



An Overview of Patient Satisfaction among Patients with Different Psychiatric Disorders Seeking Treatment in Government and Private Settings

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ABSTRACT

Background: Patient satisfaction is directly proportional to and quality assurance of the health care system and its delivery. It serves as an improvement tool among healthcare authorities to improve the healthcare system.

Aims and objectives: To assess the Sociodemographic of patients, level of satisfaction, and assess the correlation between patient satisfaction score and psychiatric/medical morbidities.

Methods: A cross-sectional survey was done on 53 patients with the help of the PSQ-18 questionnaire, MINI-7, and BG-Prasad modified scale were used Sampling was done by consecutive, convenience-based sampling method.

Results: Our study documented a mean age of 38.42 ± 13.32 , a mean satisfaction score of 4.09 ± 0.628 in the government setting, and 4.283 ± 0.749 in the private setting. Positive correlation of 0.190 with psychiatric disorders was seen and a positive association was seen between medical comorbidities and patient satisfaction in private settings. The majority of females from rural areas unemployed married, and from joint families from the lower section of the economic class.

Conclusions: Treatment Satisfaction among patients had minimal difference between private and government treatment settings. This study can facilitate the identification of the field of improvement in both settings and can design a strategy for the enhancement of the health care system.

Keywords: Satisfaction, Health care, PSQ-18, Psychiatry

INTRODUCTION

The contentment of patients with their medical care often influences their decisions when selecting health care plans [1]. Continuity of care, which involves an enduring relationship between a clinician and a patient, is seen as an essential factor in health care delivery that can significantly affect patient satisfaction. [2]. Evidence suggests that maintaining continuity of care is linked to better disease management [3,4]. When patients are content with the role their caregivers play but they aren't available, the patients wait for their respective treating doctors. Love, et al and freidson are highlighted that factors such as the structure and accessibility of medical facilities, familiarity with specific doctors and healthcare institutions, as well as opinions from social circles, can collectively shape satisfaction within the healthcare system [5]. This amalgamation, known as the 'lay

referral system,' significantly influences patient satisfaction with treatment by John, et al [6]. Patients' satisfaction with their medical care is predictive of their decisions regarding the choice of health care plans [7]. Literature is quite evident about an association between satisfaction and outcomes in chronic diseases like diabetes [8]. Continuity of care is positively associated with higher patient satisfaction which implies that improvement in continuation can improve patient satisfaction [9]. Different factors have been associated with patient satisfaction including demographic variables and general health conditions [10]. Recent studies have shown that patients keenly observe information related to quality of care and plan their health matters [11]. Older patient satisfaction was positively correlated with the physician questioning and supportiveness on patient-raised topics; patient information-giving on patient-raised topics; the length of the visit; the physician's use of questions

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worded in the negative; shared laughter between the physician and the patient; and physician satisfaction[12].keeping in view all the facts the study was planned to assess the patient satisfaction in government hospitals and private clinics on patients who had different psychiatric disorders.

MATERIALS AND METHODS

Study area/setting

Our study was conducted on patients who visited both government tertiary care hospitals and private clinics for the treatment of different psychiatric disorders and were recruited from the outpatient department of psychiatry SKIMS MCH Bemina.

Objectives: Asses the sociodemographic variables of patients who visited different treatment settings and study the correlation of psychiatric morbidities, and medical co-morbidities with patient satisfaction score both in a private setting and government setting.

Study subjects: Study participants aged 18 years and above irrespective of sex was enrolled for the study with informed consent and participants had the liberty to withdraw from the study as per their will.

Study design: A cross-sectional type of study where ethical clearance was obtained. Consent was taken. Privacy and confidentiality were maintained and records were secured. Participant's convenience-based sampling technique was used where patients were enrolled from the outpatient department of psychiatry SKIMS MCH Bemina, and that structured Sociodemographic sheet was filled and the BG Prasad scale was used to assess economic status. PSQ-18 (Patient Satisfaction Questionnaire-18) for the private setting was applied to assess the satisfaction of patients in the government setting and PSQ-18 for the government setting was applied to patients visiting private settings to minimize the bias. The study was conducted between the months of August 2023 to November 2023. Exclusion criteria were: a) Patients who did not give consent for the study; b) patients having psychiatric/severe neurological illness or medical illness; c) Not being able to understand the questionnaire; d) Patients having records or treatment from only one setting of treatment (Government/Private).

Data collection methods, instruments used, measurements

Patient satisfaction is a critical implication of the quality of medical care. PSQ-18 is an 18-item questionnaire scale and a Likert scale where patients are asked how strongly he/she agree or disagree (strongly agree-1/agree-2/uncertain-3/disagree-4 or strongly disagree-5. It may also be classified under subset scales as General Satisfaction(Questions nos. 3,17), Technical Quality (Questions nos.2,4, and 6, Interpersonal Manner (Questions 10 and 11), Communication(questions 1 and 11), Financial Aspects(Questions 5 and 7), Time spent with Doctor (Questions 12,15), Accessibility and Convenience(Questions 8,9,16,18) items are scored so that high scores reflects satisfaction with medical care. After item scoring, items within the same subscale should be averaged together to create the final score [13]. Socioeconomic status was assessed with the help of the Modified BG Prasad scale [14]. The psychiatric disorders were evaluated using MINI-7, keeping in view reliability and validity [15].

Data management and analysis

Data has been analyzed using IBM SPSS statistics 24.0. Frequencies and percentages were used for qualitative and quantitative variables correlation bivariate analysis was performed.

RESULTS

Table 1, Indicates that n=32.07 participants were from the 19-30 years age group followed by 24.25% from 31 years-40 years, 15.09% from 41 years-50 years, 20.75% from 51 years-60 years and 7.54% from 61 years-70 years of age with a mean of 38.42 and S.D 13.32, males 43.39%, females 56.60%, and 86.79% from rural areas, 28.30% had no education,13.20% had primary education,7.54% had middle education, 18.86% had the secondary qualification, 20.75 5 had studied up to higher secondary, 5.66% graduates, 5.66% were postgraduates. Among occupations, 18.86% were laborers, 16.98% were employees, 15.09% were businessmen, and 49.05% were unemployed. In marital status, 66.03% were married and 33.96% were unmarried. 69.81% were from joint families 30.18% were from nuclear families 43.39% were from upper-middle-class families, 35.845 were from a lower middle class, 9.43% were upper, 5.66% were upper lower, 5.66% from lower economic status.

Demographic variable	N	%	
Age group	19 years-30 years	17	32.07
	31 years-40 years	13	24.25
	41 years-50 years	8	15.09
	51 years-60 years	11	20.75
	61 years-70 years	4	7.54

Mean age		38.42	
Standard deviation (S.D)		13.32	
Sex	Male	23	43.39
	Female	30	56.6
Residence	Urban	7	13.21
	Rural	46	86.79
Education	Illiterate	15	28.3
	Primary	7	13.2
	Middle	4	7.54
	Secondary	10	18.86
	Hr. secondary	11	20.75
	Graduate	3	5.66
	Postgraduate	3	5.66
Occupation	Labourer	10	18.86
	Govt. employee	9	16.98
	Businessman	8	15.09
	unemployed	26	49.05
Marital status	Married	35	66.03
	Unmarried	18	33.96
Family type	Joint	37	69.81
	Nuclear	16	30.18
Economic status	Upper middle	23	43.39
	Lower middle	19	35.84
	Upper	5	9.43
	Upper lower	3	5.66
	lower	3	5.66

Table 1: Demographic variable in different treatments.

Table 2, indicates that 47.16% had major depressive disorder, 26.41% had bi-polar affective disorder, 3.77% generalized anxiety disorder, 11.32% obsessive compulsive disorder, 7.54% schizoaffective disorder, 1.88% having conversion disorder, 1.88% schizophrenia, among 53 participants 15.09% had hypothyroidism, 7.54% had hypertension, 18.86% had hypertension, 1.88% had bronchial asthma, hypothyroidism with hypertension 1.88% and 1.885 had hypertension with diabetes

mellitus. The mean PSQ-18 scoring in the government setting was 4.094 with S.D Of ± 0.628 and in the private setting mean of 4.283 with S.D ± 0.794 was seen. The correlation coefficient of psychiatric disorder with PSQ-18 in a government setting was found to be 0.190 and in a private setting -0.060. The correlation coefficient of medical comorbidities with PSQ-18 in government settings was found to be -0.046 and 0.046 was found in private settings.

Variables	N	%
Psychiatric diagnosis		
Major depressive	25	47.16
Bipolar affective disorder	14	26.41
Generalized anxiety disorder	2	3.77
Obsessive-compulsive disorder	6	11.32
Schizoaffective disorder	4	7.54
Conversion disorder	1	1.88
Schizophrenia	1	1.88
Medical comorbid diagnosis		
Hypothyroidism	8	15.09
Diabetes	4	7.54
Hypertension	10	18.86
Bronchial asthma	1	1.88
Hypothyroidism and hypertension	1	1.88
Hypertension and diabetes millets	1	1.88
Psq-18 scoring	Mean score	S.D
Government setting	4.094	± 0.628
Private setting	4.283	± 0.794
Psychiatric disorder	Scale	Correlation coefficient
MDD (Major Depressive Disorder)	PSQ-18(government setting)	0.19
OCD (Obsessive-Compulsive Disorder)		
BPAD (Bipolar Affective Disorder)		
Generalized anxiety disorder		
Schizophrenia	PSQ-18 (private setting)	-0.06
DCB		
Schizoaffective disorder		
Conversion disorder		
Medical comorbidities	Scale	Correlation coefficient
Hypothyroidism	PSQ-18 (government setting)	-0.046
Diabetes		

Hypertension		
Bronchial asthma		
Hypothyroidism and hypertension	PSQ-18 (private setting)	0.046
Hypertension and diabetes mellitus		

Table 2: Sociodemographic variables of patients for psychiatric disorders.

DISCUSSION

Experiences and satisfaction of patient regarding their treatment are becoming important in the delivery of quality assurance of the health care system [16]. In our study, the mean age was found to be 38.42 with an SD of ± 13.32 , which was in correspondence to a current study by Podel, et al [17]. The majority of patients were females which were in line with an international study [18]. Our Majority of patients were from rural strata which were in contrast to the study by Adhikari, et al [18] reason might be because our institution is situated in the vicinity of rural areas and on the national highway which has easy access to rural areas. The majority of patients in our study were married which was quite similar to a study [19]. The majority of patients were illiterate which has been echoed by a study where the satisfaction was higher seen in lower education profile patients.[20]. The majority of patients were unemployed in the study which was in contrast with the study done by Henry et al, likely reason could be that the hospital in which the study was conducted is located adjacent to the rural areas, where the jobs opportunities are very less, and people mainly rely on agricultural farming [21]. Our study resulted in the majority of patients belonging to the middle class of socioeconomic status was in line with international studies [22,23]. Our study had contrasting results in the majority of joint families with the study by Judith et al, likely reason might be Living in a joint family creates a sense of community and belonging, which can have a positive impact on the patient, sense of financial stability [24]. The enrolment of participants for the study with different psychiatric disorders was in line with the study done by Ann et al, our study has resulted in the pattern of medical disorders visiting the tertiary care outpatient department by the study [25,26]. The results in our study were in line with the study where the mean score Overall for the patients was found to be 4.21 and 4.15 in government settings [27]. The slightly higher patient satisfaction score was also in consensus with a study by Chari, et al [28]. A positive correlation was seen between psychiatric disorders and satisfaction scores in a government setting that was in context with a study [29]. The reason might be that counseling cells and other brain stimulation treatments like ECT and r-TMS are available at government hospitals. In our study, there was a negative correlation in satisfaction between private settings and psychiatric disorders, the reason might be the introduction of new healthcare insurance schemes by the governmental organization and ease of full stay and/or long stay hospital admissions in our institutions and absence of

counseling centers and availability of other means of treatment like ECT and RTMS, presence of team approach in government sector. Our study shows a positive correlation between treatment satisfaction and medical disorders which is also highlighted by the study [30].

Implications

- To get feedback from patients in government and private settings which can facilitate improvement in the health care delivery system in private and government settings.
- To assess the degree of treatment satisfaction among patients with different psychiatric disorders so that due consideration is given to the group with lower levels of treatment satisfaction.
- To identify the domains in the health care delivery system that needs special attention.
- Team-based treatment involving a psychiatrist, psychologist, and psychiatric social worker in a government setting is likely with psychiatric disorders is likely to lead to better treatment outcomes hence satisfaction than in private clinics where only psychiatrists or psychologists are available.

Limitations

- Sample size was less to make it generalized.
- Samples were chosen from private clinics and tertiary care hospitals hence not exactly comparable.
- Need for comparative follow-up study.

CONCLUSION

Treatment satisfaction among patients had minimal difference between private and government treatment settings. This study can facilitate the identification of the field of improvement in both settings and can design a strategy for the enhancement of the health care system. Satisfaction surveys should be a regular part of updated questionnaires that would be helpful to eliminate problems faced by patients during the course of treatment. Social media platforms may be considered as an alternate important source for dissemination to analyze treatment satisfaction

CONFLICT OF INTERESTS

The authors have no conflicts of interest to declare in relation to this article.

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