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Patient satisfaction, costs and quality of care

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Abstract: **Patient satisfaction is an important and commonly used indicator for measuring the quality in health care. In practice, such a concept can be examined with quantitative, qualitative or even mixed indicators, such as ensuring that legislative and statutory requirements, which reflect upon; that standards of care are being met, waiting times are reduced, infection/pressure sore rates and complaints through patient satisfaction surveys are kept to a minimum**

Aim: This editorial explores how the concept of patient satisfaction affects the structure of contemporary health care systems and routine delivery of care.

Discussion: Cost and quality of healthcare are major concerns in the majority of health care systems worldwide. The use of patient satisfaction as a quality indicator is a way of seeking to identify the relationship between healthcare cost and quality. In this context, patient satisfaction affects clinical outcomes overall, patient retention, and medical errors. It also affects care delivery in a timely, efficient, and patient-centered mode. Therefore, patient satisfaction is a "proxy" in assessing the effectiveness of healthcare delivery.

Conclusions: Yet, the links between patients' satisfaction and the nursing service seem to be quite strong. Under this light, the patient's opinion of nursing probably reflects on his/her hospital experience as a whole. Moreover, patient satisfaction may not necessarily reflect the quality of healthcare as a whole from an objective clinical standpoint as the cost-satisfaction relationship may not be extrapolated to other quality indicators.

Keywords: **quality of care, healthcare costs, patient satisfaction.**

1. INTRODUCTION

More than three decades ago, The Patients' Charter, (Ross & Miell, 1991) has categorically put emphasis on the patient as a client, because "*after all,... they cannot take their custom elsewhere if they are dissatisfied*". Furthermore, there is a trend in many western Health Care Systems to decentralize healthcare, i.e. to implement a purchaser/provider split between health authorities and local units. Thus, health authorities are now expected to identify the health needs of their resident population and purchase health services from units accordingly. In addition, the competition of the internal market is theoretically expected to ensure and increase the quality of care that patients receive and consequently the resulting satisfaction with the service as well.

In practice, such a concept can be examined with quantitative, qualitative or even mixed indicators, such as ensuring that legislative and statutory requirements, which reflect upon; that standards of care are being met, waiting times are reduced, infection/pressure sore rates and complaints through patient satisfaction surveys are kept to a minimum (Bodenheimer & Sinsky, 2014).

The consequences of these new arrangements on services for frail sub-populations, such as the elderly are yet to be determined. Are we ensuring that the elderly will get a high standard care or perhaps are we imposing our own view of the world on them? In this context it has been suggested that the auditing tools used tend to reflect the "standards" set by the author rather than those by the user (Coulter et al., 2019).

Moreover, the typical trap into which it is easy to fall is: "I know what it's best for you". Nevertheless, one should always keep in mind that it is the elderly patients who are actually experiencing the care, not us. So, is it enough to measure the quality of care provided and consequently patients' satisfaction by monitoring self-imposed standards and does this actually meet the needs of the consumer of the service? (Theofanidis & Diktapnidou, 2006).

Furthermore, variations in who is interviewed, the timing of the interview, the type of questionnaire used and how satisfaction is rated, have a major influence on the results and make comparisons extremely difficult. Yet, "*that the future of aging persons in an aging society will depend upon our attitudes and behaviours*".

Fortunately, our perception of the elderly is not static. It does, or it should, undergo re-evaluation from the retired grandparent to a more active and participative role. In terms of the elderly patients, they should not just "*be seen*" but more importantly "*heard*".

This could also help us provide a service "free of bad surprises" which is suggested as one which negatively influences their overall feelings of satisfaction. That is, a service catering for the elderly's needs and their ideas about health care.

After all, consumers may view health in broader terms than clinical measurements. Therefore, nurses must consider each consumer's health views and goals and assist them toward attainment of these goals (Nguyen et al., 2020).

British hospitals, from the 1960s onwards, found themselves injected with a new "managerialism" based on the industrial model of scientific management. It was initially proposed that hospitals would increase their efficiency (quality of care) if based on the economy of scale of large units (Gorgulu, 2018).

Thus, the goal for every successful manager is to minimise the costs whilst maintaining quality. Free competition though, according to Chino et al., (2014), may reduce quality for the sake of an immediate competitive advantage. On the other hand, lowered standards may also be an inevitable by-product of the inflationary pressures of rising material and labour costs.

Since hospitals are becoming "industrial" organisations, these issues should be addressed in conjunction with the quality of care (the product?) which patients (the customers?) receive (buy?).

As far as consumers' expectations are concerned, these can be associated with consumers' satisfaction or dissatisfaction and with complaints about the service which can be also translated in financial terms. An unhappy customer is not going to be a customer any more, and by rule-of-thumb measurement, one complaint cancels a hundred compliments (Woo et al., 2017; McCrone et al., 2013).

Therefore, it can be argued that the major underlying reason for quality of care evaluation is measurement of costs. With regards to the rapidly rising costs, health workers, including nurses, should investigate why their services have become so over utilised that the balance between supply and demand has grown out of hand, especially in countries with a well-developed system of social services (Xesfingi & Vozikis, 2016; Xiang et al., 2017).

2. CONCLUSIONS

However, it should be noted that "modern medicine is the product, not the creator of the industrial civilisation" and "many nurses dislike analogies made between industry and the NHS". Nevertheless, the links between patients' satisfaction and the nursing service seem to be quite strong. Yet, the patient's opinion of nursing probably reflects on his/her hospital experience as a whole. Moreover, patient satisfaction may not necessarily reflect the quality of healthcare as a whole from an objective clinical standpoint as the cost-satisfaction relationship may not be extrapolated to other quality indicators.

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