Patients' trust in out Patient Department (OPD)

at Nuwara-elliya District Hospital in Sri Lanka

By

Umadevi Durairaj

MPPG 4th Batch

December 2015

Patients' trust in out Patient Department (OPD)

at Nuwara-elliya District Hospital in Sri Lanka

By

Umadevi Durairaj

MPPG 4th Batch

Thesis submitted to the
Public Policy and Governance (PPG) Programme
In partial fulfillment for the award of

Mater in Public Policy and Governance

December 2015

Department of Political Science and Sociology

North South University

Dhaka, Bangladesh

www.mppg.nsu.org

Dedicated to
My Loving Parents

Abstract

The public hospitals have revealed improvement over the years through a number of efficiency indicators of health. Administratively, the public health sector in Sri Lanka is highly centralized. Much of the research on patients' satisfaction/ trust has been focused on the external barriers and how to break down those barriers. With this concept, the purpose of this study conducts an assessment of the patients' trust in Out Patient Department at Nuwara-eliya District Hospital in Sri Lanka.

The study aimed to answer the two research questions that evaluate the level of patients' trust towards district level hospital and the factors that affect the patients' trust with regard to service delivery by Nuwara-Elliya district hospital. This study comprises of two main objectives. The first objective of this thesis is to explore the citizen trust in the service delivered by Nuwara-Elliya district hospital and the second objective is to identify and analyze different factors affecting the patients' trust on the service delivery of public institution.

Before conducting the field works in Nuwara-eliya district hospital, the researcher had a reviewed of relevant literatures on the trust level in public institution in Sri Lanka; Mainly functional provisions and the service delivery by health institutions. It was followed by a theoretical framework developed by survey of trust concept and models of trust which ultimately aim to add value in the patients' trust in health institution. According this, the concepts of trust and models of trust (institutional trust and interpersonal trust) have been taken as the theoretical basis of this research to evaluate doctor patient relationship from three perspectives: The patient, the doctor and the institution (hospital).

The study is based on empirical research through the survey of the patients', observation of service delivery by hospital and interview of doctors from the service providers' face in Nuwara-eliya district hospital. Five doctors and 50 patients and 15 people who are accompanying with patients participated in the study. Both doctors (open-ended questions) and patients (closed-ended questions) were handed out a questionnaire survey. Both the qualitative and the quantitative information from primary and secondary sources have been used. In addition, to identify patients' trust and secondary sources were used to strengthen the

research. MS-excel were used to assemble frequency, percentage and cross tabulation of the survey.

A literature review of official Government publications and other national and international published literature, as well as discussion and depth interviews with patients and doctors and direct observation in out patient department in the particular hospital. Assessing the performance of institutional factors of the hospital was also achieved using data from official Government publications and the Medical Administrative Unit in the Nuwara-eliya district hospital.

The result showed that majority of the patients was come from estate sector and working as a estate worker and farmers. The study finds that among the characteristics of the patients, middle age group being fairly satisfied than elder patients', more respondents aged 25 to 50 years (30%) are satisfied than the young (70%) or elderly patients'. In terms of gender, female respondents (63%) are highly/fairly satisfied than male (52%) respondents. In terms of economic class (37%) middle income group being fairly satisfied and among the respondents (47%) of illiterate and primary level of educate people were satisfied than educated people. In terms of ethnicity (96%) of respondents from Sinhala community were happy with the services while (74%) of Tamil respondents were not satisfied with the services delivered by the hospital.

However, the characteristics of the patients verified the mixed results in general. Quality service is depends on effective doctor patient relationship and the level of trust in the health institution. Lack of communication skills of doctors and patients, lack of facilities and poor attention from hospital managements was another factor that impacts the quality service of the health institution. Understanding the doctor patient relationship is still not taken as an important part in health care practice. According to these findings the study confirms that the status of patients' trust in the services delivered by Nuwara-eliya district hospital is medium/fair level.

Contents

Chapter Three: Methodology

Chapter Four: Health care system in Sri Lanka

Chapter Five: Data presentation and analysis

Chapter Six: Summary and conclusion

List of Tables

List of Figures

List of Abbreviation

AO	Administrative Officer
CCP	Consultant Community Physician
CA	Chief Accountant
DD	Deputy Director
DS	Divisional Secretariats
DGH	District General Hospital
DBH	District Base Hospital
DDHS	Divisional Director of Health Service
DPDHS	Deputy Provincial Director of Health Service
FHW	Family Health Worker
MA	Management Assistant
MOH	Medical Officer of Health
MoH	Ministry of Health
MDG	Millennium Development Goals
OPD	Out Patient Department
PC	Provincial Councils'
PPO	Planning & Programe Officer
PHI	Public Health Inspector
PHNS	Public Health Nursing Sisters
PMHS	Provincial Ministry of Health Service
PSHS	Provincial Secretary of Health Service
PDGS	Provincial Director of Health
RDHS	Regional Director of Health Service
SO	Statistical Officer
WHO	World Health Organization

Acknowledgements

I express my sincere gratitude to Professor Kamala Liyanage, Senior Professior Department of Political Science, University of Peradeniya who provided me the opportunity to work on under her supervision. Her untiring intellectual guidance and caring supervision made me able to generate thoughts and ideas for the completion of my research.

Likewise, I would like to express my grateful thanks to Doctor S.K.Tawfique M. Haque, Director, MPPG Programme, North South University, for his valuable comments, guidance and support for the preparation of the thesis proposal and encouragement during the study programme. My sincere thanks go to Associate Professor Salaudin Aminuzaman, Advisor, MPPG Programme, Professor Emdadul M. Haq, Head, Department of General and Continuing Education, North South University, my course mates and all members of the MPPG Programme for their continuous support during the study programme.

I extend my hearty thanks and humble acknowledgement to Dr. Ishtiaq Jamil, Associate Professor, Department of Administration and Organization Theory, University of Bergen, Norway for his generous inspiration and intellectual guidance during my entire study period. Similarly, I would like to express my grateful thanks to the NOMA programme for providing financial support throughout the study programme, and to MPPG coordinators for selecting me as a student of the programme.

In this moment of time, I remember the cooperation of my colleagues of MPPG especially Yunusa Kafle from Nepal and other my friends from Nepal and Bangladesh. My hearty regards and thanks to all of them. Mr. R. Ramesh gave valuable comments for thesis chapters and helped me edit the chapters. My sincere thanks go to him. My humble gratitude to my parents for you are the everything to me. I pay my humble thankfulness to you all. Last but not the least, I express my earnest gratitude to them all.

CHAPTER - 01

INTRODUCTION

1.1 Background of the study

Trust is the major driving force for all human relationships. Citizens' trust in public institution is an incorporeal element. It carries an intangible idea which is largely determined by citizens' desire and expectation, awareness, essential and so forth in relation to a service provider either in the public or private sector (Mishler & Rose, 2001). According to Hall et al, the dimensions of trust in health care needs five important elements, such as fidelity, competence, honesty, confidentiality and global trust (Hall, Dugan, Zheng & Mishra, 2001). Trust is an essential tool for a successful institutional development. Trust has been studied in many disciplines-political, economic, sociological, psychology and institutional studies. However citizens' trust is very important and it is needed for democratic government. Low trust is seen as an indicator that the government must be doing something wrong or that the public service does not deliver it also is a reason for worry because low trust is seen to be associated with a decrease in civic behavior and undesirable voting behavior (Nye et al, 1997).

The government of Sri Lanka provides universal health care services to its patients'. In general, there has been increased interest over the past couple of decades in patients' trust in the health system. Also, Sri Lanka has an extensive network of public health units and hospitals spread across the country with free healthcare to all patients'. There have been several studies in Sri Lanka about the factors contributing to trust in the healthcare system. These studies cover the factors such as, delivery of services, better treatment, quality of services and efficiency of health care system. However, these studies do not edequatly cover the patients' trust in the health institutions.

Sri Lanka's first modern health care institutions were set up by the British in the 19th century. Simultaneously, Western, Ayurvedic, Unani, Siddha, Acupuncture and Homeopathy systems of medicine have been practiced in Sri Lanka. Significant achievements have been made in nearly controlling community diseases such as, leprosy, malaria, Japanese encephalitis, congenital syphilis, neonatal tetanus, lymphatic filariasis, etc, and the diseases such as dengue and some other disease managed successfully (WHO 2014).

The Democratic Republic of Sri Lanka has a parliamentary democratic system of government. Under the existing administrative system, Sri Lanka has been divided into 9 Provinces, 25 Districts and 331 Divisions of Divisional Secretariats. The provincial administration is conferred in the Provincial Councils, composed of elected representatives of the people, headed by a Governor who is nominated by the Central Government. Local government is the lowest level of government administration in Sri Lanka.

Under the present administrative system, Public health care services are delivered by health institutions of different levels in the country. According to the administrative structure there is one National Hospital and there are 20 Teaching hospitals, 03 Provincial hospitals, 18 General hospitals, 68 Base/District Hospitals, functioning in the country to deliver health care services. There are 17129 qualified doctors (a doctor per 1187 patients) and 29871 qualified nurses (a nurse per 683 patients) are working in the government hospitals (Central Bank: 2012). Following table give the number of public hospitals in Sri Lanka.

Table: 01

Number of Government Hospitals in Sri Lanka according to their Types

Types of Hospitals	No	
National Hospital	**01**	
Teaching Hospitals	**20**	
Provincial General Hospital	**03**	
District General Hospital	**18**	
Base Hospital Type – A	**22**	
Base Hospital Type –B	**46**	
Divisional Hospital type-A	**42**	(More than 100 patients Beds)
Divisional Hospital type-B	**129**	(Between 50 to 100 patients Beds)
Divisional Hospital type-C	**322**	(Less than 50 patients Beds)
Primary Medical Care Unit	**474**	(Central Dispensaries & Maternity Homes)
Board Managed Hospital	**02**	
Special Hospital	**05**	
Total	**1084**	

Source: *http://www.health.gov.lk/en/pdf/Hospitallist.pdf*

In the central level, the Ministry of Health is mainly responsible for the terms of complete health services. In the provincial level, there are nine provincial ministries of health and an equal number of Provincial Directors of Health services (PDHS) responsible for health care services. Deputy Provincial Director of Health Services (DPDH) is responsible for the management and effective implementation of all health services including public health services in the respective district. Divisional Director of Health Services (DDHS) is responsible for the divisional level health care services in Sri Lanka.

The Sri Lankan national health policy and the system of health care which are strongly committed to a free health policy of the government have contributed to the preservation of the free health system. The current national health policy has evolved over time, and an explicit health policy was first declared in 1996 (Annual Health Bulletin, 2012). Those policies are targtted to achieve the health-related goals envisaged through the UN Millennium Development Goals (MDGs), Mahinda Chinthanaya - Vision for the Future, Health Sector Master Plan 2007-2016 based on strategic frame work for health development and NHDP for 2012 - 2017. It covers the future developments in the whole sector under several strategies. The increasing importance on the achievement of the Millennium Development Goals, especially those related to health, was another significant keystone of the national health development process of health plans (WHO 2014).

The public health expenditure consists of recurrent and capital spending from government budget, external borrowing, grants and social health insurance funds (WHO, 2012). According to World Health Organization (WHO) Sri Lanka's expenditure on health (Public and Private) was around 3.2% of GDP or US$ 89 per head (WHO-2012). Health expenditure in Sri Lanka was last measured at 7.40 in the year 2013. Also number of international partners are active in the health sector in Sri Lanka, and they include UN Agencies (ILO, IOM, UNDP, UNFPA, UNICEF, WFP and WHO), international NGOs, multi-lateral and bi-lateral organizations (World Bank, ADB, JICA, Aus AID, USAID etc.) (WHO, 2014).

The public healthcare service in Sri Lanka had faced many challenges in terms of service delivery to the public. Low capacity and limited availability of specialty treatment in the healthcare sector being among them. In general, the out-patient departments of base and provincial government hospitals frequently see long queues and waiting times, exacerbated by unnecessary patient arrivals and inadequate facilities to support the demand (Standpoint Commentary, 2013).

The in-patient divisions of the main government hospitals also record high bed-occupancy. At the same time floor patients are a common occurrence. The lack of specialty treatment in rural areas, limited availability of drugs and lack of capacity have extended waiting periods which are the main issues in the public institutions.

The health sector in Sri Lanka is praiseworthy largely due to its effective public delivery system, providing both preventive and curative care at low cost. The health care service delivery system which includes different types of sections such as, Health Administration, Curative Care institutions, community health services and public health programs, training institutions, other resources for health care and financing mechanism. The population of Sri Lanka has easy access to a reasonable level of healthcare facilities provided by both state and private sector through the extensive network of Healthcare Institutions. Most of the people live within about 3 kilometers of a public healthcare facility. Both the government and private sector have been rapidly building and improving the infrastructure, quality of services and human resource in the health care system. The public sector accounted for 73% of the hospitals and 93% of the available capacity end of 2014.

The focus of this study is the doctor patient relationship in the healthcare services. This study is limited to the Out Patient Department (OPD) at the Nuwara-eliya district hospital in Sri Lanka. The people (plantation) who live under the privatized plantation management do not have equal access to public services in Sri Lanka. They also have limited connection with the public institutions. In this background, the present study aims to do a survey in the Nuwara-elliya district which has the highest percentage of plantation workers among its population. The Nuwara-elliya District is situated in the central part of Sri Lanka, it has eight local authorities. According to the 2012 census report, the total population in the district was 706588 (Census Report, 2012). Tamil being 57% and the rest being Sinhala and Muslims respectively. Within each district, there are several divisions, each in charge of a Divisional Director of Health Services who is responsible for the provision of complete health care services to a defined population, with special emphasis on protective and promotion of health care. The Nuwara-elliya district hospital provides services for a large number of citizens. Hence, there is a need to know the level of citizens' trust in this health care institution. Trust can which enhance the quality of services and develop the institutional performance a good understanding of trust in these settings will help to planning the national and universal health coverage.

1.2 Statement of the Problem

The healthcare relationship is based on trust, which is the patient's voluntary acceptance of his vulnerability in the expectation that the healthcare provider will do the best for him (Hall, Dugan, Zheng, & Mishra, 2001). Therefore, patients' trust is very important in the health care institution to develop the health services. Compared with many developing countries a majority of health institutions in Sri Lanka are resourced by different categories of trained health care workers.

The issues of patients' trust in public hospitals are highly relevant in the context of Sri Lanka, especially in the estate sector and rural areas. Trust between public institutions and citizens' imposes a special duty of honesty and disclosure on the government and its officials.

In general, lack of human resources (medical officer, nursing, paramedical staff, severe geographic misdistribution, insufficient facilities and service training) in the health care system in Sri Lanka has become a major problem in the health sector. The main reason for these shortage of medical staffs is that, those trained persons move to private hospitals or go abroad to seek better salary and advanced work environment (Sarath and Samarage, 2006). The lack of human resources has caused an obstacle to provide quality services to patients'. Also in Sri Lanka there is no overall human resources policy and development plan to improve the health service. This has become the main issue in the district as well as divisional hospitals.

A number of previous studies (Rannan-Eliya and Sikurajapathy 2009, Sri Lanka: "Good Practice" in expanding health care exposure to enjoy all serious health care system and Professor Dulitha Fernand, Dr. Nalika Gunawardena, Dr. Chrishantha Weerasinghe, Rapid Assessment of Essential Public Health Functions in Sri Lanka) illustrate that various factors which influence the levels of trust in the public institution and health service delivery system, performance of the institution, quality of service and health reforms in health sector. However, these studies does not address the patents' trust in the health institutions. Some studies done on citizens'/ patients satisfaction, there is no specific reference to patients' trust in the health institutions. Also, a majority of the studies done on health sector and public institutions are project based.

A study done on 'Measures of Equity, Efficiency and Quality of Selected Health care Services; 2008, found that there were no incidents reported against discrimination. However, language barrier and lack of personal relationships with the health staff in the Nuwara Eliya hospital were pointed out by many patients' of Tamil speaking estate community.

According to another study, at present the health care institutions of Sri Lanka are facing many challenges. Those are:

- Investment in health
- Attaining millennium development goals
- Controlling life style diseases
- Taking Sri Lanka towards global best
- Strategic health plan for Sri Lanka to address, - organizational changes of care; health system challenges; poor governance and performance monitoring; aging population and emerging diseases (Mahipala, 2011).

There are 188 health institutions in the Central Province plantation sector in managed by Regional Provincial Councils (RPC). All preventive, Promotive & basic curative care are provided by the health staff on the plantations. The main problem in the plantation sector is the non availability of qualified staff to deliver the essential health services. Another problem is drug shortage; it leads to reduced quality of health care received by patients who in the mean time cannot afford to purchase prescribed drugs. Drugs shortage makes the patients dissatisfied with this hospital.

Some researchers have found that compared to other district hospitals, Nuwara-elliya hospital lack of facilities and the people face more difficulties in receiving services. They are face difficulties mainly in communicating with the doctor and other medical staff. In such situations, the doctors seek help from a person who can speak both languages (Sinhala and Tamil). In many cases a majority of the patients speaking Tamil as the main language while most of the service providers speak only Sinhala.

1.3 Research Questions

1. What is the level of patients' trust towards the service delivered in the district level hospitals?
2. What are the factors affecting the patients' trust with regard to service delivery at Nuwara-Elliya district hospital?

1.4 Objectives of the Study

This study intends to know about factors that influence the patients' trust in the Nuwara-eliya district hospital. Specific objectives of this study are:

i. To examine the patients' trust related to the service delivered in the Nuwara-Elliya district hospital.
ii. To identify and analyze different factors affecting the patients' trust on the quality of service delivery in public institutions.

1.5 Significance of the study

The public institutions are given a significant place in the development of Sri Lanka. Presently, their activities are not limited to delivering quality services. Since independence, the successive governments of Sri Lanka have taken a number of initiatives to provide quality services to the citizens'. Citizens' trust is an important and powerful tool for the adoption of such institutions. Also, providing services to outdoor patient are still a major issue faced by the health sector in Sri Lanka. Although a considerable number of research studies have been conducted on the health care services, a limited number of them have deal with the patients satisfaction in the public institutions.There are studies on citizens' trust in public institution, but there is almost no research found to have addressed the patients' trust in the health institutions. A distinct feature of the present research is that it emphasizes on patients' trust in the health system among the doctors and patients. Apart from this most of the researches on the public institutions are outdated, in the context of the phenomena of the health of structural changes. A trivial amount of studies have been conducted in the recent years.

Therefore, it is a timely need to conduct a research in order to examine the level of the current patients' trust in the health system in Sri Lanka. This study may provide new knowledge to policy makers and implementers about the ground level realities related to their trust on public health service. At the practical level, the results of this study can be used to deliver quality service and to develop mechanisms for ensuring smooth and effective relationship. Furthermore, it will enable the health institutions to improve the institutional amenities between the service provider and service receiver.

1.6 Limitation of the Study

This present study is confined to examining the issues related to patients' trust in the public health institution in Sri Lanka, and specially the major focus of this study is to find out how far and to what extent doctor - patient (OPD- Out Patient Department) relationship influences the level of trust in the public institution. However, the basic data is especially applicable to the Sri Lanka's health care system. Furthermore, among the public hospitals and clinics in Nuwara-eliya district, this study only represents doctor patient relationship regarding one hospital and one unit in the hospital. This study does not cover all departments and the administrative staff attached to the hospital. Also findings of this study may not be relevant generally the other units of the hospital nor other hospitals throughout Sri Lanka. But patients' trust is a useful tool to improve the health care service delivery.

1.7 Organization of the Study

The thesis has been organized in *six* chapters: *"Chapter One – Introduction"* establishes the foundation of the research by presenting a brief background of the study and research questions. It also presents the significance and rationale of the study with the scope of the research. *"Chapter Two - Literature Review & Theoretical Framework"* describes conceptual issues related to current study followed by a discussion of the relevant literature. It also discusses about the relevant theoretical framework and analytical framework of the study. *"Chapter Three – Methodology"* focuses on the methodological description with an elaborative discussion on research approach, research strategy, unit of analysis, data collection and analyzing strategy. "*Chapter four - organizational structure of Nuwara-elliya district Hospital"* describes the major features of the hospital structure and whether it supports to maintain a positive doctor patient relationship and the level of trust. "*Chapter five*

– *Research findings and Analysis"* presents a critical analysis of the collected data. The *Chapter six* - concludes the study by suggesting some recommendations and draws attention to the scope for further research. This chapter also tries to relate hypotheses of the study to its empirical findings.

CHAPTER - 02

LITERTURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter presents literature review and discusses on theoretical framework to develop an understanding of patients' trust. I chose one of the public institutions in Sri Lanka as the location of the study. Trust is believed to be particularly prominent to the provision of health care because it is a setting characterized by uncertainty and an element of risk regarding the competence and intentions of the practitioner on whom the patient is dependent (Alaszweski 2003; Titmuss 1968, Cited in Michael Calnan and Rosemary Rowe 2005).

Trust is important for a successful doctor–patient relationship and also it has increased attention in the health system over the past couple of years. The fundamental basis of a healthcare relationship is trust (Gopichandran, 2013). The changing socio-political, economic and healthcare environment in Sri Lanka may be creating different types of doctor-patient relationships. Therefore there is a need to look at the 'trust in healthcare system' in the context of Sri Lanka, in contrast to the number of literature considering trust from the patient perspective, trust from the practitioner perspective and from an organizational perspective.

Since the issue has come up, many academics, policy makers, practitioners, researchers and common people have also developed different approaches and models to measure it. One of the most widely used classic theories regarding trust is institutional or organizational theory, and generally, in the models of trust, delegates authority to an individual as well as organization to act in their interests and assures the trust via socio political and economical incentives and sanction.

This chapter is divided into four parts. The first part explains different conceptual issues. The second part is about a brief review of related literature on citizens' trust. The third is to explain the theoretical point of the study. The fourth part presents the analytical framework of the study. The analytical framework of the study is grounded on the literature review and theoretical framework. The arrangement of the thesis is structured according to this framework. The institutional model and the interpersonal models have also been placed under this wide range of trust concept in order to build the analytical framework.

2.2 Review of Related Literature

Vast literature has shown that effective communication in medical treatment leads to improved health, functional and emotional status, and fulfillment with medical treatment, clinician satisfaction, and reduced medical malpractice risk (Wong & Lee, 2006). This research specifically aims to analyze the value of doctor patient relationship. Literature review is first conducted to describe the importance of patients' trust in health care.

2.2.1 Citizens' trust in health care

A basic level of trust is important for any transaction between and among human beings. Trust is an important value in health care. The vulnerability associated with being ill may specifically lead trust in medical settings to have a stronger emotional and instinctive component (Coulson 1998 & Hall et all 2001). According to Calnan and Rowe 2004, they found that the trust relations in health care (mainly carried out in the United States has addressed pressure to patient-provider relationships and trust in health care systems from the patient's perspective, but studies in the organizational literature suggests that trust relations in the workforce, and between providers and managers, may also influence patient-provider relationships and levels of trust (Gilson, Palmer, & Schneider 2005). The patient trusts that the doctor will not resort to any kind of exploitation. Vulnerability, power differential and exploitation are involved in the concept of trust in health care.

Trust also appears to be an issue to patients as well as health care providers. A number of studies investigating patients' experience of health care trust emerged impulsively as a quality indicator, with patients suggesting that high quality doctor-patient connections are characterized by high levels of trust (Safran et al 1998). Trust in health care is usually defined as a set of expectations that the patient has from the doctor and the health care system to help them heal. This set of expectations includes appropriate diagnosis, correct treatment, non-exploitation, genuine interest in the welfare of the patient and transparent disclosure of all information. Trust, although highly correlated with patient satisfaction, is believed to be a distinct concept (Thom & Ribisi, 1999). It has been suggested that trust is a more sensitive indicator of performance than patient satisfaction in health care (Thom, Hall, & Pawlson 2004). From an organizational perspective trust is believed to be important in its own right. Public and patient trust in health care in Sri Lanka appears to be shaped by a variety of influences. From a macro perspective, any change in the levels of public trust in health care

institutions appears to take partly from top-down policy makers that have changed the way in which health services are organized and partially from changes in public attitudes to healthcare.

2.2.2 Literature Reviews/ Previous Empirical Study on Citizens' Trust

The number of publications on trust has been increasing significantly in the present world. There have been several studies in the developed counties about the factors influencing trust in healthcare. In a typical resource-deprived setting in Texas, a study revealed that cultural, ethnic, linguistic and social factors play a significant role in trust in healthcare (Franzini; 2008 Cited in; Gopichandran & Chetlapalli, 2013). Some of the existing literature which is related to Sri Lanka's health institutions indicated the issues related to health care system and their practice. However, little studies have been done on citizen trust in public institution, especially in doctor - patient relationship and consequently, a number of conceptual frameworks have been developed to explain the concept of trust along with the growing interest in public institutions.

As interest in citizens' trust in health care has grown, numerous conceptual frameworks have been developed to explain the concept. **Gopichandran and Chetlapalli,** The matrix provided by them covers perceived competence, treatment assurance, and willingness to accept drawbacks in health care, loyalty, and respect for the doctor. These are the major dimensions which reflect the level of trust in health care. To determine the level of trust in health care it is necessary to assess the level of the patient comfort with the physician and health facility, personal involvement of the doctor with the patient, behavior and approach of doctor, economic factors, and health awareness (Gopichandran and Chetlapalli, 2013).

A study from Sri Lanka showed that even in the presence of a robust public health system, trust in health care seems to rest on private providers due to perceived quality of care (Russell: 2005 Cited in; Gopichandran & Chetlapalli 2013)

A study done by **Steinar Askvik, Ishtiaq Jamil and Tek Nath Dhakal,** has emphasized that more the trust citizens have in public institutions and the process of governance, the closer the relationship will be between the state and society. Trust is high for a number of professional institutions, such as schools and hospitals. It is also quite high for local government institutions. Trust in the parliament and the government is much lower. Furthermore, this study reveals a weak relationship between institutional trust and identity variables. And also the demographic and social characteristics of participants, such as caste,

and religious and political affiliations, have some significance in explaining the level of citizens' trust in political and public institutions. Such trust primarily depend upon how citizens assess the performance of these institutions (Askvik, Jamil and Dhakal, 2011).

Muhammad Anisuzzaman (2012), views that within a bureaucratic organization, old aged employees are more trusting and the middle aged employees within the organization are less trusting. It is also found that less educated employees show high trust in co-workers and the highly educated employees show less trust in coworkers (Anisuzzaman, 2012). As an aside **Sarbani Kattel** states that in his findings citizens' trust has come from four major issues such as: to determine the status of communication; to determine what effect demographic variables of patients have upon communication in the doctor- patient relationship; to determine whether the organizational structure and procedure affect doctor communication with patients, and finally, to examine if patients play an active role in interacting with doctors.

Tom Christensen and Per Li1egreid (2005) have pointed out that, trust is measured in terms of particular support-as indicated by people's satisfaction with particular public services and compared with political culture and demographic actors. They argue that as long as people have a general level of satisfaction with how the democracy works in a country, they will also have a high level of trust in government. According to that concept they gave three general characters to government:

- A high level of trust in one institution is likely to extend to other institutions
- Political and cultural variables are the strongest overall effect on differences in people's trust in government
- Citizens who are satisfied with specific public services generally have a higher level of trust in public institutions than citizens who are dissatisfied.

The study of trust in government has been almost used macro-level analysis. **Virginia A. Chanley Thomas J. Rudolph Wendy and M. Rahn (2000)** suggest that trust in government is influenced by social-cultural factors and public trust in government as unifying concepts that link together a network of subordinate concepts. The result of this study is to provide new evidence of public concern about understanding public evaluations of the national government and new evidence of how declining levels of trust in government may influence elections and domestic policy making. With empirical research they found that more positive evaluations of the economic feature lead to an increase in trust in government.

Ezckiel, J.Emanuel and Linda L. Emanuel 1992, focus on four models of the physician-patient relationship. The authors discussed about the physician- patient relationship needs to be redefined to allow both the physician and patient to take an active role in treatment decisions. In this study they **proposed paternalistic model, informative model, interpretive model and deliberative model**. In this study they added the following six points to justify these models.

- The deliberative model more nearly embodies their ideal of autonomy;
- The society's image of ideal physician not limited to one who knows and communicates to patient relevant factual information and competently implements medical interventions;
- The deliberative model is not a disguised form of paternalism;
- Physician values are relevant to patients and do inform their choice of a physician'
- Physicians should not only help fit therapies to the patients elucidated values, but should also promote health related values
- Many physicians have a lack of training capacity to articulate values underlying the recommendations and to persuade patients that these values are worthy.

To examine the relationship between interpersonal trust at the organizational, managerial and co-worker level and organizational learning capability, **Aninha L. Lobo and A. M. Dolke,** contacted an exploratory study of 147 managers from the manufacturing and service sector. They found how trust impacted at the organization level, managerial level and co-worker level. For this research they used Organizational trust and inter personal trust to learn capability of interpersonal and organizational process and performances.

In concentrating specifically on citizens' trust in public institution literature in Sri Lanka, one can identify a substantial amount of publications and empirical studies conducted on trust and satisfaction related issues. Both national and international writers have shown great interest on various issues on trust in Sri Lanka. For an example, Ravi P. Rannan-Eliya and Lankani Sikurajapathy (2009) depict some basic concepts on Sri Lanka: "Good Practice" in Expanding Health Care Coverage. **Ravi P. Rannan-Eliya and Nishan de Mel** wrote on Resource Mobilization In Sri Lanka's Health Sector and **Dulitha Fernando, Nalika Gunawardena and Chrishantha Weerasinghe** carried out study on Rapid Assessment of Essential Public Health Functions in Sri Lanka, Country cooperation strategy- **WHO**, and

also Annual Health Forum Secretariat and Annual health bulletin also have been considerable importance as literature in health sector in Sri Lanka.

The rationale for citing above Sri Lanka related studies is to express that there have been a considerable amount of studies accomplished regarding the health sector, mostly focusing on effectiveness, quality of service, satisfaction, service delivery and infrastructure and so on. However, only a very few studies have been conducted to address the satisfaction issues in the context of Sri Lanka. There has been no study done on patients trust in the health care institutions in Sri Lanka.

One of the most significant works, regarding the health care in Sri Lanka, is "Good Practice" in Expanding Health Care Coverage", written by Ravi P. Rannan-Eliya and Lankani Sikurajapathy (2009) where they have examined the economic, socio, demographic aspects of the health care system. They have also focused on health service delivery system and health coverage reforms in the context of Sri Lanka, that inspired me to use as the theoretical guideline in my research. Dulitha Fernando, Nalika Gunawardena and Chrishantha Weerasinghe (2006) have also framed as their theoretical base of study in the district and divisional level health service delivery system. Ravi P. Rannan-Eliya and Nishan de Mel have analyzed the Resource Mobilization in Sri Lanka's Health Sector. They have stated in the findings, the Estate Tamils are unusual because until the mid- 1980s they had been disenfranchised and not considered to be part of the national population. They did not enjoy access to publicly-financed health services that were considered the right of all Sri Lankan citizens.

Though these studies have covered a number of indicators in the health institution, but an in-depth study on trust has not been done. However, they have mentioned some basic accessible key mechanisms and process of service delivery in health care. It can be considered that these studies are a brief overview of satisfaction level of Sri Lanka. Goudge and Gilson in their review on researching trust in health care, indicate the importance of qualitative studies to understand the contextual nature of trust before quantitative studies can be done (Goudge, Gilson, 2005 ; Cited in Gopichandran and Chetlapalli, 2013). In keeping with this idea, this study was done to understand the dimensions and determinants of trust in health care and also go much deeper to analyze the citizens' trust in the health institution in the Sri Lankan context.

2.3 Conceptual Issues

2.3.1 Trust

Many scholars have paid attention to the problem of defining trust, but a comprehensive and universally approved definition has remained intangible (Krammer, 1999). One of the most widely cited definitions of trust is given by Mayer, Davis and Schoorman (1995). They define trust as "the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control the other party", (Mayer et. al., 1995; 712). Trust is believed to be particularly prominent to the provision of health care because it is a setting characterized by uncertainty and an element of risk regarding the competence and intentions of the practitioner on whom the patient is dependent (Alaszweski 2003; Titmuss 1968, Cited in Calnan and Rowe, 2005).

A trusting person, group or institution will be "freed from worry and the need to monitor the other party's behavior, partially or entirely" (Levi and Stoker 2000, 496). In that sense, trust is an efficient means for the lowering of transaction costs in any social, economic or political relationship (Fukuyama, 1995). According to Fukuyama, trust has increasingly come to be recognized as a critical element in democratic governments. The willingness to trust strangers promotes civic engagement and community building and helps overcome the dilemma of collective action (Fuckuyama, 1995, Putnam, 1993 &Uslaner, 2002). The result of the higher trust has been associated with greater citizens' involvement in the politics, lower the corruption, effective and efficient public services and economic development.

Trust, it is said, contributes to economic growth and efficiency in market economics, to the provision of public goods, to social integration, co-operation and harmony, to personal life satisfaction, to democratic stability and development, and even to good health and longevity (Delhey & Newton, 2003).

'Trust is one of the most important synthetic forces within society' (Simmel, 1950: 326). Trust has been classified in many ways – micro-level and macro-level, formal and informal. The aim of this section is to give an outline of different forms and types of trust. There are two broad thoughts about trust. (1) Trust is an individual property (2) Trust is a property not of

individuals[1]. To begin with the concepts of social scientist, they identified six types of trust in the contemporary world summarized in the following table:

Table: 2

Six theories of trust and related variables

Theories	Variables
1. Individual Personality theory	Optimism, life control
2. Success and well-being theory	Income, social status, life satisfaction, job satisfaction, happiness, anxiety
3. Social Voluntary organisation theory	Membership of voluntary associations Networks of friends
4. Social network theory	City size, satisfaction with the community, community safety
5. Community theory	Social conflicts, satisfaction with democratic institutions, political freedom, public safety
6. Societal theory	

Source: Jan Delhey and Kenneth Newton ;2003.

The literature on social trust contains different theories of the origins and determinants of social trust, and also it varies with organizations.

People's satisfaction with public services as related to trust can be seen in a broader or narrower performance perspective (Bouckaert & Walle, 2001). Satisfaction with public services may span a large number of different elements, which are of both a process and output nature (Bouckaert & Walle, 2001:25-29). When the individual's experiences are largely good, he or she tends to trust the state (Kumlin, 2002; Rothstein & Steinmo, 2002). The people may be satisfied with the efficient services, information concerning services, the accessibility and friendliness and fairness of the service providers they meet. The situation regarding service delivery and satisfaction is, of course, further complicated by the fact that people's needs and perceptions of what services should provide be different (Aberbach & Rockman, 2000).

[1] (1) Trust is an individual property - it is associated with individual characteristics, either core personality traits, or individual social and demographic features such as class, education, income, age, and gender.
(2) Trust is a property not of individuals but of social systems (Jan Delhey and Kenneth Newton 2003).

2.3.2. Types of trust

The trust is explained in different ways by different disciplines. The economists define it as trusting the institutions and their accounts while the psychologists explain it with the reliable and unreliable behavior of the individual and the sociologists use it as the reliable, fair and ethical behavior in interpersonal relations (Milligan, 2003; 20). Accordingly there are three types of trust prevailing in an organization, such as general trust, organizational trust and interpersonal trust. The study went beyond the interpersonal trust and institutional trust to cover different aspects in order to investigate complications and significance of citizens' trust in the public institutions.

2.3.2.1. Interpersonal trust

The interpersonal trust was defined as,

> "a belief in the trustworthiness of the other person(s); a belief in the willingness and ability of the other person(s) to advance the common good, leading to trusting behaviors that imply reliance on, or confidence in some process or person(s)." (Lobo and Dolke, 2003).

According to Whitener et al (1998), a model concerning the relationship between the manager and the employees which lists some basic behavior of the superiors, such as;

- Consistency in acts,
- Honesty in acts,
- Sharing and distributing the control,
- Correct and explanatory communication,
- Showing interest and concern (Whitener et al, 1998).

Interpersonal trust is a complex concept with different bases and factors, which operates at multiple levels in the organization to facilitate knowledge exchange. An employee will be better able to attain and share informal knowledge if s/he does not expect harmful effects from that action. When trust is absent, relationships form distress, deep and hidden aggressiveness rather than goodwill.

Interpersonal trust has both a cognitive and an affective component. The cognitive side of trust pertains to the rational decision to another party. It has three qualities based on trust, such as responsibility, dependability (reliability), and competence, which provide evidence of the

presence of trustworthiness (Lewis and Weigert, 1985; McAllister, 1995).These three qualities of trust may be relatively consistent with dyadic relationships involving co-workers and supervisors. The component affective is affect-based trust involves a deep emotional investment in a relationship (Lewis and Weigert, 1985; McAllister, 1995). A trustor's deep care and concern of the trustee characterize such a relationship. Past measures of trust in organizational settings suggest that competence and responsibility are central elements (Butler, 1991; Cook & Wall, 1980). Therefore, interpersonal trust is important to understanding the organizational learning capability, knowledge gaining and distribution.

2.3.2.2. Institutional trust

Over the decades a number of undeniable arguments and empirical findings have been put forward to support the study of institutional trust. Most fundamentally, institutional trust has commonly been conceived of as a democratic good in and of itself as well as an important weight of a democracy's political health (Dalton 2004; Pharr and Putnam 2000).

According to Calnan and Rowe, some of the trust relations literature in health care have formed threats to patient-provider relationships and trust in health care systems from the patient's perspective (Calnan & Rowe 2004), but studies in the organizational literature suggests that trust relations in the workforce, between providers and managers, may also influence patient-provider relationships and levels of trust (Gilson, Palmer, & Schneider 2005).

According to Taylor (1990) organizational trust has four important impacts on the relationship between the employees and the organization, such as:

(1) Facilitating management,

(2) Facilitating changing high risks,

(3) Facilitating effective use of resources,

(4) Affecting all activities of the organization.

From an organizational perspective trust is believed to be important in its own right for instance, it is essentially important for the delivery of effective health care and has even been described as a collective good, like social trust or social capital (Gilson 2003). A doctor's power relates to his/her position and role within the organization and managers act as

administrators, taking strategic decisions as to how services are to be delivered and how resources are to be used to doctors. “The willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control the other party”, (Mayer et. al., 1995:712). Therefore the interpersonal trust and institutional trust are very important to measure the level of trust.

2.3.3 Trust in public institution

Trust covers general and systemic factors; it has been more specific an experience with the government and its services. Also it has the dynamic interaction with the legislative as well as the and administrative system. Citizens are often skeptical toward the public sector when asked in general and abstract terms, but relatively satisfied with more specific services. Generally speaking, they desire a greater amount of services delivered from the public sector (Bennett & Bennett, 1990; Goodsell, 1994; Huseby, 1995; Ladd, 1983). Performance of public sector and its working influence is building trust in government institutions (Asfar, Kahkohen & Lanyiet et.al; 1999: 22-23).

Citizen trust in government is the core concern in public administration, especially since it has been seen as declining over the last several decades (Denhardt and Denhardt, 2009). Some scholars in public administration have paid considerable attention towards enhancing opportunities to restore citizen trust in government (Bonson et al, 2012). Citizen with a high level of trust in one institution also tends to trust the other institutions, whereas distrust in one is associated with distrust in others. Therefore trust in government is a growing pattern. La porta et. al (1999) and Knack & Keefer (1992) have found through cross country survey the citizens’ trust to be a matter of efficiency of judiciary, corruption, quality and its working citizen participation in public service.

Trust in public institutions varies significantly with political, cultural and economical factors. Generally citizens who are integrated, involved, and engaged in the political system generally have an extensively higher level of trust in most public institutions than people who are less integrated, less involved, and less engaged (Christensen and Laegreid, 2005). Also these factors have an influence on levels of trust in public institutions. Trust in government has both institutional and personal aspects. People may trust both the systems as such and individual actors they encounter or observe which may include both central political leaders and actors in the administration and public service sector.

Citizens' trust in public institution is a general character, with some varying features. Variations in trust among the private institutions are relatively small, but trust is highest in the public institutions, and also there is a strong correlation between trusts in the different institutions everywhere. Citizens' satisfaction with public services is connected to their trust in the government. This finding is in accordance with broad Norwegian studies of trust in local government (Rose & Pettersen, 2000). People who are satisfied with the treatment they receive from the public health, employment, and social services generally have a higher level of trust in public institutions than citizens who are not satisfied with their treatment.

2.3.4 Trust in Doctor Patient Relationship

Blomqvist (1997) claims that there does not seen to be a universal definition of trust possible because trust is always situation specific. According to him, trust is a collection of expectations, confidence, and an unwritten agreement and is optimistic of vulnerability in health care system. Therefore, trust is a set of expectations that the healthcare provider will do the best for the patient. As such a number of scholars in social science assumed different types of definition on trust in health care.

- patient trust in the physician as a *collection of expectations* that the patients have from their doctor
- It was a *feeling of reassurance or confidence* in the doctor
- Is "an *unwritten agreement* between two or more parties for each party to perform a set of agreed upon activities without fear of change from any party"
- Is "an *optimistic acceptance of vulnerability of the patient* that the physician will do the best in treating him/her with good will"(Hall, Dugan, Zheng & Mishra, 2001).

According to Thom, Hall and Pawlson, trust is a more sensitive indicator of performance than patient satisfaction might be used as a potential 'marker' for how patients evaluate the quality of health care (Thom, Hall, & Pawlson 2004). It might also be argued that all trust relationships have a conditional element to them and that traditionally there has been widespread ambivalence about scientific medicine and medical practitioners (Calnan, Montaner, & Horne 2005). Successful relations between doctor – patient, are based on mutual respect for their different capabilities and knowledge; and communication skills. Also providing information would be important in building trust.

Trust is important to patients as well as health care providers. Trust would be important in successful doctor-patient relations as also has been defined, to increase self-reported good health among patients. Trust facilitated commitment to the organization, enhanced collaborative practice between clinicians and was associated with satisfaction and motivation (Gilson, Palmer, & Schneider, 2005). Trust is important because confidence on trust leads to increased flows of information between individuals and the organizations and at the same time, the lack of adequate information to patients, poor communication skills of doctors and uncertainties about conflicts of interest naturally, lead to doubts.

Erickson (1963), assumed that trust is an element of life. It begins with birth. The basic way of getting to know the people for a new born human being is to decide if they are reliable or not. The model of trust in healthcare has developed significantly, and there are a number of models applied in the health care system. However, any doctor-patient relationship essentially discovers the susceptibility of the patient to the doctor, with patients giving their body to the doctor in good confidence that he/she (doctor) will take care of them.

Trust is important for a successful doctor–patient relationship, and also attention to it has been increased over the past couple of years in the health system. The fundamental basis of a healthcare relationship is trust (Gopichandran, 2013). The changing socio-political and healthcare environment in Sri Lanka may be creating different types of doctor-patient relationships. There is a need to look at the 'trust in healthcare system' in the context of Sri Lanka, in contrast to the number of literature considering trust from the patient perspective, trust from the practitioner perspective and from an organizational perspective.

2.4 Theoretical Stance of the Study

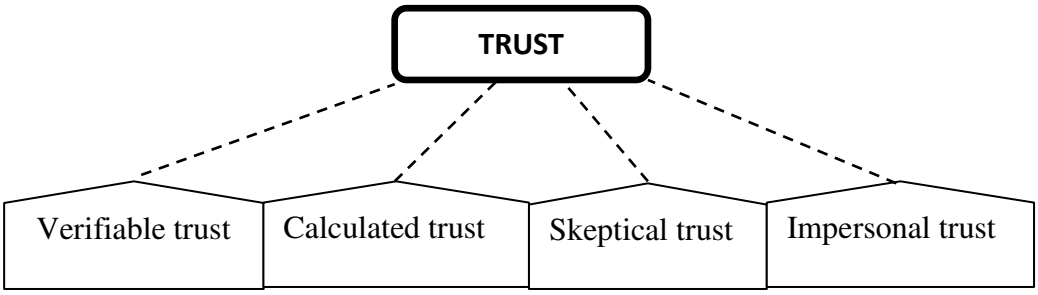
The provision of health care is still characterized by uncertainty and risk and there is evidence that not only are patients skeptical of institution confidence building mechanisms such as performance ratings, but that interactions between managers and clinicians continue to rely on informal relations and unwritten rules rather than performance management (Goddard & Mannion 1998).

Trust in healthcare is a very important phenomena in the contemporary world. To the understanding of trust in the health care, some of the scholars provide different types of expectations that the healthcare provider will do the best for the patient. There has been a

rapid growth in technology in the medical field starting from the late 20th century. This has resulted in major advances in the understanding of disease processes, and in the diagnosis, treatment and course of diseases (5). Using evolving concept of trust, Vijayaprasad Gopichandran (2013) provided a broad framework to address the trust in the health care. This approache has been utilized by some studies like trust in health care. His framework comprises four distinct categories of trust concern, such as:

Figure: 1

Categories of trust



Source: Own compilation based on concepts of Gopichandran, 2013

These four categories almost cover the trust in health care. A brief description of these trust model is as follows:

Verifiable trust: The development of information technology has given access to information and thus can verify the doctor's decisions. Patients expect that the doctor will do what is best for them. But they are also alert enough to ask questions and verify the doctor's advice if needed. This relationship has been described as "verifiable trust" (Lee & Lin, 2009).

Calculated trust: Autonomous patients may choose to have "calculated trust" in which they reflect on their choices and make a calculated choice to trust the doctor.

Skeptical trust: The patient's strategic acceptance of his vulnerability while remaining skeptical in the belief that money determines trustworthiness.

Impersonal trust: Patients gather information about the disease and treatments, and the trust they develop is more in the standardized protocols and treatment procedures than in the physicians. This makes the trust impersonal.

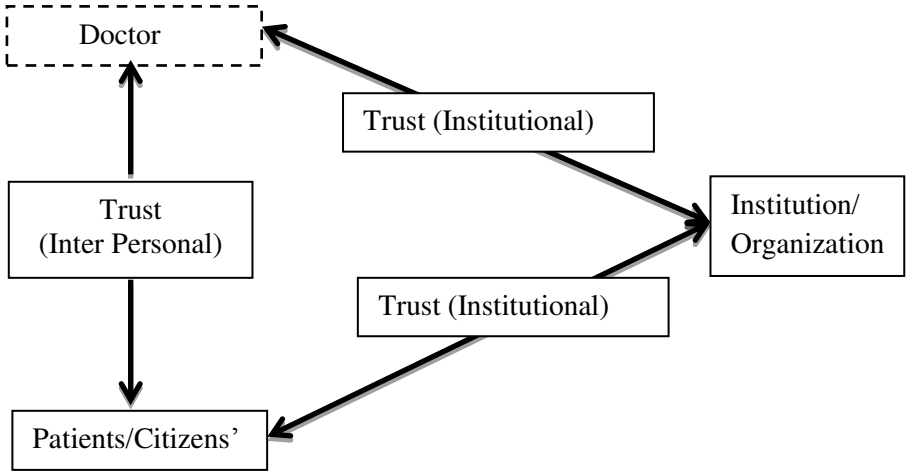
In this context, I will provide a framework that can address a wider trust relationship in universe. The purpose of the study is to describe the patients' trust in health care from a

broader perspective and theoretical framework, undoubtedly. The descriptions of trust models are as follows: The models presented here are to identify the level of trust between physician and patient, to the extent trust is eyeless or well educated. The proposed study explores the relationship between trust at the organizational and doctor patient level.

The trust relations in health institutions can be varied at the micro level between an individual patient and doctor, between doctor and organization or between a patient and institution, and those at the macro level which include patient and public trust in doctors and institution in general.

Figure – 02

Framing trust relationships in health care



Different theoretical frameworks for addressing the question of trust in healthcare have already been discussed in the literature section. Most of them highlight a particular aspect of trust. Some of them focus on the service delivery in the health sector, while the rest focuse on the process of trust in health care. Some are given more emphasis on satisfaction level and functional level rather than citizens' trust in health care. Some are dedicated to the health institution.

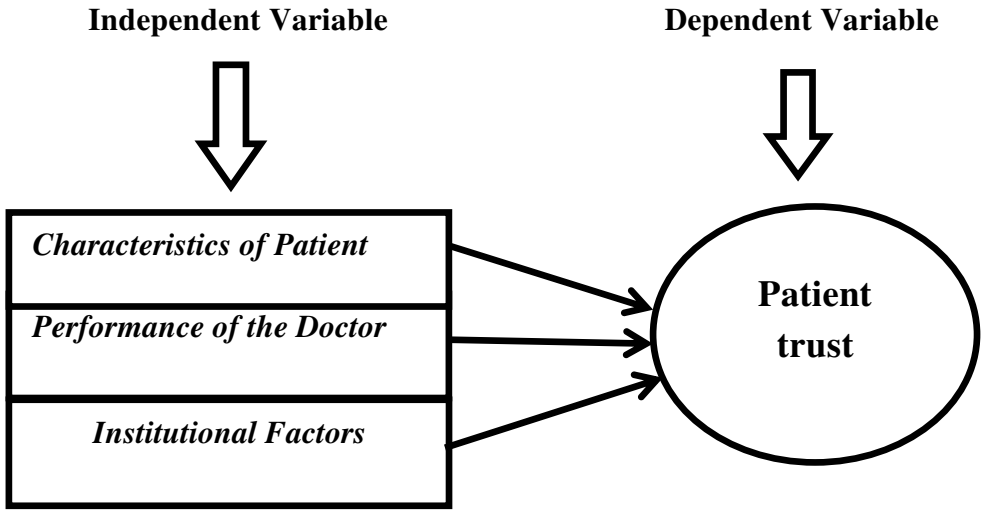
2.5 Analytical Framework: Linking Variables into Theoretical Framework

The basis of analytical framework of present study covers the concept of trust and broad theoretical framework. In the light of different theories used in the study and previous literature on trust, three independent variables were chosen with a view to studying the state of citizens' trust in the public institutions in Sri Lanka. In accordance with the above theoretical discussion and the concept of trust developed from the study of literature, an

analytical framework has been developed containing three independent variables that are likely affect the only dependable variable 'Doctor Patient Relationship'. These independent variables have been categorized as three different aspects: Individual, doctor and institutional level. The following framework intends to show a relationship between dependent and independent variables through the theoretical framework and review of literature of the study.

Figure: 3

Analytical Framework of the study



The foundation of the above analytical framework lies on the basis of theoretical framework and review of literature, the analytical framework of the study itself being further guided by the concept of trust and models of trust. This framework displays a causal link between doctor and patient and chosen variables. The first variable *characteristics of patient* have been drawn to see how patients are accountable to patron. The variable *performance of the doctor* has employed to see the level of trust between the physician and patient. The following variable *institutional factors* have been particularly employed to explain how patients trust smoothens works in the health institution. It is noteworthy that the variable patient trust is applicable to all three variables of this study.

2.5.1 Variables of the Study

2.5.1.1 Dependent Variable: Patient trust

The dependent variable of the study is "*Patient trust"*. It is operationalized through three different independent variables mentioned in the above figure that have been established from the proposed theoretical framework. Present study considers the citizens' trust in public institution definition as the operational definition of patient's trust. The purpose of present research is to find the level of trust in a broader sense and the institutional trust given definition is a precise match to current research. The definition of patients trust is given bellow.

2.5.1.2 Independent Variables

2.5.1.2.1 Characteristics of patient's

The health care system reflects an emphasis on the patient needs and preference. The available of information reveals an increasing expectation that patients drive changes in the system for improved quality, efficiency, and effectiveness (Reid, Compton, Grossman & Fanjiang, 2005). To understand patients' own illness in terms of their subjective experience and meanings of illness, to identify possible psychosocial causes of illness of the patients self concept and everyday activities, and to understand patients' beliefs, priorities and preferences for treatments, are very important in the health care system. According to this perception Mead & Bower examine the key aspects of a patient consultation in the following manner.

- Biopsychosocial perspective (willingness to become involved in the full range of difficulties patients bring to their doctors and not just their biomedical problems)
- Patient-as-a-person (understanding the individual's experience of his or her illness)
- Sharing power and responsibility (mutual participation of patient and doctor)
- Therapeutic alliance (creating a situation in which the patient feels able to be involved in treatment decisions)
- Doctor-as-a-person (doctor is aware of and responds to patient cues)

(Mead & Bower, 2000).

The trust context, in which the doctor patient relationship takes place, is shaped by characteristics of the patients (e.g., age, gender, occupation, education, ethnicity etc.). The indicators are given below.

Gender: Male and female patients be different in their communicative style. According to some studies women are not more likely than men to express their feelings and psychological issues to a male doctor.

Occupation: The occupation or status reflects education and income prominence of patients. For example (less query asking, less opinion giving, less affective feeling, less liking for decision making). This possibly reflects their greater knowledge, confidence and the smaller status gap between doctor and patient. For instance, a study done on 1470 general practitioners or consultants showed that only 27% of working class patients sought clarification of what the doctor had said compared to 45% of middle-class patients. These requests for information by patients in turn led to fuller explanations being given by doctors and a rather longer consultation (Tuckett et al, 1985).

Ethnicity: Ethnicity is also a characteristic which explains the ethnic difference & how it breeds more particularized, than generalized trust. Ethnic difference is assumed to generate a high trust (Fukuyama, 1999).

Tamil speaking people form distinct ethnic group which comprises 4.2% of the population. Majorities are Tamil but service providers are Sinhalese. So the matter of ethnicity has been examined with respect to the way the doctor treated the patient and the way doctor explained things in an understandable manner.

Education: Patients with a higher educational level have more skills and confidence in talking to their doctors and tend to provide more information, ask more questions and speak longer than other patients (Willems, Maesschalck, Deveugele, Derese & Maeseneer, 2005). Therefore, more educated, higher income, mature, and female or male patients may receive more information because they have communicative styles that provoke better information from doctors than less educated patients'.

Patients with a high social and advanced educational level also tend to participate more in the consultation in terms of asking questions and asking for explanations and clarification than patients from a lower socio-economic background and educational level.

2.5.1.2 Performance of the Doctor

The second independent variable of the health care system consists of doctors; this study focuses mainly on performance of the doctors in the health care system. Patient's trust is given an important place for doctors as they have to interact with the delivery of care to a patient. The duty of a doctor is to maintain the trust of the patient. The cost of medical care depends significantly on doctors. Doctors advice the testing, drugs, admission and release from hospitals. Lack of patient's trust causes the cost of medical care for patients to increase. Interaction in the consultation and the information and explanations provided by doctors have been shown to reflect their assumptions of the interests of different patient groups (Street 1991). The indicators of performance of the doctors are given below.

Time: In general practice the average consultations time is about six minutes, although there may be wide dissimilarities, with the actual length of consultations ranging from about 2 minutes to over 20 minutes. Pressures of time encourage a more tightly controlled doctor-centered or paternalistic consultation with less attention paid to the social and psychological aspects of a patient's illness. As a result, fewer physical problems are identified and more prescriptions are issued (Howie et al, 1992). The length of time available for consultations is itself partially a function of practice style, as well as the pressures of time serving to limit the discussion. Providing sufficient time to listen and respond to patients' problems and concerns can reduce the number of return visits and long hour waiting.

Communication: In contrast to the paternalistic model and informative model, interpretive model, also known as deliberative model, takes into account the doctor patient communication in all stages of decision making process in the health care system. The matter of communication has been examined with respect to the way the doctor listens to the patient, the way doctor explains things in an understandable manner and the availability of time for asking questions from the doctor. Doctors normally overestimate the amount of information provided to patients, and judge that patients are satisfied with the communication they receive during a consultation, but it may be difficult for patients to be satisfied with the consultation time given. It fully depends on the way of communication between doctor and patient.

Quality of services: Good health care quality means "Providing patients with appropriate service in a technically competent manner with good communication, shared decision making and cultural sensitivity" (Schuster et.al 2012, Cited in: Mohammad, 2004). A good service

delivery can increase the level of trust as worse service delivery may create distrust or lack of trust in the doctor - patient relationship. Several authors have given emphasis on quality of services in health care. According to Cunningham (1991), there are three types of quality of services in the health care system, namely (a) Clincal quality (b) Economic/ finance driven quality (c) Patient-driven quality. Ovreveit (2000) identified four important components of quality of service in health care, such as:

i. Used patient quality: giving patients what they want
ii. Professional quality: giving them what they need
iii. Management quality: using the least resource without error or delays in giving patient what they want and need. (Ovreveit; 2000 Cited in \ Abuosi & Roger, 2012)

2.5.2.3 Institutional Factors

The third level of the health care system is the institution/ hospital. The institution provides infrastructure and other corresponding resources to support the delivery of services and development of health care. Moreover, lack of patients trust in medicines and doctors, and also the lack of familiarity with the institutional practices increase uncertainty, and leads to repeated medical visit. Therefore, institutional factors are very important to determine the patient trust.

Rules and Regulation: Hospital rules and regulations play an important post in supporting relationship between doctor and patient. These rules and regulations determine whether a patient centered care has developed an effective relationship between doctor and patient in the health care decision making.

Basic amenities**:** A health care system cannot function efficiently without adequate medical equipments, when medical devices are often broken, when there is a lack of drugs, facility to check up, when tools go missing and where water and sanitation are poorly maintained. This leads to an uncomfortable doctor-patient relationship when medical equipment and facilities are not available. So facilities and a peaceful work environment are indispensable to improve the doctor-patient relationship.

Resources: Resources are very important to well maintain and provide efficient health care services to people. It also promotes the doctor-patient relationship and enhance the quality of the health care services. The resource shortage adds to employees job stress, which consequently affects the quality of their profession (Mossdegharad, 2004). Human resources and financial support determine the condition of the health institution as well as for better doctor-patient's relationship.

2.6 Conclusion

The doctor-patient relationship is a two way process, and they may be a lot of complication arising in the course of opinion, belief and through exchanges, aimed as gathering information and solving problems. This might, as well increase patients satisfaction his/her relationship with the doctor. This study has been intended to understand the status of relationship between doctors and patients by understanding the level trust. Patient trust is the dependent variable and patient, doctor and the institution are the independent variable of this study. The following chapter will give out the methodology and the methodological approach used in this study in order to analyse the analytical framework.

CHAPTER - 3

METHODOLOGY

3.1 Introduction

This chapter presents the methodology used in this study on the patients' trust in the Out Patient Department: A study on Nuwaraelliya District hospital was taken as the case study. The aim of the chapter is to elucidate the methodology that has been adopted for the study and its rationality for selecting those approaches. Both primary and secondary data collection methods are discussed in detail. At the same time, the following section deals with research design, research methods, and sources of data, data collection techniques, data processing and analysis plan in detail.

3.2 Research Approach: Mixed method

Research is an art of scientific exploration. Research approach is a way to systematically solve the research problem. According to Clifford Woody, research comprises defining and redefining problems, formulating hypothesis or suggested solutions, collecting, organizing and evaluating data, making deductions and reaching conclusions and at last carefully testing the conclusions to determine whether they fit the formulating hypothesis. "The range of methods and techniques of data-gathering open to researcher include use of qualitative or quantitative data or some combination of the two" (Layder, 1998:42). According to this notion, the basic types of qualitative, quantitative or a combination of (Mixed) approaches are used in the research.

In quantitative approach, numbered data can be analyzed using statistical procedure (Cresweell, 2009:4). The quantitative study designed with a hypothesis, collects data through well structured methods (structured and close ended format questionnaires, surveys, observation and interviews). On the other hand, qualitative research is an approach to exploring and understanding the research problem and also its attempts to build the meaning of phenomenon from the views of participant setting. Qualitative research usually emphasizes words, takes an inductive approach and constructivist ontology (Bryman, 2001 as cited by Cribb, 2005). In general, qualitative study designs use research questions and semi structured methods, field notes, focus group discussions, open-ended questions on surveys, and direct observation. Qualitative data tends to be open-ended without prearranged responses while quantitative data usually includes close-ended responses such as found on questionnaires.

Mixed methods research is an approach to examine and involving collecting both quantitative and qualitative data. It means using both qualitative and quantitative elements in research and is known as mixed method research. This method involves combining of qualitative and quantitative research in this study. Tashakkori & Teddlie (2010) discussed the procedures for expanding mixed method research such as:

- Ways to integrate the quantitative and qualitative data, such as one database, could be used to check the accuracy (validity) of the other database.
- One database could help explain the other database, and one database could explore different types of questions than the other database.
- One database could lead to better instruments when instruments are not well-suited for a sample or population.
- One database could build on other databases, and one database could alternate with another database back and forth during a longitudinal study (Tashakkori & Teddlie, 2010).

The aim of this study is ascertaining the extent of patient trust in the public hospitals. The mixed method approach has been applied mainly to allow the researcher to collect data from a verify of sources, documents, patients and common people. This approach helped me to examine various trust mechanisms in detail. It also helped me to understand the doctor and patients interactions. Moreover, the common people got an ample opportunity to tell their own stories.

3.3 Field work

Field work is an essential tool for observations and interviews to capture clear, detailed, and descriptive notes (Lynch, 1996:116). Fields notes are an important means of recording observations in the field. According to Neuman (1997:367) field notes must be as concrete, complete and comprehensive as possible, and also, he argues that the researcher's emotional feeling and private thoughts must also be included in such notes. Field notes were used as an important part of this research. It helped to get more hospital administrative information, such as; communication patterns between doctor and patient, consultation time, patient waiting hours, the number of patients and delays.

The study has been carried out in Nuwara-elliya district hospital in Sri Lanka. The field work carried out from July to August 2015 and the initial unit of research as per the thesis proposal, Nuwara-elliya district hospital. I chose this district mainly because this is my native place; I know its environment, its local languages and cultural aspects. This setting made it advantageous for me to undertake the research in this hospital.

3.4 Data collection method

Data collection is an essential phase in any empirical study since it is collecting data regarding research question that finally acts as a base for investigation and conclusion. Both primary and secondary data were examined for this research. Before going to the field work to collect primary data, secondary data was reviewed in detail (published journals, articles, and books). Secondary data is mainly focused on the content analysis of the research. This research has gathered both primary and secondary data in the following ways:

3.4.1 Questionnaire survey

The data collection methods have been basically open and close ended questionnaire survey method. The question patterns have been close-ended with answers provided, and the respondents asked to choose from among them. In addition, open-ended questions, which provided the flexibility to the respondents to clear their opinions have also been asked. As the study has been designed to understand the patients' trust in this particular hospital from institution and service provider sides, three sets of questionnaire were prepared, one set for service providers/ doctor and another for service seekers/ patients and another for people who accompany patients. This research has used both structured and unstructured questionnaire to gather answers.

Patients: In this study, a close-ended questionnaire has been used for patients, requiring them to select from the questionnaire, the most important problem between patient and doctor. In all total 55 patients were selected from among the three ethnic groups (55% of Tamil, 27% of Sinhala, and 18% Muslim). As per survey, 70% of the patients came from outside the district.

Doctors: The sampling has been again purposive. The bulk of the questionnaire included open-ended questions to understand their perception on trust in doctor patient relationship. The advantage of using open-ended questions is that one can discover the responses that doctors give impulsively.

A total number of 5 questionnaires were handed and all of them participated in filling in the questionnaire. As routine only five doctors turn up at OPD daily. All of them are in the age group of 30-40 and MBBS qualified (Medical Officers).

People who accompany the patients: Open ended questions have been used for people who accompany the patients (patients who were not in a position to respond to the questionnaire based interview due to their health condition) to understand their perception on the service provided by the institution and the service provider. Fifteen people were selected from among the three ethnic groups, Tamil -5 Sinhala-5 Muslim-5.

3.4.2 Direct observation

Observation helps expose some relevant behaviors and conditions (Yin, 2003). Qualitative observation is essentially naturalistic and it occurs in the natural setting under study where the observer is unobtrusive and inconspicuous, neither manipulating nor controlling the situation (Mays & Pope, 1995).

Participant observation allows researchers to check definitions of terms that participants use in interviews, observe events that informants may be unable or unwilling to share when doing so would be impolitic (unwise), impolite, or insensitive, and observe situations which informants have described in interviews, thereby making them aware of distortions or inaccuracies in description provided by those informants (Marshall & Rossman, 1995 Cited in, Kawulich, & Barbara, 2005). The researcher observed the patients and other hospital staff at the OPD. That was no the opportunity to observe the direct conversation between doctor and patient. However, I went on a couple of field visits to the hospital to observe service delivery and it enabled to me to receive some understanding about the services given by the hospital. Observation was done to see how the common people was treated in the hospital, how they were communicating with the doctor and other staffs, how the basic amenities were etc.

3.4.3 Semi structured interview

Interviewing involves asking questions and getting answers from participants in a study. Interviews can be structured, semi-structured or unstructured. In addition to questionnaire survey, interviewing a couple of patients and doctors were the source of primary data in this study. Interview was carried out on the first week of September 2015. The interviews were semi-structured to mainly allow-wider responses and to get different perspective. Thus, on

the basis of the interview guide and primary result of the questionnaire findings in-depth interviews were carried out to understand the level of patients' trust. Moreover, in order to have a clear understanding about the quality of service in the hospital, the doctor was also interviewed.

3.5 Qualitative content analysis

Hsieh & Shannon suggests that "A research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005:1278), Content analysis is a widely used qualitative research technique. Marshall and Rossman (1989) defined observation as "the systematic description of events, behaviors, and artifacts in the social setting chosen for study" (Marshall and Rossman, 1989:79). Patton (2002) argues that "Any qualitative data reduction and sense-making effort takes a volume of qualitative material and attempts to identify core consistencies and meanings" (Patton, 2002:453). As suggested by Smith, "qualitative analysis deals with the forms and antecedent-consequent patterns of form, while quantitative analysis deals with duration and frequency of form"(Smith, 1975:218). Weber (1990) also pointed out that the best content-analytic studies use both qualitative and quantitative operations.

3.6 Sources of Data

The research is based on both primary and secondary sources of data. Primary sources are original materials on which research is based. "Primary sources originate in the time period that historians are studying. They vary a great deal. They may include personal memoirs, government documents, transcripts of legal proceedings, oral histories and traditions, archaeological and biological evidence, and visual sources like paintings and photographs" (Storey & Kelleher, 1999). The study had applied three tools for collecting primary data, namely questionnaire, direct observation and interview.

Secondary data is data that has been collected for another purpose. Secondary sources were very useful to analyze the relationship between dependent and independent variables. The study used numerous sources to collect secondary data, such as from different relevant publications, review articles, dissertations, books, journal articles, reports, websites etc. In this study, reviewing existing literature was a major component.

3.7 Sample size

Sample size is one of the important elements in research that researcher needs to consider as he/she plans the study. The study used purposive sampling method so as to get the best information to achieve the objectives of the study. Total number of respondents included in the study was seventy five; i.e.; 55 patients and 15 accompanying patients and 5 doctors.

Table: 3

Sample Size

	Number of respondents by ethnicity	**Number of respondents**
Patients	Tamils – 30 Sinhalese – 15 Muslims – 10	55
Doctors	Sinhala + Tamil	05
people who accompany the patients	Tamils – 08 Sinhalese – 04 Muslims – 03	15
Total		**75**

This method made is easy for the researcher to carry out the research and select the people who are likely to have the required information and be willing to contribute it. Furthermore, the sample size helped to ensure representation of different variation of service providers as well as service receivers.

3.8 Data analysis

The process of data analysis involves preparing the data for analyse, conducting different analyses, moving deeper and deeper into realizing and understanding the data, representing the data and making an interpretation of the larger meaning of the data (Creswell, 2009: 183).

The data were processed with the help of MS excel. The Data collected along with the information obtained through observation and interviews were used to provide an overview of the condition of communication. Frequency, percentage and cross- tabulation were employed to analyze the data. “Content analysis is a research method for making replicable

and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action" (Krippendorff 1980 as cited by Elo & Kyngas, 2007:108).

3.9 Conclusion

The chapter was tried to discuss the methodological aspects of the study. Research strategy, research approach, data collection methods and data analysis technique have been discussed. A mixed method research approach was selected to carry out this research. This research used both open and close ended questionnaire, interview, content analysis, and qualitative observation to increase the strength and truth of the results. The following chapter will deal with the health care system in Sri Lanka.

CHAPTER - 04

HEALTH CARE SYSTEM IN SRI LANKA

4.1 Introduction

The quality of health system consists of all organizations, people and actions whose primary intention is to promote, maintain health (WHO, 2007). Quality of health care system depends on good doctor patient relationship. The health outcome is strongly influenced by when the health organization identifies effective health care services as an essential element of public health and a core component of health care quality. This chapter specifically aims to ascertain describe whether the Sri Lanka's health care system and service delivery by Nuwara-elliya district hospital supports good relationship between doctor and patients.

4.2 Health care system in Sri Lanka

In 1505, during the period of the Portuguese the western medical system was introduced to Sri Lanka. In 1658-1796 during (Dutch period) a few hospitals were established in this country. However, it was during the British colonial rule (1976-1948) that western medical system was established alongside the local systems of medicine (Uragoda, 19787). After 1796, the current health care services based on 'western' system of medicine was evolved from the military and estate medical services in Sri Lanka. Health care services in Sri Lanka are mainly provided through a well organized health network in the country.

Health service was a centralized subject in Sri Lank, which today retains its unitary character. However, with introduction of the Provincial Councils in 1987, Health service among others cares to be devolved to the Provincial Councils (PC) under the 13th amendment to the constitution of Sri Lanka. There are 9 Provincial councils, 25 Districts and 331 Divisional secretariats. Each districts is administrated by a District Secretary appointed by the central government (Claus Kruse, 2007). The PC drives Provincial Council (PC) is an autonomous body, not functioning under any ministry. The powers and authority from the Constitution and Act of Parliament (Public Administration Country Profile, 2004). Each province contains two or three districts. The Central Province is one of them and it has three districts namely, Kandy, Matale and Nuwara-eliya. The Nuwara-eliya District is located in the hill country of the Central Province in Sri Lanka. There are 5 Divisional Secretariats, 491 Grama Niladary Divisions, 5 Pradeshiya Shabas, 1199 Villages, one Municipal Council and 2 Urban Councils in this district.

Sri Lanka's healthcare system is in the hands of both public and private sector. In general, the health care institutions in Sri Lanka are registered in the PC. Public Sector hospitals play a crucial role in reaching and providing outpatient and inpatient hospital services to a large majority of Sri Lankans. The Private Sector provides mainly the curative care through outpatient services. Public Health Services are divided into two serviceable arms – curative and preventive. The preventive services function in a countrywide network of around 300 physician-led, separate health units, which deliver preventive services in their respective areas. The curative services are provided by all the hospitals and other outpatient-only facilities, ranging from primary care units to tertiary and specific hospitals (Dalpatadu, Perera, Wickramasinghe and Rannan-Eliya, 1999).

4.2.1 Organizational Structure

The public sector health services function under a Cabinet Minister. In 1987 the introductions of the 13th amendment to the constitution lead to the devolution of power of to the Provincial Councils. As a result, the responsibility of health care system came to be a Provincial Council subject.

However, at the central level, the Ministry of Health (MoH) is mainly responsible for the contry's health services which cover all aspects of preventive, promotive, curative and rehabilitative care. There are eight main departments functioning under the Provincial Director of Health Service (PDHS). The key functions of the Department of Health Services are: setting policy guidelines, training of health personnel, management of teaching and specialized medical institutions and medical rudiments. The central Medical Officer of Health answerable to be Cabinet Minister, and this makes the health service, a subject managed by both the Central Government and the Provincial Government.

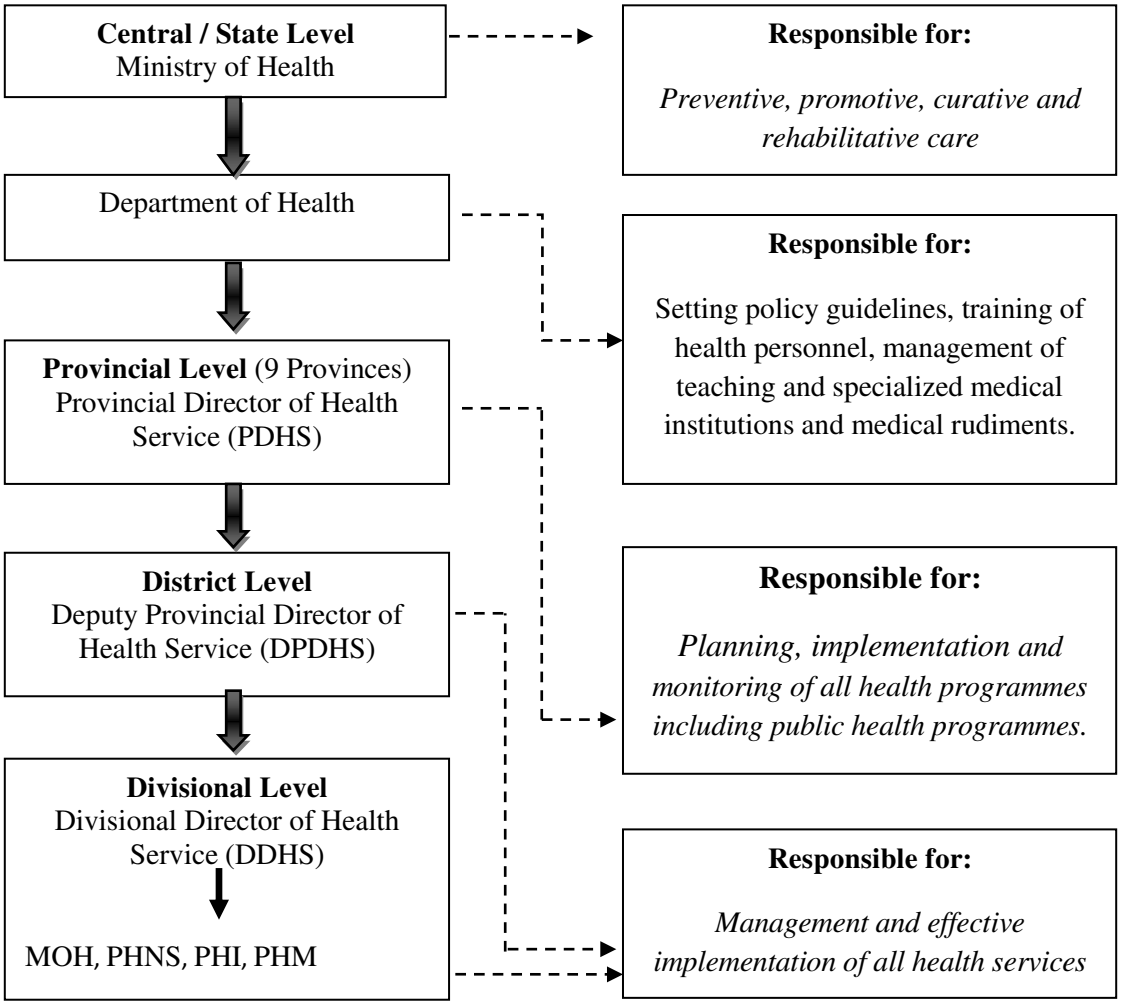
Each of the provinces has its Minister of Health and Provincial Directors of Health services, responsible for planning, implementation and monitoring all health programmes including public health programmes. There are also several Deputy Provincial Directors for each district within the province. (Fernando, Gunawardena & Weerasinghe, 2006).

At the District level, a Deputy Provincial Director of Health Services (DPDHS) is responsible for the management and effective implementation of all health services including public health services and the management of all hospitals other than teaching and specialized hospitals in the respective areas (Fernando, Gunawardena & Weerasinghe, 2006).

At the Divisional level, there are several divisions within each district, each in charge of a Divisional Director of Health Services (DDHS) / Medical Officer of Health (MOH). At the divisional level the health care services are provided by a medical officer/s, Public Health Nursing Sisters (PHNS), Public Health Inspectors (PHI) and Family Health Workers (FHW).

Figure: 4

Organizational structure of Health care institution



Source: Author's compilation

The above diagram illustrates the link between the health ministry and other health institutions at the provincial level, district level and divisional levels.

4.3 Background of Nuwara-eliya District hospital.

The plantation population in the Central Province constitutes 20% of the total population. 40% of Sinhalese and 4% of Muslims are living in this district. Fifty three percent (almost 60%) of the population in the Nuwara-eliya District lives on the plantations. There are 196 such plantations in the Central Province. The plantation population belongs to a different socio cultural background with a lower literacy rate than other populations in Sri Lanka (Annual Health Buletin, 2013). Nuwara-eliya District hospital was established under the Provincial Council Act in Sri Lanka. To fulfill the medical needs of public mainly from the plantation and rural areas. Also it functions under the provincial health care structure.

In the mid 1990's a Presidential Task Force was appointed to inquire into and report on health service available to the estate area and the quality of health services to the sector and it was followed with the appointment of the Estate Health Steering Committee of the PC level, tasked with the facilitating of the takeover of estate hospitals. In 2007, a Cabinet decision was taken to provide equitable preventive health services to the estate sector like in the rural and urban sectors (Annual Health Buletin, 2013). The MOH were able to contact all field and biological clinics in the plantation sector in Nuwara-eliya. Special outreach clinics were conducted by the VOG from the District General Hospital (DGH), Nuwara-eliya and District Base Hospital (DBH) and Dickoya hospital are selected hospitals in the Nuwaraeliya district (Annual Health Buletin, 2013). Given below are a summary of health care institutions and field areas in the Nuwara-eliya District.

The required number of Medical Officers is 227 while there are only 103; The required number of Nurses is 800 while there are only 227 and there is one Medical Administrators and 23 Consultants. The following table illustrate this human resource shortage of the Nuwara-elliya hospital.

Table: 4

Hospital Staff

Staff	Number	Need
Medical Officers	103	227
Nurses	227	800
Medical Administrator	01	-
Consultant	23	-
Total carders	829	1304

Data received from planning unit of Nuwara-eliya district hospital (2014/15)

The hospital controls number of health institutions in the plantation sector at the district and health care officers are working in various parts of the district. Table 5 shows the health care institutions in Nuwara-eliya District.

Table: 5

Health care institutions in Nuwara-eliya District.

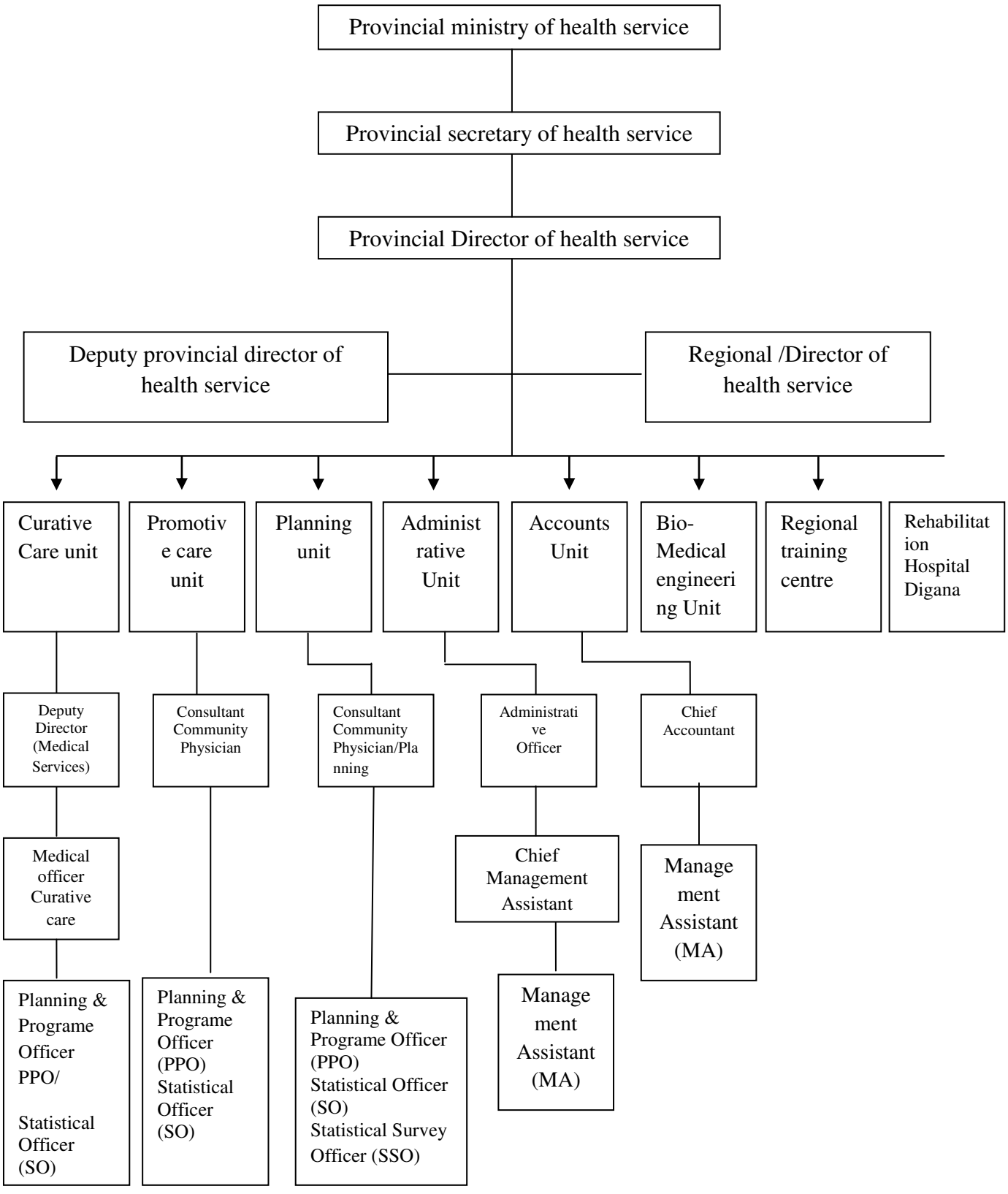
Health care institutions	Number
MOH areas	13
PHI areas	35
PHM areas	317
DGH & DBH	03
DH	24
PMCU	21
Specialized Units	18

Source: National Health Bulletin: 2013

The Nuwara-elliya District Hospital is functioning under the provincial ministry of health. The Regional Director of Health Services is responsible for the district level health care system. The structure of district hospital is shown in the figure below.

Figure: 5

Structure of the District Hospital



Source: Annual Health Bulletin: 2013

In 2011, the total indoor patient 1000 and the number of discharged were 275. While the public sector accounts for over 95% of the total indoor patient care (Institute for Health Policy, 2012b). The hospital caters to a large number of people from various parts of the district. But the total number of beds it has in 17919 of 2.4 per 1000 persons Also doctors are the major workforce in this hospital.

Shortages in all categories of staffs are evident in all hospitals. The services delivered by Nuwara-eliya district hospital in the year of 2012/13 is shown in table.

Table: 6

Basic information and services delivered in by Nuwara-eliya District hospital – 2012/2013

Nuwara-Eliya District Hospital	2012	2013
No. of beds	1112	1081
No. of wards	100	95
Bed occupancy rate (%)	36.9	27.5
No. of Admissions	68168	61671
OPD Attendance	1078409	986439
Total inpatient days per year	149750	108315
No. of clinics held	5471	9912
Clinics Attendance	259858	173562
Total No. of Deaths	340	231
No. of Deliveries	2510	2081
No. of Emergency Treatment Units (ETU)	22	22
No. of patients treated in the ETU	13302	12040

Source: National Health Bulletin: 2013

4.3.1 Medical Equipments:

The shortage of medical equipments is the major obstacle in the way to health related development. Hospitals in some districts frequently report a serious shortage of medical equipments in Sri Lanka. Need more improvement to enhance the quality of services to the

patients. However, In Nuwara-elliya district hospital, yet some medical arrangements are necessary to provide to increase the quality of services in the health care system.

4.3.2 Health expenditure

All public sector health institutions are funded by the central government from the general taxation. Hospital capital budgets are held and allocated centrally by MOH, although provincial ministries have some powers to obtain hospital equipment. The government of Sri Lanka gives more attention to allocation for health care development in the annual budget. According to the World Bank, the public health expenditure in Sri Lanka was 7.40 in 2013.

4.3.3 Work environment:

A peaceful environment where the doctors and patients could communicate is very important to ensure that the health service provided in qualitatively high. The environment is the main contribute to enhance the level of trust in the institutions and at interpersonal level. At interviews doctors stated that they believed that their work environment might have an impact on their relationship with patients. Overcrowd in the OPD rooms and a lack of privacy when talking to patients was the major problem they encountered. Two or three doctors are sitting in one room. Patients, surrounded by other patients and doctors feel embarrassed in openly communicating with doctor.

4.4 Conclusion

One of the major shortcomings in the Nuwara-eliya District hospital, it has not been able to become accustomed to a patient centered communication, due to the absence of the government procedure, work environment and rules and regulation of the provincial government. The proper doctor patient relationship would allow patients and doctors to be aware of the rights of patients and information regarding their health. Lack of a conducive work environment and poor facilities of the hospital are the other factors that have weakened the doctor patient relationship in the Nuwara-eliya hospital. However, meeting its increased demand for public health care has been a challenge in providing health care and has had an impact on the quality of health care.

CHAPTER - 5

ANALYSIS OF DATA

5.1 Introduction

This chapter presents the analysis of data collected during the field survey. It analyses the factors that determine the interpersonal trust and institutional trust in doctor patient relationship. This chapter explains the level of patient trust as well as it touches upon the level of doctors satisfaction. It also explains how the trust affected by socio-economic characteristics of the patient. The chapter goes into depth to reveal the level of patient trust on the basis of his/her gender, ethnicity, education, age and occupation. Finally, this chapter also presents the doctor's perspective on the doctor patient relationship and how the institutional factors affect the doctor patient relationship. Almost all indicators of responsiveness are related to the quality of services and each of the indicators are examined in detail below, under three variables.

5.2 The characteristics of the patient on trust

The level of trust is an important phenomenon to build the trust between the doctor and patient and to deliver quality of services. The level of trust presented under three categories; low, medium and high.

Table: 7

Level of trust by patient

Level of trust	**No. of respondents (Total)**		**% of Respondents**
	Tamil	**Sinhala**	
Low	12	**-**	**21%**
Medium	**25**	**10**	**61%**
High	3	5	**14%**

The question asked the patient was: "to what extent do you have trust on this hospital?"
1= Low, 2= Medium, 3= High.

From above data we can assume that out of 65 respondents 61% (T-25+S-10) have medium level trust on this hospital. A small number of respondents 14% (T-3+S-5) has a high level of trust and rest 21% (T-12) of the respondents have low level trust. As per data findings, the average level of trust on this hospital is medium. The respondents who rejected medium level of trust on this institution have been taken into considerable for the purpose of the data analysis. On the basis of findings the study tries to analyse the relationship of socio-economic variables and interpersonal trust and institutional trust.

The people who accompany the patient have medium level (60%) of trust on the service rendered by the hospital. The level of trust assessed falls into three, namely; low, medium and high.

Table: 8

Level of trust by people who accompanying with patients'

Level of trust	**No. of respondents (Out of 15)**		**% of Respondents**
	Tamil	**Sinhala**	
Low	01	03	**22%**
Medium	**08**	**01**	**60%**
High	00	02	**18%**

The question asked patient was: "To what extent do you have trust on the health care services?" 1= Low, 2= Medium, 3= High.

The above data shows that out of 15 respondents 60% (09) have medium level trust on this hospital. Twenty two percent of them were low trust and a very small number of the respondents 18% (03) have high level trust in the hospital.

The doctor patient relationship is a basically an important factor that builds the trust on the health institution. The patients generally discuss their symptoms for the doctor is understand the cause of his/her illness and afford the treatment. At this stage, the doctor will listen, and be friendly to the patient's concerns. Therefore, the socio-economic background of the patient plays an important role to build trust on the institution.

When there are many factors linked to socio-economic characteristics of the patients that may affect the level of trust, this study has considered only five variables: gender, age, ethnicity, education and occupation. This study also analyse the way patients communicate with doctors. The patients understanding of the way doctors communicate with patients about illness and whether the patients are serious in their own care at the Nuwara-eliya district hospital. In addition, an observation exercise was conducted during doctor patient consultation in the OPD to know the nature of doctor-patient relationship in this institution.

5.2.1 Age, Gender, Ethnicity, Occupation and education of the patient

In general a majority of patients 56% are females and 44% are male. As per ethnicity 55% are Tamil, 27% Sinhala and 18% are Muslim. By age group 4% are between the age 15-25, 30% between the ages 26-35, and 44% between the ages 36-50 and rest of the 22% them are above 50 years old. As per occupation, 35% are estate workers, 25% were farmers, 16% are business people, 7% un employed, 13% self employed and only 4% are working in the government sector. In terms of education, almost 47% are illiterate and only 31% have completed secondary level education. Table 9 shows the percentage of respondents visited to the OPD at Nuwara-eliys district hospital.

Table: 9

Socio-demographic background of the patients

Identity characteristics	Number of patients			High/Fair satisfaction	Law Satisfaction
Age	15-25	2	04%	02 - (8%)	-
	26-35	20	30%	09 - (34%)	11- (38%)
	36-50	20	44%	08 - (31%)	12 - (41%)
	Above 51	13	22%	07 - (27%)	06 - (21%)
Gender	Male	24	56%	11- (37%)	13 - (52%)
	Female	31	44%	19 - (63%)	12 - (48%)
Ethnicity	Tamil	30	55%	10 - (36%)	20 - (74%)
	Sinhala	15	27%	14 - (50%)	01 - (34%)
	Muslims	10	18%	04 - (14%)	06 - (22%)
Education	Primary	15	27%	09 - (28%)	06 - (21%)
	Up to 5-10 class	12	22%	07 - (22%)	05 - (18%)
	O/L	11	20%	06 - (19%)	05 - (18%)
	A/L	06	11%	04- (12%)	07 - (25%)
	Illiterate	11	20%	06 - (19%)	05 - (18%)
Occupation	Estate workers	19	35%	10 - (37%)	09 - (32%)
	Farm workers	14	25%	08 - (30%)	06 - (21%)
	Business	09	16%	04 - (15%)	05 - (18%)
	Self employment	02	13%	01 - (4%)	01 - (4%)
	Government	07	04%	02 - (7%)	05 - (18%)
	Un employment	04	07%	02 - (7%)	02 - (7%)

Source: Calculate data from field work

5.2.1.1 Age of the patients

Age has been considered as the important variable factor which affects the level of satisfaction with the services delivered by the Nuwara-eliya District Hospital. Among them, 4% belonged to the age group of 15-25 years, 30% to the age group of 26-35, 44% to the age group of 36-50 and 22% were above 50 years of age.

Young people have more satisfaction than older people. Among the different age groups of the respondents, 30% of respondents (25-35 years) are highly or fairly satisfied. The satisfactions of respondent's in the age group of 36-50 that they have low level of satisfaction. The different satisfaction is mainly due to level of education or level of occupation of the patient. People who are educated and who understand the language get the necessary information regarding their illness and treatment. Also, they try to participate more in the consultation process in terms of asking questions and answering the questions asked by the doctors. Patients who were belonged to the lower socioeconomic backgrounds and lower educational level do not spend much time with the doctor. It is mostly too much expectation that does not match with the participation and lack of awareness regarding the medical problems, that possibly impacts good doctor patient relationship in the health care.

5.2.1.2 Gender

In terms of gender, 56% are female and 44% male. Among them 31 females, 19 (63 %) responded that they were highly or fairly satisfied. While out of 24 males, 13 (52%) had low level of satisfaction with the hospital services. However, the study shows, the female respondents have more trust than male respondents.

5.2.1.3 Ethnicity

"People of ethnic/indigenous groups have the feeling of discrimination by the government in the field of ethnic identity, language, religion and culture" (Bhattachan 2008:13). In terms of ethnicity, 55% are Tamil, 27% Sinhala and rest 18% are Muslim. Out of 15 Sinhala respondents, 14 (96%) were highly satisfied with the services, than the patient who speak Tamil.

The Tamils and Muslims patients were less satisfied than were the Sinhala patients. Out of 30 Tamils, 20 (74%) of respondents were not satisfied with the services. The patients who were belonged to the (out of 10) Muslim community, 6 (22%) respondents had law satisfaction with the service, and rest of the 14% were highly or fairly satisfied.

5.2.1.4 Education level of patients

Satisfactions levels with the health care services were varied according to the educational level of the patients. Twenty seven percentage of the respondents had primary level education, 22% of the respondents completed education up to grade 5-10, 20% of the respondents were illiterate and only 31% had completed the secondary level education or higher education. Twenty eight percentage of respondents with primary education and 19% of illiterate respondent had more satisfaction than people who have completed the higher or secondary level of education. 22% respondents with primary level of education and 19% illiterate trust the doctors more than educated people. More educated respondents ask questions about their health conditions and also they can understand the language. 28% of the respondents were highly/ fairly satisfied and 25% of the respondents were less satisfied with the services.

5.2.1.5 Occupation of the patients

As per occupation, 35% was estate workers, 25% was farmers, 7% were unemployed, 13% was self-employed, 16% was business people and only 4% was employed in government sector.

Economic status of the patients also have an influence in implying or expressing the level of trust with the service delivery of the Nuwara-eliya District Hospital. This study shows that, out of 19 estate workers, 10 (37%) of the respondents were fairly satisfied with the services. Out of 14 farm workers, 9 (32%) were not satisfied with the services. On the other way, the lower income group respondents had higher trust than the people who work in the government, business and self employment sectors. However, the overall findings reveal that the respondents had a low level of satisfaction.

5.2.2 Result of the interviews based on structured questions with patient

The quality of services can be determined by the institution efficiency and better doctor patient relationship. The indicators for patient trust are the degree of comfort, better relationship with the doctor and high level of confidence on the services. However, the study has considered the quality of services as the indicator of independent variable which improves service delivery by the public institution.

5.2.2.1 Doctors careful listening about the illness of the patient

As per the data findings 47% of patients responded "Yes" when asked whether the doctor listened to them and how long the doctors inquire them about their illness?. 35% of the patients responded "Some time" and rest of them responded "No". Among them, 45% belonged to the Tamil community who responded "yes", was given by 80% Sinhala patients they said that the doctors listen to them carefully. Also, 20% of the patients from both ethnic groups responded that the doctors do not listen to them.

5.2.2.2 Understanding of patients about their treatment

Twenty three percent of the patients responded "very well" to a question on whether they were asked about the process of their treatment (illness, examination, tests, medication etc.) during their hospital visit. Forty two percent of them responded "good" and rest of patients responded "Sometimes".

When they were asked whether you understand the treatment process 65% of the respondents said "yes" and 10 % of the respondents is did not provide any information. However, they were content with the limited information provided by the doctors. People from the tea plantation; believe that when the doctor's explanations and treatment are higher the possibility to cure their illness are also higher. They believe that, the doctors' explanations are correct.

5.2.2.3 Understanding the language used by the doctor

Fifty one percent of the patients responded "Sometimes" when they was asked whether they understood the language used by the doctor. Thirty nine percent of patients responded "yes". However, 99% of Sinhala and 40% of Tamil patients agreed that they understood the language, and only 10% of the Tamil patients responded "no". Sixty percent of the patients chose to visit the doctors because they assumed doctors as medical professionals could correctly diagnose their illness. The remaining 40% of the patients believed that doctors could give better treatment and they trusted the doctor.

When asked whether they understood the language used by the doctor, 75 % of the patients irrespective of age, gender, occupation and education responded that they understood the language used by the doctor.

But most of them mentioned that they did not understand the medical language used by the doctor. They stated that doctors were kind when they communicated with them but the language they used was difficult to understand without the help of the nurse or others who could understand the language. Overall 45% of the patients were satisfied with the care they received with 10% expressing major dissatisfaction. It appears that Sinhala people are more comfortable in engaging with the doctor than Tamil people.

5.2.2.4 Time allocated for patients by the doctor

Forty nine percentage of the patients responded that they had enough time with the doctor when they required. The remaining 51% expressed that it was difficult to obtain sufficient time from the doctors. Among them 73% of the Sinhala patients and 15% of Tamil patients responded "yes". Only 10% of the Tamil patients responded "no". Rest of them responded "sometimes". Moreover, patients were asked whether they were given enough time to speak to the doctor and to discuss about their illness, treatment, the future necessities and preventive messages. Thirty one percentage of the respondents stated that doctors were available when they wanted to meet them. The remaining respondents believed that, it was difficult to get an appointment from the doctors. Due to their heavy work load and the patients mentioned that they had to spend hours in lines at crowded OPD.

5.2.2.5 Difficulties faced by the patients to the hospital visit

Many respondents believed that they faced difficulties during their hospital visit. Lack of explanation of doctors (19%), lack of time (23%), and lack of concentration (17%), expensive medicine (19%) and communication gaps (22%) are the main difficulties faced by them.

5.2.2.6 Barriers to communicate with doctors

The communication barriers were examined with respect to the way the doctor was listening to the patient, the way doctor explained things, the way of treating patients and the availability of time to ask questions from doctor. Sixty seven percent of the patients sample believed that the language, economic status, ethnicity, gender, and different social status are main barriers to have better communicating with the doctor. The remaining 33% of the respondents believed that they did not have any hesitated in communicating with the doctor. Among them 80% of the Tamil respondents they believed that they have barriers to

communicate with doctors. A small number of respondents (10%) believed that they have felt some discrimination against their ethnicity. This is mainly due to the large number of Sinhala staff of the hospital and the large number of Tamil patients at the OPD in Nuwara-eliya district hospital.

5.2.2.7 Satisfaction with the care provided by doctor

Forty two percentage of patients responded "yes" when they were asked whether about the satisfaction with the care provided by the doctor. Thirty six percentage of patients responded "to certain extent" and the rest of them responded "no". Among them, 27% of the Sinhala and 20% of the Tamils responded "yes" and 73% of the Sinhala and 30% of the Tamils responded "to certain extent". The respondents were not fully satisfied with the care provided by the doctors, 15% of the patients remarked "better treatment and advice given by the doctor", 20% of the patients remarked "doctors are friendly and helpful", 19% of the patients remarked "well explanation by the doctor about their illness", 17% of the patients remarked "doctors spends enough time with patients" and 14% of the patients remarked "doctors listen to the patient carefully.

5.2.2.8 Satisfaction of patients with services provided by the hospital

Thirty percentages of the patients responded "yes" when they were asked about their satisfaction with the care provided by the doctor. Forty six percentage of the patients responded "to certain extent" and the rest of them responded "no". The respondents were not fully satisfied with the care provided by the hospital. In regards to the lack of maintenance and basic amenities of the hospital, 17% of the patients remarked "needs/clean", 22% remarked "poor attention by doctors and nurses", 18% remarked "no place for wait", 15% remarked "expensive medicine", 14% remarked "no enough drugs.

5.3 Interpersonal Trust

As per survey results of the questionnaire, 80% of the patients came from distance places and especially from the plantation sector and rural areas. Those who come from the estate and rural areas have problems due to poor transportation facility. They are poorly educate; they have access barrier and the prevalent language barrier. These patients had medium level of

trust in this institution. In looking at the overall characteristics of the patients, 47% of the patients were illiterate and belonged to the age group of above 40. Majority of the patients (35%) were estate workers and (25%) were farmers.

Observation was conducted during the field visits. The medical report file shows the patient's age, ethnicity and gender were not seen as important criteria and decisive in doctor patient relationship. Patients were more concerned about explaining about their illness rather than answering questions from the doctor. The patients do not know the language spoken by the doctor but they willing to accept what the doctor says irrespective of the inability to understand what the doctors says. The doctors on the other hand repeat the same questions to the patients during consultation, because they have limited knowledge of the language spoken by the doctor.

The people who had low level of education (speaking knowledge) did not understand the medical language but they were satisfied with the services compared to the people with higher education. Because of the way the doctors talks and behaves, coupled with their education, the patient trusts that the doctor knows well about their illness than others and also they trust in the medical treatment afford. It is also one of the contributory factors for better doctor patient relationship in this hospital.

Buton, Dunn, Tattersall, Jones (1994), have stated that in the medical science, the patients should ask some important questions such as follows during a medical consultation.

i. What is the diagnosis?
ii. What does the test results say?
iii. What treatment do I need?
iv. Does the treatment have any side effects?
v. What is the purpose of taking the medication?
vi. What can be done for the pain and discomfort I might experience?
vii. What should I do or not do while having treatment? (Buton, Dunn, Tattersall, Jones, 1994)

However, in this sample, many patients did not ask sufficient questions from the doctors. In observing the services to the hospital, researcher did not find any patients asking any important questions related to their illness from the doctor. Due to lack of time and long

queue of patients, doctors spent very little time to a patient in the consultation process. They also control the conversation with the patient. To have better doctor patient relationship, patients must be willing to voice their concerns to doctors and collect much information about their health condition. Illiterate, poor health concern, inadequate health knowledge, lack of ability in questioning about own illness and occupation were seen as a key factors for patients to be inactive during the consultation time. These factors are the causes for the unawareness of patients of the different health issues. As the research shows that there is no significant age and gender discrimination reported. But the patients feel that there is an unfair treatment on the basis of ethnicity, social status, education and occupation.

The following case studies provide some evidence to prove the above statements

Case studies

Letchumi, a 60-year-old female

"Many people want to come from the distance places to the Nuwara-eliya *hospital for better treatment. There is no enough medicine, staff and even there is no space in the waiting room. In my last visit, I had to wait more than two hours in the queue before I see a doctor and before buy the drugs from the counter. In the morning hours, there is a long queue at the OPD. In such situation the people cannot access service in the health care"*

Sugumar, a 45- year-old male, estate worker, from Watagoda-Nuwaraeliya:

"Doctors are good. They are kind enough. They listen to us and give medicine. But we do not understood well the questions the doctor also. It is hard to communicate with doctors due to our language barrier. Sometimes if the doctor does not understand Tamil, he set the support from people who accompany us from hospital staffs to understand about our complain. Some nurses are good but some are fright. Many minor staff are very rude. The estate people are very innocent and they do not make high voice, so some hospital administrators scold us in Sinhala. I have noticed several time when patients rush to see doctors, nurses and minor staff members of the OPD shout at them in an cruel manner".

Chathurangani, a Female, From- Welimada:

"Doctors treat us kindly; doctors were willing to talk about my illness with me. But they don't have much time because of their work load and huge crowed in OPD. I never get disappointed with the doctors treatment, because they are kind and allow me to explain about my illness therefore I'm happy with their services. However, in the hospital there are no enough facilities, toilets are not cleaned and stink, waiting room is very small and overcrowded, and there is no sufficient room for doctors at the OPD. We too do not receive all the necessary drugs from the hospital and in many cases we have to buy medicine from private pharmacies".

Source: Field work, 20.09.2015

5.4 Trust of health care professional at the OPD

The doctors are the main actors and experts in the health institutions. The pressure of time allocation limits the discussion. Giving sufficient time to listen to patients' problems and concerns for patients' treatment can reduce the number of return visits. This part analyzes the data and observations information gathered by done in the medical offices. It focuses on doctors work load, the time allocate to them, communication skills and quality of their services. This part analyse the barriers which influence doctor patient relationship in the health care institution.

The data given below collected by administering an open ended questionnaire survey and observation at the hospital conducted by the researcher. Parsons, viewed the role of the doctor as balancing the role of patient.

> "The patient is expected to cooperate fully with the doctor, doctors are expected to apply their specialist knowledge and skills for the benefit of the patient, and to act for the welfare of the patient and community rather than in their own self-interest". (Parson, 1951)

In the Nuwaraeliya District Hospital in some days the doctors are required to treat more patients than other district hospitals. Table 10 shows that total number of patients visited the OPD in Nuwara-eliya district hospital the year of 2014/15.

Table: 10

Number of patients visit to OPD - Nuwara-eliya district hospital.

OPD patients (quarter vise)	2014	2015
1st quarter	48238	56866
2nd quarter	47501	57290
3rd quarter	52599	-
4th quarter	36315	-

Source: Data collected from planning unit Nuwara-eliya hospital 10.09.2015

According to Medical record officer in the hospital, "total daily OPD patients visit is around 750 – 850. Only five doctors are working in the OPD and among them one is a Tamil. Generally, one or two doctors absent per day. Therefore, for consultation only 2-4 minutes time is allocated for examining one patient (depending on the health condition of the patient)". Doctors are the major workforce in the hospital, especially in the OPD. They are working six days in a week from 8:00am to 4:00 pm.

5.4.1 Communication skills of doctors

Due to low education levels and poor medical knowledge of patients, it is very difficult to make them clear about their illness and treatment. Giving enough time for patient is a very important factor for explaining about medical problems of the patient. Main reason is language barrier on both parts.

The major problem faced by the service provider is language problem (communication gap). The major problems identified by the doctors are;

- Low level of education of the patients
- Lack of patients fluency in Sinhala language
- Lack of Tamil language speaking ability to doctors
- Lack of sufficient number doctors and large number of patients at the OPD
- Lack of necessary drug

- Lack of sufficient time to devote patients
- Poor doctor patient relationship

The sequent communication by patients is central to diagnosis and treatment decisions, unless patients feel uneasy when they try to talk freely. If they know the language they will not hesitate to disclose their problems. At an interview a doctor described about the language barrier that he has in the following manner.

> *"We are working with Tamil speaking people, but we do not understand the language by patients, and they too are facing difficulties when we speak to them in Sinhala. So we need a translator, but it is not possible to have in every time. I'm not much satisfied with the service provided by me. Because of the communication gap that we have between patients' and as not receive our advice and consultations fully. My suggestion is to increase Tamil speaking doctors in the OPD" (Interview contacted on 10th of September 2015).*

The satisfaction of communication is influenced by a number of factors such as time availability, frequent visit and quality of services. However, the perception of doctors regarding the nature of medical responsibilities and their relationship with patients are more important. The doctor patient relationship also influences doctors satisfaction. Failure to elicit patients' worries and understanding of treatment and illness can sometimes lead doctors to believe that patients have consulted improperly and that their time and skills are being wasted. This can be illustrated from some doctors' dissatisfaction at Nuwaraeliya District Hospital.

However, the most common complaint made by patients about doctors, lack of communication skills of doctors, and doctors do not listen what patient say or ask. As a result, a large number of patients leave the consultation without asking questions about their diagnosis, because patients do not receive what they consider as a satisfactory response. According to Silverman et al, communication skills and consultation steps are,

i. Initiating the session (establishing the initial rapport and identifying the reason(s) for the consultation)

ii. Gathering information (exploring the problem, understanding the patients' perspective, providing structure to the consultation)
iii. Building the relationship (developing rapport and involving the patient)
iv. Explanation and planning (providing the appropriate amount and type of information, aiding accurate recall and understanding, achieving a shared understanding and planning)
v. Closing the session (Silverman et al, 1998).

As noticed during my observation, doctor patient conversation takes place only when doctors start the conversation by asking the patient about their health problem. If the doctor is convinced of his/her symptoms, than he focus mainly asking about medical related questions and provide a prescription. This approach of conversation limits the patients' active participation while the treatment process. Typically conversation style between doctor and patient gives lack of time and choice to the patient and usually elicits a "yes" or "no".

5.4.2 Influence of time

General practice consultations take average 6 minutes; this was demonstrated by an experiment in general practice time available for consultations and it was recommended to increased to 10 minutes (Ridsdale et al 1992). As a result, all doctors can ask more questions and patients can also answer. Also, it facilitates patients to participate and explain the nature of their physical problem. This type of practice can increase doctor patient relationship; quality of services as well. Time is the prime concern of the patients and mostly the respondents should evaluate the quality of service delivery. When the respondents were asked to rate the level of satisfaction with the time taken by the doctor, they were not much satisfied with the time allocation by the doctor.

In the Nuwara-elliya Hospital since a majority of the patients complain that patients are not able to get enough time with the doctor and at the same time the doctors also complain the same problem. Overcrowded and poor maintenance are cause for poor diagnosis of the illness rather than a quality of services. Doctors do not have enough time to individually explain the treatment process, diagnosis and results of medical treatment.

5.5 The Institutional Factors

Institutional factor is an independent variable of this study. The institutional factors human resources, basic amenities, rules and regulation and financial resources. Which this section elaborates the data findings. There are number of factors determining the human resources of any institution. This study had defined the human resources in terms of the two indicators viz. service provider and service receiver. The following table shows the satisfaction level of quality of service in the Nuwaraeliya District Hospital.

Table: 11

Patient's trust on the Nuwara-eliya district hospital

Facilities of the hospital	**No of Tamils**	**No of Sinhalese**	**Total Percentage**
Not clean	22	04	17%
No improvement in toilets and water supply	26	06	22%
Lack of space in waiting room	22	00	15%
Expensive medicine	14	07	14%
Lack of drugs	15	06	14%

Field work: 2015

According to the above table, one can see almost 22% percent of the respondents said that there was no improvement in the toilets, both men and women need to use the single toilet and also not clean and stink.

The other institutional factor is the shortage of staff at the OPD. Lack of staffs at hospital and lack of time to receive services from doctors, make the patients more dissatisfied and lose trust on the doctor patient relationship. Similarly, basic amenities and waiting room services not have been improved. Institutional factors for quality of services, time, use of language, cleanliness have been the most significant factors to affect the patients trust in the hospital management.

The Nuwara-eliya General Hospital as a public institution does not charge high cost for services and drugs. However, most of the respondents were unhappy about the shortage of drugs and amount of drugs they received. Around 28% of the respondents were not satisfied

with the drugs in the hospital, as most of the time patients need to purchase drugs from pharmacy. Similarly 15% of respondents were not satisfied with the waiting room facility, patients having to wait long hours standing.

5.6 Conclusion

The above data analysis demonstrates the patients' trust regarding the services centered by the Nuwara-eliya District Hospital. The dependent variable, patient trust is analyzed with respect to the three sets of independent variable (characteristics of the patient, performance of the doctor and institutional factors). The communication between doctors and patients is a major determinant factor which influences the success of the doctor patient relationship. Patients' trust on the consultation depends on their perception of the doctors', communication skills, and the treatment of the doctors. The next chapter will discuss about the conclusion and recommendation of the study.

CHAPTER – 06

SUMMARY AND CONCLUSSION

6.1 Introduction

This study was conducted to find out the status of patient trust in the OPD services delivered by Nuwara-eliya District Hospital. The findings of the study are presented, followed by the major highlights of the study. The main aim of this research is to explore the level of patient trust with the services delivered by Out Patient Department. The specific objectives of the study are (i) To explore the citizens' trust in the service delivered by Nuwara-Elliya District Hospital; and (ii) To identify and analyze different factors affecting the citizens' trust on the quality of service delivery in the public institution.

Nuwara-eliya District Hospital is functioning under the control of the Provincial Government. Although hospital delivers a number of services to the public, this study mainly focuses on three issues; to find out the status of doctor patient relationship; to identify whether the institutional factors affect the doctor patient relationship and to focus on the role of patients in interacting with doctors. To carry the empirical survey, the data was analysed by using independent variables (characteristics of the patient, performance of the doctor and institutional factors) and the dependent variable identified as patients trust with the quality of service delivery by Nuwara-elia District Hospital. To study the patient trust through an empirical study, a survey of the citizens who receive services and who provide services from OPD at Nuwara-eliya District Hospital was conducted. The core assumption of this study is to provide some evidence which influence the importance of effective relationship in the health care delivery and to show its state of inconsequence in Nuwara-eliya District Hospital.

The theoretical aspect of this study concentrates on the concepts of trust and two models of trust in health care (interpersonal trust; between doctor and patient) and (institutional trust; between doctor and institution and between patients and institution) that supports the development and provide quality of service to the patients.

To analyse the study, both qualitative and quantitative techniques of research methods were used. Empirical survey of patients generated through mix method (qualitative and quantitative both) to collect information. Also both primary (field work through survey) and

secondary data (books, reports and publications etc.) written on trust, research reports and journals etc.) were collected. An analytical framework that has been followed in this study was developed in a way to demonstrate relationship between the dependent variable (patient trust) and three independent variables, (characteristics of patients, performance of the doctor and institutional factors).

6.2 Doctor patient relationship

Results of the survey so patients show that more than half of the respondents have a positive responses about the way doctors communicated with them. However, contradictorily the respondents demonstrated their dissatisfaction in communicating with doctors (language barrier) and limited time allocation for consultation. Although, the majority of the respondents mentioned that they were satisfied with the overall service delivered by the hospital, when it comes to their points, may respondents were not satisfied. This factor made the patients more dissatisfied and losing the trust on the Nuwara-eliya District Hospital.

In terms of patient characteristics of the respondents, gender, age, ethnicity, education and occupation were examined. Among them 26-35 age group were highly/fairly satisfied than the young or elderly respondents with the service delivered by the hospital. In terms of gender, a higher number of satisfied female patients more than the male. In terms of ethnicity, Sinhala patients had more trust than other two ethnic groups. According to social and economic class, lower income group being most satisfied and low level educated people also highly/fairly satisfied with the hospital services. Although there are two significant factors as mentioned above affected the patients trust, the study illustrate diverse results, since the patients characteristics were different.

6.3 Performance of the doctor and institutional factors

The study attempted to find out the effects of the performance of the doctors in delivering their services through Nuwara-eliya District Hospital. Performance of the doctor was measured in terms of quality service delivered by doctors in different ways. Some patients were satisfied with the care given by doctors, some patients satisfied the way that doctor communicating and some others give patients to the attention they received. It is noteworthy to mention that more than half of the patients lack education. Therefore, the doctors generally believe that the factors such as, patient's socioeconomic background, low level of education or lack of education and language barriers have effects doctor patient relationship.

A study shows that the people who speak Sinhala, tend to resist explaining about their physical problems to doctors than people who speak Tamil. Therefore, the doctors are not motivated to speak to patients. Communication should be both ways, one way communication in the consultation process it is difficult to understand the issues of patients. Moreover the other reasons such as, language barrier of doctors, overcrowded at OPD, lack of health knowledge and lack of facility in hospital and working environment of the doctors, have influenced the communication between doctors and patients.

Institutional factors also have influenced the doctor patient's trust. Lack of sufficient time for consultation, poor basic amenities, expensive drugs and drugs shortage have been identified as most significant factors which affect the patient's satisfaction. The overall evaluation of service delivery given by the hospital to patients was not considerable as very satisfied. By cross checking and validation, I realized that service delivery by doctors are not done regularly and punctually. However a small number of respondents were dissatisfied with the personal traits of service providers. Many respondents suggest a number of suggestions to increase the quality of services in the hospital which will enhance patient's trust in the future. Most of them requested to appoint more Tamil speaking doctors for this hospital, to solve the problem of drug shortage and to develop basic facilities such as, drinking water, toilets & spaces, seats of waiting room of this institution.

6.4 Scope for Future Research

This study was conducted with limited scope, time and resources and it primarily focused on the Out Patient Department in Nuwara-eliya District Hospital. Social sciences continuously demand new research on the basis of social issues. The health context of Sri Lanka is still in experiment phase and lot of research can be done on this sector. This study focused only quality of service aspects of patient trust.

This study was done mainly to the researcher's academic requirement. In this research patients trust has been mapped and evaluated against only three independent variables, characteristics of the patient, performance of the doctor and institutional factors with regard to time and language, difficulties to communicate with doctor, and impacts of institutional factors. The research did not examine other factors which influence the dependent variable and also it did not examine the status of other departments in this hospital, or a comparative study with other hospitals. Moreover it did not analyse political factors. Therefore, future

researchers can explore the relationship of those variables in evaluating the performance of the district hospital, and the trust level between doctor patients.

6.5 Conclusion

Patients were more concerned with their communicating language, time spent for examination their illness, cost of drugs, and the way of handling the patients and treatment of service providers. Language is a main tool in building doctor patient relationship and improving patient's health awareness in order to deliver a quality service to the patient. In such situation, the healthcare institution can provide a quality services. If both the doctor and patient have a satisfactory communication, it will lead to decrease unnecessary complications.

The level of patient's trust with health institution in Nuwara-eliya was medium level i.e. fair level of satisfaction. The result shows a direct link between the feeling of the patient's and the level of their education and knowledge on health. These two factors in one way, the number of patients who seek consulting doctors have been increased & on the other way, it has established a better relationship between doctors and patients, has improved the level of their communication.

REFERENCES

Aninha L. Lobo and A. M. Dolke, *Interpersonal Trust and Organizational Learning Capability,* Sophia College for Women, Behavioral Science Center Pvt. Ltd., India

Aminuzzaman, S. M. 1991. *Introduction to Social Research*, Bangladesh Publishers, Dhaka.

Alaszweski, A. 2003, *"Risk, Trust and Health",* Editorial Health, Risk and Society, vol. 5, no. 3, pp. 235-240 (Available at: http://www.tandfonline.com/doi/abs/10.1080/1369857031000160694 1?journalCode=chrs20).

Annual Health Forum Secretariat, 2008 *Measures of Equity, Efficiency and Quality of Selected Healthcare Services,* Annual Health Management Developing & Planning Unit, Ministry of Healthcare & Nutrition, No: 385, Rev. Baddegama Wimalawansa Thero Mawatha, Colombo – 10. Available at: www.health.gov.lk

Aaron.A, Abuosi & Roger A. Atinga; 2012 Service quality in health care institutions: Establishing the gaps for policy action, Department of Public Administration & Health Service Management, University of Ghana Business School Accra, Ghana. (Available at: www.emaraldinsight.com/0952-6862.htm Access on: 27.10.2015 at 10.15 am)

Ali Mohammad Mossdegharad; 2004 Factors influence health care service quality, International Jounnal of health Policy and Management, Kerman University of Mediccal Science. (Available at: http://ijhpm,com Access on: 227.10.2015 9.30am)

Aberbach, J.D., & Rockman, B.A. (2000). *"In the web of politics: Three decades of the U.S. federal executive".* Washington, DC: Brookings Institution Press (Available at: http://jpart.oxfordjournals.org/content/13/1/103.extract).

Annual Health Bulletin, (2012) Medical Statistics Unit, Ministry of Health, Colombo, Sri Lanka.

Annual Health Bulletin, (2013) Medical Statistics Unit, Ministry of Health, Colombo, Sri Lanka.

Bouckaert, G., & Van de Walle, S. (2001). *"Government performance and trust in government"*. Paper for the Permanent Study Group of Productivity and Quality in the Public Sector at the European Group of Public Administration Annual Conference, Vaasa, Finland (Available at: https://www.researchgate.net/publication/228767477_Government_Performance_and_Trust_in_Government)

Bahry, D., Kosolapov, M., Kozyreva, P., Wilson and R. K. 2005. *Ethnicity and Trust: Evidence from Russia*. (Available at: http://brl.rice.edu/Siberia/papers/APSR_Trust_final.pdf).

Bonson, E., Torres, L., Royo, S., and F. Flores. (2012). "*Local e-government 2.0: Social media and corporate transparency in municipalities"*. Government Information Quarterly 29: 123-32. Cited on: *Can Social Media Restore Citizen Trust in Government?,* Changsoo Song (changsosong@unomaha.edu) Jooho Lee (jooholee@unomaha.edu), School of Public Administration University of Nebraska at Omaha Prepared for the presentation at the Public Management Research Conference, Madison, Wisconsin, June 20-22, 2013.

Calnan, M., Montaner, D., & Horne, R. (2005). "*How Acceptable are Innovative Health-care Technologies? A Survey of public Beliefs and Attitudes in England and Wales"*. Social Science &Medicine 60, 1937-1948.

Christel Lane and Reinhard Bachmann (1998). "*Trust Within and Between organizations : Conceptual Issues and Empirical Applications"*, Oxford University Press, New York. 119-123 (Available at: www.emeraldinsight.com/doi/abs/10.1108/00483480310488405).

Cresswell, J.W. & Clark, V.L.P. (2007) "*Designing and Conducting Mixed Method Research"*. Australia and New Zealand Journal of Public Health. 31(4): 388-389. (Available at: rsw.sagepub.com/content/early/2008/05/.../1049731508318695.full.pdf).

Denhardt, R. B. and Denhardt, J. V. 2009. "*Public Administration: An Action Orientation"*. Boston: Wadsworth, (Available at: http://ebook.stepor.com/book/public-administration-an-action-orientation-with-coursereader-0-30-public-administration-printed-access-card-89912-pdf.html).

Dalton, Russell J. 2004. *"Democratic Challenges, Democratic Choices: The Erosion of Political Support in Advanced Industrial Democracies"*, Oxford; New York: Oxford University Press. Cited on "Institutional Trust, Education, and Corruption: A Micro-Macro Interactive Approach" Armen Hakhverdian University of Amsterdam Quinton Mayne Harvard University (Available at: https://dash.harvard.edu/bitstream/handle/1/9639965/MayneInstitutionalTrust.pdf?sequence=1).

Donna Bahy, Mikhail kosolapov, Polina Kozyreva and Wilson; (Nov., 2005), "*Ethnicity and Trust: Evidence from Russia"*, The American Political Science Review, Vol. 99, No. 4 pp. 521-532, American Political Science Association Stable Available at : http://www.jstor.org/stable/30038962 (Accessed on: 05-03-2015 11:39)

Dulitha Fernando, Nalika Gunawardena and Chrishantha Weerasinghe (2006). "*Report on Rapid Assessment of Essential Public Health Functions-Sri Lanka"*. Health system Research Unit, Department of Community Medicine, Faculty of Medicine, University of Colombo, Sri Lanka.

Ezckiel, J.Emanuel and Linda L. Emanuel (1992), "*Four Models of the Physician-Patient Relationship"*, JAMA, The journal of the American medicine, American medical association, 222 Rosewood Drive, Danvers MA 01910, America.

Fukuyama, F. "*The Social Virtues and the Creation of Prosperity"*. New York: Free Press, 1995. Cited in Peri K. Blind 2007 *"Building Trust In Government In The Twenty-First Century: Review of Literature and Emerging Issues",* 7th Global Forum on Reinventing Government, Vienna, Austria, (Available at: http://www.eastwestcenter.org/fileadmin/stored/pics/03%20Building_Trust_in_Government_Pakistan.pdf).

Francis Fukuyama. 1995 Trust: The social values and the creation of prosperity, New York, Free press. Cited on Ethnicity and Trust: Evidence from Russia Author(s): Donna Bahry, Mikhail Kosolapov, Polina Kozyreva and Rick K. Wilson Source: The American Political Science Review, Vol. 99, No. 4 (Nov., 2005), pp. 521-532Published by: American Political Science Association Stable URL: (Available at: http://www.jstor.org/stable/30038962Accessed: 05-03-2015 11:39 UTC).

Gilson, L., Palmer, N., & Schneider, H. (2005), "*Trust and Health Worker Performance: Exploring a Conceptual Framework Using South African Evidence"*. Social Science and Medicine.

Gilson, L. 2003, *"Trust and the Development of Health Care as a Social Institution",* Social Science and Medicine, vol. 56, pp. 1453-1468.

Hall MA, Dugan E, Zheng B, Mishra AK. (2001). "*Trust In Physicians And Medical Institutions: What is it, can it be Measured, and Does it Matter?"* Milbank Q.79 (4):613-39 (Available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=285943).

James Warner Björkmanzm, (1985) "*Health Policy and Politics in Sri Lanka: Developments in the South Asian Welfare State"*, Asian Survey, Vol. 25, No. 5 (May, 1985), pp. 537-552Published by: University of California PressStable Available at : http://www.jstor.org/stable/2644406. [Accessed: 27/01/2015 08:17]

Jan Delhey, Kenneth Newton; 2003, *"Who Trusts? The origins of social trust in seven societies",* European Societies, Taylor & Francis Ltd (Available at: https://books.google.lk)

Kawulich, Barbara B. (2005). *"Participant Observation as a Data Collection Method"* Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 6(2), Art. 43, (Available at: http://nbn-resolving.de/urn:nbn:de:0114-fqs0502430).

Kumlin, S., & Rothstein, B. (2002, August). *"The welfare state and social capital"*. Paper presented at the Scandinavian Political Science Conference, Aalborg, Denmark (Available at: http://www.istiseo.org/pdf/summerschool/2014/Ferragina.pdf).

Lee YY, Lin JL. *"Trust but Verify: The interactive effects of trust and autonomy preferences on health outcomes".* Health Care Anal. 2009 Sep; 17(3):244-60, (Available at: http://philpapers.org/rec/LEETBV).

Marshall, C. a. Rossman, G.B. (1999). "*Designing qualitative research Thousand Oaks*", Sage Publications, (Available at: lhttp://www.amazon.com/Designing-Qualitative-Research-Catherine-Marshall/dp/141297044X).

Mahipala P.G., (2011). "*Public Health Interventions then and Now How They Will Shape the Future Health System in Sri Lanka (Presidential Address)",* The Sri Lanka Journal of Medical Administration, Volume 13, College of Medical Administrators of Sri Lanka. (Available at: http://www.cmasl.lk/download/2011_03%20%20Sri%20Lanka%20Journal%20of%20Medical%20Administration%20Vol%2013.pdf).

Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995), "*An Integrative Model of Organizational Trust".* Academy of Management Review, 20: 709–734.

Mishler, W. & Rose, R. (2001). *What are the Origins of Political Trust?: Testing Institutional and Cultural Theories in Post-Communist Societies*. Comparative Political Studies 4(30) (Accessed 20-02-2015 Available at: http://www.u.arizona.edu/~mishler/TRUSTorigins.pdf).

Michael Calnan and Rosemary Rowe (2005), "*Trust Relations in the 'New' NHS: Theoretical and Methodological Challenges",* 'Taking Stock of Trust' E.S.R.C Conference, London School of Economics (Available at: http://www.hsrc.ac.uk/Current_research/research_projects/public_trust.htm)

Muhammad Anisuzzaman (2012). "*Trust within Field Bureaucracy: A study on District Administration in Bangladesh",* Master in Public Policy and Governance Program, Department of General and Continuing Education. North South, University, Bangladesh, (Available at www.mppg-nsu.org).

Mead N, Bower P (2000). *"Patient-centeredness: a conceptual framework and review of the empirical literature".* Social Science and Medicine 51:1087–1010, (Available at: https://ideas.repec.org/a/eee/socmed/v51y2000i7p1087-1110.html).

Rose, L.E., & Pettersen, P.A. (2000). "*The legitimacy of local government-What makes a difference? Evidence from Norway".* K. Hoggart & T.N. Clark (Eds.), Citizen responsive government. Research in Urban Policy, vol. 8. Amsterdam: JAI Press (Available at: http://www.emeraldinsight.com/doi/abs/10.1016/S1479-3520(00)80006)

Ravi P. Rannan-Eliya and Lankani Sikurajapathy (2009). "*Sri Lanka: "Good Practice" in Expanding Health Care Coverage",* Research Studies Series, Number 3, Colombo, Institute for Health Policy.

Ravi P. Rannan-Eliya and Nishan de Mel, (1997). *"Resource Mobilization in Sri Lanka's Health Sector"* Research International (Pvt.) Ltd, Sri Lanka.

Sarbani Kattel (2010). "*Doctor Patient Communication in Health Care Service Delivery: A Case of Tribhuvan University Teaching Hospital"*, Kathmandu. Master in Public Policy and Governance Program, Department of General and Continuing Education. North South, University, Bangladesh. (Available at: www.mppg-nsu.org).

Steinar Askvik, Ishtiaq Jamil and Tek Nath Dhakal (2011). *"Citizens' Trust in Public and Political Institutions in Nepal"*. International Political Science Review / Revue international de science politique, Vol.32, No. 4 (SEPTEMBER 2011), pp. 417-437, SAGE publication Limited. Available at : http://www.jstor.org/stable/41308702. Accessed: 27/01/2015 07:44pm.

Steven Van De Walle and Frederique Six (2013). "*Trust and Distrust Concepts: Why Studying Distrust in Institution is Important",* Journal of Comparative Policy Analysis Research and Practice, London. (Available at: http://www.tandfonline.com/loi/fcpa20 Accessed on : 23rd of Apr 2013 at: 02.35pm)

Sarath M. Samarage 2006, *"Migration and human resources for health: From awareness to action"*, Health Care System: Sri Lanka, Ministry of Healthcare & Nutrition, Sri Lanka, CICG Geneva (Available at: https://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/microsites/IDM/workshops/mhrh23240306/abstract_samarage.pdf)

Shanti Dalpatadu, Prasadini Perera, Ruwani Wickramasinghe, Ravindra P. Rannan-Eliya (2012). *"Public hospital governance in Sri Lanka :A case study on processes and performance",* Institute for Health Policy. Unpublished analysis of Private hospitals and nursing homes database 1990-2011. Colombo, Sri Lanka.

Street. R. (1991). *"Information-giving in medical consultations: the influence of patients' communicative styles and personal characteristics*". Social Science and Medicine 32:541–548, (Available at: http://www.freepaperdownload.us/1773/Article2778880.htm).

Storey, William Kelleher. "*Writing History: A guide for Students*" New York, NY: Oxford University Press, 1999, p.18. (Available at: http://web.calstatela.edu/library/guides/pswhat.htm).

Tom Christensen and Per Li1egreid 2005. studied on, *Trust in Government: The Relative Importance of Service Satisfaction, Political Factors, and Demography*, Public Performance & Management Review, Vol. 28, No. 4 (Jun., 2005), pp. 487-511, Available at http://www.jstor.org/stable/3381308. Accessed: 25/02/2015 02:27.

Titmuss, R. 1968, *Commitment to Welfare* George Allen and Unwin Ltd, London.

Thom, D., Hall, M., & Pawlson, L. (2004). *"Measuring Patients' Trust in Their Physicians When Assessing Quality of Care",* Health Affairs, VOL, July/August, pp. 124-132.

Thom, Hall Pawlson (2004) cited on Michael Calnan and Rosemary Rowe, 2005; "*Trust relations in the 'new' NHS: theoretical and methodological challenges",* Talking Stock of Trust E.S.R.C. Conference, London School of Economics. (Available at: http://www.hsrc.ac.uk/Current_research/research_projects/public_trust.htm.

Tuckett D, Boulton M, Oban C, Williams A,. (1985). *"Meetings between experts: an approach to sharing ideas in medical consultations".* Tavistock Publications, London.

Vijayaprasad Gopichandran and Satish Kumar Chetlapalli, 2013, *Dimensions and Determinants of Trust in Health Care in Resource Poor Settings – A Qualitative Exploration,* School of Public Health, Sri Ramaswamy Memorial University, Tamil Nadu, India Madhukar, Pai, McGill University, Canada, (Available at: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0069170).

Virginia A. Chanley Thomas J. Rudolph Wendy and M. Rahn; 2000. *The Origins and Consequences of Public Trust in Government : A Time Series Analysis* The Public Opinion Quarterly, Vol. 64, No. 3 (Autumn, 2000), pp. 239-256, Oxford University Press (Available at : http://www.jstor.org/stable/3078718. Accessed: 21/02/2015 01:17.

Yin, R. K. (2003). "*Case Study Research: Design and Methods"* 3rd edition. California: Sage Publication, (Available at: http://www.hampp-ejournals.de/hampp-verlag-services/get?file=/frei/ZfP_1_2012_93).

Williams, MV. Davis, T., Parker, RM., Weiss, BD., (2002). "*The role of Health Literacy in Patient-Physician Communication*." Family Medicine, Vol. 54, Issue 5: 383-389.

World Health Organization (2014), "*Country Cooperation Strategy at a Glance".* Available at http:// www.who.int/countries/en/ Accessed on : 26th of Apr 2015 12.30 pm).

APPENDICES

Appendix: 1

Patients' Survey Questionnaire

Part A: Socio-economic background of patients

1. Gender: Male ☐ Female ☐

2. Age of patient:
   (a) 15-25 ☐ (b) 26-35 ☐ (c) 36-50 ☐ (d) 51 or above ☐

3. Language of patient:
   Sinhala ☐ Tamil ☐

4. Ethnicity
   Sinhala ☐ Tamil ☐ Muslim ☐

5. Religion
   Buddhist ☐ Hindu ☐ Muslim ☐

   Christian ☐ Others ☐

6. Level of education

Bachelor/ Higher degree	☐	Higher secondary level	☐
Secondary level	☐	Lower secondary level	☐
Primary level	☐	Illiterate	☐

7. Occupation of patient

Estate worker	☐	Farm worker	☐
House wife	☐	Business	☐
Government	☐	Other	☐

8. Distance from residence to hospital: …….

Part B Patient information

1. What is the illness to admit the hospital …….
2. Did the doctor inquire about your illness clearly?

   Yes ☐ No ☐ Sometimes ☐

3. Do you think the doctor listen to you carefully/ seriously?

   Yes ☐ No ☐

4. During your hospital visit, how well did the doctor explain to you about your illness, or examinations/ tests and medications that you are given?

   (a) Very well ☐ (b) Good ☐ (c) Sometimes ☐ (d) No ☐

5. If not, to whom s/he refers you to communicate regarding the above mentioned things?

   1. ----------
   2. ----------
   3. ----------

6. Did you understand what you were told about the treatment?

   Yes ☐ No ☐ Sometimes ☐

7. Did you get enough time with the doctor to discuss about your treatment and about your future necessities and prevention?

   Yes ☐ No ☐ Sometimes ☐

8. Are you satisfied with the time allocated by the doctor for you?

   Yes ☐ No ☐ Sometimes ☐

9. Why did you decide to visit a Doctor?

   (a) They are medical professional

   (b) They can diagnosis my illness

   (c) I believe in him/her treatment

(d) Any other reason ……..

10. Has the consulting with the doctor this time been useful to you?

Yes ☐ No ☐ Some time ☐

11. Do you have any barriers to communicate with the doctor?

Yes ☐ No ☐ Some time ☐

12. If yes, what are the barriers?

(a) Language barrier ☐
(b) Economic barrier ☐
(c) Ethnicity ☐
(d) Gender difference ☐
(e) Status difference ☐
(f) Appearance ☐
(g) Social relationship ☐
(h) Other ……..

13. Did you understand the language used by the doctor?

Yes ☐ No ☐

14. If not, who translated your communication to doctor?

Attendance ☐ Nurse ☐
People who are accompanying with me ☐ other ☐

15. Did you face any difficulties during this visit?

(a) Lack of time to explain about your illness ☐
(b) Lack of concentration listening by doctors ☐
(c) Lack of sufficient explanations ☐
(d) Expensive medicine ☐
(e) Communication gaps ☐

Other……

16. Are you satisfied with care given to you by the doctor?

Yes ☐ No ☐ Not at all ☐

17. If not, why are you not satisfied?

(a) Doctor was not punctual ☐
(b) Poor attention to the doctors ☐
(c) Lack of effective of treatments ☐
Others ……

18. What you think about the Doctor?

(a) Listens to you ☐
(b) Spent enough time to you ☐
(c) Explains about your illness ☐
(d) Friendly and helpful ☐
(e) Gives you good advice and treatment ☐
(f) Answers your questions ☐

Part C: Organization Information

1. To what extent do you have trust on this institution/ hospital?

Low ☐ Medium ☐ High ☐

2. If not, why you not satisfied?

(a) Not enough medicine ☐
(b) Expensive medicine ☐
(b) No place to wait/ sit ☐
(c) Poor attention by doctors and nurses ☐
(d) No improvement of health care services (Sanitation, water) ☐
(e) Not clean ☐
Others ……..

3. Are you satisfied with care you are receiving from hospital?

Not Satisfied	☐	Minimally Satisfied	☐
Somewhat Satisfied	☐	Mostly Satisfied	☐
Completely Satisfied	☐		

4. Do you get enough services from this hospital?

Yes ☐ No ☐ To a certain extent ☐

5. Did you pay any extra fees for treatment or medicine

Yes ☐ No ☐ Some times ☐

6. Did you complain?

Yes ☐ No ☐

7. Do you think doctors/ nurses are enough (number) here to provide service on OPD?

Yes ☐ No ☐

8. Would you recommend this hospital to your friends and family?

Yes ☐ No ☐

9. What is your suggestion to improve this hospital?

……

……

……

……

Appendix: 2

Survey Questionnaire People who accompanying with Patients'

1. Gender : Male ☐ Female ☐

2. Age of patient:

(a) 15-25 ☐ (b) 26-35 ☐ (c) 36-50 ☐ (d) 51 or above ☐

9. Language of patient:

Sinhala ☐ Tamil ☐

10. Ethnicity

Sinhala ☐ Tamil ☐ Muslim ☐

11. Religion

Buddhist ☐ Hindu ☐ Muslim ☐

Christian ☐ Others ☐

12. Level of education

Bachelor/ Higher degree ☐ Higher secondary level ☐

Secondary level ☐ Lower secondary level ☐

Primary level ☐ Illiterate ☐

13. Occupation of patient

Estate worker ☐ Farm worker ☐

House wife ☐ Business ☐

Government ☐ Other ☐

14. What do you think about this hospital facility

(a) Neat and clean building ☐
(b) Ease of finding where to go (Directions, Assistance) ☐
(c) Comfort and Safety while waiting ☐

15. During this hospital visit, how well did the staff explain instructions (finding lab, X-ray, scanning) to you that you could understand?

(a) Very well ☐ (b) Good ☐ (c) Not at all ☐ (d) No ☐

16. In general, would you say that health care service is

Very good ☐ Good ☐ Fair ☐
Poor ☐

17. Are you satisfied with the service given to the patients by the hospital staff?

Yes ☐ No ☐

18. If not, why you are not satisfied?

(c) Not enough medicine ☐
(d) Expensive medicine ☐
(b) No place to wait/ sit ☐
(c) Poor attention by doctors and nurses/ lab attendants or supportive staff ☐
(d) No improvement of health care services (Sanitation, Canteen, Water) ☐
(e) Not clean ☐
Others ……..

19. Are you satisfied of the way that the doctor examines, counsel and explain to your illness?

Not Satisfied ☐ Minimally Satisfied ☐
Somewhat Satisfied ☐ Mostly Satisfied ☐
Completely Satisfied ☐

20. Do you think whether there were sufficient doctors/ nurses and supportive staff to provide service and full fill the patient needs in the OPD?

Yes ☐ No ☐ To a certain extent ☐

21. Would you recommend this hospital to your friends and family?

Yes ☐ No ☐ Not at all ☐

22. What are your suggestions to improve this service?

……

……

……

……

Appendix: 3

Survey Questionnaire for Doctors

1. Age:
   (a) 20-30 ☐ (b) 31-40 ☐ (c) 41 years and above ☐
2. Gender:
   (a) Male ☐ (b) Female ☐
3. Language:
   (a) Sinhala ☐ (b) Tamil ☐ (c) Other ☐
4. Position / Specialty: _____
5. Do you have any difficulties in communicating with Patients?
   Yes ☐ No ☐
6. If yes, Please identify some reasons

   ……
   ……
   ……
   ……
7. Do you believe that effective communication with patients will lead to greater health outcome and patient satisfaction?
   Yes ☐ No ☐ Sometimes ☐
8. What kind of patients that you are having difficulties in treating?
   (a) Uneducated ☐
   (b) Male ☐
   (c) Female ☐
   (d) Patients from Estate/ villages ☐
   (e) Patients from the city ☐

(f) Older patients ☐

(g) Younger patients ☐

If other, Please specify_____

9. Do you understand any language used by the patient?

Yes ☐ No ☐ Somehow ☐

10. Have you ever failed to reveal the truth to a patient about his/her condition?

Never ☐ Sometimes ☐ Often ☐

Usually ☐ No answer ☐

11. Do you face any obstacles in delivering an effective health service?

Yes ☐ No ☐

12. When a patient needs further treatment/ test/ examination etc... Who decides about it?

(a) I generally decide and direct the patient ☐

(b) I decide it according to the interest of patient ☐

(c) The patient and I decide together after discussion ☐

(d) The patient is asked to decide based on information given by me ☐

(e) The patient decides by him/her self ☐

13. What are the necessary factors influence in having a proper and effective doctor-patient relationship?

……

……

……

14. Do you have any suggestions to improve the service delivery of this hospital?

……

……

……

……