.2. DEFINITIONS OF HEALTH CARE QUALITY

The most comprehensive and perhaps the simplest definition of quality is that used by advocates of total quality management (W. Edwards Deming, 1982): "Doing the right thing right, right away."

Almost as universal is the view by Ovretveit J. (1992), who, almost a decade later, recognized the three "stakeholder" components of quality, namely client, professional and management quality. *Client quality* addresses what the clients and carers want from the service. *Professional quality* indicates whether the service meets the needs as defined by professional providers and referrers and whether it correctly carries out techniques and procedures which are believed to be necessary to meet the client needs. The *management quality* aspect is concerned with the most efficient and productive use of the resources within limits and directives set by higher authorities and purchasers.

The integrated definition of health care quality combines these three elements: "A quality health service/system gives patients what they want and need at the lowest cost" (Ovretveit J., 1992).

The client-focused definitions of quality come from Donabedian A. (1980) and Morgan and Murgatroyd (1994): "*Client satisfaction* is of fundamental importance as a measure of quality of care because it gives information on the providers' success at meeting those client values and expectations on which the client has authority".

By the 1990s, Donabedian A. saw health care as consisting of two parts: a technical task and an interpersonal exchange whereby doctor and patient discussed and agreed treatment. Morgan and Murgatroyd (1994) focus on the customer and physician for, in their view, quality in health care is "that care that has the capacity to achieve the goals of both the physician and patient...which provides an important redress to the traditions which have existed in health and other occupational areas of the public sector". These three much cited views reflect the multiplicity of stakeholders engaged in the determination, provision and assessment of quality in health care.

Defining quality means developing expectations or *standards* of quality (Brown L. et al.). Standards can be developed for inputs, processes, or outcomes; they can be clinical or administrative. Standards can be applied at the level of an individual, facility, or a healthcare system. A good standard is explicit, reliable, realistic, valid, and clear. Standards of quality can be developed according to the dimensions of quality and should be based on the best scientific evidence available. Stakeholders (including client and community) expectations of quality should also be incorporated in the definition of quality standards. Defined standards or definitions of quality are prerequisites for measuring quality. If standards don't exist, they must be designed. Although standards are context-specific, universally accepted standards are often a good starting point for developing local standards. Sometimes, even when they exist, standards must be refined to make them usable by health professionals.

3.1.3. QUALITY DIMENSIONS IN MEDICAL CARE

Diversity arises when examining what is meant by quality in medical care. Medical quality consists of a mixture of hard technical elements such as correct diagnosis, appropriate interventions and effective treatments as well as soft elements such as good communications, patient satisfaction and consideration for patient preferences (Gill M., 1993). It is not sufficient to consider only the technical competence of those providing care. Rather, a high quality service is one that provides effective care and is delivered humanely and efficiently. Good medical quality consists of technical competence as well - the correct decisions and appropriateness of interventions, audit and evidence based medicine. Ovretveit J. (1990) stated that: "Professional quality has two parts: (1) Whether the service meets the professionally assessed needs of its clients; and (2) Whether the service correctly selects and carries out the techniques and procedures which professionals believe meet the needs of clients".

Brown L. et al. describe nine quality dimensions of health service delivery: effectiveness, efficiency, technical competence, interpersonal relations, and access to service, safety, continuity and physical aspects of health care (table 1).

Table 1. Quality dimensions (Brown L. et al., undated)

Quality dimensions	Description
Effectiveness	The degree to which desired results (outcomes) of care are achieved through appropriate diagnosis and treatment
Efficiency	The ratio of the outputs of services to the associated costs of producing those services (taking into consideration both material and time resources)
Technical competence	The degree to which tasks carried out by health workers and facilities meet expectations of technical quality (according to clinical guidelines)
Interpersonal relations	Level of respect, courtesy, responsiveness, empathy, effective listening, and communication between clinic personnel and clients
Access to service	The degree to which healthcare services are unrestricted by geographic, economic, social, organizational, or linguistic barriers
Safety	The level of trust, confidentiality, and privacy in the services and the degree to which the risks of injury, infection, or other harmful side effects are minimized
Continuity	The degree to which consistent and constant care is provided, including the value of visiting the same provider and continuing treatment
Physical aspects	The physical appearance of the facility and the level of cleanliness, comfort, and amenities offered
Choice	As appropriate and feasible, client choice of provider, insurance plan, or treatment

3.1.4. CONCEPT OF INPUT-PROCESS-OUTPUT

There is general agreement that quality should be assessed from the viewpoints of major stakeholders (e.g. users, care providers, payers, politicians and health administrators) and against explicit criteria which reflect the underlying values of a given society (Shaw C., 2002). The most commonly quoted elements of a “good” health care system relate to Donabedian’s adaptation of the concept of input-process-output (table 2), but it is not realistic to expect to concentrate on all of these values at the same time.

Table 2. Donabedian’s adaptation of the input– process–output concept.

Structure - availability of human, financial, technical resources(investment)	How resources are allocated in terms of time, place and responsiveness to the needs of populations	Access
	Fairness in sharing costs and benefits	Equity
Process – how the resources are applied (stewardship)	Use of time and resources	Efficiency
	Avoidance of waste	Economy
	Reduction of risk	Safety
	Evidence-based practice	Appropriateness
	Patient-focused care	Continuity
Outcome – what results are achieved (performance)	Public information	Choice, transparency, accountability
	Population health	Health improvement
	Clinical outcome	Effectiveness
	Meeting expectations of public and workforce	Satisfaction
	Value for money	Cost–benefit

Three categories under which quality of care can be classified denotes attributes, activities and effects of care (Donabedian A., 1997). *Structure* denotes the attributes of the settings in which care occurs. This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure (such as medical staff organization, methods of peer review, and methods of reimbursement). *Process* denotes what is actually done in

giving and receiving care. It includes the patient's activities in seeking care and carrying it out as well as the practitioner's activities in making a diagnosis and recommending or implementing treatment. *Outcome* denotes the effects of care on the health status of patients and populations. Improvements in the patient's knowledge and salutary changes in the patient's behavior are included under a broad definition of health status, and so *is the degree of the patient's satisfaction with care*. Patient satisfaction has been increasingly recognized as an important measure of outcome and quality of care. Patient's satisfaction with the care they receive has been found to influence whether patients seek medical advice and comply with treatment. The literature on clinical patient's satisfaction with care highlights aspects of care considered important by them and areas indicating their dissatisfaction. Sources of dissatisfaction are related to organization of care, continuity of medical responsibility, length of waiting time for medical test results and medical appointments, health care providers' interaction, and referral to specific psychosocial services in case of need.

Quality of health care initiatives has led health care organizations to use patient satisfaction data to identify facts about the processes of work and the root causes of failures in those processes. Improvement efforts are monitored and benchmarks are used to identify the direction of established standards of excellence leading to best clinical practices. Quality improvement principles that seek to improve all aspects of service include managing and improving processes so intended outcomes are achieved, and meeting the needs and exceeding the expectations of patients.

3.1.5. THE MEANING OF QUALITY

The definitions and dimensions outlined above constitute a broad conceptual framework that includes almost every aspect of the health system performance. All these dimensions come into play as clients, health providers, and health care managers try to define quality of care from their unique perspectives. What does quality of health care mean for the communities and clients that depend on it, the clinicians who provide it and the managers and administrators who oversee it?

The Client. For the clients and communities served by health care facilities, quality care meets their perceived needs, and is delivered courteously and on time (Brown L. et al.) In sum, the client wants services that effectively relieve symptoms and prevent illness. Because of satisfied clients often are more likely to comply with treatment and to continue to use health services, the dimensions of quality that relate to client satisfaction affect the health and well-being of the community. Patients and communities often focus on effectiveness,

accessibility, interpersonal relations, continuity, and amenities as the most important dimensions of quality. However, it is important to note that communities do not always fully understand their health service needs - especially for preventive services - and cannot adequately assess technical competence. Health providers must learn about their community's health status and health service needs, educate the community about basic health services, and involve it in defining how care is to be most effectively delivered. Which decisions should be made by health professionals and which should be made by the community? Where does the technical domain begin and end? This is a subjective and value-laden area that requires an ongoing dialogue between health professionals and the community. Answering these questions requires a relationship and two way communication between the parties.

The Health Service Provider. From the providers' perspective, quality care implies that he or she has the skills, resources, and conditions necessary to improve the health status of the patient and the community, according to current technical standards and available resources. The providers' commitment and motivation depend on the ability to carry out his or her duties in an ideal or optimal way. Providers tend to focus on technical competence, effectiveness, and safety. Key questions for providers may be: How many patients are providers expected to see per hour? What laboratory services are available to them, and how accurate, efficient, and reliable are they? What referral systems are in place when specialty services or higher technologies are needed? Are the physical working conditions adequate and sanitary, ensuring the privacy of patients and a professional environment? Does the pharmacy have a reliable supply of all the needed medicines?

Are there opportunities for continuing medical education? Just as the health care system must respond to the patients' perspectives and demands, it must also respond to the needs and requirements of the health care provider. In this sense, health care providers can be thought of as the health care systems internal clients. They need and expect effective and efficient technical, administrative, and support services in providing high-quality care.

The Health Care Manager. Quality care requires that managers are rarely involved in delivering patient care, although the quality of patient care is central to everything they do. The varied demands of supervision and financial and logistic management present many unexpected challenges and crises. This can leave a manager without a clear sense of priorities or purpose. Focusing on the various dimensions of quality can help to set administrative priorities. Health care managers must provide for the needs and demands of both providers and patients, to be responsible stewards of the resources entrusted to them by the government, private entities, and the community. Health care managers must consider the needs of multiple clients in addressing questions about resource allocation, fee schedules, staffing patterns, and management practices. The multidimensional concept of

health care quality is helpful to managers who tend to feel that access, effectiveness, technical competence, and efficiency are the most important dimensions of quality.

Integrated quality development increases the capability of a service to achieve high quality in quality dimensions (patients, professionals, managers) at the same time. If quality activities are performed in the right way, then there is no trade-off between increasing patient satisfaction, improving professional outcomes, and reducing costs (Ovretveit J., 2001). A definition of quality needs to guide towards what should be measured. It should be one which resonates with professionals' values, but also conveys a patient focus, and brings in the idea of reducing waste and increasing efficiency. According to Donabedian A. (2003), concept of quality can be rather precisely defined, and that it is amenable to measurements accurate enough to be used as a basis for the effort to monitor and assure it.

3.2. QUALITY EVALUATION METHODS

Common principles of quality evaluation methodology include the following (Shaw C., 2002): *Statutory mechanisms* ensure that the safety of public, patients and staff is established and evaluated. Their regulations, standards, assessment processes and results are accessible to the public.

Voluntary external quality assessment and improvement programmes are recognized by and consistent with statutory investigation and inspection. Their standards, assessment processes and operations comply with international criteria.

There are formal mechanisms to define and protect the rights of patients and their families in relation to the receipt of health services.

Local quality programmes are systematically planned and coordinated to meet national priorities and the needs of local stakeholders. They use standards, measures and improvement techniques which are explicit and known to be effective.

The capacity to collect meaningful and consistent information on outcomes - in relation to the means employed and the goals that have been set - is vital for improving the performance of any system (Shaw C., 2002). The availability or unavailability of information on specific areas may tell a lot about the strengths and weaknesses of a system. For example, without information on patients' experience of the system *via* satisfaction surveys or on their re-operation, re-admission rates it may not be possible to evaluate the quality of health care provided. While there has been an international mobilization for establishing appropriate

performance indicators for health systems, and procedures for collecting data, system-wide information on the quality of care still remains rare.

What is being measured, and how, is important in a health system, equally relevant is who is doing the measurement and who has access to the information. The public dissemination of performance information on individual providers is not an easy decision in any country. Physicians and hospitals are often skeptical, underlying difficulties of interpreting data and importance of confidentiality for medical work. To be able to design new approaches to quality monitoring and improvement, health policy makers will need to understand the likely origins of those findings, their magnitude relative to other sectors of the economy and potential models of improvement (Mattke S., 2002). There is much potential in sharing the experiences in different countries to understand which factors are conducive to the design of successful models.

In general, three policy options exist to reform existing arrangements for performance measurement and improvement:

- Strengthening and/or modifying the institutions for professional self-regulation
- Using improved information to strengthen 'external' regulation
- Providing consumers with sufficient information about performance and with choice of providers so that market forces can lead to better quality

These choices raise technical, economic and political issues. In particular, they have different implications for whether the benchmarking of performance is open or closed to public view.

There are different types of measurement of health care institutions performance (WHO, 2002):

Regulatory inspection. Most countries have statutory inspectorates to monitor compliance of health care institution with published licensing regulations. Inspections standards have legal authority and are transparent, but by the same token are not easily updated. Standards address the minimal legal requirements for a health care organization to operate and care for patients; they do not usually address clinical process or hospital performance. Inspection of health care institutions induces conformity, and measures performance in terms of minimal requirements for safety. It does not foster innovation or information for consumers or providers.

Surveys of consumers' experiences. Standardized surveys of patients and relatives can reliably measure health care institution performance against explicit standards at a national level. Performance is becoming more focused on health education, patient empowerment, comfort, complaint mechanisms and continuity of care.

Third-party assessments. A research project funded by the European Union (Shaw C., 2000) identified systematic approaches linking national or international standards to local practices of private or public health care institutions. These approaches have been compared in a number of studies of standards and methods used by industry-based (ISO, Baldrige) and health-care-based (peer review, accreditation) programmes (Klazinga N., 2000, Australian Quality Council, 1999, Donahue K.T., van Ostenberg P., 2000, Bohigas L., Heaton C., 2000).

The programmes, which are voluntary and independent to varying degrees, use explicit standards to combine internal self-assessment with external review by visits, surveys, assessments or audits (Shaw C., 2001).

ISO Standards. International Organization for Standardization certification measures health care institution performance in terms of compliance with international standards for quality systems, rather than in terms of institution functions and objectives. ISO developed a series of standards (ISO 9000) originally for the manufacturing industry (medicines, medical devices) that have been used to assess quality systems in specific aspects of health services and hospitals and clinics. Health care institutions (or, more commonly, parts of them) are assessed by independent auditors who are themselves regulated by a national "accreditation" agency. The theoretical advantage is that ISO certification is internationally recognized in many other service, but ISO 9000 standards relate more to administrative procedures rather than to health care performance. Furthermore, the terminology of the standards is difficult to relate to health care, and interpretations vary among national agencies (Sweenwy J., Heaton C., 2000). The audit process tests compliance with standards and is not intended for organizational development.

Peer review. Peer review is a closed system for professional self-assessment and development. Peer review schemes could provide a source of standards and assessments to harmonize professional and human resource management within and between countries with reciprocal recognition of training.

Accreditation. Accreditation programmes measure health care institution performance in terms of compliance with published standards of organizational – and, increasingly, clinical – processes and results. They are mostly independent and aimed at organizational

development more than regulation but could contribute reliable data to national performance measurement systems.

Statistical indicators. Statistical indicators can suggest issues for performance management, quality improvement and further scrutiny. They provide relative rather than absolute messages and need to be interpreted with caution inversely proportional to the quality of the underlying data and of the definitions used.

The OECD project on Health Care Quality Indicators (HCQI) is developing measures to help decision-makers formulate evidence-based policies to improve the performance of health systems, rather than of hospitals. In 2003, a WHO Regional Office for Europe working group (WHO, 2003) began to define performance measures for hospitals' voluntary self-assessment and for external benchmarking in six domains: clinical effectiveness, patient centeredness, production efficiency, safety, staff development and responsive governance. The group has considered background information on international, national and regional or provincial systems that use standardized data to evaluate several dimensions of health care institution performance for purposes of public reporting, accountability, accreditation or internal use (Guisset, A.L., Sicotte C, Champagne F., 2003).

Factors such as underlying values, financing and organizational arrangements plays role in the selection of possible performance measurement methods (Leatherman Sh., 2001). The choice of method also depends on whose behaviour is tried to change: providers, professional bodies, citizens or managers. Identifying a best method may not be realistic, but being aware of the possible approaches, their strengths and limitations, and the experience of countries that have tried them, can help in making a choice.

Performance indicators are employed for four basic functions: facilitating accountability; monitoring healthcare systems and services as a regulatory responsibility; modifying the behaviour of professionals and organizations at both a macro (population) and micro (patient) level; and forming policy initiatives. *Professional accountability*, dominant in most health systems historically, views the physician as the key to controlling quality and uses certification, accreditation, licensing and litigation as instruments for enforcement. But the professional model of accountability is increasingly regarded as insufficient unless accompanied by one of the other two. *The economic model* is based on the idea that the competitive market can be used to enforce accountability. Health plans can influence physicians' choice of treatment by declining to fund some practices or encouraging others. And accountability through public reporting is believed to have resulted in improved

performance in certain areas. *The political model* meanwhile views the citizen as receiving a public good, so the governments role is to act as an agent of change on behalf of the public.

Objective measures of performance are increasingly used at several levels. Importantly, performance indicators can help to make policy priorities explicit, for example by defining national priorities and then identifying specific performance targets within those priorities. Assisting healthcare professionals in practicing evidence-based medicine is a key objective for improving quality. Performance indicators, embedded in clinical guidelines and peer reviews, are among the most common approaches aimed at bridging the knowledge gap, but have limited effectiveness when used alone to change physician behaviour.

3.2.1. QUALITY MONITORING IN EUROPEAN COUNTRIES

Concerning quality monitoring in international perspective a number of questions could be set: what is the approach to quality in other countries, what outcome measures are used and how do they compare to our own, do we use common standards, are we learning from each other's approaches? (Lugon M., 2002). Many countries in Europe and elsewhere have similar concerns and have developed their quality agenda using various approaches, such as the launch of national mandatory accreditation program for all health facilities in France, a regional accreditation program in Italy, independent voluntary accreditation program supported by government in Germany. France is the most active in developing external control mechanisms, not only to check the quality of services provided but also to assure efficiency of resource use. A number of tools have being employed, such as accreditation of hospitals, financial incentives and sanctions, and mandatory guidelines. Improving the health information base has also been an important part of performance improvement efforts. Both in the Netherlands and in Sweden, mechanisms such as external audit and accreditation have not gained much popularity, probably because the medical profession and health care providers have been active in developing their own quality management measures (Zeynep Or, 2002). In both countries regulation appears to be strong in providing principles and goals for the system rather than in sanctioning.

Quality of care is used as a criterion in negotiating hospital budgets in *France*. Quality is measured either by surveyors of state and accreditation (by ANAES) or by specific conditions upon which hospitals negotiate their financing with the Agences Regional d'Hospitalisation (ARH). Each institution develops a "*contract d'objectifs et de moyens*" with a part defining more precisely their quality and safety objectives and the areas where they would invest to improve the quality of care to get the financing. Medical inspectors working for state regional and departmental offices carry out regular visits to ensure the respect to safety and quality norms in hospitals, such as monitoring hospital infections or patient satisfaction. The main

policy objectives of the *Dutch* health system are to improve the health status of the population by safeguarding universal and equal access to care. Solidarity, universal access, equal treatment and providing good quality services are expressed as principal policy goals. At the same time, professional autonomy, patient choice and satisfaction have long been underlying principles of the health system in the Netherlands. Improving the quality, flexibility and user friendliness of both acute and long-term care systems are avowed policy objectives. Since the beginning of 2001, Balanced Scorecards are used in *New Zealand* for evaluating the performance of hospitals by pooling together information on four areas: quality and patient satisfaction; organizational health; process and efficiency; and financial performance. Within this framework 12 key performance indicators are identified (4 for each dimension) for which data is collected from all hospitals. In *Sweden*, health care is a public responsibility, and good health and equal treatment for the entire population are the fundamental goals. Health and Medical Service Act states that medical services must be of high quality and designed to meet patient's need for security and treatment, accessible to all and based on respect for capability and integrity of patients. There is a special emphasis on offering designing the treatment and care, as much as possible, in consent with the patient.

3.2.2. "VOICE OF THE CUSTOMER"

Increased contact with external/internal customers was listed among ten the most important factors to the management development. The benefits of increased customer contact are plain. It provides managers with new ideas for improvement and ultimately assists a manager to measure and adjust his or her performance against that all-important barometer of customer satisfaction (Longenecker C., Neubert M., 2003).

The information available to insurers consists of utilization data linked to reimbursement schemes. These can be used to identify variations in practice, but do not provide any information on health outcomes and quality. While a lot of information on outcomes and patient satisfaction is exchanged among professionals in their local debates, no standardized data in outcomes and quality is available. The fact that each institution decides on what to measure and how (which indicators) means that the quality information cannot be used for comparison. Standardized techniques such as reviewing patient management, record-keeping, and a patient satisfaction questionnaire on the doctor's interpersonal skills should be used for evaluation.

There are a variety of methods for finding out what customers think about a service (Ovretveit J., 1993): talking to staff or clients about what clients like and dislike about the service; routine customer group meetings; a letter sent to a sample of clients; comments

cards; free telephone lines for comments and complaints; observation against check-list; objective indicators of customer satisfaction, e.g. client-cancelled appointments, demand, waiting times. Each measures different thing and is used for different purposes in different situations. The combined data collection methods give rich insights into clients' perspectives on service quality. However, to implement all the methods require significant resources. Data collection methods are assessed according to three criteria: relative validity, utility, and feasibility/cost. Understanding the advantages and disadvantages of each method with respect to validity, utility, and feasibility/ cost allows managers to weigh these considerations and select the best methods relative to individual priorities and resource constraints. Validity is the degree to which the data seems to accurately capture what it is supposed to capture and is of primary importance because it indicates the extent to which the objectives of the data collection will be achieved. Utility refers to how useful the information for quality improvement activities and indicates the extent to which the results of the data collection will be used. Feasibility/cost refers to how easy or difficult and how costly it is to obtain participants, apply the tools, analyze findings, present results, and routinely use the data collection method (Santillán, D., Figueroa M., 2001).

To attain more in-depth information and to permit exploration of factors that influence patient satisfaction, researchers used the advice to complement survey research with follow-up methods such as interviews and observations. Although they are time consuming and potentially expensive, interviews and observations permit a deeper, richer, contextual examination of patients' perceptions of the quality of their care. Interviews provide an opportunity to gather data both quantitatively and qualitatively.

The validity and accuracy of the method is not always the most important consideration. The choice of method should be influenced by its cost-effectiveness, its credibility and its likely use by service provider to make continual improvement and to judge the effect of their changes over time.

3.3. PATIENTS SATISFACTION AS QUALITY INDICATOR

Consumers of health care services play a variety of roles in health care quality assessment and monitoring. By expressing their preferences, they supply the valuations needed to choose among alternative strategies of care (Donabedian A., 1987). They help define the meaning of quality in the technical sense. Moreover, their preferences are the paramount consideration in defining the quality of the interpersonal process and of the amenities of care. Consumers are also valuable sources of information in judging the quality of care. Some

data, mainly, about non-technical aspects of care are most easily obtained from consumers. Most importantly, consumers can and do, through expressing satisfaction or dissatisfaction, pass a judgment about many aspects of the process of care and its outcomes. Consumers, if properly informed, could help to regulate the quality of care by means of their choices. Health care is now entering an age of "accountable consumerism" in which patients demand service excellence. Patients' expectations for care have been defined differently in the literature. Some studies view patients' expectations as probabilities, judgments about the likelihood that a set of events will occur (Mc Kinley, 2002; Conway T., Willcocks S., 1997). Others view expectations as values-patients' desires about care are expressed as perceived needs, wants, importance, standards, or entitlements (Kravitz R. L., 1996). These expectations may pertain to health care in general or to a specific health care encounter such as a clinic visit or hospitalization. Whether patient expectations are considered as probabilities or values, an understanding of patient expectations is important because meeting these expectations may lead to greater satisfaction with care.

The measure of patient satisfaction is viewed as important in outcomes research and quality improvement efforts (Maxwell D., 2001, Kenagy et al., 1999, Pichert et al., 1998). In addition to increased patient compliance and health outcomes, patient satisfaction has been linked to greater service utilization and risk management. As a result, managed care organizations are placing greater emphasis on patient-perceived outcomes measures, such as satisfaction and functional status. Patient satisfaction even has been found to moderate individuals' decisions to sue in the face of adverse outcomes. As the patient is becoming widely recognized as a reliable and important source of information about quality of medical practice (Lawthers A.G., Rozanski B. S., Nizankovski R., Rys A., 1999), important steps towards making performance transparent comes with the publication of concrete figures on the quality of outcomes relevant to patients. Patient surveys are an important part of this. Advantages of the patients' surveying are that it identifies what is valued by patients and the general public, and standardized surveys can be tailored to measure specific domains of experience and satisfaction. However, to reach the valid and reliable results still remain a challenge for the health care organisations (Sitzia J., 1999). If questionnaires and the process itself are validated by rigorous scientific scrutiny, then a useful comparison of the data is guaranteed. Health care institutions using performance indicators to differentiate themselves and demonstrate customer focus reap considerable advantages, especially if they have a quality management system to underpin the development of performance. That is the benefit of both patients and staff (Kolking H., 2003, Dolan T.C., 1998).

The Commission for health improvement has embraced patient centeredness as a core organizational value (CHI, 2004). It states: "Patients, careers and service users matter to

CHI. Our inspections help improve the quality of care people receive on the NHS. We work with patients and patient organizations to do this". One of these principles is that CHI will be patient centered. Placing the patient at the center of the provision of care is yet another new and important approach to improving the quality of medical care (Grol R., 2001, Elaine Y. et al., 2002). From an ethical perspective, patient autonomy is seen as a basic value and underlying premise for the provision of health care in itself. From a psychological perspective, greater patient involvement and greater patient control are assumed to lead to better adherence to treatment recommendations and thus to better health. From an epidemiologic perspective, patients are seen as rational beings who, after being informed of the relevant benefits and risks of treatment alternatives, can share in decision making.

Satisfaction of health care consumers can refer to two things: first to "revealed preferences", that is to real consumption, assumed to be the expression of what consumers want, and second to what consumers say they want ("stated preferences") (Dussault G., 1999). In health, there are so many economic, social, cultural, organizational potential obstacles to the expression of consumers' real preferences that revealed preferences say little about what consumers really want. Also, consumers have only imperfect information about their needs and about the options of services available, and most of their utilization of services is on the recommendation of providers. Indeed, the utilization of services probably reflects more the preferences of providers, than of users. There are now many validated indicators which measure the stated satisfaction of consumers, and it is possible to rely on these to assess satisfaction. According to Jenkinson C. et al. (2002), patients' experiences of health and medical care are at the very core of the purpose of clinical medicine. If medical treatment succeed only in a limited technical sence, but without any benefit to those receiving them, then interventions have failed. Health care providers must consider whether and how patient expectations of their services can be managed (McKinley et al., 2002). Dissatisfaction with the health care services provided could be reduced if consumers know what they can expect and then receive it.

3.4. LEGISLATION ON QUALITY IN HEALTH CARE

Quality in health care is strongly linked with quality assurance (QA) and patients' rights. Quality assurance - is a planned and systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis within the existing resources. QA should encompass three perspectives on quality:

- Clinical standards
- Performance management
- Client satisfaction

In March 1996 the UEMS (European Union of Medical Specialist) launched the Charter for quality assurance in European Union. The charter contents 6 articles about QA for individual specialist group practice, for hospital, professional scientific organizations, EU Member State or region and financing of QA (Charter on quality assurance in medical specialist practice in the European Union, 1996).

QA is a professional concept initiated and controlled by professional itself. Professional and scientific organizations are required to develop quality criteria in their specialty. QA is moral and ethical obligation for individual specialist, but basically it should be a voluntary responsibility. The policy of UEMS is the encouragement of the implementation of the process of QA projects at all practice whether for individual specialist, group practice, department hospital, professional scientific organizations, EU Member State or region.

3.4.1. QUALITY ASSURANCE IN POLAND

In 1992, Poland began participating in European Union project aimed to improved quality of care in several Hospitals. The following year a Polish Association for Promotion of Quality in Healthcare was formed, and in 1994 a National Center for Quality Assessment (NCQA) was established under the auspices of Ministry of Health. The center was assisted by USAID and its purposes are to promoted awareness of modern quality assurance technologies and to provide assistance to provider units that wish to improve quality by applying these methods. Poland, now, is a member of European Society for Quality in Health Care (ESQH), which is a network of national societies dedicated to improvement of quality at national and international levels.

3.4.2. PATIENTS' RIGHTS AT EUROPEAN LEVEL

The notion of patients rights is developed on the basis of two concept, recognized by Universal Declaration of Human Right formalized in 1948, "inherent dignity " and equal and unalienable rights of all members of the human family".

The recognition of patients' rights throughout Europe is a recent phenomenon dating back just two decades. A conference held in Amsterdam in March 1994 under the auspices of

WHO regional office for Europe was instrumental in laying the groundwork for the development of policy in the area of patients' rights. The Amsterdam meeting produced strategies to promote patients' rights as a part of the reform of European health system.

The Declaration of Amsterdam, in its scope and focus, seek to reflect and express peoples' aspiration not only for improvements in their health care but also for further recognition of their rights as patients. So, it keeps in mind the perspective of health care providers as well as of patients (Declaration on the promotion of patients' rights in Europe Amsterdam, 1994).

At European level a Charter of Patients' Right was introduced in November 2002, with the influential Active Citizenship Network and 15 national associations involving in drafting the final text. Because the 14 rights it specified were also anchored in the European Charter of Fundamental Rights, they must be protected at both national and European level. The 14 rights are: the right to preventive health measures; the right to access to health service; the right to information; the right to consent; the right to privacy and confidentiality; the right to respect for patients' time; the right to observance of quality standards; the right to safety; the right to innovation; the right to avoid unnecessary suffering and pain; the right to personalized treatment; the right to complain and the right to compensation.

Council of Europe based on the Art.11 of the European Social Charter, recalling Amsterdam Declaration on the promotion of Patients' Rights and recognizing health care system should be patient-oriented, recommends that the government of Member States:

- Ensure that citizens' participation should apply to all aspects of health care system, at national, regional and local level and should be observed by all health care system operators, including professional, insurers and the authorities;
- Create legal structures and policies that support the promotion of citizens' participation and patients' rights, if these do not already exist (Recommendation Council of Europe, 2000).

3.4.3. PATIENT'S RIGHTS IN POLISH LEGISLATION

Patient's rights have been widely discussed in Poland recently .The movement involved in improving and complying with patient's rights has increased with social, cultural, ethical and political development.

The patients' rights charter is established in December 1998 and it is based on the principle act of Constitution of 2nd April 1997, defined in acts: 30th August 1991 on health care facilities, 19th August 1994 on protection of sanity, 26th 1995 in the transplantation of cells, tissue and

organs; 5th July 1996 on the nurse and midwife profession; 5th December 1996 on the health care provider profession.

According to the Charter, the patient's rights can be defined as an entitlement to share the benefit of health services (Polish Patients' Rights Charter, 1998). Patients' rights in Polish legal system are dispersed among legal acts and result from regulations that place responsibility on different entities providing health services.

Each patient should know his/her rights and be able to take advantage of them. Such knowledge enables patients to be better oriented in this matter and may contribute to their satisfaction from medical services. It also enables to settle a rising argument by means negotiations between partner knowing their rights and obligations.

3.5. QUALITY ASSURANCE IN EUROPEAN COUNTRIES

In May 2000, the European Commission adopted a new public health strategy and introduced the concept of actively spreading best practice in health care (and thus quality improvement) among member states of the EU – and among those seeking to join.

The social protection systems created in the Member States aim to ensure access for all to quality care. Following the Lisbon and Gothenburg European Councils, which highlighted the need to reform and adapt social protection systems, including health care, in order to meet the challenge of demographic ageing and ensure social cohesion, the Commission identified three principles (COM, 2001) that could serve as a basis for this reform. These principles were approved by the Barcelona European Council in March 2002:

- Accessibility of care* for all, based on fairness and solidarity, taking into account the needs and difficulties of the most disadvantaged groups and individuals, as well as those requiring costly, long-term care;
- High-quality care* for the population, which keeps up with medical advances and the emerging needs associated with ageing and is based on an assessment of their health benefits;
- Measures to ensure the long-term *financial sustainability* of this care and aiming to make the system as efficient as possible.

The joint report of the Commission and of the Council "*Supporting national strategies for the future of health care and care for the elderly*" of 10 March 2003 emphasized that technological and treatment innovations, improved wellbeing and patient information, and

demographic ageing are raising new problems in terms of the capacity of the national systems to ensure accessibility and high quality and to guarantee their financial sustainability over the long term.

The Lisbon Strategy is therefore a coherent framework for catching up in terms of the level and quality of care, and is supported by a range of instruments, including the “open method of coordination”.

Joint objectives for developing care systems are developed by the European Commission (COM, 2004). The lower risk of ill health-, accident- or old age-related poverty and the significant improvement in Europeans’ state of health are valuable achievements of Europe’s social protection systems. They must continue to provide high-quality care based on the principles of universal access – i.e. covering all the population – and solidarity – i.e. based on collective contributions, not on individual wealth – and which is financially sustainable. Moreover, a key to the development and reform of the systems is their ability to implement effective governance based on involving and giving responsibility to the players concerned – including the social partners, regional and local authorities, patients and civil society – and coordinating care providers, financial organizations, NGOs and the public authorities. At European level, it would be desirable for the sectoral social partners to make a tangible contribution to the reform efforts.

Health care quality assurance issues became even more important with the enlargement of the EU and the free movement of persons and goods. This means that Community citizens could, when feeling ill, seek health services in any of the Member States, or with mitigated acceptance, receive health care in the country where circumstantially they happen to be, regardless of their country of origin (Delgado M., 2004). Only in recent years have quality policy and quality assurance become priorities for the new comers’ countries. As a result, existing strategies tend to focus on improving structural quality. The principal reasons for introducing quality assurance are: deviations in performance, practice and outcome; ineffective or inefficient medical technologies and/or service delivery; complaints by patients; inequitable access to services; waiting lists; and high direct and indirect costs (Puringer U., 2003). European countries have already introduced legislation on quality and many have established quality task forces or appointed expert commissions or national commissioners to oversee quality issues in defined areas. Licensing, whether of medical practitioners, health providers, medicines, medical technologies or blood products, is the most common quality strategy. Others include the development of diagnostic and treatment guidelines, medical audit and peer review. Regular surveys of patient satisfaction are also a feature of quality policy in some countries. Latvia’s approach to quality in health care hinges on plans to systematically improve the quality of structures, processes and outcomes in the country’s health system, while Poland have introduces mechanisms to initiate health technology

assessment. Organizations representing the professions have expressed a strong interest in developing diagnostic and treatment guidelines as a means of improving their work on a practical level and underpinning clinical decisions and scientific knowledge. Health care quality assurance concept in Lithuania defines main aims and tasks in quality assurance in health care sector (2002, Order of the MoH). Strategic goal for the Health Care Quality Assurance in Lithuania is to formulate and implement system of means for realization of the Health Care Quality Assurance Concept, approved by the Order of the Minister of Health striving for good public health and quality of life (Lithuania's Health Care Quality Assurance Program, under revision). Purposes for the QA concept implementation are to orient Health Care towards needs of Patients and Public; to improve quality and safety of Health Care Services, provided to patients; to elaborate Health Care Quality Management.

Various obstacles and difficulties have been cited as hindering the introduction of a comprehensive quality assurance system in the various health systems. The main among them are the absence of national quality policies, including focused strategies, the lack of ring fenced funding, and the failure to co-ordinate activities. In some cases, the required structures – e.g. quality centers or national co-coordinators – and/or uniform quality assessment criteria or indicators do not exist.

A global study of WHO identified 36 nation-wide accreditation programmes. A survey of the WHO European Region in 2002 (WHO, 2003) identified 17 such programmes focusing on whole hospitals. Mandatory programmes have recently been adopted in France, Italy and Scotland.

National programmes within Europe have agreed in principal to voluntary convergence of standards and assessment processes according to the ALPHA Principles of the International Society for Quality in Health Care (ALPHA program, 2000). The ALPHA programme aims to make standards-based assessment systems more reliable, valid and compatible within and between countries (Heidemann E. G., 2000). Most established programmes have been subjected to internal (Shaw C.D., Collins C.D., 1995) or external evaluation, but few of these evaluations have used comparable methods to permit synthesis. There is ample evidence that health care institutions rapidly increase compliance with the published standards and improve organizational processes in the months prior to external assessment, but there is less evidence that this brings benefits in terms of clinical process and outcome.

4. MATERIAL AND METHODS

A cross-sectional study design was applied to this pilot study in order to assess patients' perception and satisfaction with the quality of care and services provided. A survey took place at outpatient psychiatric, dermatology, immunology and nuclear departments at the University Teaching Hospital in Lodz in a period from 18th of May till 4th of June. Based upon the literature analysis on the patients' satisfaction and quality in health care, 31-items questionnaire was developed. The cover letter with the purpose and instruction was enclosed to the patient satisfaction questionnaire. The participants were assured in information received to be treated confidentially and no identifications were asked and the study was voluntary based. 280 questionnaires were equally distributed to each of the above mentioned departments. The first day of surveying the questionnaires were handed out to all the patients attending the outpatient departments by the reception desks nurses. During the rest surveying period the questionnaires were put at the reception desks and each interested patient could fill it in. The self-administered questionnaires were collected to the special boxes at the each health care unit and a total of 240 patients returned the filled in questionnaires. From the all respondents of the study 33.2% were from the department of dermatology, 29.4% - from nuclear medicine department, 17.6% - from immunology department and 19.7% from psychiatric department. The study population covered less than 10% of the patients flow during the day: the average number of the patients attending dermatology department is 110, psychiatric – 73, immunology – 65, and nuclear department – 30.

STUDY MATERIAL

The proportion of females in the study was higher than males: 65.4% of the respondents were females, 34.6% males. The average age of the respondents was 44.8 ± 13.5 years. All of the respondents were grouped to the four age groups according to the 25th, 50th and 75th percentiles values: 26.7% of the respondents were attributed to the youngest age (till 35 years) group, 21.7% - to the age group of 36-45 years, 32.7% - to the age group of 46-55 years and 18.9% - to the age group 56 and more years.

A half of the patients (49.6%) had secondary education, quarter (23.5%) - university education degree, 13.7% - basic vocational education, 6.6% – higher and 6.6% - primary education degree. The majority part of the patients (60.4%) was employed, 22.4% were

retired and 17.2% were disabled. At the group of disabled patients ten percent were the first group of disability, a half of them - the second, and 39.3% - third group of disability. Respondents were grouped into four groups according to their self-assessment of the health status. Most of the patients (53.9%) compare their health status with people in their age, 6.5% of them evaluated their health much better, 17.8% - better and 21.7% evaluated their health status worse than people in their age.

Criteria used to develop the questionnaire

According to the literature analysis dimensions of the quality in health care and patients' satisfaction were adopted in the development of the questionnaire: health care accessibility and waiting times (four questions), information provided to the patient (two questions), communication with the medical personnel (three questions), patients rights (five questions), care and treatment (five questions), and facilities (one question). Overall items were covered by eleven questions.

STATISTICAL ANALYSIS METHODS

Statistical analysis was performed using SPSS for Windows 11.5 statistical package. Descriptive analysis was performed to get the data about the overall items. To compare the opinion of the patients groups according to the age, employment, health status and to examine the hypothesis that the distribution of the variables is independent to each other, the Chi-square test was used. Significance level (p) less than 0.05 was considered as statistically significant.

5. RESULTS OF THE STUDY

5.1. GENERAL PATIENTS' SATISFACTION IN THE UNIVERSITY TEACHING HOSPITAL

About three fourth of the patients (74.5%) were completely satisfied and 23.8% satisfied to some extent with the health care provided in the Ambulatory Care Unit. Only 1.7% pointed dissatisfaction with the services.

Almost all of the patients (96.9%) indicated that they were satisfied with the amount of diagnostic and treatment procedures, which are given to them and only 3.1%, expressed dissatisfaction with that. More than a half of the respondents (69.4%) were satisfied with the time devoted to them during consultation, 29.3% would like more time and 1.3% said that devoted time to them was too long.

46.8% of the patients evaluated the quality of services excellent, 44.6% - very well, 8.2% - good and only 0.4% evaluated the services as poor ones. Almost all the patients (99%) indicated that they would like to recommend the outpatient service to the other peoples (family and friends) and if they need, they will utilise the same service of ambulatory care in the future. For more than a half of the patients (57.9%) the tidiness and hygienic conditions of ambulatory care unit were very good or good (40.4%) compared with less than 2% who indicated that the level of conditions was poor.

About of a half of the patients indicated (51%) that the communication among patients and health care professionals is very important for increasing the level of their satisfaction, 45,6 % of them indicated that the communication is important, 3,2% indicated that the communication is less important. None of them indicated that the communication was unimportant.

While answering to the question what could increase patients satisfaction with the services in general, 51% of the respondents as the most important thing pointed out better communication with the health care professionals and better provision with information about patients health and treatment, 49.7% of the patients would appreciate the reference to the specialized health care services in time, 48.7% gave the priority to the provision with disease preventive care and in the opinion of the 33.6% - enhancing of the health care professionals knowledge and qualification is of the most importance to the level of patients satisfaction. According to the comments of 29.2% of the patients their satisfaction would increase if the time devoted to the consultation would be longer, and the paper work to the doctors (31.2%) as well as the number of assigned patients to the doctors (26.1%) would be diminished.

Almost ten percent of the respondents pointed out that the consultations by phone would increase their satisfaction with the services.

5.2. DESCRIPTIVE ANALYSIS FOR THE HEALTH CARE QUALITY DIMENSIONS

5.2.1. ACCESSIBILITY AND WAITING TIME

78.2 % of the patients indicated that opening hours of the ambulatory care unit comply with their needs, while the rest of the patients didn't think so. For 95.2% it was possible to make the visit appointment via phone. The waiting time was short enough for 69.2% of the patients compared with 30.8%, who indicated that waiting time was long. About one fourth of the patients (26.5%) indicated that they had to wait for their appointed visit after arrival to the ambulatory care unit in a long queue, but the majority of the patients respond that they didn't have to wait.

5.2.2. INFORMATION PROVIDED TO THE PATIENTS, PARTICIPATION IN DECISION MAKING, COMMUNICATION AND CARE

Two thirds of the patients (69.3%) indicated that they have had the opportunity to take part in the decision making process on their treatment, while the others 30.7% commented that they hadn't such opportunity. 94.9% of the respondents felt themselves free to speak about their problems and 91% have had the impression that personnel communicate sufficiently in respect to their health, while 5.1% marked that they miss speaking because of the fault of the personnel, and 8.9% felt lack of communication with the medical staff.

More than a half of the patients (60.1%) pointed out that the doctor's care during their visit in Ambulatory Care Unit was very good, 39.1% assessed care as good, while less than 1% indicated poor doctor's care. 67.4% of the patients evaluated the nurse care as very good, 31.7% - as good and less than 1% of patients commented nurse care being poor.

74.4% of the respondents indicated that the doctors always informed them about the disease diagnosis. Less than a quarter of the patients were informed sometimes and only 2.7% wasn't provided with the necessary information about diagnosis.

About a half of the patients (53.8%) indicated that the doctors always provided them with information about the disease complications, and 17.3% opined that the doctors didn't provide to them this kind of information.

50.3% indicated being provided with the information about alternative treatment methods, while one fourth indicated they didn't. The other part (24.4%) of the patients indicated that

the doctors sometimes provided the necessary information about the alternative treatment methods.

5.2.3. PATIENTS' KNOWLEDGE OF THEIR RIGHTS

Knowledge about patients' rights among the respondents of the study was analyzed in terms of perception of dignity and intimacy; complain procedures and possibility to get a right treatment.

According to the opinion of more than a half of the patients (59.5%) they were treated with dignity and intimacy in very good way, compared with 0.9% of the patients who indicated that they were treated without dignity and intimacy.

Almost a half of the patients (44.4%) indicated that they would complain to the doctor if they would be not satisfied with the health care services provided to them and 35.6% would like to complain to the head of the health care institution. 11% of the patients didn't know where to complain and 4.9% didn't believe that somebody would listen to them. A few of the patients indicated that they would complain to the MoH. Less than a half of the respondents (41.9%) knew that they could apply for compensation to the damage to their health.

64.3% of the patients indicated that they or a member of their family were treated well even they didn't pay during the last year. About one third of the patients (32.1%) stated that they didn't pay and they didn't get right treatment, while 3.6% indicated that they paid and got a good treatment.

5.3. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE PATIENTS AND PERCEPTION OF QUALITY IN AMBULATORY CARE UNITS

5.3.1. AGE RELATED DIFFERENCES

All of the respondents were grouped to the four age groups according to the 25th, 50th and 75th percentiles values.

Patients satisfaction with the health care services provided were different statistically significant in the age groups ($\chi^2 = 18.078$, $df = 6$, $p < 0.01$). The result suggested that younger patients tend to be less satisfied with the health care than older patients. 62% in the youngest (till 35 years old), 70.2% in the middle (36-45 years), 84.3% in the group of 46-55 years and 87.5% in the group of 56 and more years reported satisfaction with the services.

There is no statistical significant difference in comparison the opinion of the different age group patients about health care quality. Almost nine of ten respondents in each age group assess health care quality as very good.

Higher percentage of the younger age patients expressed dissatisfaction with the waiting time – 42.1% of the youngest group in comparison with 12.5% of the oldest age group ($\chi^2 = 11.768$, $df = 3$, $p < 0.01$). The younger patients (71.9%) had more opportunities to take part in the decision making on their treatment than oldest patients group (52.8%) ($\chi^2 = 9.021$, $df = 3$, $p < 0.05$). 78.9% of the patients in the age group of 56 and more and 82.1% in the 46-55 years group stated that they are satisfied with the time devoted to them during the visit ($\chi^2 = 18.669$, $df = 6$, $p < 0.01$). 74.4% of the patients of age 56 and more and 43.1% of the youngest age group evaluated doctors' care during the visit as very good ($\chi^2 = 18.989$, $df = 9$, $p < 0.05$). Older patients groups reported (65.8%) very good respect of the dignity and intimacy while in the youngest age group very good respect was marked by 43.9% of the respondents ($\chi^2 = 14.479$, $df = 6$, $p < 0.05$).

5.3.2. PATIENT PERCEPTIONS IN RELATION TO THEIR HEALTH STATUS

There was no statistically significant difference among health status groups in comparison their opinion about satisfaction and quality evaluation of the services. The opinion of the patients in relation to their health status was different according to their reporting about the information provided to them about the treatment methods. More than a half of the worse health care group patients (58%) stated that the information about treatment methods was provided to them always. Patients at the groups of the compare and better health in comparison to the others same age people groups comment that they were provided with information about treatment methods 48% and 44% respectively ($\chi^2 = 13.222$, $df = 6$, $p < 0.05$). The highest percentage of the worse health group patients (75%) stated that better health care professionals' communication with the patients and providing the patients with the information could increase their level of satisfaction with a services. In the compare health group 44% of the patients and in the better health group – 42% was the same opinion ($\chi^2 = 10.406$, $df = 4$, $p < 0.05$). The statistically significant higher percentage of the patients in the worse health care group in comparison with a compare and better health groups reported their preferences to providing consultations by phone ($\chi^2 = 13.068$, $df = 6$, $p < 0.05$) and diminishing number of assigned patients to the doctors ($\chi^2 = 12.952$, $df = 6$, $p < 0.05$) in order to increase the level of the patients' satisfaction with the services.

5.3.3. PATIENT PERCEPTIONS IN RELATION TO THE EMPLOYMENT STATUS

According to the results of data analysis higher percentage of the patients in the group of retired patients (90%) in comparison with disabled (85%) and employed patients (65%) reported satisfaction with the provided health care ($\chi^2 = 13.583$, $df = 4$, $p < 0.01$).

Patients perceptions in relation to employment status were different statistically significant according to the reported opinion about the accessibility to the services. The opening hours of the ambulatory care units comply with the highest percentage of the disabled patients group (94%) in comparison with retired (85%) or employed patients (70%) ($\chi^2 = 10.300$, $df = 2$, $p < 0.01$). The bigger part of the disabled patients (84%) and retired (83%) than employed (62%) reported that the waiting time for the appointment was short enough ($\chi^2 = 9.612$, $df = 2$, $p < 0.01$). Patients experiences were different according to the participation in the decision making process on their treatment. Bigger part of the employed (80%) than retired (56%) or disabled patients (58%) opined that they had opportunity to participate in the decision making ($\chi^2 = 11.150$, $df = 2$, $p < 0.05$). According to the opinion of 84% of disabled, 68% of retired and 54% of employed they were treated with a respect to the dignity and intimacy ($\chi^2 = 12.724$, $df = 4$, $p < 0.05$). The disabled (90%) and retired patients (73%) in comparison with employed (48%) evaluated doctors' care as very good ($\chi^2 = 21.696$, $df = 6$, $p < 0.01$). The similar distribution of the opinion of the patients according their employment was in their evaluating of the nurse care: 93% of disabled, 76% of retired and 58% of employed patients stated that nurse care during their visit was very good. 87% of the retired, 80% of disabled and 72% of employed patients stated that they always were provided with information about the disease diagnosis ($\chi^2 = 12.565$, $df = 4$, $p < 0.05$). The employed patients (49%) as well as disabled (48%) were more informed about the compensation to the damage to their health in comparison to 19.2% retired patients ($\chi^2 = 7.140$, $df = 2$, $p < 0.05$).

Patients into two categories of employment (disabled and retired) treated health care quality issues as one group. Special possibilities for the employed should be developed to enlarge accessibility to the health care services.

5.3.4. PATIENTS PERCEPTIONS ATTENDING SERVICES IN DERMATOLOGY, NUCLEAR, PSYCHIATRIC AND IMMUNOLOGY OUTPATIENT DEPARTMENTS

The highest percentage of the satisfied with the health care services patients was at the nuclear department (92%). 73% of the patients at the dermatology, 70% at the psychiatric and 51% at the immunology department reported satisfaction with the services ($\chi^2 = 26.243$, $df = 6$, $p < 0.01$). More patients at the nuclear department evaluated quality of health care

services better in comparison with the patients in the other departments ($\chi^2 = 20.060$, $df = 9$, $p < 0.05$).

Issues related to the accessibility to the services were valued differently by the patients attending different departments. All nuclear department patients stated that the opening hours of the department comply with their needs, while 87% from the psychiatric, 74% from the immunology and almost 57% from dermatology had different opinion ($\chi^2 = 41.047$, $df = 3$, $p < 0.01$). 88% of the patients from nuclear, 64% from psychiatric, 63% from dermatology and 54% from immunology departments commented that the waiting time for the appointment was short enough ($\chi^2 = 17.945$, $df = 3$, $p < 0.01$). 97% of the patients from nuclear, 67% from immunology and 62% of the patients from psychiatric as well as dermatology departments claimed that they didn't have to wait for the appointed visit after arrival to the ambulatory care unit in a long queue ($\chi^2 = 32.620$, $df = 3$, $p < 0.01$). The highest percentage of the patients at the nuclear department (72%) in comparison with the patients at the psychiatric (69%), dermatology (54%) and immunology (40%) departments pointed out that they were treated with the respect to the dignity and intimacy ($\chi^2 = 16.040$, $df = 6$, $p < 0.05$). Doctors care during the visit was evaluated as very good by the highest percentage of the patients at the nuclear department (72%), than at the psychiatric (68%), dermatology (53%) or immunology (46%) departments ($\chi^2 = 17.234$, $df = 9$, $p < 0.05$). Similar opinion of the patients was revealed according assessment of the nurse care during the visit: 81% of the patients at nuclear, 75% at the psychiatric, 66% at the dermatology and 40% of the patients at the immunology department claimed that nurse care during the visit was very good ($\chi^2 = 27.284$, $df = 6$, $p < 0.01$). The highest percentage of the patients at the nuclear department (72%) in comparison with the immunology (50%), psychiatric (47%) and dermatology (38%) departments were provided with a information about the treatment methods ($\chi^2 = 17.530$, $df = 9$, $p < 0.05$).

6. DISCUSSION

Quality is one of the domains of providers' performance that has attracted considerable attention in recent years. We identified three main dimensions of quality of service providing within health care system: access or waiting time; patient experience, like communication, respect and caring, continuity and coordination as well as clinical quality and competency.

Patient satisfaction is crucial to remaining competitive in today's health care market. Satisfied patients tend to remain loyal to one particular health care institution and though, in turn, has a positive impact on revenues. Likewise, dissatisfied patients can negatively affect a hospital's revenues, leaving for another one often concurrent one.

According to the results, patients in our study exhibited high levels of satisfaction; 74,4% of them were satisfied with the health care provided and almost all of them would like to utilize this outpatient care again in the future. The willingness to recommend the provider to their family and friends in general was very high level, up to 99%, related to such factors as staff behaviour, communication, information, patient's participation in decision making, waiting time, care, and hospital environment.

A few studies on waiting times and satisfaction in healthcare settings have mixed results. For example, Mowen, Licata, and McPhail (1993) found that patients in the emergency department (ED) who waited longer than their expected waiting times had significantly lower satisfaction levels than patients whose waiting time expectations were met or positively exceeded. Although following two recent studies conducted in outpatient settings (Kurata et al. 1994; Zapka et al. 1995) found that long waiting time was not a significant predictor of patient satisfaction.

Studying the level of satisfaction among different departments, the patients were more satisfied with the service provided at nuclear department: 92.5%, compared to the lower level of satisfaction of the patients from immunology department, 51.2%, $p < 0.05$). In the latter one, almost half of the patients stated on questionable quality of service provided during their visits both by doctors and nurses; treatment with less respect, dignity and intimacy. Some of them did not receive needed information at that department.

Despite the fact that the Polish legislation is being quickly adapted to the world standards in the area of patients' rights, the implementation of rules written in the legislative act is still not sufficient both from the point of view of legislator and patients.

Halik J. reports, that for physicians many of patients' rights (especially those concerning the informed agreement for treatment) are controversial. The large survey of the public opinion in Poland showed that only 29% respondents after the hospital treatment confirmed that they were always asked about agreement from treatment or operation. Only 15% confirmed that they were asked about their agreement almost always.

In our study 44% of the patients are concerned and knowledgeable about their rights and familiar with legal procedures in case of a professional harm. As well such confirmation was strongly associated with educational level, profession and their self-perception.

It is still believed among many health professionals that consumers are not in a position to make judgments about technical competence. We believe if patients judge technical competence by outcomes, then surely they are the best judges. Similar statements were proved in a study by Graham J.D., 2001.

Physicians must elicit, detect, and meet patients' individual needs throughout each stage of the health care experience. Failure to recognize and address patients' unique needs and emotions has been a consistent, pervasive, and unfulfilled opportunity for improvement in physician-patient interactions. To understand patients and their individual needs, physicians need to possess acute self-awareness of their own feelings, attitudes, and behaviors.

7. CONCLUSION

About three fourth of the patients were completely satisfied with the health care provided in the Ambulatory Care Units. Almost nine of ten patients' assessed quality in the Ambulatory Care Units as very good or good. More than a half of the respondents were satisfied with the time devoted to them during consultation. Almost all of the patients indicated that they were satisfied with the amount of diagnostic and treatment procedures.

Almost 80% of the patients indicated that opening hours of the ambulatory care unit comply with their needs and the waiting time was short enough.

Generally, two thirds of the patients indicated that they have had the opportunity to take part in the decision making process on their treatment, 91% have had the impression that personnel communicate sufficiently. More than a half of the patients pointed out that the doctor's and nurse's care during their visit in Ambulatory Care Unit was very good.

Three fourth of the respondents indicated that the doctors always informed them about the disease diagnosis, a half of the patients indicated being always informed about the disease complications, and alternative treatment methods.

More than a half of the patients reported being treated with dignity and intimacy. The similar percent of the patients would complain to the doctor if they would not be satisfied with the health care services, one third would complain to the head of the health care institution. Less than a half of the respondents were familiar that they could apply for compensation to the damage to their health.

Younger patients tend to be less satisfied with health care services, as well as with the waiting time in comparison to older ones. Middle aged patients had more opportunities to participate in the decision making, while older patients reported being treated with respect to the dignity and intimacy.

More patients in the worse health group reported being informed about the treatment methods, and state that better communication with health care professionals will improve their satisfaction with the services.

More patients from retired and disabled groups reported higher satisfaction with the health care services, opening hours and waiting time compared to employed patients and reported the opportunity to participate in the decision making, being treated with respect and dignity. Employed and disabled patients were more informed about the compensation to the damage to their health compared to retired.

The higher percentage of patients from the nuclear department reported better satisfaction with the services, better quality, shorter waiting times, treatment with dignity and respect, and better doctor's and nurse's care compared to patients from the immunology, psychiatry and dermatology departments.

8. RECOMMENDATIONS

We would like to make following recommendations for improving quality in health care:

- To facilitate communication between healthcare providers and patients, specially at immunology department. The aspects of the patient-doctor interaction, the extent to which patients perceive that their doctors seek to involve them in decision making show significant level of satisfaction among patients.
- To decrease waiting time and make waiting time more productive by providing leaflets and medical journals etc., in the waiting rooms. Improve appointment system, including telephone communication.
- To provide the access to needed information for the patients as well as information related to legal issues and their rights.
- To motivate health care personal on devoting more time for patients; increasing the perception on patients-centered approach.
- To enlarge and developed special accessibility to health care service for employed patients.

8. GLOSSARY

Access - Identifies the ability to utilize needed health services by a patient or population in terms of the following: health services delivery system characteristics such as availability, organization, and financing of services; characteristics of the population such as demographics, income, care-seeking behavior; and whether or not the care sought adequately met the individual or group's basic medical needs.

Access to care - A performance dimension addressing the degree to which an individual or a defined population can approach, enter, and make use of needed health services.

Accreditation - A system of external expert examination of correspondence to a set of standards; based on the principle of voluntary participation of the examined. Daily compliance to practice and conduct standards by the entire staff ensures that they do everything according to expectations.

Ambulatory care - All types of health services provided to patients who are not confined to an institutional bed as inpatients during the time services are rendered.

Continuous quality improvement – A management approach to the continuous study and improvement of the processes of providing health care services to meet the needs of patients and other persons.

Criterion - An attribute or rule that serves as a basis for evaluation, definition or classification of something; an evaluation standard.

Evaluation - A process of determining the actual status of an object (process, phenomenon, system) in relation to the desired status or to another object (process, phenomenon, system).

Input - The total volume of resources allocated for a certain purpose that are used for the functioning of a system. Types of inputs include: personnel, financial, material and technical, information and time resources.

Measurement - Objective assessment but does not itself include judgement of values or quality; these may be added by those who later present and interpret the data

Monitoring - A purposeful activity related to observation, assessment and evaluation of the status of a process, phenomenon or system.

Outcomes management - A philosophy of making health care related choices based on better insight and understanding into the effect of those choices on a patient's life.

Patient-centered care - An approach to care that consciously adopts a patient's perspective. This perspective can be characterized around dimensions such as respect for patients' values, preferences, and expressed needs; coordination and integration of care; information, communication and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; transition and continuity.

Patient satisfaction - A measurement that obtains reports or ratings from patients about services received from an organization (health plan), hospital, physician, or health care provider.

Patients' rights - A set of rights, privileges, responsibilities and duties under which individuals seek and receive health care services.

Performance - The extent to which the health system is meeting a set of key objectives.

Performance indicators - Measurements used to evaluate how well providers, insurers, or health plans are providing the services or products for which they are responsible. The term is used to refer to a range of indicators including financial stability, technical quality, patient satisfaction, access, utilization, and availability of qualified providers.

Process of care - A discrete interaction between a patient and provider.

Performance measurement - Measurement of adherence to recognized standards of quality. Performance measurement may take place at the national, system, institution, or individual provider level, and it includes measures of process and outcome.

Quality assessment - Determination of how rendered medical care corresponds to the current standards, as well as a patient's satisfaction with it.

Quality assurance – 1) A planned and systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis within the existing resources.
2) The activities and programs intended to provide adequate confidence that the quality of patient care will satisfy stated or implied requirements or needs.

Quality control - The use of operational techniques and statistical methods to measure and predict quality.

Quality improvement - The attainment or process of attaining, a new level of performance or quality that is superior to any previous level of quality.

Quality indicator - An agreed-upon process or outcome measure that is used to assess quality of care. Quality indicators include hospital readmission rates, providers' rates of adherence to clinical guidelines, and ratings of patient satisfaction with care.

Quality management - The aspect of the overall management function that determines and implements the quality policy.

Quality of medical care - The understanding of quality applied to health care; the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality policy - The activity of developing the goods and services required to meet customer needs.

Quality system - A combination of the resources, organizational structure, and techniques that are necessary to achieve quality.

Service - A result of provider's actions aimed at meeting the needs of a consumer.

Standard - A normative document regulating a set of rules, norms, and requirements to an object.

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2004 EUROPHAMILI AESCULAPIUS

Patients' satisfaction with the health care services provided by Ambulatory Care Units

Abstract : The study addresses the issue of quality in health care sector. Patients' satisfaction was chosen as the indicator of service quality provided by ambulatory care units. The study is focused on searching for main sources of satisfaction versus dissatisfaction with health care services and their relation to socio-demographic characteristics of ambulatory care units' patients.

Material and methods: A cross-sectional study design was applied to this pilot study in order to assess patients' perception and satisfaction with the quality of care and services provided. A survey by using the self-administrated anonymous questionnaire took place at outpatient psychiatric, dermatology, immunology and nuclear departments at the University Teaching Hospital in Lodz in a period from 18th of May till 4th of June.

Results: Result obtained from the survey indicates that overall, clinical patients are satisfied with the outpatients services in psychiatry, dermatology, immunology and nuclear department received at the University Teaching Hospital.

Conclusion: Almost all of the patients would like to utilize this outpatient care again in the future. The willingness to recommend the provider to their family and friends in general was very high, related to such factors as staff behavior, communication, and information, patient's participation in decision making, waiting time, care, and hospital environment.

Key words: patients' satisfaction, health care quality, accessibility, patient's rights, information, assurance

The opinions expressed in the memoranda are not necessarily those of the schools that are members of the AESCULAPIUS network: these opinions must be considered

