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Determinants of Patient satisfaction that impact hospital quality improvement: Evidence from a systematic literature review

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ABSTRACT:

Patient satisfaction in healthcare is recognized internationally as important for patient-centered, high-quality healthcare delivery. As part of continuous quality improvement, its measurement requires development of agreed standards and observable metrics. The identification of patient satisfaction determinants has been tackled in a large number of studies, and the findings are still inconclusive. Moreover, it is understood that there is conflicting data in patient satisfaction surveys. The objective of the current study was to systematically review the extent of patient-reported satisfaction indicators obtained, articulated and used to influence quality improvement across healthcare settings. Two research priorities such as reviewing evidences on necessary patient satisfaction measures and systematically identifying patient satisfaction in healthcare settings around the world were explicitly addressed with a view to enhancing the quality of Bangladeshi hospitals. This systematic analysis complied with the guidelines of the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) report. The research was conducted in Google Scholar, Medline, Emerald, Pub-Med and Science Direct in December 2020. The peer-reviewed English language journals published between January 2001 and December 2020 were included for the synthesis in this study. In a wide range of research, many determinants of patient satisfaction have been studied. However, due to no internationally agreed formulation of patient satisfaction and measurement method, the study findings were diverse. The most important determinants of patient satisfaction in the studies were healthcare service quality measures. Among them, the interpersonal care quality of health professionals was the critical determinant of patient satisfaction. The influence and direction of patient satisfaction groups have been found to be inconsistent. Therefore, the possible determinants and confounders can simultaneously be considered to be person-related characteristics. All possible features that could have had effects on satisfaction could not be seen by the selected studies. There is a need for further research using a structured questionnaire about how cultural, behavioral, and sociodemographic variations impact patient satisfaction.

1 INTRODUCTION

Patient satisfaction is a widely used, important measure of assessing the level of hospitals when patients have quality improvement contributor, goal, and reformer positions. Patient satisfaction survey findings allow healthcare facilities to identify quality variables that require enhancement. It also helps politicians to consider the needs of patients and, as a result, to make realistic

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strategies for reliable and higher quality care. On the other hand, greater patient interaction with hospital facilities changes the behavioral intentions of patients, such as alignment with the prescribed prescription of doctors and follow-up visits, resulting in improved clinical conditions and program referrals for others (Cheng, Yang & Chiang, 2003). (Cheng, Yang & Chiang, 2003). (Cheng, Yang & Chiang, 2003). (Cheng, Yang & Chiang, 2003). (Cheng, Yang & Chiang, 2003). (Cheng, Yang & Chiang, 2003). (Cheng, Yang & Chiang, 2003). Health programs are not only produced by providers. Providers and patients both work together in the development of healthcare. As a result, evaluating the efficiency of providers to determine the quality of health care is not enough. The function and characteristics of patients are equally essential to the success of providers in determining the quality of healthcare (Donabedian, 1992; Batbaatar, Dorjdagva, Luvsannyam, Savino &Amenta, 2017).

A central feature of high-quality care is patient interest in hospitals. Improved health benefits, including reduced hospital visits, decreased readmission, improved functional status and decreased mortality, are correlated with it. atient engagement leads to better decision-making, decreased physician negligence and adverse outcomes, improved adherence, optimized self-management and expanded retention of staff (Boulding, Glickman, Manary, Schulman &Staelin, 2011; Silva, 2014). With this perspective, patient participation is internationally recognised as important for the implementation of high-quality, consumer-centric healthcare (Phillips, Street & Haesler, 2016).

ecause of insufficient market capital, developing countries are making every effort to entitle their people to universal healthcare (Mossialos, Wenzl, Osborn, &Sarnak, 2015). In offering health facilities or programs for people needing basic medical services, community hospitals play an important role (Hu, Duan, Qiu, & Yu, 2014). A world of despair and deprivation will be a world without basic health services. Hypothetically speaking, it would only create more distress and deprivation if the planet had a comprehensive healthcare system that was widely regarded as offering low quality. The cost of healthcare will further stress and escalate under this imaginary scheme, growing patient concern and worry. A healthcare unit is useless if it is unable to reduce the suffering of patients. Every country's healthcare sector is a critical cornerstone of its overall growth, as it also affects all other industries, such as the financial, moral, political, social and business sectors. In addition, it has a variety of financial consequences (Bahadori et al., 2018).

Healthcare is one of the key goals of the 2030 Strategy for Sustainable Development (SDGs) of the United Nations Organisation (UNO), which states: "ensuring healthy lives and promoting well-being for all at all ages" and its goal of achieving universal health coverage, accessible medication, accessibility, effective and safe quality and access to quality basic healthcare for all (WHO, 2015). Even if you are rich, if it is annulled without good health, any part of life is nullified. Through promoting health tourism, the developing world is continuously constructing its health sectors by raising income for the national economy. In comparison, politicians in emerging countries, such as Bangladesh, are assisting developed countries' health sector by regularly pursuing their services at the cost of taxes charged by their own residents (Javed& Ilyas, 2018), rather than building their own healthcare infrastructure.

Received 05 March 2021; Accepted 01 April 2021

Healthcare concerns attract more attention from researchers in developing nations such as Bangladesh than from policy makers (Javed& Ilyas, 2018), which is a matter of significant concern in Bangladesh. It is regrettable that the number of disgruntled patients providing healthcare in public hospitals in Bangladesh has gradually risen. In addition, a substantial number of Bangladeshi people are desperate to assume that graft is seriously harming the country's healthcare system (Hussain et al., 2019).

In the healthcare industry, standard of care is a dominant theme in quality assurance and quality management systems. The value of quality in the healthcare industry has been acknowledged, but with the development of quality insurance, quality assurance systems and patient agendas, it has been accelerated over the last decade. While the primary issue of healthcare is quality of care, rather than price (Cheng et al., 2003), the technical skill of the service provider, as well as the immediate outcomes of certain procedures, is very difficult for a patient to determine (Asubonteng, Mccleary, & Swan, 1996).

It has been suggested that healthcare quality can be assessed by analyzing its composition, procedures and effects (Donabedian, 1988). Although the priorities of healthcare quality and wellbeing are almost similar, communities and cultures around the world vary in the degree to which the specific goals of patient-centeredness, timeliness, productivity and fairness are stressed. Healthcare interventions are created by different populations that would choose to use them for the acquisition, or efficiency enhancement in healthcare, including process measures. It is important to provide meaningful, scientifically sound, generalizable and interpretable meanings for all these purposes (McGlynn, 1998).

However, patient satisfaction is an essential indicator of the efficiency of healthcare as it includes feedback on the performance of the provider in fulfilling the client's most significant requirements and a primary determinant of the behavioral intent of the patient perspective. Patient loyalty is associated with significant effects, such as excellent enforcement, reduced use of emergency care, reduced prosecution of malpractice and improved prognosis (Al-Refaie, 2011). Over the last twenty years, the lack of a clear objective foundation and consistent measuring tool for customer satisfaction has led to a multitude of studies focused exclusively on patient engagement, i.e. facets of treatment experience such as waiting times, the quality of basic services, and contact with healthcare professionals, all of which serve to define concrete quality goals. Some scholars have indicated that identifying quality enhancement from the perspective of patients offers better value for their money with improved reliability, convenience, fairness, and comprehensiveness of treatment, while from the point of view of a supplier, quality improvement could be more effective, delivering more efficient services to a larger range of consumers with a fair degree of satisfaction (Patwardhan & Spencer, 2012; Xesfingi&Vozikis, 2016). Therefore, the method of quality management on the basis of patient satisfaction includes the association of patient interactions recorded on particular facets of healthcare to be evaluated.

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2 BACKGROUND: HEALTHCARE IN BANGLADESH

As the Constitution of the People's Republic of Bangladesh specifies the responsibility of the state to ensure public health for all citizens, health is a basic human need and fundamental human right (Ashrafun& Uddin, 2011). It is the obligation of government and health care workers to deliver healthcare coverage in equal proportion to all persons and to ensure that the health needs of the general population are fulfilled. The health situation of the world's developed countries is wretched and inappropriate. A significant segment of the population is deprived of access to basic healthcare in developed countries. The programs offered by healthcare providers are not up to the patients' level of need and understanding. The World Bank and other donor organizations have urged developed countries in recent years to ensure that scarce resources not only have an optimal effect on the health of the people at reasonable rates, but also that health systems are required to respond specifically to the needs and requirements of patients (Uddin, Ashrafun, &Kubra, 2016). Further analysis is needed to measure patient satisfaction as a predictor of the quality of healthcare (Prabhu et al., 2018).

Bangladesh's attempts to develop the delivery system of healthcare have increasingly stressed the quality of care. Bangladesh's government has an administrative network to provide health services from the grassroots level upwards. The primary public sector healthcare is structured at the sub-district level around the Upazilla Health Complex (UHC), which is known to be a healthcare base. District clinics and specialist medical colleges and hospitals are situated above the sub-district, offering secondary primary services and national tertiary level healthcare facilities. Bangladesh has made impressive strides on certain health indicators, such as child, maternal and under-five mortality controls, according to statistical estimates. A reliable record of achieving 90% plus vaccination coverage has been maintained in regular EPI with NIDS (national immunization days) since 1995 (WHO 2015). Despite this development, it is well known that Bangladesh has acute problems with access to modern healthcare facilities and reliable treatment. In Bangladesh, frustration and lack of confidence in the quality of health facilities have driven a significant number of Bangladeshi patients to visit neighboring countries such as India, Thailand and Singapore (Ali &Medhekar, 2018). The primary purpose of this analysis is to conduct an in-depth study of a variety of academic findings that objectively examine the determinants of patient satisfaction in addition to their effect on the continuum of quality management within healthcare organizations. The literature also concentrates on the importance of customer satisfaction assessment devices.

3 AIM OF THIS RESEARCH

The goal of the current study was to systematically review the extent of patient-reported satisfaction indicators obtained, articulated and used between 2001 and 2020 to influence quality enhancement across healthcare settings. Two research priorities were explicitly addressed with a view to enhancing the quality of Bangladeshi hospitals:

1. To review evidenceson necessary patient satisfaction measures in hospitals.
2. To systematically identify patient satisfactionin healthcare settings around the world.

Received 05 March 2021; Accepted 01 April 2021

4 METHODS

4.1 DESIGN

The criteria of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) comment is adopted by this systematic review (Liberati et al., 2009). The PRISMA declaration contains a 27-item checklist that guarantees accountability, iteration and full systemic evaluation documentation.

4.2 SEARCH STRATEGY

In December 2020, the databases used were Google Scholar, Medline, Emerald, Pub-Med and Science Direct. A variety of variations of search terms for keywords used in the papers found in the scoping exercise is used due to the flexibility in the usage of terms covering patient satisfaction and quality improvement (Hempel et al., 2011). Using the following phrases defined from the title, abstract, keywords, or medical topic headings, the electronic databases were searched: patient satisfaction surveys, quality enhancement, patient reviews, hospitals and assessment of patient satisfaction. The search words were modified for a similar reason from the previous study research. To find additional publications, this analysis also manually scanned reference lists of related journals. Finally, to remove the duplications and to address proper reporting criteria for the chosen papers, sources of all included studies were listed.

4.3 ELIGIBILITY CRITERIA

Both quantitative, qualitative, and mixed process studies have been considered for systematic study, including experimental, quasi-experimental, analytical, examination, and so on. Studies were used in which (1) overall patient satisfaction with health services was measured; (2) the association between healthcare determinants, patient-related variables, and patient satisfaction was analyzed; (3) patient satisfaction or its determinants were contrasted between particular populations or environments; and (4) a literature review, systematic review, or meta-analysis of patient satisfaction was performed. This included articles published in full in peer-reviewed journals and in the English language between January 2001 and December 2020. Other academic papers which were not considered for this review include government or corporate articles, books or book chapters, conference abstracts or proceedings, dissertations, theses, commentaries, editorials, and letters. Studies of patient satisfaction with specific health facilities (mental, rehabilitation, etc.) or diseases (psychosis, cancer, transplant surgery, etc.) were omitted, except for patient satisfaction studies of general or primary healthcare.

4.4 SELECTION OF STUDIES

For the next stage of the study, the titles and abstracts of studies in the search results were reviewed by two separate authors. The settlement was reached by negotiation whether there was a dispute between them. Complete texts of all the included studies were independently reviewed by two authors against the eligibility conditions, and differences were settled by discussions. In the view of both authors, all the qualified or theoretically eligible studies were evaluated. Studies which did not meet the qualifying requirements or were not found to include complete texts were removed from the next level of evaluation.

Received 05 March 2021; Accepted 01 April 2021

4.5 DATA EXTRACTIONS

The systemic review was entered separately by two authors into a previously prepared data extraction sheet. The dialogue resolved disputes and incomplete review questions. Reviews were gathered by (1) the name of the author, published year and country (2) the purpose and objectives of the report, (3) the methods of sampling and data processing, (4) the evaluation and interpretation methods, and (5) the main findings.

4.6 QUALITY ASSESSMENT

Variability and heterogeneity in the nature of qualified studies indicated that the validated methods for design-specific quality evaluation were inappropriate; therefore, the GRADE method for grading the quality of proof and the severity of recommendations was tested for each eligible sample. This method was built in order to increase process accountability in the creation and dissemination of data for comprehensive public health and policy assessments and recommendations (Guyatt et al., 2011; Aiken et al., 2012; Schünemann, Guyatt, &Oxman, 2013). Five key data quality considerations were evaluated: (1) probability of bias, (2) inconsistency of findings, (3) indirectness of evidence, (4) inaccuracy, and (5) bias in publication. Most of the experiments included were in non-experimental nature, and their proof content was therefore rated as poor. Therefore, unless their methods and consistency is severely deficient, this analysis contained as many papers as possible in the review. Two reviewers separately evaluated the validity of all the studies used and reviewed for the completeness and consistency of the evaluation. Through consensual dialogue, gaps in the quality evaluation were addressed.

4.7 DATA ANALYSIS

The present review illustrated a summary of the features of the studies included. The heterogeneity of the theoretical bases, procedures, measurements and results of the studies included in the research did not enable the incorporation of data into this analysis using statistical methods. In addition, there were different research nations, settings, population attributes, and data collection methods. As a result, for a meta-analysis, this article did not aim to pool the information. The data was then narratively synthesized. The results were broken down by patient satisfaction determinants as determinants related to healthcare providers and predictors related to patient context factors. For each group of experiments, consistent and contradictory findings were synthesized. On the basis of the sample features involved, potential reasons were attempted to be understood for different findings in relationships between determinants and patient satisfaction through analysis.

4.8 SEARCH FLOW

The present study adhered to the PRISMA checklist guidelines. The analysis followed the stages listed in figure 1 below, based on best practice guidance.

The original search returned 3213 papers that were imported for scanning to the Endnote; 2841 papers were kept after elimination of duplicates. Two writers screened >20 percent of the titles and abstracts against the inclusion criterion with 90 percent consensus to ensure reliability. The same two authors finished the scanning of the majority of the titles and abstracts with 95 percent consensus after addressing discrepancies; the remaining inconsistencies were overcome through

Received 05 March 2021; Accepted 01 April 2021

debate. The presence of 113 articles contributed to this initial screening. The key explanation for removing papers at this point was that in some situations, the papers did not report on the quality improvement patient satisfaction indicator, quality improvement programs were commented on, but they were not based on any evidence on patient satisfaction. These articles also aimed to argue in favor of using and collecting data on patient satisfaction for quality management and to identify the possible advantages to patients and staff in doing so. This would mean that, from a patient satisfaction viewpoint, the study of healthcare change is a developing area with more studies required to establish a systematic body of evidence to show which interventions are more successful.

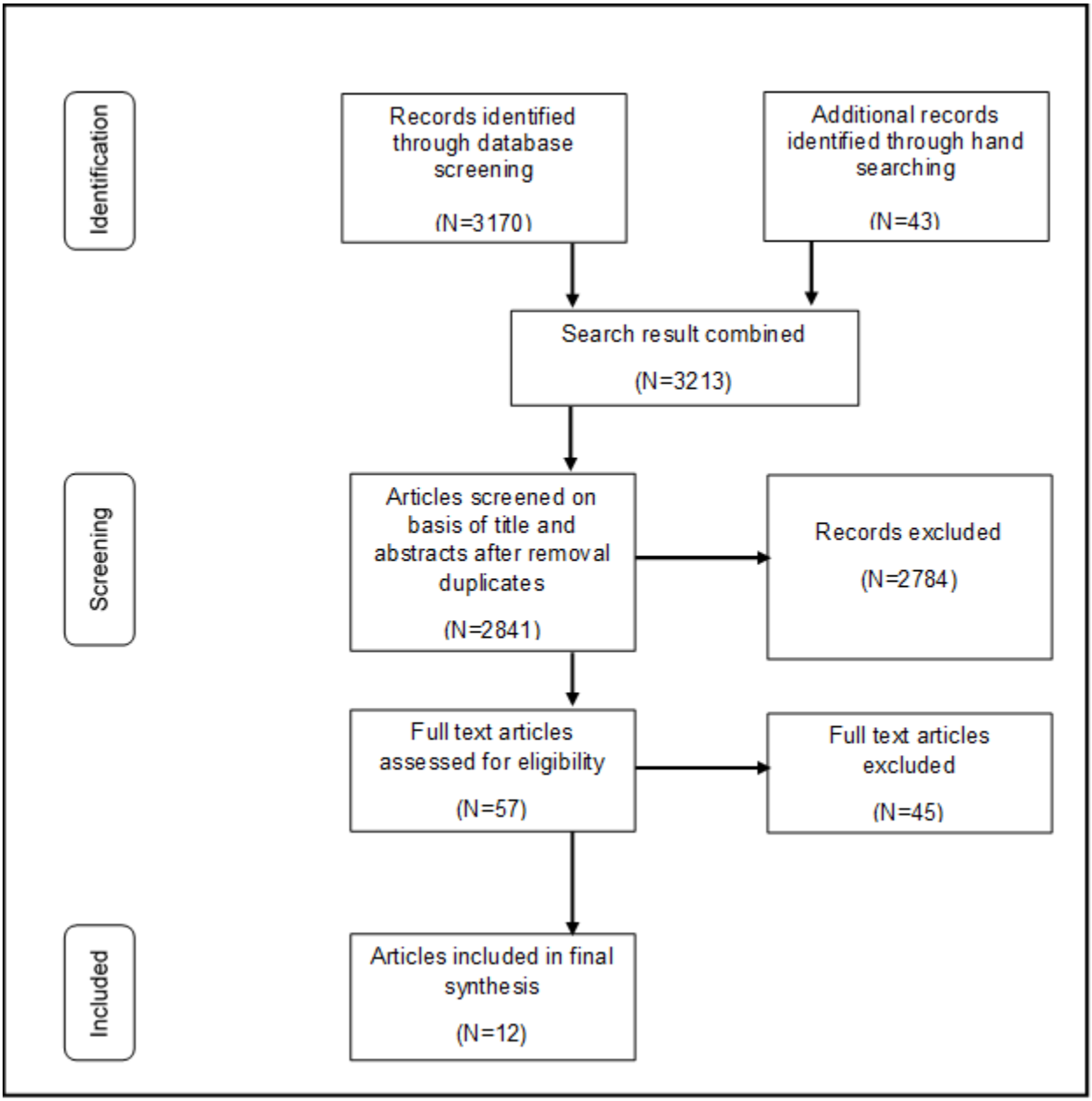

Figure 1: PRISMA Flow Chart

Received 05 March 2021; Accepted 01 April 2021

5 RESULTS

5.1 STUDY SELECTION

Full-text publications have been retrieved and reviewed by the reviewers for inclusion, of which 12 have been maintained for final inclusion. At this point, the key explanation for exclusion was that papers indicated that they reported on quality improvement in the abstract but did not include any specifics of approaches to quality improvement; several papers provided overviews of approaches to quality improvement used in healthcare environments, but these were not adequately detailed to obtain valuable information for the purposes of this study. Synthesis was built according to the two research objectives of the study, inside and through the experiments, by exploring relevant themes. A description of each analysis included is shown in Table 1.

5.2 RISK OF BIAS ASSESSMENT

This research revealed that 27 studies stated no competitive interests in the remaining studies, three declared some competing interests and no specific statements were found. Most of the included studies have a strong likelihood of bias from the roots of selection bias, information bias, and confounding bias. All results of the studies may have been biased due to their research style, non-random sampling, improper sample size, data collection techniques, inappropriate data sources, systematically separate non-respondents, data handling error, lack of valid instruments, confounding, inappropriate study methods, favorable outcome interpretations, reporting bias, and so on.

5.3 DETERMINANTS OF PATIENT SATISFACTION FOR QULAITY IMPROVEMENTIN HEALTHCARE

To enhance the efficiency of healthcare delivery services, it is necessary to recognize the patient and healthcare provider-related predictive factors of patient satisfaction for each country. In each of the included reports, Table 1 summarizes the specifics of the quality management measures identified.

Table 1: Summary of Included Studies

Authors Name, Published Year & Country	Aims of the study	Sampling and data collection	Analysis	Key findings
(Boyer, Francois, Doutre, Weil, G., & Labarere,, 2006); France	To evaluate the views of clinical workers on the outcomes of in-patient satisfaction surveys and their use in the QI process	500 care providers randomly selected through questionnaire surveys	Quantitative analysis through SPSS 10.1	Respondents considered that the patient should judge the standard of hospital service

Received 05 March 2021; Accepted 01 April 2021

(Gill & White, 2009); Australia	To study the literature on patient satisfaction and to present evidence for the perceived standard of service	NA	NA	Patient satisfaction was found an unpredictable construct to perceive service quality
(Camgöz-Akdag & Zineldin, 2010); Turkey	To examine the major factors affecting patients' perception to evaluate quality of healthcare	1500 patients using survey questionnaire	Quantitative analysis through factor analysis	For patient satisfaction, five quality dimensions (5Qs) were important, such as object quality, process quality, infrastructure quality, interaction quality and atmospheric quality.
(Sodani, Kumar, Srivastava, & Sharma, 2010); India	To assess the satisfaction of public healthcare patients with OPD (Outpatient Department)	Pre-structured questions were surveyed to 561 OPD patients in eight district public healthcare	Data analyzed through SPSS V.12	Compared to higher level facilities, patients were more pleased with the actions of physicians and workers at lower health facilities.
(Dayasiri & Lekamge, 2010); Asian countries	To define the variables in Asian Hospitals that assess patient satisfaction	NA	NA	Demographic factors such as age, gender, level of education, socio-economic status and other factors such as hospital type, technical and physical facilities and healthcare professional-patient relationship quality often alter the satisfaction of patients based on country-to-country

Received 05 March 2021; Accepted 01 April 2021

(Al-Abri & Al-Balushi, 2014); Oman	To review the literature related to patient satisfaction and quality improvement and its impact on quality process	NA	NA	Patient satisfaction surveys are a proven criterion for quality improvement strategies for healthcare and it is understood that a patient satisfaction survey is considered to be an effective one. Tool for Improving Consistency
(Russell, Johnson, & White, 2015); USA	To collect these metrics in order to track and improve the quality of healthcare, including patient quality evaluations.	Survey questions sent to 6824 patients and returned 1,514	Regression analysis	Results showed that access factors, movement through the appointment, nurse/assistant, care provider and personal problems have a major effect on overall care quality assessments.
(Phillips et al., 2016); Australia	Reviewing literature aimed at defining methods for assessing patient engagement in healthcare and reporting on their reliability and validity	NA	PRISMA	A few accurate and relevant instruments are found to be critical for assessing patient involvement in healthcare. While the dyadic Observing Patient Participation in Decision Making (dyadic-OPTION) method is the most promising to quantify key components of decision-making Patient engagement

Received 05 March 2021; Accepted 01 April 2021

(Batbaatar et al., 2017); Italy	To systematically classify and analyze data on patient satisfaction determinants and to search for reasons to refute outcomes in relationships between determinants and determinants Satisfaction with patients	NA	PRISMA	A wide variety of studies have identified many determinants of patient satisfaction explored in the report. However, due to no internationally agreed formulation of patient satisfaction and measurement method, the findings of the study differed.
(Kraska, Weigand, & Geraedts, 2017); Germany	To explore which hospital features have an effect on patient satisfaction	300200 patients surveyed from 999 hospitals	Cross-sectional study using secondary data	Hospitals' structural and safety features have a major effect on patient satisfaction. The study indicated that patients are vulnerable to severe measures of hospital quality and enhances the perception of patient satisfaction as a measure of the quality of care.
(Ng & BHK Luk, 2019), HongKong	To explore the concept's attributes in the wider sense of healthcare		Inductive method of concept analysis	Studying patient experience will definitely help clinicians better embrace patient experiences in the provision of services and increase patient satisfaction, thus improving the quality of healthcare

Received 05 March 2021; Accepted 01 April 2021

(Asamrew, Endris, & M Tadesse, 2020); Ethiopia	Identifying the essential dimensions that have a greater effect on the degree of patient satisfaction associated with hospital services in the Ethiopian context	Randomly selected 398 patients	Bivariate analysis using linear regression	Major predictors were physician service, laboratory and radiology services, pain control, inpatient pharmacy service, bathroom cleanliness, room accommodation, and hospital dietary service.

6 DISCUSSION

Evidence from the Boyer et al. (2006) observational research, most respondents (94%) favorably viewed patient satisfaction surveys and found them 'useful',' vital',' appropriate' or 'significant'. They considered that patients, particularly in their relational, organizational, and environmental aspects, were able to assess the level of hospital care. Responders, especially physicians, were morewillingness of patients to assess the level of technical treatment or the skill of doctors, however. Respondents have found that quality polls would have an effect on the treatment organization (74%) and their work (72%).

According to Gill & White (2009), the desired need to assess patient satisfaction was largely motivated by the overarching "new public management" agenda (Hood, 1995) and the concomitant growth of the health market movement, with one of the articulated priorities of healthcare delivery being patient satisfaction. The controversy about the relationship between patient satisfaction as an assessment of the treatment process versus the quality of technical care was well known with the rise of the patient rights movement (Williams, 1994). As a result, the use in the health sector of patient satisfaction metrics has become increasingly common. For example, since 1998, measuring patient satisfaction has been obligatory for French hospitals, and is used in a consumerist way to enhance the healthcare atmosphere, patient services and equipment, but not generally to improve treatment (Boyer et al., 2006).

Finding from the Sinha, Camgöz-Akdağ, &Zineldin (2010) report, the patients' main concern was the quality of food served and the right to sleep in hospitals for family members of patients. The second aspect affects the conduct of the workers in dealing with patients at Turkish hospitals. The part linked to physicians' politeness was the highest load provided in this factor. The approach model for enhancing patient satisfaction in hospitals in Turkey is to affect admissions, such as infrastructure quality, ambient quality and item quality.

Sodani et al. (2010) recommended that policy makers and hospital management should take the following measures to improve patient satisfaction at public health facilities: 1) Attempts should be taken to decrease patient load at higher-level facilities so that patients can be provided more care and resources by doctors and other staff; 2) Efforts are also needed to enhance infrastructure The results of the current research should be applied to improve the care at state public health institutions, resulting in people visiting those public hospitals becoming more pleased.

Received 05 March 2021; Accepted 01 April 2021

Dayasiri&Lekamge (2010) found evidence that demographic variables such as age, gender, level of education and socio-economic status may have an effect on patient satisfaction with healthcare quality. However, this effect is not seen in the same way across Asian countries. Cultural variables, prior healthcare experience of patients and expectations may account for this variability. Health provider-related variables such as hospital form, technological and physical services, and health professional-patient relationship consistency may alter the satisfaction of patients. As with previous findings, their satisfaction effects can differ from country to country.

Evidence from the Al-Abri & Al-Balushi (2014) report has gained growing interest over the past 20 years in patient satisfaction surveys; however, there is little reported research on changes arising from patient satisfaction survey input information, and these findings are most frequently inconsistent in the outcomes. The literature review examined to what degree patient opinions are collected by healthcare practitioners and decision makers to target new projects for quality enhancement. More recently, a study conducted in a teaching hospital in France found that recorded results from satisfaction surveys culminated in some development programs being introduced mostly in a hospital setting, but no substantial change in the behaviour of care providers such as interpersonal skills.

Phillips, Street & Haesler (2016) identified nine determinants of healthcare facilities that may have played a role in patient satisfaction variations: technological care, interpersonal care, physical environment, access, organizational features, continuity of care, and result of care.

The positive correlation in terms of procedure and result consistency extends to the dimensions of patient satisfaction (satisfaction with medical treatment, nursing care, organisation and operation, and overall/recommendation), according to Kraska, Weigand &Geraedts (2017). In general, the associations listed stress that the patient experience must be viewed as a significant standard of consistency of hospital care.

Contexts are events that take place before the definition arises. Given that patient satisfaction is an emerging phenomenon in the healthcare setting, it is important to recognize that the occurrence of patient satisfaction is influenced by a variety of personal and environmental variables. The current definition study has shown that understanding of preferences, patient demographics and personality, as well as market competitiveness, are considered prerequisites for patient satisfaction (Ng &Luk, 2019).

Asamrew, Endris, & Tadesse, (2020) showed that other experiments were statistically correlated with the importance of information resources offered for patients, correct admission procedures, short processing time to access care, and ensuring privacy and confidentiality for services provided by the hospital. Different literatures, on the other hand, often suggest that the main predictor for patient satisfaction is the level of contact and interpersonal skills.

7 CONCLUSION

In this study, on the basis of online datasets, research conducted on patient satisfaction and its determinants between 2001 and 2020 have been analyzed. In a wide variety of research, including areas of marketing, behavioral science, psychology, clinical management, and so on,

Received 05 March 2021; Accepted 01 April 2021

this review finds many determinants of patient satisfaction studied. Nevertheless, research outcomes between and within sectors were different, leading to no internationally agreed formulation of patient satisfaction.However, healthcare efficiency metrics in the surveys have clear and optimistic effects on patient satisfaction. Of the service metrics, the most reliable and highest determinant of patient satisfaction was interpersonal treatment.

There is evidence that patients' socio-demographic characteristics determine their happiness with health care. The strength and direction of the impact on patient satisfaction, however, is distinct. This diverse results can show that not only can socio-demographic influences influence patient satisfaction, they also play a moderating and mediating role in the relations between determinants of health care and patient satisfaction. In this way, all possible predictors of patient satisfaction and confounders in the same analysis should be viewed as person-related variables to monitor their positions in the true relationships between determinants and patient satisfaction.

In general,studies have found very similar to higher levels of satisfaction. Higher reported satisfaction does not generally mean that the output of all determinants has been adequate, and that the measuring method needs to be enhanced. Measuring frustration and causes of dissatisfaction with health care could theoretically minimize and offer a more realistic view of the commonly recognized high degree of satisfaction.

Diverse and inadequate metrics arose from the diversity of the conceptual description of patient satisfaction. Some initiatives were still not sufficient to encompass all patients' interactions with health care. It is also proposed that the vulnerability can be minimized by using population-wide or setting specific and valid instruments with free questions for feedback and complaints from patients. In comparison, a significant proportion of the experiments were cross-sectional and informative, and the findings excluded causal associations between determinants and satisfaction from being estimated. Thus, to identify real causal correlations, there is a need to use longitudinal or experimental research design.

Furthermore, all possible features that could have consequences on satisfaction could not be seen by the chosen research. Further studies are needed on how cultural, physiological, and socio-economic variations impact patient satisfaction with structured questionnaires that can be modified for further comparisons of individual populations and countries.

8 LIMITATION

There were some drawbacks to this report. First, the research did not contain papers in foreign languages that could have added bias against the study goal of globally evaluating determinants of patient satisfaction and avoiding the incorporation of socio-economic and cultural-specific data.

Second, the research did not provide clear terminology for patient satisfaction with socio-demographic and psychological well-being. Therefore, research that discussed population-specific happiness might have skipped it. In the other hand, this analysis used limited parameters for inclusion and exclusion to capture as many experiments as possible; nevertheless, this effort

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resulted in collecting and synthesizing a large amount of data. Therefore, in the study, possible unspecified or under-interpreted unique structures may have been included.

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