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Case Study.

CLIENTS' PERCEPTION OF QUALITY HOSPITAL SERVICE IN EKITI STATE, NIGERIA.

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In this study, four hospitals out of the twenty - one state government hospitals in Ekiti State were sampled in order to examine the clients' perception of quality hospital service using structured exit interview method. 328 respondents were interviewed. From the analysis, the average score of perceived quality of hospital service was 75 percent from a thirteen- question format. The highest score was for doctor-patient communication (over 90%), followed by drug use explanation (88%). The least score was on adequacy of health personnel especially doctors and nurses (68%), followed by affordability of drug (75%) and availability of drug (76%). Equally the ranking of assessment of quality shows that University Teaching Hospital was first with 91%, Aramoko General Hospital with 90%, Emure General Hospital with 80% and lastly Ikere Specialist Hospital with 77%. These findings and other explanations affirm the people's positive evaluation of best service from the University Teaching hospital while the General Hospitals in the state have better perceived quality than the sampled Specialist Hospital. It is concluded that though there is physical access to existing structures of health care, there is a need to strengthen and improve the quality of health infrastructure and manpower in order to assure of sustained health outcomes.

Keywords: Quality, health, outcomes, care, satisfaction, access, sustainability

INTRODUCTION

Quality health care is concerned with the degree to which the resources for health care or the services included in health care correspond to specific standards. Those standards if applied are generally expected to lead to desired health results. The paper identifies two levels of quality health care; the first is the general conceptualization which involves the system of health care itself and includes the resources, activities, management and the outcomes of the health care in terms of its merit or excellence. The second conceptualization is more specific and restricted; it is more on the resources and activities in relation to standards compliance. Resources include category, types, quantity, their unit cost, and their quality while Activities include type, quantity, effectiveness, coverage and quality. The latter conceptualization was denoted to be more appropriate for operational purpose.

The concern for quality health care was majorly popularized in family planning and reproductive health programs. Kols and Sherman, (1998)'s Population Report was devoted to improving quality. It is defined from public health perspective as offering the greatest health benefits with the least health risks, to the greatest number of people, given the available resources, while other definition will be, satisfying the client's needs. Roener and Montaya-Aguilar (1988) equally affirmed that the initial concern about quality health care has been from the clinical viewpoint.

The Population Report therefore has two perspectives, the provider's perspective which includes issues of cost, efficiency, while outcomes for population and the clients' perspective include issues of "choice of methods, information given to clients, technical competence, interpersonal relations, and mechanism to encourage continuity and appropriate constellation of services". The Report further identifies seven expectations or concerns of clients accessing health services. These concerns include; being treated with respect, personalized service with provider understanding of particular situation and needs, provider of service assuring complete and accurate information, assuring technical competence of providers, ready access to reliable, affordable services, providers to offer thorough explanation and examinations to everyone alike and fulfillment of clients purpose of visit, getting desired result.

In a lucid review of client-centered quality care, Creel *et al.*,(2012) emphasized the importance of addressing client perspectives on quality of care since this will lead to improved client satisfaction, continued and sustained use of services, and improved health outcomes. However the review identifies two dimensions of client perspectives in health care; first before the time of service (outside of the

clinic setting) and second during the time of the service (inside the clinic). Barriers to health seeking informing quality care outside of the clinic include socio-cultural barriers of women autonomy, norms, rumors and myths, gender and discrimination, also access, distance, and costs. The review further explained that clients' perception is shaped by their cultural values, previous experiences, perceptions of the role of the health system, and interactions with providers. They cautioned that, "Clients satisfaction may not necessarily mean that quality is good, it may indicate that expectations are low" or "they want to please the interviewer or fear of the consequence of complaining. This is equally the caution of Courtier (2006) that patient's perception of care does not actually predict clinical protocol or effectiveness. Key elements of quality services within the clinic setting are identified as method choice and availability, respectful and friendly treatment, privacy and confidentiality, competent service providers, information and counseling, convenient schedules and waiting times, and affordable services.

The work of Jayadevappa and Chhatre (2011) extensively reviewed over 143 literatures published between 1910 and 2010 on the subject matter of "patient-centered care". The paper asserts that the concept emerged in the 1950s but popularized in 1990s as a health care research subject. It is defined as care that respects and responds to the individual patient's preferences, needs, and values and ensures that clinical decision incorporates patients' values. It has the benefits of improving communication, appropriate intervention, enhanced satisfaction and patients reported outcomes.

Jelly and Madeley (1983) equally explained the importance of communication skill of health provider in determining patient's assessment of quality. Here quality health care is defined as the extent of communication between the nurses and mothers and the additional support and advice given to mothers with specific problems. This is equally reinstated in study by Oluwadare (1998) where the most recurring factor measuring clients' satisfaction with clinical experience is the personal disposition of the clinic nurse to the mothers.

From the above explanations of the subject matter, this paper examines the level of quality hospital care in Ekiti State using the perspective of the end users of the service. In order to achieve this, two specific objectives are set and they include:

1. To examine the perceptions of the clients, here both patients and care givers to the quality of care provided
2. To use the findings above to recommend the best measures to improve quality of hospital service delivery in the State.

MATERIALS AND METHODS

The study area

Ekiti State is located in the south west Nigeria and its capital city is Ado Ekiti. The 2006 census population was 2.3 million people with annual growth rate of 2.6 percent. There are sixteen local government areas and each is served with at least a General Hospital, two Comprehensive Health Centers and one basic health centre per political ward. There are 283 Primary health Care (PHC) facilities. There are also three Specialist Hospitals, one in each Senatorial District while the state capital has the University Teaching Hospital (UTH). A Federal Medical Centre (FMC) is located in Ido Ekiti being a referral health facility utilized by the whole state. (Ekiti State, 2010a).

Materials and Sampling Process

This study used survey design and structured interview method adapted from existing literature reviewed and its content covers client or patient focused health quality indicators. The interview schedule was previously pretested among 20 outpatient students in a University Health Centre to assure of reliability and validity. Revision was made on the pretested schedule before final use for this study. The sample for this study was taken from the list of all public hospitals under the jurisdiction of the State government. The sampling procedure for General Hospitals and Specialist Hospitals was by simple random sampling after listing of the respective hospitals. The sampling produced the Aramoko General Hospital and Emure General Hospital and Ikere Specialist Hospital while University Teaching Hospital (UTH) in Ado Ekiti was purposively sampled. Thus 11.8 percent of the General Hospitals and one third of the Specialist Hospitals were sampled.

350 interview schedules were administered but 328 responses were eligible for the analysis. Ado UTH and Aramoko GH contribute about 30 percent respectively, while Emure GH and Ikere SH have 15 and 24 percent of the total sample respectively. Assurance of the confidentiality and privacy of research respondents was assured in writing and guaranteed through the authority concerned. Clients in this study were either patients or care givers who volunteered to answer the questions after the interviewer had explained the content or implication of the research to them. Data was analyzed and presented using descriptive method of frequency and multivariate tabulations.

RESULTS

Social Characteristics of the Respondents

Female respondents constituted 57 percent while male respondents were 43 percent. Age distribution showed a mean of 36 years with a little above 30 percent in 20-29 years category. Respondents from age 60 years made up 15 percent of the total respondents. It should be stated that most of the children under age 15 years were represented by their respective care givers in the study.

From the occupational distribution, about one third of the sample was students followed by traders. Civil servants constituted 20 percent. While 10 percent were unemployed or underemployed like housewives and the aged patients or care givers. The occupational distribution dominated by students is reflected in the educational background where more than 60 percent had at least secondary school education. About 14 percent had less than primary school education. Since about one third of the respondents were students, 47 percent of the respondents were also single and 48 percent were married while 4.5% of the respondents were divorced, separated or widowed.

More than one third of the respondents reported malaria as the reason for the hospital visit while bodily injuries and body pains formed the second highest (21%) case for hospital visit. Clients with maternal health related cases like ante-natal visits, deliveries and menstrual pains made 11 percent. Related to this category is that about four percent of the respondents reported STIs and HIV issues. Communicable diseases ranging from typhoid, cough, chicken pox, diarrhea, cholera constituted about 14 percent while about 12 percent responses showed chronic sicknesses like pneumonia, High Blood Pressure, cancer, ulcer and diabetes.

Perception of Quality Hospital Service

Measuring respondents' perception of the adequacy of hospital service was through a structured 20-question schedule which focused on issues of waiting time, communication, assured confidentiality and privacy, adequacy of diagnoses, pharmaceutical and drug services, affordability of service and adequacy of doctors and other health personnel. The responses were either "Yes" or "No" or a 4-point scale of "bad, fair, good and better" which make interpretation easier. Thirteen of the responses are presented in Table 1 and it shows significant positive perception with over 70 percent of respondents affirming quality of medical services provided. Three quarter of the respondents complained that they were not attended to in time with average waiting time across the hospitals as 54 minutes. The range of waiting time was about 20 minutes and three hours.

The highest positive score was on communication between patients and doctors. This was measured by four questions and all of them recorded higher scores than other questions. But adequacy of health personnel recorded the least score. More than 60 percent of the respondents affirmed that there are inadequate doctors and nurses across the hospitals. Equally, service points apart from diagnosis room had lower acceptable perception, the same 24 percent of respondents complained about delayed test results and drug availability in the hospitals. 21 percent complained of negative attitude of other health workers like health technicians, cleaners, and other assistants. Of equal importance were the 22 percent that complained that the pharmacist or pharmacy technician failed to explain the use and possible side effects of drugs dispensed. Also about three quarter complained that they could not afford the price of the drugs prescribed.

A question on overall perception was asked using a 4-point scale of "bad, fair, good and better". This was analyzed in order to explain individual hospital's level of perceived quality of care and presented in Table 2. Ado UTH has the best score in terms of overall positive assessment of good and better which is 91%, followed by Aramoko (90.6%), Emure GH (80%) and lastly Ikere SH (77%). The last two hospitals equally had highest negative scores of over 20 percent, though Ikere SH had the least worse.

Explaining this further, on the representative scores of communication, drugs availability and attitude of health workers, Ado UTH and Aramoko GH still showed better assessment than Ikere SH and Emure GH. But in terms of perceived adequacy of health personnel, respondents in Aramoko GH had the least score of 40 percent far less than 63 percent in Emure GH and 78 percent in Ikere SH. Ado UTH still had the highest score of 98%. Overall Emure GH was least in terms of perceived overall quality service especially given the impact of negative attitude of health workers to uptake demand for health services.

Table 1: Percent Distribution of Respondents' Perception of Hospital Service

S/N	Questions	Responses (N=328)	
		Yes	No
1.	Were you attended to in time?	75.6	24.4
2.	Was explanation of your case done?	91.9	8.1
3.	Were you given Opportunity to explain yourself?	92.2	7.8
4.	Doctor answered your questions?	89.6	10.4
5.	Your privacy guaranteed during diagnosis?	86.8	13.2
6.	Was test result given to time?	76.2	23.8
7.	Did pharmacist explain drugs use and reaction?	88.8	11.4
8.	Drugs prescribed available in the hospital?	76.1	23.9
9.	I can afford the prescribed drugs?	74.9	25.1
10.	Mode of prevention of the sickness explained?	76.5	23.5
11.	Attitude of other health providers were polite?	78.7	21.3
12.	There are enough doctors and nurses?	68.3	31.7
13.	Physical environment tidy enough?	82.6	17.4
	Average	74.7	25.3

Table 2: Percent Distribution of Respondents' Assessment of Hospital Service by Location

Locations	General assessment of hospitals				Total
	1 Bad	2 Fair	3 Good	4 Better	
Ado UTH	4(4.4)	4(4.4)	51 (56.0)	32(34.2)	91 (28.6)
Aramoko GH	1(1.0)	8(8.2)	69(70.4)	20(20.4)	98 (30.8)
Emure GH	0	10(20.0)	38(76.0)	2(4.0)	50(15.7)
Ikere SH	2(2.5)	16(20.3)	49(62.0)	12(15.2)	79 (24.8)
Total	**7(2.2)**	**38(11.9)**	**161 (65.1)**	**63(20.7)**	**318(100.0)**

DISCUSSION

From the above findings, there seems to be a relative and overall good perception of hospitals in Ekiti State with over 70 percent affirming quality on most of the variables. The variables or indicators used in this study; communication skill (privacy of diagnosis session, courtesy politeness, health workers' feedback to clients, opportunity to ask questions), waiting time, drug availability and affordability, physical environment, personnel availability and adequacy, were identified from previous empirical and theoretical literature reviewed and also pretested for validation. But it will be appreciated that there are variations across the hospitals and elements measuring quality service. Ekiti State health system is equally one of the best in Nigeria with health facilities existing in each political wards and avowed impact of health intervention by the Department for International Development (DFID) in strengthening the structure from 2003 to 2006 through health commodity support, capacity building for health staff and the strengthening of the drug revolving scheme which guarantees availability of drugs in over 80 percent of the facilities (Ekiti State, 2010b).

The structure to assure the sustainability of the mechanism does not exist with the collapse of monthly integrated supervisory and support visits by state health officers as attested to by the data file 2007-2010 for all health facilities in the State (Partnership for Transforming Health System, 2008a). The outcome is relative poor availability of drugs and the more the distance from the State Drug Revolving Store, the worse for availability of drug. This is a failed expectation compared to 96 percent availability of drug in 2007 (Partnership for Transforming Health System, 2008b). The challenge of availability is compounded by the cost and affordability of the drugs by the clients in a state that has one of the least GDP per capital in Nigeria and 52.4 percent of the population with absolute poverty (UNDP 2008; National Bureau of Statistics, 2012). The State government will do well to revitalize the drug revolving scheme and make it more affordable and available in all health facilities in the State.

Therefore in this study, though physical access is assured, social access of the people needs to be assured especially according to Williams *et al*., (2000) clinic hours, clinic location, waiting time and health workers disposition before and after diagnosis. In this analysis, the sampled Specialist Hospital had the least score while one of the sampled General Hospital located in Aramoko though with the least score in adequate number of medical personnel (40%) had the highest score for doctor's communication (97%) and positive disposition of other health workers (95%). It therefore shows that the number of available medical personnel is not enough to guarantee clients' satisfaction rather the attitude and personal disposition of available staff. This is the earlier comment of Jelly and Madeley (1983) which emphasized health workers communication skill as most important measure of quality health care.

The State University Teaching Hospital is the referral point apart from the Federal (Government owned) Medical Centre (FMC) located in Ido Ekiti. The latter scored 42.5 percent and 12th among fourteen Federal government owned medical centers in a survey of compliance with SERVICOM standards (Otolorin, 2012). The state University Teaching Hospital had the best perceived quality with overall 91 percent score, but no doubt it also had relative least score of 85 percent in health workers' (doctors not inclusive) attitude to patients. This hospital is structured to be insulated from other direct public control with its separate personnel policy, drug procurement, staff discipline, and importantly clinical protocol. The people also look up to it as the best unlike other hospitals that serves as formal and informal referral points.

CONCLUSION AND RECOMMENDATIONS

In order to make health care service to be more responsive and focus on meeting the needs of the people, client-focused framework must be applied in clinical operations in Nigerian hospitals. Medicine produced by public investments should be directed at achieving health outcomes especially reducing morbidity, reducing call backs and generally producing clients' satisfaction with services. Nigerian people are eager to see the health sector working again and the structure helping to meet the health millennium development goals. But the medical personnel and health care providers especially the doctors and other paramedics must be made to apply all the elements of patient-focused quality service delivery. In this study, elements like availability and affordability of drugs, attitude of health workers to clients, and recruitment of more doctors and nurses came up. All these are germane and since state government is the sole financial of the hospitals, it must ensure that

these basic elements of quality health care are applied. With government increasing budgetary allocation to the health sector focusing on procurement of equipments, building of structures and higher cadre medical personnel with no commensurate sensitization of its hospital manpower to clients' needs, it will not automatically sustain utilization even when immediate access is achieved. Governments at all levels should therefore as part of the health sector reform implement people oriented programs and they should also start a process of capacity building for health staff on client oriented quality health service.

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