

Assessment of the Satisfaction of Families of Inpatients in Ilocos Training and Regional Medical Center

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Abstract — There is a pressing need for a universal method or indicator for the assessment of satisfaction beyond patient perception and deficiency on responsiveness of health systems.

This study was conducted to assess the satisfaction of present-day Filipino families regarding the services and support for their index patients according to Universal Health Care Act's Implementing Rules and Regulations. Gathered information may shape future healthcare policies. The family members were screened to ensure the diversity of the respondents. The distribution of respondents is based on Age, Biological Sex, Relationship with the index patient, Highest educational Attainment and Religion. It also considered respondents based on their index patient's length of stay in the hospital.

Data collated from the study exhibited the level of satisfaction of participating family members on Comprehensive Healthcare Service Provision which was divided into five areas namely Promotive and Preventive Care; Curative, Rehabilitative and Palliative Care; Accessibility to healthcare; Health Financing; and Medical Information Management.

The level of satisfaction of family member respondent in terms of Promotive and Preventive Care had an 88.86% satisfied to very satisfied rate, with 11.14% moderate to severely dissatisfied.

For Curative, Rehabilitative and Palliative Care, 91.11% rated satisfied to very satisfied, with less than 10% moderate to severely dissatisfied (8.89%).

Accessibility of healthcare had the highest satisfaction rating at 92.29% with a little more than 5% dissatisfaction.

More than 90% respondents regarded as Satisfied to Very Satisfied and around 9.0% moderately dissatisfied to severely dissatisfied when it comes to Health Financing area.

With the Medical Information Management provided by the facility, there were 91.36% satisfied to very satisfied and 8.64% moderately dissatisfied to severely dissatisfied family member respondents.

In general, the overall satisfaction of participating family members was 90.11% satisfied to very satisfied. Only few family member respondents were moderately dissatisfied to severely dissatisfied (9.89%).

Keywords — *Assessment of Family Satisfaction*

I. Introduction

The biopsychosocial approach as a model in clinical practice introduced in 1977 by Engel(1) has shifted the paradigm of healthcare philosophy to focus beyond the pathophysiological needs of patients mostly derived from the best professional opinions of physicians, thus placing patients at the center of decision making in health (2). This philosophy is clearly considered by the

World Health Organization by including patient-responsiveness of health systems as a domain indicator to attain health-related Sustainable Development Goals (3a). The indicator for responsive health systems remains to be determined (3b). The aforementioned philosophy is also adopted by the Philippine National Objectives for Health 2017-2022 with the advent of the Universal Health Care Act in the Philippines enacted last February 2019, aligning to the health-related Sustainable Development Goals (4). With efforts to achieve Ambisyon 2040 of the Philippine Development Plan: Matatag, Maginhawa at Panatag na Buhay, these national objectives for health aim to monitor the strategies to be employed in the achievement of goals (5a), particularly Goal number 2; however, similar to the gap recognized by the WHO, there is a need for more suitable indicators for health system responsiveness (5b) since the present scorecards have yet to show impact (5c).

As a DOH-retained institution, Ilocos Training and Regional Medical Center guided by its quality policy (6) has employed patient satisfaction surveys (7) in its different sites of care. Lacking however, is the consideration for patients' families as allies in patient-care, as to the impact of illness on the remodelling of family psychodynamics and even structure (8a) and as units of care on being entry points for health promotion and disease prevention, and even on being possible future patients as well (8b). No study has ever directly associated patient satisfaction survey scores with satisfaction of the family members. Hence the need to create a tool that can measure family satisfaction in the primary and secondary care settings to complement the information provided by patient satisfaction surveys, so that health care policies can be better informed (3c), like the public health effects observed from the tobacco excise tax law (9), so that health institutions can better address the demands of Universal Health Care that is people-oriented and comprehensive; likewise, primary care providers can have a more holistic understanding of the patients and their families.

Family satisfaction surveys though are not new in health care; their paucity however seemed limited for the purpose of being substitutes to patient satisfaction surveys when the latter is deemed impossible if not impractical to implement: when the patient is unconscious or in the critical care unit, when the patient is for end-of-life care (10, 11) or when the patient is a minor (12). Moreover, the published article available in the Philippines which was closest to the concept of family-oriented care was a study implementing the FS-ICU-24 at UP-PGH intensive care unit (13). These limitations defeat the purpose of providing family-oriented care that is inclusive at the level of primary and secondary care where majority of patients are encountered (8b).

The National Unified Health Research Agenda (NUHRA) 2017-2022 of the Philippine National Health Research System or PNHRs encourages six research themes that are catered to focus on the needs of Filipino patients, especially those in a geographical locality; one of them is "responsive health systems" and "holistic approach to health and wellness"(14); this is cascaded through the Regional Unified Health Research Agenda (RUHRA) 2017-2022 of Region I (15) prioritizing researches on health governance and policies. With the unique culture and behaviours of Filipinos and of Ilocanos, possibly furthered by the unique behaviours and expectations of present-day families coined Millennials and Generation-Z, the formulation of this tool is structured

to begin with qualitative studies that will catch the opinions of present-day family members in the primary and secondary sites of care of Ilocos Training and Regional Medical Center; furthermore, results of its preliminary studies may be used as a parameter to measure healthcare system responsiveness in ITRMC.

Objectives

General Objective

This study aims to assess the satisfaction of family members of index patients of Ilocos Training and Regional Medical Center (ITRMC) regarding health services provided in the hospital.

Specific Objectives

To determine the family satisfaction of the participating family members of index patients regarding Ilocos Training and Regional Medical Center's (ITRMC) health care delivery as to:

- Promotive and Preventive Care
- Curative, Rehabilitative and Palliative Care
- Accessibility of Health Care
- Health Financing
- Health Information Management

To determine the overall family satisfaction of index patient on comprehensive health care service provision.

II. Methodology

Design

The study design is descriptive using a construct-validated questionnaire. Construct validation done prior to the study is described in the Development of Data Collection Tool.

Materials

Data Collection Tool

Data collection tool in this study refers to the paper questionnaire used to gather information from respondents and collect data.

Informed Consent Forms

These were based on the WHO template (21) for informed consent in qualitative studies. Consent forms were translated in English, Tagalog and Ilocano to ensure all respondents are competent to make a voluntary decision about whether to undergo and participate in the study.

Methodology

1. Development of Data Collection Tool

The preliminary part of the study followed an abridged version of the recommendations of Collingridge (16), a stepwise approach summarizing the different types of validation methods (17). The researchers created a pool of questionnaire-items as guided by the UHC Act of the country (18, 19). These questionnaire-items underwent construct validity testing through a pilot-study for principal component analysis and reliability testing.

Satisfaction parameters for family members included in the questionnaire guided by the areas of the Implementing Rules and Regulations of the Universal Health Care Act, those which are of concern to patients and their families (18, 19).

Satisfaction regarding Comprehensive Healthcare Service Provision surveyed the five areas of care namely Promotive and Preventive Care; Curative, Rehabilitative and Palliative Care; Accessibility of Health Care and Medical Information Management.

Items guided by the USPSTF (20) were used for promotive and preventive care. (9 Items)

- Promotive Care
- How satisfied are you on how we treated your patient regarding:
 - ♣ Education on how to keep your patient healthy?
 - ♣ Evaluation of risk factors that may affect your patient's health?
 - ♣ Advice for screening tests appropriate for your patient's age and sex?
 - ♣ Formulation of vaccination schedule for your patient?
- Preventive Care
- How satisfied are you on how we treated you as family member regarding:
 - ♣ Evaluation of your own health status?
 - ♣ Education on how to keep you healthy?
 - ♣ Evaluation of risk factors that may affect your health?
 - ♣ Advice for screening tests appropriate for your age and sex?
 - ♣ Formulation of vaccination schedule for you?

Vignettes from the FS-ICU-24 (11) were modified and used for the questions on curative, rehabilitative and palliative care. (9 Items)

- Curative, Rehabilitative and Palliative Care
- How satisfied are you on how we treated your patient regarding courtesy, respect and compassion that we gave to your patient?
- How satisfied are you with the amount of care time and our willingness to answer and explain for your questions?

- How satisfied are you with the inclusion of your patient in planning for his/ her own health?
- How satisfied are you with your participation in the decision-making for your patient?
- How well did we show interest and provide emotional support to you?
- How well did we coordinate our teamwork?
- How complete is the information we gave on what was happening to your patient and why things are done?
- How similar was the explanation given to you by the doctor, by the nurse, and by other staff members?
- Overall, how satisfied are you on how we treated your patient regarding assessment and treatment of your patient's pain, breathlessness, agitation and other symptoms?

Satisfaction regarding Accessibility of Healthcare had survey coordination of either population-based or institution-based referral system (19). (4 items)

- Accessibility of Healthcare
- How satisfied are you on how we referred your patient to the:
 - ♣ Health facility most easily accessible to your family?
 - ♣ Healthcare providers whom you see to be skilled for your patient's need?
- How satisfied are you with the time and effort we gave to plan your patient's follow-up so that treatment is continuous?
- How satisfied are you with the distance of the different departments inside the hospital?
- How satisfied are you with the distance of the hospital to your home?

Satisfaction regarding Health Financing were surveyed out-of-pocket spending, perceived fairness of healthcare costs (i.e., diagnostics, medications/ surgery/ therapy)and support systems (19).(10 items)

- Health Financing
- How satisfied are you on how much was spent using your family's budget (i.e., outside of Philhealth and HMO insurance)?
- How satisfied are you with appropriateness of healthcare plans such as:
 - ♣ Laboratory tests and biopsies?
 - ♣ X-Rays, CT scans and other imaging tests?
 - ♣ Medicines?
 - ♣ Surgical and dental procedures?
 - ♣ Physical and other therapies?
- How satisfied are you with the financial support provided for your patient by:
 - ♣ Philhealth?
 - ♣ The institution's social services?
 - ♣ Other government agencies such as LGUs?

- How satisfied are you with our efforts to find and mobilize financial support?

Satisfaction regarding Medical Information Management had surveyed the ease in the access of patient health records, data privacy and data security (19). (7 items)

- Medical Information Management
- How satisfied are you on how easily your patient can acquire needed papers such as:
 - ♣ Diagnostic test results?
 - ♣ Home instructions, follow-up instructions and prescriptions?
 - ♣ Clinical summaries or abstracts?
 - ♣ Medical certificates?

- How satisfied are you on how well we maintain your patient's privacy?
- How satisfied are you on how well we explain and seek your patient's permission when medical data will be used for purposes such as research or public health?
- How satisfied are you on how well we keep and secure your patient's medical records?

The expert was identified based on her knowledge in family dynamics, public health and research, and experience in handling patients and families in clinical practice (see Curriculum Vitae of Contributors). The expert was oriented on the objective of the study, the construct which the questionnaire tried to measure, and she generally assessed parameters looked valid measures of family satisfaction and which seemed otherwise, from the point-of-view of families, based on her expert opinion. The draft was sent to her in a medium she preferred, and her response was collected. The expert deciphered which satisfaction-parameters best represented the main construct under study. Additional satisfaction-parameters were requested from the expert.

The face-validated questionnaire was sent to a professional translator-editor to contain 3 translations: English, Tagalog and Ilocano. Likert scales of 1 (very dissatisfied), 2 (moderately dissatisfied), 3 (satisfied) and 4 (very satisfied) were attached to each satisfaction-parameter, in preparation for the pilot study. An epilogue was attached at the end of the questionnaire containing "What is your suggestion on how best the medical services provided for your family member be improved?" (This was also provided to the professional translator mentioned above).

For the pilot-study, participants were aged 19 to 59 years, with any level of literacy, and conversant with either English, Tagalog and/or Ilocano languages, who were recognized as family members by index patients in the DCFM ward. Excluded in the pilot-study were family members suspected or diagnosed with any psychiatric condition. Participants who were themselves or whose index patient within the 3rd degree relations were employed in any DOH-retained institution were also excluded from the pilot testing to minimize undue influence or duress. Sampling was convenience, purposive until 12 participants were identified. Identified index patients were asked to identify their respective family member, preferably the main decision-maker involved in the

health care of the patient. The purpose, procedures, rights, risks and benefits of the study were comprehensively explained to the family member in a secure and private setting. Consent was secured with utmost consideration of privacy (see Informed Consent Forms). The family member was invited to a location the participant wished for the pilot-testing. The consenting participants were assigned a code then given instructions on how to answer the draft's Likert scales. Contact information kept completely confidential by the researchers were secured for purpose of sharing the results in the future. To maximize accuracy, the contents or "meanings" of the parameters in the drafts were NOT explained. Maintenance of confidentiality throughout the pilot-study was emphasized so that their identity and those of their patients were kept private and that the medical services given to their patient and to them would not be affected by the pilot-study. All responses were collected for data cleaning and encoding. The collected responses were plotted on an MS-Excel file (or spreadsheet) accomplished by a pair of encoders: one verbally read the values while the other entered the values on the spreadsheet (This strategy aimed to minimize coding error). The results were forwarded to a biostatistician for analysis. Preliminary principal component analysis was conducted by identifying the satisfaction-parameters in questionnaire that shared similar concepts. Likewise, initial internal consistency of the questionnaire was identified for reliability testing by calculating the value of Cronbach alpha. The draft was edited by deleting satisfaction-parameters or placing them as parameters of separate component/s if deemed very important by the authors and advisers until the Cronbach alpha value became >0.7 .

2. Selection of study participants and Data Collection

For the study's main part, a sample size of 383 participants was computed using the free online application of www.openepi.com with a 95% confidence interval, anticipated frequency of 50% and design effect of 1.0; based on the census of the hospital's Ward of 108,834 index patients from January to September 2019. Sampling was systematic random.

Included for the study were participants aged 19 to 59 years, with any level of literacy, and conversant with either English, Tagalog and/or Ilocano languages, who are recognized as family (16) by index patients in the ALL regular wards (at least 48 hours of admission). Excluded in the study were family members suspected or diagnosed with any psychiatric condition. Participants who were themselves or whose index patient within the 3rd degree relations were employed in any DOH-retained institution were also excluded from the study to minimize undue influence or duress. Family members whose index patient was managed in the ICU during the present admission are also excluded.

The sampling used was systematic random among the admitted patients (as guided by the admitting office). Identified index patients were asked to identify their respective family member, preferably the main decision-maker involved in the health care of the patient. The purpose, procedures, rights, risks and benefits of the study were comprehensively explained to the family member in a secure and private setting. Then, consent was secured with utmost consideration of

privacy (see Informed Consent Forms). Once consented, the family member was invited to any location the participant wished for the study.

The consenting participants were assigned a code then given instructions on how to answer the questionnaire's Likert scales (i.e., placing a check on the Likert score of their response). Additional information including the age, biological sex, highest educational attainment, religion, perceived relationship with the index patient, and duration of the index patient's hospital stay were collected for purposes of demographic analysis. Contact information kept confidential completely by the researchers were secured for purpose of sharing the results in the future. To maximize accuracy, the contents or "meanings" of the parameters in the drafts were NOT explained (i.e., SELF-ADMINISTERED). Due to present shortage of possible GCP-certified research assistants, maintenance of confidentiality throughout the study had been EMPHASIZED when securing informed consent; it was reiterated to patients that their identity will be kept private at all times and that the medical services given to their patient and to them now and in the future will not be affected by this study. Participants were attended and accompanied during the entire course of the study. There were no participants who showed signs of or overtly develop or verbally expressed psycho-emotional difficulties during the answering of the questionnaire. The contact numbers of the participants to the study were collected for purpose of results-sharing alone, while maintaining utmost confidentiality by keeping all collected information in a locked cabinet accessible only to the principal investigator and co-investigator.

All responses using the questionnaire (see Data Collection Tool) were immediately collected for data cleaning and encoding. The collected responses were plotted on an MS-Excel file (or spreadsheet) which was accomplished by a pair of encoders: one verbally read the values while the other entered the values on the spreadsheet. Inappropriately answered parameters were excluded in the statistical analysis.

3. Ethical Consideration

Social Value

- Relevance

This study will help provide information that will complement patient satisfaction surveys in the provision of medical services that is patient-centered and family-oriented, catered to the needs of present-day Ilocanos; promoting the well-being of patients, families and even communities. This study may contribute to the NUHRA 2017-2022 as mentioned in the Introduction.

- Results-dissemination Plan

Once published, this study may primarily provide a tool that can be used by the institution, the region and even the country to assess family satisfaction. The results will be shared with all

participants from pilot-study to the study-proper. The results of the study will be shared with the institution as archived by the REC, which may help provide complementary information to guide policies. Likewise, future interested researchers may learn from this study's methods and results through publication in respectable journals of the country.

- Informed Consent Procedures

All participants in the study were thoroughly briefed and asked to sign on the informed consent form. Prior to signing of the consent form for the family members in the study, the participants were asked on their preferred site for briefing on the study and the signing of the consent; and were offered the DCFM office for such site. Essential information including but not limited to the names, contact numbers and affiliations of authors; objectives and methodology of the study; contact number of REC; respect for privacy; sharing of results at the end of the study; compensations (i.e., zero) were disclosed.

The consent will be valid only for one year or upon completion of the study whichever comes first. If the consent expires, significant changes, new information and developments in the study will be explained prior to repeat signing of consent. This was also explained to each participant.

The consent forms were explained to each participant in a language that is best understood. Undue influence or intimidation were avoided. Participants were assured that the present medical services provided for the index patient and other family members are maintained at best quality; regardless of decision to participate or not.

After the briefing, the participants were asked for any further questions regarding any matter about the study. Feedback were requested regarding the purpose, benefits and risks of the study to maximize understanding.

The participants who agreed to join, were asked to affix his/her name and signature on the consent form (see Informed Consent Forms).

- Vulnerability of Research Participants

Children and the elderly can be index patients but were not included as participants in the study. Participants suspected or diagnosed with any psychiatric condition were excluded. Members of the indigenous groups, pregnant women, differently abled persons, and members of the LGBT community were included in the study. Cautions were taken in the conduct of the study with utmost consideration for their cultures, conditions and preferences. To avoid undue influence, participants who were themselves or whose index patient were employed in any DOH-retained institution were excluded from the study.

- Risks, Benefits and Safety

Participants, both patients and family members of patients will benefit from this study in the furtherance of quality of patient-centered, family-oriented care by helping provide information that may influence future policies in healthcare. Before the signing of the informed consent form, participants were briefed on all the possible benefits and psycho-emotional risks expected from this study. Participants were provided support through appropriate referrals for debriefing and counselling.

- Privacy and Confidentiality

Privacy of participants were maximized by assigning codes; and sensitive information and any identifier were kept confidential throughout the study duration.

It was explained to each participant in the study prior to consent, that if in case, although unlikely, any illegal or harmful behaviour is uncovered, confidentiality may be breached, hence reporting and referral to Ilocos Training and Regional Medical Center (ITRMC) Legal Office for needed actions will be initiated by the investigators.

Data collected from the study were accessed only by the investigators who were accountable for their disposition and safety. Encoders, biostatistician and advisers were briefed on and will not have any access to the identity of all participants.

All data collected whether written or digital, especially those that may identify participants will be permanently destroyed upon completion of the final research paper.

- Justice

Systematic random sampling in the wards, with appropriate inclusion and exclusion criteria previously stated were used for fair selection of participants.

Prior to signing of consent, lost earnings were discussed with no monetary compensation; and professional fees were not provided for the experts, encoders and biostatisticians for their contributions (details for such fees were disclosed to the REC).

The researchers conducted monthly monitoring for the development of psycho-emotional distress among all participants in the entirety of the study. This was done by contacting participants every month through SMS or Messenger and provided updated reports to the REC every 8 weeks. Such distress did not occur, hence there was no need for the researcher to advise consultation to the OPD nor referral for counselling,

The criteria for authorship of the International Committee for Medical Journal Editors were upheld by all investigators, contributors and advisers. All contributors to this study who completed the definition set by ICMJE criteria were termed co-authors with approval by the REC. The

arrangement of the authors on the final paper were based on the relative amount of contribution of each author and with written agreement between all authors.

- Transparency

Provision of copies of the final draft without any identifying information of all partners: patients, family members and experts, were assured prior to consent and upon completion of the study, were implemented to all partners.

Affiliations and loyalties of the authors that may prejudice the integrity of the results, and the objectives and procedures of the study were disclosed to the REC and all partners. Presently, the authors declared no conflict of interest.

The researchers were open to the REC regarding the monitoring for any occurrence of research misconduct.

III. Results and Discussion

Demographic Profile of the Respondents

The distribution of the respondents was according to their age, biological sex, educational attainment, religious affiliation, perceived relationship with the index patients, and index patient's duration of stay in the hospital (Table 2). Only the respondents who provided the information during the interview were included in the computation. Hence, the total respondents vary.

Analysis of the data revealed that a great majority of the respondents (86.49%) were between 20 and 49 years old. The rest were 19 years old (3.86%) and between 50-59 years old (9.65%). About the biological sex, the percentages of the males and females were not so different where 45.81% were females and 54.19% were males. In terms of educational attainment, around 94.01% were with education up to above secondary-level graduate. Only 5.99% did not have formal education. In terms of religious affiliation, a great majority of the respondents were Roman Catholics (87.90%). The rest were non-Roman Catholics such as Born-Again Christian (2.82%), Iglesia Ni Kristo (2.82%), Anglican (1.21) among others.

Further analysis of the data revealed that a majority of the respondents were spouse (50.56%) and parents (20%) of the index patients. The rest were sons/daughters (10%), relatives (9.44%), siblings/sisters/brothers/sisters-in-law (7.78%), and friends/girlfriends (2.22%) of the index patients.

In terms of duration of stay in the hospital, majority (62.03%) of the respondents said that their index patient stayed in the hospital for less than 5 days. Around 37.34% other respondents said that their index patient stayed in the hospital between 5 days and 30 days. And only a few (0.63%) of the respondents said that their index patients stayed for longer than 30 days.

Level of Family Satisfaction on Comprehensive Health Care Service Provision

The study revealed the level of satisfaction of the participating family members on the five areas such as promotive and preventive care; curative, rehabilitative and palliative care; accessibility of healthcare; health financing; and medical information management. The overall family satisfaction is also presented. Only respondents who provided the information during the interview were included in the analysis. Hence, the total number of respondents for each dimension varies.

The data collection tool contains set of questions for each domain. The response of family members revealed the questions in each area where they were most and least satisfied.

Promotive and Preventive Care

Analysis of the data showed that majority (n=327 or 88.86%) of the 368 participating family members were satisfied to very satisfied on the promotive and preventive care. Advising for screening tests appropriate for patient's age and sex were the reason for most satisfaction (n=342 or 91.94%). About 6.25% (n=23) were moderately dissatisfied. Only few, representing 4.89% (or n=18) of the participating family members were severely dissatisfied about the promotive and preventive care. Scheduling of vaccination was the area of least satisfaction (n=323 or 89.72%).

Curative, Rehabilitative and Palliative Care

Further analysis of the data revealed that majority, (328 or 91.1%) of the 360 participating family members were satisfied to very satisfied about curative, rehabilitative and palliative care. They were most satisfied with team coordination (n=341 or 93.42%). The rest were moderately dissatisfied (n=20 or 5.60%) and severely dissatisfied (n=12 or 3.30%). Respondents were least satisfied (n=330 or 91.16%) with the amount of care time and willingness to answer and explain for their questions (n=333 or 91.16%)

Accessibility of Healthcare

As regards to the accessibility of healthcare, it was noted that a great majority (n=335 or 92.29%) of the 363 participating family members were satisfied to very satisfied. Providing time and effort to plan their patient's follow ups for a continuous treatment was said to be the area they were most satisfied with (n=347 or 93.53%). Only few (n=28 or 7.71%) of the participating family members were moderately and severely dissatisfied. They were however least satisfied with the travel they have to make to the hospital (n=314 or 85.09%).

Health Financing

Ninety percent (321 out of 356) participating family members were satisfied to very satisfied in terms of health financing. 93.70% or n=342 said they were satisfied with the appropriateness of healthcare plans such as the institution's social services. While some other 24, representing 6.74%, were moderately dissatisfied. Only 11 family members, representing 3.09%, were severely dissatisfied. Respondents were least satisfied (n=320 or 89.64%) on how much was spent using their family's budget and on X-rays, CT scans and other imaging tests.

Medical Information Management

The same pattern was seen in terms of medical information management. As shown, around 91.36% (or n=328) of the 359 participating family members were satisfied to very satisfied. They were satisfied with how well the privacy of their patient was maintained (n=346 or 94.02%). The other 6.13% (n=22) were moderately dissatisfied. Only few (n=9 or 2.51%) were severely dissatisfied. Respondents said they were not able to easily acquire their patient's diagnostic tests results (n=359 or 89.97%).

Taken together all the dimensions to get the overall family satisfaction, it showed that around 90% (or n=328) of the 364 participating family members were satisfied to very satisfied. Some 24 families (representing 6.59%) were moderately dissatisfied. Only few (12 or 3.30%) of the 364 participating family members were severely dissatisfied.

DISCUSSION

The responses of each participants were analysed according to the five domains, namely Promotive and Preventive Care; Curative, Rehabilitative and Palliative Care; Accessibility of healthcare; Health Financing; and Medical Information Management. The analysis of data revealed that overall satisfaction of many participating family members was Satisfied to Very Satisfied and only few Severely Dissatisfied to Moderately Dissatisfied.

Promotive and Preventive Care

Participating family respondents were generally satisfied on how their patient was treated. They were informed on how they could help in keeping their patient healthy and were also advised on the risk factors that could affect their patient's health. The Promotive and Preventive Care provided was not only for the patient but also extended to the family members to ensure they look after their own health as well.

Indeed, some evidence does suggest that there are opportunities to save money and improve health through prevention. Studies have concluded that preventing illness can save money in some cases, but in other cases can add to health care costs. (Joshua T. Cohen, 2008)

Curative, Rehabilitative and Palliative Care

The respondents were mostly satisfied with how their patients were treated with courtesy, respect and compassion in assessing, coordinating and managing their condition.

The Institute for Patient- and Family-Centered Care outlines four concepts that underlie patient-centered care: respect and dignity, information sharing, participation, and collaboration (Institute for Patient- and Family-Centered Care, 2011). The National Quality Forum's National Priorities Partnership characterizes patient-centered care as health care that "honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and to differing cultures, languages, and social backgrounds" (NPP, 2010). (Mark Smith, 2013)

Accessibility of healthcare

The Accessibility of Healthcare area presented the highest level of overall satisfaction from participating family members.

The satisfaction level pertained to how accessible are the health facilities to the family members; how skilled the healthcare providers with regards to the patient's needs; the time and effort provided for continuous treatment plan; the distance of the different departments inside the hospital and the distance of the hospital to the family's home.

Access to healthcare is central in the performance of health care systems around the world. In fact, the importance of service delivery for people has resulted in measurement of utilisation and access having a prominent role in the health policy literature. However, access to health care remains a complex notion as exemplified by the varying interpretations of the concept across authors. (Jean-Frederic Levesque, 2013)

Health Financing

The institution's social services; home & follow up instructions and prescriptions are among the areas where participating family respondents were mostly satisfied with. In addition to this, they were also satisfied with the efforts to find and mobilize financial support.

There are many ways to promote and sustain health. Some lie outside the confines of the health sector. The "circumstances in which people grow, live, work, and age" strongly influence how people live and die. Education, housing, food and employment all impact on health. Redressing inequalities in these will reduce inequalities in health. But timely access to health services – a mix of promotion, prevention, treatment and rehabilitation – is also critical. This cannot be achieved, except for a small minority of the population, without a well-functioning health financing system. It determines whether people can afford to use health services when they need them. (WHO, 2010)

Medical Information Management

Participating respondents were satisfied that the handling of medical records, maintaining patient's privacy and seeking permission to use medical data were adequate at ITRMC.

The health information system provides the underpinnings for decision-making and has four key functions: (i) data generation, (ii) compilation, (iii) analysis and synthesis, and (iv) communication and use. The health information system collects data from health and other relevant sectors, analyses the data and ensures their overall quality, relevance and timeliness, and converts the data into information for health-related decisionmaking. (WHO, Health information systems, 2010)

IV. Conclusion

This research was conducted to assess the level of satisfaction of Families of In-patients in Ilocos Training and Regional Medical Center on five areas of Health Care Provision.

Based on all the information and data collected from respondents, it was evident that their overall level of satisfaction was satisfied to very satisfied regarding the health services provided in ITRMC.

The Accessibility of Healthcare is the area where most of the respondents were satisfied to very satisfied. This was followed by Medical Information Management. Not far behind was the Curative, Rehabilitative and Palliative Care. These were followed by the Health Financing then Promotive and Preventive Care as the area with the least satisfied respondents.

Although dissatisfaction level is slightly higher when it comes to the Promotive and Preventive Care, the overall level of satisfaction of respondents is still satisfied to very satisfied.

It is perceptible that the services provided at ITRMC to the patients and its family members are generally adequate with some areas for improvements to further advance the level of healthcare provision.

V. Recommendations

Limitations:

- The researcher strived to provide unbiased information as possible, but there are limitations that could affect the outcome of the study.
- The data collection tool offered participants space for additional comments and explanations for their response. However, there were no feedback or remark received.
- Statistics collated were dependent on the honesty of the participating respondents and how the questionnaires were understood, interpreted and answered truthfully.
- There were areas that were not responded to and only the respondents who provided the information during the interview were included in the computation.

Recommendations:

The following recommendations are hereby made:

- Routinely perform satisfaction survey on index patients including family members
- Encourage feedback and suggestions from index patients including family members and ensure these are evaluated and addressed as necessary
- Conduct training and awareness of all health workers to ensure standardized care is extended not only to index patients but including family members.
- Inclusive and robust assessment of competence of the health workforce to respond to the healthcare needs of index patients including family members.
- Establish a comprehensive and dependable health information system where medical records can be generated readily and identify evidence-based areas for improvement.

- Review the process and improve the turn around time on how patients or family members can easily acquire medical documents (e.g. diagnostic test results, instructions, medical certificates, clinical abstract)
- Strengthen primary care level in their respective areas in order for them to receive the services needed instead of going to higher level facility.
- Different strategies in care in ITRMC could be improve in several aspects and ensure that family members are included throughout the process.:

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