HEALTHCARE SERVICES QUALITY IN THE RURAL HEALTH CENTRES AND ITS IMPACT ON NIGERIA CITIZENS

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Abstract

Empowering patients and understanding their views should be central to activities at the Primary Health Care Level. This is because community cooperation and involvement is a high priority of the primary Health Care. This study, based on administered questionnaire to users of primary Health Care examines Patients/Users view of quality of care at the primary level in order to assist care providers to be more responsive to patients needs and, hence, deliver better quality of care. The study employed an additive compensatory model to integrate and stratify respondent’s responses and then subsequently correlate key service quality attributes to determine association. The findings suggest the need to emphasize ‘empathy’ for care providers and the provision of a reasonable level of physical facilities to encourage care seekers/users to place ‘faith’ in primary facilities and hence capacity utilization at the primary level facilities.

Keywords: Health Centre, Primary Health Centre (PHC), Healthcare Customers/Users, Service Quality, Providers, Empathy.

JEL classification: I10, I18

1. INTRODUCTION

Good health is a treasure of inestimable value. It has implications for individual and national economic activities. Indeed, “the health of people not only contribute to better quality of life but is also essential for the sustained economic and social development of a country as a whole” (FMOH, 1998). Health related issues therefore are of strategic concern to all (government, professionals and consumers). Government and stake holders in the health sector are concerned or focused on the provision and maintenance of such levels of
health care and will make it possible for individuals to live socially and economically productive life. That is, Health facilities, reduction of cost barriers, distribution of facilities and access to care that facility relatively ready access to healthcare. This is because poor health generally imposes cost on the society and individuals in terms of reduced ability to enjoy life, earn a living or to work effectively.

Thus the health goal for most governments is the World Health Organization objective of “the attainment by all people of the highest possible level of health (WHO in Lambo, 1989). The pursuit of this objective, that is, health for all, has led many governments to the adoption of World Health Organization’s option: Primary health care (PHC). Primary Health Care represents “essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full involvement (FMOH, 1988). This approach to health care emphasizes the cooperation and involvement of the community as contributors and customers in the health care system.

A community health center is a core institution in the primary health care program. In fact, in many communities in Nigeria it is not only the first point of contact but the only available health practice in the rural areas (Lambo, 1989). Therefore a quality of health care at these primary care facilities is an issue of interest not only for the success of primary health program but for the justifications of the community resources deployed therein. Indeed, health care services are examples of services in which quality is critical. It is demanded, many times, out of necessity. Hence, it is often asserted and demanded that providers supply output of highest quality, an output that produces perceptible health gains or reduction of sufferings (Ann & David, 1998).

Admittedly, quality as applicable to healthcare is difficult to define if one wishes to reflect the values of all interested parties in a coherent statement. That is, users or consumers, government and management. For example, users’ satisfaction with quality of care will reflect on both the technical and interpersonal skills of providers. But professionals’ quality efforts, on one hand, are mainly directed at the efficacy of conventional practices and improvement of technical competence among professionals (Greene, 1976). Mangione-Smith and McGlynn (1998), however, asserted that, the most appropriate measure of quality to use in a particular study is determined by what the investigators are attempting to understand. Measures employed in effort to understand providers, concept of quality may, therefore, differ from when attempting to view health service quality from users or governmental perspective.

The perceived quality of care has demonstrated effect on household decision making with respect to demand for healthcare. Indeed, perceptions of quality care may ultimately be responsible for whether a particular patient or user will be willing to return to a facility and, or refer other people. And, given that, research has proved that satisfaction assessment and service quality perceptions are closely connected, it can be useful to examine Lambo’s comment in terms of user’s perceptions of quality (Fowler, et al 1999; Oswald, Turner, Spipes & Bulter, 1998). Lambo (1989) has observed that capacity utilization at the primary level is grossly low. Consequently, there is overcrowding of the secondary facilities due to patients “lack of faith” in the lower facilities. A lack of faith that is premised on users’ perception of the systems output quality as doubtful and therefore offering little or no help in needful hours. Clearly, providers concept of quality of care cannot readily be evaluated technically by consumers of healthcare; thereby making their perception of quality (hence satisfaction) all the more important to ensure customer retention rates at the primary care
Healthcare Services Quality in the Rural Health Centres and its Impact on Nigeria Citizens

(Dawn and Thomas, 2004; Oswalt et al, 1998). Therefore, the general problem of interest in this study is the issue of quality of care at primary level. In more precise term the study will inquire empirically, into what perceptions users/ consumers have of the care in the primary health centers or put differently their evaluations of the system service on quality term.

The purpose of this study is to gain insight into user’s view of quality of healthcare provided at the primary level. We depart from care providers’ value judgment of quality to users/ consumers judgment as valued by his/ her degree of satisfaction with care. We further seek to determine which of the health care services quality characteristics influences health-care users’ attitude towards care and thereby provide feedback to health workers and Management for learning and change. Consequently, health care providers can then be more responsive to patients needs and deliver better quality care. In addition, community’s perception of quality will not only assist providers to deliver care in manners that reduces users’ perceived risks associated with rural health center but will help enlist communities participations as required in Primary Health Care (PHC).

According to Donabedian Quality of care can be measured by assessing the structure, process or outcome of care. He further argues that most direct route assessment of quality care is an examination of actual process of that care (Donabedian, 1980 in Mangione-Smith et al, 1998). Literature has identified five key features of managerial interest in health care which can be separated into process, structure or outcome. From the works of Lee and Jones (1933); Barr and Gaus (1972) in Greene (1976) four major aspects of quality can be derived efficiency; efficacy, acceptability, accessibility and competence of providers. Indeed, service quality has been found to be multi-dimensional construct that is composed of two sets of attributes: structure and process (Gronroos, 1995).

“Structure” refers to physical environment and facilities in which the service occur while ‘process’ refers to interaction with service personnel within the environment during the service performance, the manner in which the service is delivered to customers. Success and process attribute are quite important to customers satisfaction assessment and service quality perception (Fowler et al, 1999; Oswald et al, 1998). And in healthcare, customers hold normative standards regarding many different aspect of the health care encounter and often perceived quality (and, hence are satisfied) in terms of structure and process (Kravitz, 1996; Zifko – Baliga & Krampf, 1997). During the health care encounter, users or health-care customers are exposed to service attributes that are cognitively processed and help to affect consumers’ perception of quality service delivery leading to his satisfaction (Scotti and Dolinsky, 1997; Aderson & Mittal, 2000; Hanson, 1992)

Furthermore, customers’ perception of quality may be derived from their assessment of the intangible elements associated with the interaction between the customers and health personnel during care. These intangible elements include such customers as responsiveness, courtesy, competence, access and availability of physicians and other hospital staffs (Dawn & Thomas, 2004; Zeithaml et al, 1990 in Bergman & Klefsjo, 1994). Other process characteristics as identified by Reidenbach, et al include care givers expressions of empathy. However, communication and interpersonal aspects of health caring have been found to rank most in important to health customers (Cohen, 1996; Hall & Dornan, 1988; Williams& Calnan, 1991). These considerations from the field within which the concept of this study is located. Our building block for accessing users’ quality of care perception is based on process characteristics as in Dawn and Thomas (2004) and perceives treatment effectiveness. Primary healthcare emphasizes on patient involvement and satisfaction is aimed to be responsive to patients concern and ultimately enhance quality of care.
2. MATERIALS AND METHODS

This study was conducted among users of rural primary health care centers in three villages in a local government in south western part of Nigeria. The local government lies within a transitional zone between the forest and savannah vegetation in the plain of south western Nigeria. The populations for the study were users of these rural health centers, current and past users that could be identified with the assistance of health workers in these centers. Respondents were selected using a purposeful sampling which excludes teenagers of 17 years and under. The aim was exclude respondents who could not comprehend the demand of the research instrument and hence trivialized their responses, in all, samples were drawn for each facilities bearing in mind the size and usage of the facilities to being the sample size to two hundred respondents.

Questionnaire was the main instrument employed for gathering data for this study. In any case, the receivers of services are in the best position to evaluate or relate their opinions on ‘what’ they had received and ‘how’ they had received. The questionnaire was made up of eight questions. A total of two hundred were administered of which one hundred and eighty three were duly completed and returned. The response rate was thus over ninety percent. The questionnaires were distributed through research assistants and health personnel in the health centre’s to past and current users of these facilities. The questions were designed to enable respondents, on the strength of their experiences with these health centers, directly evaluate the care received. These questions were centered on such service quality related variables as “effectiveness” or “outcome of care” received to altering health for better reduction of pains, access to care, skills and knowledge employed by the health personnel in service delivery, that is providers competence, physical facilities, empathy, providers’ courtesy and responsiveness of patients.

Respondents were to indicate their judgment of the care received in these health centre’s on a scale indicating levels of how strongly they believed the attribute specified was to be associated with a particular facility’s service. This is intended to reveal the users sensitivity to each attribute and believe that the care offered in a facility possesses those attributes- a measure of user’s satisfaction with care. An additive “compensatory” model was the employed to integrate respondents self stated ratings on each health centre’s services for each service attribute into a perception of quality, and hence satisfaction, for the centre’s services. These perceptual scores were obtained by combining the perceptual attributes through.

\[
P_{im} = \sum_{k=1}^{8} \alpha_{ikm}
\]

Where
- \(P_{im}\) = the perception scores for centre’s “m” on quality by individual “i”
- \(\alpha_{ikm}\) = for individual “i” scores for attribute “k” health centre “m”

This instrument was preferred because it integrates respondents’ scores for each of the service attributes into a perception of service quality scores. Hence, we are able to reflect the various attributes of quality in care of scores. The scores resulting from the application of
our instruments were then categorized according to scoring key developed at the onset of the study which enables us to categorize respondents perceptions of the services received from extremely poor – lower bound of the scores – to outstanding— upper bound of the scores. This score was unknown to respondents to minimize errors as related to the respondents’ responses. A further analysis involves the use of percentages and correlation analysis of the scores; that is, the perceptual scores and the key underlying attributes.

3. RESULTS AND DISCUSSIONS

The gender distribution of the respondents was skewed towards the female in each location. 60.1% of the respondents were females while 39.9% were males. This seems understandable because our empirical evidence suggests that females utilize these facilities more on the account of theirs and their children care. The majority of the respondents were in the age ranging from 30-39, and 40-499. The mobility of these groups, reproductive activities or accessibility may have occasioned their usage of these facilities. Parents’ perception of care quality was assumed to influence the decisions of the <29 years group, been dependant.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Village/ Hamlet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Males</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Males</td>
<td>27</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Males</td>
<td>34</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Age composition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 29 years</td>
<td>35</td>
<td></td>
<td>19.2</td>
</tr>
<tr>
<td>30 – 39</td>
<td>74</td>
<td></td>
<td>40.4</td>
</tr>
<tr>
<td>40 – 49</td>
<td>54</td>
<td></td>
<td>29.5</td>
</tr>
<tr>
<td>50 years and above</td>
<td>20</td>
<td></td>
<td>10.9</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>37</td>
<td></td>
<td>20.2</td>
</tr>
<tr>
<td>Primary education</td>
<td>63</td>
<td></td>
<td>34.4</td>
</tr>
<tr>
<td>Secondary</td>
<td>54</td>
<td></td>
<td>29.5</td>
</tr>
<tr>
<td>Post secondary</td>
<td>29</td>
<td></td>
<td>15.9</td>
</tr>
</tbody>
</table>

Majority of the respondents have at least primary education. And being a rural environment without tertiary institution the percentages of respondents with education above secondary level is 15.9%. These respondents have higher likelihood of interaction with advance health facilities normally associated with tertiary institutions. Expectedly, therefore, they are most likely to possess a more sophisticated view of quality of care, one that encompasses structure, process and outcome of care (Abiodun, 2005). Above all, respondents’ educational level influence their assessment
Respondents' assessment of quality of health care(satisfaction) in these health centres indicate that 37%, 40% and 39% of the respondents considered the care in facilities A, B, C respectively to be below average, that is, varying degrees of poor service components (Table 2). In the same vein, 31% (A), 40% (B) and 32% (C) evaluated the care received in these centres as average. Only the facility in Hamlet A, the smallest in terms of population, was rated above average by 31% of the respondents, B (20%) and C (29%) were rated above average by less than 30% of respondents in each location.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Hamlet 1</th>
<th>Hamlet 2</th>
<th>Hamlet 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely poor quality</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Poor quality</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Slightly poor quality</td>
<td>8</td>
<td>21</td>
<td>19</td>
<td>48</td>
</tr>
<tr>
<td>Average quality</td>
<td>11</td>
<td>28</td>
<td>25</td>
<td>64</td>
</tr>
<tr>
<td>Good quality</td>
<td>10</td>
<td>11</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>Outstanding quality</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>70</td>
<td>68</td>
<td>173</td>
</tr>
</tbody>
</table>

However, the proportion of respondents evaluating the health care services in these health centers from average and above on quality appear insignificant. The explanation for this can be found in the fact that these facilities rank among the best health facilities in these communities in terms of equipment, personnel and physical structures. In fact, this health centre is the available health care facility in community A.

Correlations between respondents' perceptual scores (Pim) and service quality attributes identified in the study were generally positive but higher for tangibles (physical facilities), health personnel’s competence and empathy. The correlations coefficient is r=0.68, 0.67 and 0.66 (Table 3) for facilities in communities A, B and C respectively. This seems to bring to fore the need to stress effective management of physical facilities employed in care for users will normally seek for evidences of quality and make inferences about quality from physical environment and technology employed in care delivery. Thus, ‘attractive’ facilities need to be provided at the primary level to make health care consumers seek to primary care facilities.

<table>
<thead>
<tr>
<th>Location</th>
<th>Responsiveness</th>
<th>Competence</th>
<th>Empathy</th>
<th>Courtesy</th>
<th>Access</th>
<th>Tangibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamlet A</td>
<td>0.72</td>
<td>0.63</td>
<td>0.67</td>
<td>0.55</td>
<td>0.65</td>
<td>0.68</td>
</tr>
<tr>
<td>Village B</td>
<td>0.52</td>
<td>0.64</td>
<td>0.64</td>
<td>0.51</td>
<td>0.28</td>
<td>0.67</td>
</tr>
<tr>
<td>Village C</td>
<td>0.58</td>
<td>0.65</td>
<td>0.65</td>
<td>0.57</td>
<td>0.60</td>
<td>0.66</td>
</tr>
</tbody>
</table>

Most of the correlation is Significant at 0.05 Significance level.

The fair association of providers competence with respondents’ assessment of quality at r=0.63(A), 0.64(B) and 0.66(C) suggest providers fair communication of their skills to patients. This search is in line with Greene (1976) that providers communicate with patients some understanding of the diagnosis and treatment in order to enlist their cooperation and minimize their distress. Users’ perception of providers’ technical skill may assist in addressing Lambo’s comment of overcrowding of secondary facilities due to their ‘lack of faith’ in the primary level facilities. If the care provider is perceived as competent by users there is
high likelihood that demand for care in times of need will have increased for such facilities, given users ability to pay.

Furthermore, Greene (1976); Reidenbach et al (1990) suggested that providers' empathy and adjustment can be expected to have demonstrable benefit and that care givers' expression of empathy is an important component of process quality appeared supported by our findings. Table 3 indicates a correlation between Pim and Empathy Attribute ($r=0.67(A)$, 0.64(B) and 0.65(C)) for these entire health centre. Generally speaking, all human related factors have fair association with assessment of quality.

4. CONCLUSIONS AND RECOMMENDATIONS

A link between consumers' assessment of quality care and providers’ characteristics can assist in discerning providers’ characteristics that can be accorded recognition in the care value system, especially at the primary level. Consequently, providers may be encouraged to modify their behaviour in the path of those characteristics that make for users' quality perceptions. From the study it seem rational to encourage 'empathy' among the health personnel, and possibly when choosing new entrants into primary care training program and, or when promotion to higher cadre to use a measure of empathy as a criterion for selection.

Furthermore, it seems necessary that providers need to communicate their technical skills such that users perceived such skill for it to have demonstrable effect on users judgment of care quality. The association of providers’ competence with quality assessment suggest that Lambo’s fear of ‘lack of faith’ in the primary facilities and subsequent overcrowding of the secondary facilities may be address by effective communication of providers’ technical skills to patients.

Furthermore, it does appear that if health care consumers will utilize the primary health centre and have ‘faith’ in their care, a reasonable level of physical facilities will be required. Therefore, planning effort need to devote careful attention to the facilities employed at the primary level. In addition, management of these facilities needs to employ managerial tactics that projects the key attributes sought by users as evidence of quality.

Good and valued interactions between health workers and users have psychological effect that may make users/patients overlook disagreeable experiences during care encounter.

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