



Satisfaction with healthcare services among elderly patients attending Korle-Bu Teaching Hospital in Ghana

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Abstract

Background: An increasing elderly populace poses several impediments to the healthcare system because the health characteristics and complexity of care necessary for the elderly differ from those required for the younger populace, and this populace merits a precise healthcare service system. An effective and well-organised healthcare organisation is important for the survival of the elderly. Such a healthcare organisation can meet the desires of present and future generations of the elderly and support them to age positively. Furthermore, quality healthcare services should be made available, accessible and affordable for the elderly to attain a healthy lifestyle.

Objective: The study was to assess the perception of satisfaction with healthcare accessed by the elderly attending the Korle-Bu Teaching Hospital.

Methods: The study was a descriptive cross-sectional survey using a sequential explanatory mixed-method approach. Simple random sampling was used to sample 361 elderly patients from seven Out-Patient Departments in the Korle-Bu Teaching Hospital. The quantitative data was analysed using One-way ANOVA to establish the bivariate relationship between the socio-demographic characteristics and quality of services. Also, generalised linear model (GLM) was used as a multivariate tool to examine the relationships between each socio-demographic factor and quality of healthcare services whilst accounting for the mutual effects of the socio-economic factors on each other. Qualitative study was conducted to obtain an in-depth understanding of the satisfaction of healthcare services by the elderly patients attending the Korle-Bu Teaching Hospital. Thematic content analysis was used to analyse the data. The interview transcripts were read to identify emerging themes and sub-themes, and were exported into Nvivo version 11 software for data organisation.

Results: The results indicated that there was a statistically significant difference in the quality of healthcare with decreasing trend in quality and increasing level of OPD ($F=14.611$; $p<0.001$). Majority of the elderly respondents, 305 (84.5%) rated the quality of healthcare services as moderate. The elderly respondents stated that the feedback from the health personnel were harsh, they provided negligible assistance for them at the units, and they sat on very low seats that gave them bodily pains whilst waiting for the doctors. Unexpectedly, the elderly were satisfied with the healthcare services at the Korle-Bu Teaching Hospital. For the elderly respondents, satisfaction meant improvement in their health.

Conclusion: Impediments in accessing healthcare services led to a decrease in satisfaction of healthcare. A healthier well-being of the elderly led to satisfaction of healthcare services provided at the hospital.

Keywords: Elderly, healthcare services, satisfaction

Introduction

The gradual ageing of the population tends to increase the total number of the elderly, and elderly who are fragile, which in turn requires an offer of care that meets their health needs [1]. As people advance in age, their health and welfare could be a challenge. Sickness is inevitable and forms an integral part of human life [2, 3]. The prevalence rate of chronic Non-Communicable Diseases (NCDs), neurodegenerative disorders and disability (all forms) are expected to rise among the elderly [4]. In India, it was found that the quality of healthcare services was poor [5]. Hospitals can attain client satisfaction by providing quality healthcare services, having clients' expectations and unceasing improvement in the healthcare service [5, 6]. Quality of healthcare services is important, because human beings' health is a subject that is crucial, and it is important to provide healthcare services that meet or surpass the clients' expectations [7].

The Health Belief Model was used for explaining and

predicting health and medical care of the elderly attending Korle-Bu Teaching Hospital. The model was oriented to the avoidance of sicknesses while it did not overlook the potential role of barriers to accepted healthcare services [8, 9]. It also attempted to clarify the behaviour of persons who were being charged little or nothing for the healthcare service [9]. The Health Belief Model consisted of six constructs which were: perceived susceptibility: perceived seriousness: perceived benefits: perceived barriers: and cues to actions [9, 10]. An additional construct namely, 'Satisfaction' was identified, resulting in seven constructs.

Perceived susceptibility

The perceived susceptibility construct suggests that, people vary widely in their feelings of personal vulnerability to an illness. Hence, this dimension refers to the people's subjective perception of the risk of contracting a disease condition [8, 9, 10, 11]. At one extreme end, there might be an individual who refutes any likelihood of contracting any

disease. In a more reasonable position is the individual who may acknowledge the “statistical” possibility of a disease incidence, but a possibility that it is not likely to happen [8, 9]. Lastly, an individual may demonstrate a feeling that he/she is at a real risk of getting the illness.

Perceived seriousness

The second construct is the feeling regarding the seriousness of contracting a disease (or of leaving it untreated) likewise varied from individual to individual [10, 11, 12]. This construct includes the evaluations of both the medical or clinical consequences (e.g., death, disability and pain) and possible social consequences (e.g., effects of the conditions on work, family and social relations), which are perceived severity by people [10, 12].

Perceived benefits

The third construct is perceived benefits. This is the acceptance of personal susceptibility to a condition, and the belief that it is serious enough to produce a force that could lead to a behaviour [9, 11, 12]. The particular course of action that is likely to be taken depends upon beliefs regarding the effectiveness of the various actions available to reduce the disease threat [9, 10].

Perceived barriers

The fourth construct is perceived barriers. It is believed that the acceptance of one’s susceptibility to an illness to be very serious is thought to provide a force that could lead to an action, but not defining the specific course of action that is likely to be taken [9, 10, 11]. The course that the action takes is thought to be influenced by beliefs concerning the relative effectiveness of no obtainable alternatives in reducing the risk of illness to which people feel endangered [9, 10].

Cues to action

Cues to action is the fifth construct and it indicates that a person may believe that a set of actions would be effective

in decreasing the risk of disease condition, but at the same time sees that action itself as being inconvenient, expensive, unpleasant, painful or upsetting [9, 10]. Numerous resolutions of the conflict were thought to be promising: if the willingness to act were high and the negative features were seen by the elderly as comparatively fragile [9, 10]. This suggests how encouragements from other people such as reminders by the health personnel, advice from persons, mass media, and diseases of a relative or a friend could help individuals take up an action. The action in question was possible to be taken if, on the other hand, the readiness to act were low while the potential negative features were seen by the elderly as robust, the negative aspects operated as barriers to inhibit action [9, 10].

Self-efficacy

The sixth construct is self-efficacy. Self-efficacy describes a person’s confidence in their ability to implement the actions in question [11, 13]. The individual may not want to do something new unless they consider that they can perform it. If the individual believes that the new behaviour is beneficial but does not consider being competent in performing it, the probabilities are that they may not attempt the new behaviour [11, 13].

Satisfaction

Satisfaction is achieved when individuals have confidence to perform an action. That is, to undergo any medical procedures that would decrease or stop any disease condition(s). Satisfaction is then attained when there is a positive change in their health. An observed stable, improved and better health leads to satisfaction with healthcare services. Shown in the figure below is the Health Belief Model adapted from Rosenstock et al. (1988).

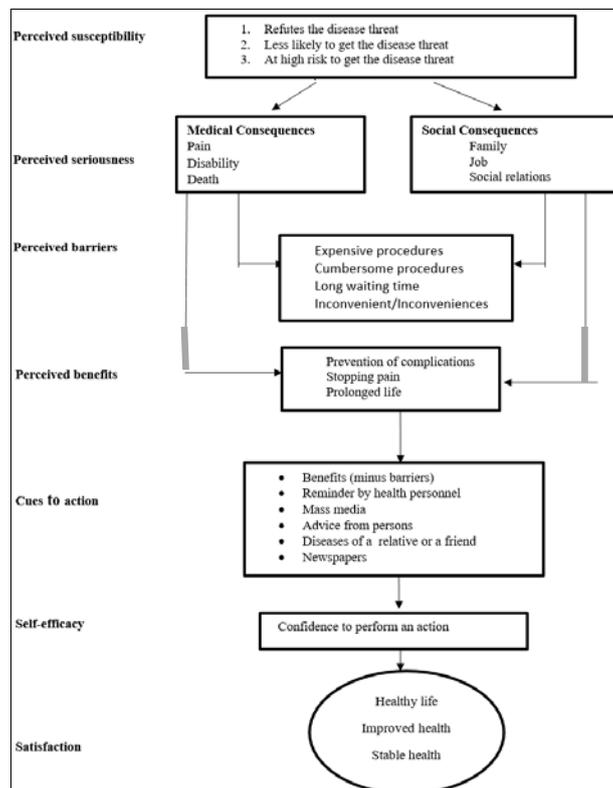


Fig 1

The study assessed the perception of satisfaction with healthcare services accessed by the elderly attending the Korle-Bu Teaching Hospital in Accra.

Materials and Methods

Study design

The study was descriptive cross-sectional survey using sequential explanatory mixed methods. This design analysed the satisfaction of healthcare services received by the elderly patients attending the Korle-Bu Teaching Hospital. The qualitative results were used to interpret and explain the quantitative results. This provided the rationale behind the results in the quantitative method. The aim of the study was to find out the satisfaction of healthcare services from the elderly patients attending the Korle-Bu Teaching Hospital in Accra. A pilot study was conducted at the Out-Patient-Department of the Greater Accra Regional Hospital in Accra, Ghana.

Study setting

The study site was the Korle-Bu Teaching Hospital. It covers an area of about 441 acres. Korle-Bu Teaching Hospital has become a major national referral centre in Ghana, and the third biggest health facility in Africa [14]. Currently, Korle-Bu Teaching Hospital has more than 4,000 medical and paramedical workforce with an average daily turnout of 1,500 clients, about 250 of which are hospitalized [14]. Korle-Bu Teaching Hospital has 17 departmental OPDs. These are: Polyclinic, Maternity, Medical, Child Health, Surgery, Diabetic Clinic, Gynaecology, Orthopaedic, National Cardiothoracic Centre Unit (CTU), Ophthalmology Clinic, Casualty, Ear Nose and Throat (ENT), Genito-Urinary (GU), Dental, Physiotherapy, Chest and Audiology [14]. This study used seven departmental OPDs, which had high attendance of the elderly compared with the other departmental OPDs. These OPDs were Cardiothoracic Centre Unit CTU, Medical, Surgical, GU, Polyclinic, Ophthalmology OPD and Diabetic Clinic. Korle-Bu Teaching Hospital was chosen for this study because it provides all the three levels of healthcare [primary, secondary and tertiary]. It is also the premier healthcare facility in Ghana. Although it provides tertiary healthcare, the departmental OPDs selected provide primary, secondary and tertiary healthcare to the elderly.

Sample size and sample size calculation

364 respondents were sampled from seven OPDs for the quantitative study. This number was based on sample size methods gleaned from three studies [15, 16, 17]. However, 361 completed questionnaires were analysed producing a response rate of 99.2%. Seventy-six elderly patients from the seven OPDs were used in the in-depth interviews.

Study population/subjects and selection

The population consisted of all elderly patients 60 years and above, regardless of gender, who attended the Korle-Bu Teaching Hospital over one month. Simple random technique, specifically, lottery method, was used to select respondents for the quantitative study. Purposive and convenient sampling techniques were used for the qualitative study.

Dependent variables for quality of healthcare

The dependent variable used for this study was quality of healthcare. The elderly respondents described the quality of healthcare received at the various OPDs. Scale of measurement was categorical (low, moderate and high).

Independent variables for quality of healthcare

The independent variables for the quality of healthcare were as follows. Gender was classified as male and female, age was classified as < 70 years and ≥ 70 years, marital status was classified as spouse and no spouse, educational level was classified as below secondary and above secondary, monthly earnings was classified as < 500 and ≥ 500, NHI status was classified as insured and uninsured. All these were measured using binary scale. Chronic disease was classified as one chronic disease and two or more chronic diseases, locality was classified as Korle-Bu environs, Greater Accra Region and outside Greater Accra Region and OPDs attended was classified as primary, secondary and tertiary. These were measured using categorical scale.

Statistical analysis

Composite score for quality of healthcare was found by the average of all the questions under quality and expressed as a percentage of five, which was the highest rank for each question. A higher score means higher quality. The scores of each of the six variables were categorised as low (0-49), moderate (50-74) and high (75-100) [24]. In addition, the relationships between each socio-demographic variable and quality of healthcare was done by comparing average quality index score across categories of each socio-demographic variable using one-way analysis of variance (ANOVA). One-way ANOVA was used to establish the bivariate relationship between the socio-demographic characteristics and quality of healthcare. A generalised linear model (GLM) was also used as a multivariate tool to examine the relationships between each socio-demographic factor and quality of healthcare whilst accounting for the mutual effects of the socio-economic factors on each other. Furthermore, content analysis was used to analyse the interview data. A compilation of all the words and phrases was made and similar phrases were grouped together as emerging themes. A thorough and critical look at all the themes that emerged were carried out in order to identify patterns among them (codes or themes). The data was organised for analysis by the use of Nvivo version 11.

Background characteristics of respondents

The socio-demographic characteristics of the elderly respondents in frequencies and percentages for the quantitative study revealed that, 184 (51%) were male respondents. Three hundred and thirty-five, 335 (93%) were beneficiaries of the National Health Insurance. Majority 222 (65%) monthly earnings were below GHS 500.00. One hundred and sixty five (45.7%) were diagnosed with one chronic disease, which was followed by 145 (40.2%) who were diagnosed with two chronic diseases. Most of the elderly respondents, 350 (97%) spent more than two hours on a visit at the OPDs. Table 1 shows the detailed information on the socio-demographic characteristics of the elderly respondents.

Table 1: Socio-Demographic Characteristics of the Elderly Respondents

Variables	Categories	Frequency	Percentage (%)
Gender	Female	177	49.0
	Male	184	51.0
Age	< 70 years	191	52.9
	≥ 70 years	170	47.1
Educational Level	No formal education	80	22.1
	Standard-seven/middle school	150	41.6
	Secondary/vocational/technical	58	16.1
	Professional/polytechnic	44	12.2
	University	29	8.0
Marital Status	Single	16	4.4
	Married	203	56.2
	Widow/widower	113	31.3
	Separate	7	2.0
	Divorced	21	5.8
	Co-habitation	1	0.3
NHI Status	Uninsured	26	7.2
	Insured	335	92.8
Monthly Earnings	Below GHS 500.00	222	65.3
	GHS 501.00-GHS 1000.00	81	23.8
	GHS 1001.00- GHS 1500.00	21	6.2
	Above GHS1500	16	4.7
Employment Status	Unemployed	286	79.2
	Employed	75	20.8
Time Spent	< 2 Hours	11	3.0
	≥ 2 Hours	350	97.0
Chronic Disease	One	165	45.7
	Two	145	40.2
	Three	39	10.8
	Four	12	3.3
Accompanied	Unaccompanied	174	48.2
	Accompanied	187	51.8
Financial Assistance Locality	Not Assisted	241	66.8
	Assisted	120	33.2
	Korle-Bu Environs	58	16.1
	Greater-Accra Region	233	64.5
	Out-side Greater-Accra Region	70	19.4

Results

Majority of the elderly respondents, 305 (84.5%) rated the level of quality of healthcare services as moderate. This was an indication that, the elderly respondents viewed the quality of healthcare services accessed at the KBTH as average. The results are detailed in figure 1.

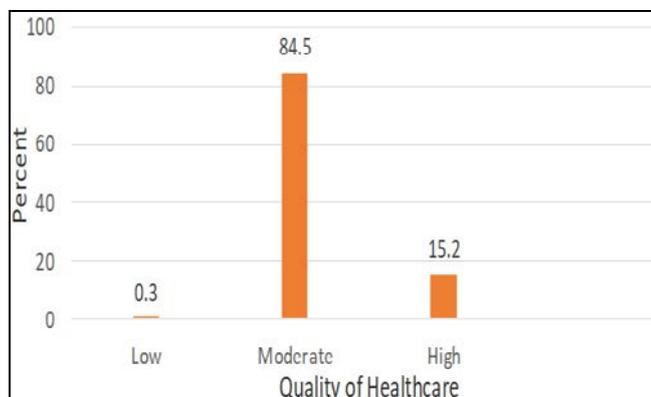


Fig 1: Level of quality of healthcare services.

The bivariate analysis of the association between socio-demographic characteristics and quality of healthcare showed that the elderly respondents who attended the primary OPDs rated the quality of healthcare highest, with an average of 70.9. The elderly respondents who attended the tertiary OPDs, rated the quality of healthcare lowest, with an average of 64.8. The results indicated that there was a statistically significant difference in the quality of healthcare with decreasing trend in quality and increasing level of OPD ($F=14.611$; $p<0.001$). Furthermore, the elderly respondents diagnosed with one chronic disease rated the quality of healthcare the highest with an average of 69.54. In the case of the elderly respondents who were diagnosed with four chronic conditions, they rated quality the lowest, with an average of 65.5. The chronic conditions were significantly associated with quality of healthcare ($F=2.97$; $p=0.032$). This result revealed that the greater the number of chronic diseases diagnosed, the lower the average quality ratings of the healthcare accessed by the elderly. There was a decreasing trend in the rating of the quality of healthcare with increasing number of chronic diseases.

Tale 2: Bivariate Analysis: Association between Socio-Demographic Characteristics and Quality of Healthcare

Factor	Categories	Quality Healthcare		F-statistic	p-value
		Mean	Std. Deviation		
Gender	Female	68.48	6.48	0.214	0.644

	Male	68.81	7.02		
Age	<70 years	68.99	6.29	1.004	0.317
	≥70 years	68.27	7.24		
Educational Level	< Secondary	69.11	6.34	2.762	0.097
	≥ Secondary	67.89	7.34		
Marital Status	Spouse	68.65	6.68	0.995	<0.001*
	No Spouse	68.65	6.86		
Monthly Earnings	<GHS 500.00	68.88	6.33	0.678	0.411
	≥GHS 500.00	68.28	7.38		
NHI Status	Uninsured	68.33	6.69	0.063	0.803
	Insured	68.68	6.77		
OPD Attended	Primary	70.90	7.01	14.611	<0.001*
	Secondary	68.62	6.38		
	Tertiary	64.75	6.13		
Chronic Disease	One	69.54	7.20	2.970	0.032*
	Two	68.41	6.31		
	Three	66.74	6.40		
	Four	65.50	4.39		
Locality	Korle-Bu Environs	68.93	7.94	0.067	0.935
	Greater-Accra Region	68.62	6.33		
	Outside Greater-Accra Region	68.51	7.14		

The associations between socio-demographic characteristics and quality of healthcare were accessed by the elderly persons who attended KBTH using Generalized Linear Model. In adjusting for the mutual effects of the variables, the elderly respondents who attended the secondary OPDs rated quality of healthcare on an average of 2.19, which was lower than the elderly respondents who attended the primary OPDs. The effect was significant (p=0.011). The elderly respondents who attended the tertiary OPDs rated quality of healthcare on an average of 6.24, which was less than the elderly who attended the primary OPDs. The effect was

significant (p<0.001). This implied that the elderly respondents who utilised the primary OPDs valued the quality of healthcare higher than those who attended the other OPDs.

Also, the elderly respondents who were diagnosed with three chronic diseases significantly rated quality of healthcare with an average of 2.79, which was less than the elderly respondents diagnosed with one chronic disease (p=0.020). This was an indication that the more chronic diseases an individual was diagnosed with, the lesser the quality of healthcare accessed.

Table 3: Generalised Linear Model: Association between Socio-demographic Characteristics and Quality of Healthcare

	Effect	Wald Statistic	95% CI for effect lower upper	p-value
Gender Female Ref Male	0.18	0.24	-1.27 1.63	0.808
Age <70 years Ref ≥ 70 years	-0.21	-0.3	-1.62 1.19	0.765
Educational level <70 Secondary Ref ≥ 70 Secondary	-0.69	-0.88	-2.22 0.84	0.379
Marital Status Spouse Ref No spouse	-0.56	-0.72	-2.07 0.96	0.471
Monthly Earnings < GHS 500.00 Ref ≥ GHS 500.00	0.48	0.61	-1.07 2.03	0.542
NHI Status Uninsured Ref Insured	-0.78	-0.57	-3.45 1.90	0.570
OPD Attended Primary Ref Secondary Tertiary	-2.19	-2.53	-3.89 -0.49	0.011*
	-6.24	-5.2	-8.60 -8.60	<0.001*
Chronic Diseases One Ref Two Three Four	-1.35	-1.79	-2.84 0.13	0.074
	-2.79	-2.38	-5.13 -0.44	0.020*
	-3.80	-1.92	-7.67 0.07	0.054
Locality Korle-Bu environs Ref Greater-Accra Region Outside Greater-Accra Region	-0.02	-0.02	-1.95 1.90	0.982
	-0.31	-0.26	- 2.68 2.05	0.794

The study engaged 76 elderly who participated in the in-depth interviews from the seven OPDs in KBTH. Thirty-nine of the elderly were females. With regards to the age of the respondents, 43 elderly were above the age of 70 years.

Forty-eight elderly respondents attained above secondary school education. The elderly who had been diagnosed with multiple chronic conditions were 54 and those with one chronic condition were 22.

Table 4: Socio-demographic Characteristics of Respondents

Variables	Categories	Frequency
Gender	Male	37
	Female	39
Age	< 70 years	43
	≥ 70 years	33
Marital Status	Spouse	38
	No spouse	38
Educational level	Above secondary school	28
	Below secondary school	48
Ethnicity	Akans	31
	Gas	18
	Ewes	16
	Dagombas	7
	Gonjas	4
Employment status	Retired	70
	Employed	6
Chronic Disease	One chronic	22
	Multiple Chronic Conditions	54
Residence	Korle-Bu environs	6
	Greater Accra Region	54
	Other Regions	16

The study sought to explore the elderly patients' perception of satisfaction on the quality of healthcare accessed at the KBTH. They stated that the feedbacks from the health personnel were harsh, they provided negligible assistance for them at the units, and they sat on very low seats that gave them bodily pains whilst waiting for the doctors. However, they described the health personnel as skilful and knowledgeable. The themes and sub-themes which emerged under the quality of healthcare services have been presented below.

Physical support

The elderly persons were basically not as energetic as they used to be. They were weak, some with disabilities, and had problems with walking. Most health facilities in Ghana do not have gadgets such as grasp bars on the steps, hand rails on the steps, enough wheel chairs, accessible path leading to the lift and other supportive gadgets. The respondents explained that at the OPDs, the health personnel provided very minimal physical support. The health personnel hardly assisted them physically. However, they were assisted by their family members who accompanied them:

"The health personnel do not provide any physical support [laughing]. They hardly assist. My wife comes with me to support me. My daughters who mostly accompany me provide physical support when I come to the unit" (IDI M₁₇ 87 years).

The seeming absence of geriatric care and associated equipment at the tertiary healthcare facility of the country was brought to light during the analysis of the interview data.

Health personnel attitude

The health personnel are supposed to be in constant

interactions with the patients at the hospital. The health personnel have been trained to listen to the patients and address their needs appropriately. However, what the elderly patients expected from these qualified professionals was reportedly missing in their responses to the patients. The respondents in this study lamented that the health personnel were harsh when responding to them. The conversation with the elderly respondents revealed that:

"[...] other health personnel are harsh with their words and sometimes when I do not understand what they explained to me they get annoyed" (IDI F₉ 76 years).

It was observed that, since the respondents could not measure the technical aspect of quality of healthcare, they assessed it on the basis of how they were addressed by the healthcare personnel.

Poor seats and sitting arrangements

Most of the seats at the waiting rooms were reportedly low and uncomfortable using them, which made it very difficult for the elderly to get up, and caused bodily pains. In addition, at the waiting room, the arrangements to see the doctors were not orderly, leading to the elderly persons arriving early, yet not seeing the doctor on time. Instead, those elderly persons who reported late at the unit could see the doctor first. These situations made the waiting time very stressful.

"The sitting arrangements to see the doctor is not the best, because those who came in late most often see the doctors before those of us who came in early. Moreover, the seats are very low, getting up from the seats is very difficult. In addition, the seats are not comfortable to use and I get painful backaches when I sit for some time" (IDI F₄₂ 61 years).

The view was that there should be the provision of suitable seating arrangements at the departments since patients spent a long time to see the medical doctors.

Improved stabilised health

The elderly persons in the study stated that they were satisfied with the healthcare services provided at the KBTH. They were satisfied with the healthcare services based on their evaluation of their state of health. They explained that their health had improved remarkably and stabilised without any deterioration. In addition, they clarified that the pain, palpitations, poor vision, retention of urine and other signs and symptoms of the diseases they experienced when they first came to KBTH had all stopped. Their state of health had improved and had been stable for a while. With these results, they were satisfied with the healthcare services at the units. Below is a quote from a respondent:

“My health has improved and stabilised for some time now. It has not deteriorated at all. I am satisfied with the care provided here” (IDI M₁₅ 66 years).

Discussion

The discussion of the findings are related to existing literature and explained based on the Health Belief Model.

Health personnel attitude (Perceived barriers and cues to action)

The HBM that had applied here was the cue to action, which shows that people take action to accept an intervention when encouraged by health personnel, mass media or other means of communication. However, since the attitude of the health personnel was not the acceptable one, it rather led to dissatisfaction of healthcare by the elderly persons. It was discovered that the main problem the elderly persons had with communication was the manner in which the health professionals spoke to them. The health professionals reportedly used harsh words when speaking with the elderly persons. The official mode of communication in Ghana is English. The vernacular that is mostly spoken in Ghana is either “Twi” or “Ga” typically in the city of Accra. Most of the elderly persons sometimes did not understand what was communicated to them by the health personnel in English or in the local dialect, thus leading to communication difficulties. The elderly Chinese immigrants complained that “professionals there do not speak your language” and most of the difficulties the elderly immigrants faced were associated with language [18]. Fundamentally, when one does not understand what is being communicated, it is very difficult to comprehend and act accordingly, which leads to dissatisfaction with healthcare services being provided. The elderly in this study mostly did not understand the treatment regimen.

Physical support (Perceived barriers)

The health personnel in the study did not offer physical support for their elderly patients, which was not a positive one, especially where the nurses were concerned. Nurses are expected to assist their patients to do what they (patients) cannot do for themselves. Shirking their responsibilities to family members is against the ethics of the profession. It is important that the Nursing and Midwifery Council, Ghana, as well as the Ghana Registered Nurses and Midwives Association find measures to reverse this trend in order to uphold the image of the profession. The study detected that,

the children or family members provided an atmosphere of security for the elderly persons and did not cause any distraction in the activities of the health personnel, unlike a different study which reported that the nurses viewed the family members as a barrier to providing quality healthcare [19].

Waiting time (Perceived barriers)

Waiting rooms are areas in the hospitals where patients sit and wait to see their doctors. The elderly in this study clarified that they sat on uncomfortable seats that caused them bodily pains and some of them developed swelling of the feet. The elderly persons reported very early at the hospital to be seen early. However, the consultation starts at 8.00am leading to prolonged sitting, swelling of the feet and bodily pains due to long waiting time. The hospital consultation policy starts from 8.00am. Moreover, the hospital does not have an electronic appointment system, hence, this leads to the long waiting time when the elderly persons arrive early. Furthermore, there was no policy for the elderly to be given preferential treatment in seeing the doctors: all patients were treated equally. The elderly in the study complained bitterly that the elderly persons who reported late were usually seen earlier than those who reported early.

Satisfaction with healthcare services (Outcome)

Satisfaction with healthcare services hinges on whether the elderly persons observed a transformation in their health as an outcome of the healthcare services received. The Korle-Bu Teaching Hospital provides primary healthcare to the elderly persons by curing sicknesses and preventing diseases. Moreover, the hospital provides secondary healthcare to the elderly persons by aiding their health to return to their former state of function. Furthermore, the hospital provides tertiary healthcare services by stabilising long term irreversible ailments such as cardiovascular diseases and diabetes mellitus. The various healthcare services provided at the hospital led to the satisfaction of the elderly persons. The elderly persons in the study observed that the benefits of healthcare service utilisation outweighed the barriers they encountered because their state of health became better and stabilised. Regarding healthiness, ²⁰ the respondents maintain that a better health leads to perfection in life expectation, that is a strong pointer of a person's improvement.

The Korle-Bu Teaching Hospital receives referred cases from other hospitals and clinics in and outside Ghana. Since the elderly persons in this present study were diagnosed with NCDs, they perceived that they were susceptible to disease conditions(s). The health personnel informed the elderly about the benefits of the treatments. The elderly persons had confidence in the treatments and took action(s) although there were challenges such as expensive cost of medication(s), long waiting time and other healthcare services. The elderly persons observed a positive change in their health status and mentioned that they were satisfied with the healthcare services rendered to them because their objective(s) of having a better, improved and stabilised health was achieved.

When an individual observes that he or she is susceptible to a serious disease condition(s), the individual person would take an action when the benefits of the action outweigh the barriers of the action [9, 10]. In addition, when the individuals

have confidence to undergo the treatment(s), although the treatments may involve unpleasant and painful procedures, the individuals would adhere to the treatment protocol in order to have good health. Although the procedures may be expensive, the individual would take an action to use the healthcare services because of the benefits to prolong life, prevent complications and live a healthy life. When the individual person perceives that his/her health status has improved and become stabilised, they would describe the healthcare services rendered as satisfactory^[9, 10].

In relation to the Health Belief Model, the elderly persons who attended the KBTH observed that they were highly vulnerable to a more serious condition(s) and developing complication(s) of the disease(s) if they did not utilise the health facility to receive medical care. The elderly persons analysed the benefits [reducing the severity of the disease, pain, pre-mature death] and the barriers [cost of healthcare services, waiting time, journey to KBTH, health personnel attitude] and took an action [using the healthcare services], which in effect, reduced the threat of the disease, pain, complication and pre-mature death^[10, 11]. The elderly persons in this study placed an importance on a specific goal, which was improved health. The elderly persons estimated the likelihood that a given action [using the healthcare services] would achieve their goal of improved health and overcome the disease threat, the severity of the disease or avoid illness and to get better and live their later years gracefully^[11, 12].

Similar issues have been documented in America and Europe on satisfaction with healthcare services based on the improvement of their health^[21, 22]. Some investigators identified that satisfaction had a high positive effect on the intention of the clients with respect to healthcare service utilization^[23]. From the findings of this study, the clients faced various barriers and challenges but due to their improved health, which was a positive sign, they continued to utilise the healthcare units.

It was observed that that the elderly persons were satisfied with the healthcare services because their health had improved but were dissatisfied with the waiting time. Apparently, the elderly who waited to see the doctor in less than two hours were as dissatisfied as those who waited to see the doctor for more than two hours. The elderly respondents stated that the waiting time should be improved. In a similar study^[24], it was documented that, waiting time was significantly associated with client satisfaction. The authors stipulated that waiting time was the key factor that affected satisfaction, and other issues that influenced satisfaction included duration of consultation period and the procedure of client registration^[24].²⁴ Although we observed waiting time was an issue encountered by the elderly patients, it did not outweigh the benefits of attaining good health.

Conclusion

This study explored the perception of satisfaction with healthcare accessed by the elderly utilising KBTH. The qualified health personnel and availability of equipment contributed to the improvement of the health of the elderly persons in this study. The elderly persons perceived that they were diagnosed with a serious disease condition(s) and adhered to the treatments because the benefits outweighed the barriers. The elderly in this study were satisfied with the healthcare services because they observed that their health

conditions were better and had become stable.

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References

1. Lubenow JAM, Barrêto AJR, de Almeida NJ, Oliveira SA. Access for the Elderly to Primary Health Care Services: an Integrative Review. *International Archives of Medicine*,2016;9(1):1-13.
2. Agrawal G, Arokiasamy P. Morbidity Prevalence and Health Care Utilization among Older Adults in India. *Journal of Applied Gerontology*,2010;29(2):155-79.
3. Saeed BII, Louis M, Aidoo EN, Nsowah-Nuamah NN, Yawson AE, Zhao X. Socio-economic inequalities and healthcare utilization in Ghana. *International Journal of Business and Social Research*,2013;3(1):54-63.
4. Ghana Statistical Service. Population & Housing Census Report, the Elderly in Ghana. 2013 July 2013, 2010.
5. Chakraborty R, Majumdar A. Measuring consumer satisfaction in health care sector: The applicability of servqual. *Researchers World*,2011;2(4):149-60.
6. Zineldin M. The Quality of health care and patient satisfaction. *Internal Journal of Health Care Quality Assurance*,2006;19:60-92.
7. Büyüközkan G, Çifçi G, Gülerüz S. Strategic analysis of healthcare service quality using fuzzy AHP methodology. *Expert Systems with Applications*,2011;38(8):9407-24.
8. Becker MH, Maiman LA. Strategies for enhancing patient compliance. *Journal of Community Health*,1980;6:113-35.
9. Rosenstock IM. The health belief model and preventive health behavior. *Health Education Monographs*,1974;2(4):354-86.
10. Rosenstock IM, Strecher VJ, Becker MH. Social learning theory and the health belief model. *Health Education Quarterly*,1988;15(2):175-83.
11. Orji R, Vassileva J, Mandryk R. Towards an effective health interventions design: an extension of the health belief model. *Online Journal of Public Health Informatics*,2012;4(3):1-31.
12. Janz NK, Becker MH. The health belief model: A decade later. *Health Education Quarterly*,1984;11(1):1-47.
13. Tarkang EE, Zotor FB. Application of the Health Belief Model (HBM) in HIV prevention: A literature review. *Central African Journal of Public Health*,2015;1(1):1-8.
14. Korle-Bu Teaching Hospital. Annual Report. 2016. Retrieved August 14, 2018, 2016
15. Araoye MO. 'Subject Selection' Research Methodology with Statistics for Health and Social Sciences. 1st ed. Nigeria: Nathadex Publishers, 2004.
16. Cochran WG. Sampling Techniques. 3rd ed ed. New York: John Wiley & Sons, 1977.
17. Gay L, Airasian P. Educational research: Consequences for analysis and applications. Upper Saddle River, NJ:

- Pearson, 2003.
18. Lai DW, Chau SB. Predictors of health service barriers for older Chinese immigrants in Canada. *Health & Social Work*,2007;32(1):57-65.
 19. Fry M, Chenoweth L, MacGregor C, Arendts G. Emergency nurses perceptions of the role of family/carers in caring for cognitively impaired older persons in pain: a descriptive qualitative study. *International Journal of Nursing Studies*,2015;52:1323-31.
 20. Awoyemi T, Obayelu O, Opaluwa H. Effect of distance on utilization of health care services in rural Kogi State, Nigeria. *Journal of Human Ecology*,2011;35(1):1-9.
 21. Fenton JJ, Jerant AF, Bertakis KD, Franks P. The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Archives of Internal Medicine*,2012;172(5):405-11.
 22. Stankunas M, Avery M, Lindert J, Edwards I, Di Rosa M. Healthcare and aging: do European Union countries differ? *International Journal of Health Care Quality Assurance*,2016;29(8):895-906.
 23. Aliman NK, Mohamad VN. Linking service quality, patients' satisfaction and behavioral intentions: an investigation on private healthcare in Malaysia. *Procedia-Social and Behavioral Sciences*,2016;224:141-8.
 24. Hassali MA, Alrasheedy AA, Ab Razak BA, Al-Tamimi SK, Saleem F, Haq NU *et al.* Assessment of general public satisfaction with public healthcare services in Kedah, Malaysia. *The Australasian medical journal*,2014;7(1):35-44.