

FACTORS INFLUENCING THE CHOICE OF HEALTH CARE PROVIDING FACILITY AMONG WORKERS IN A LOCAL GOVERNMENT SECRETARIAT IN SOUTH WESTERN NIGERIA

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ABSTRACT

Background: There is increasing interest in the choice of health care providing facility in Nigeria.

Objectives: This study aimed to assess the factors influencing choice and satisfaction with health service providers among local government staff.

Methods: A cross sectional survey of all 312 workers in a Local Government Secretariat in South West Nigeria was done. Chi Square and logistic regression analysis was done.

Results: The mean age was 38.6 ± 7.5 years, 55% were females and 71.7% had tertiary education. The median monthly family income of the respondents was ₦ 28, 000 (₦3,000 – ₦500,000), with 24.4% earning a monthly income of ₦21, 000 to ₦30, 000. Many (72.3%) utilized public health facilities attributing the choice to the low cost of services. Respondents who are satisfied with their usual care providing facilities are 12.2 times more likely to have used public facilities than private facilities (95%, CI 3.431 – 43.114). Respondents who described the quality with ease of getting care/short waiting times as being good are 3.9 times more likely to have private facilities as their chosen health care providing facility (95%, CI 1.755 – 8.742). Cost/payment for service is 2.9 times more likely to predict the use of public health facility as the usual health care provider.

Conclusion: Private facilities though costlier do not appear to be providing better services than public facilities. To increase access to health care the cost of services and the waiting time are important factors to address.

Keywords: Service, Quality, Cost, Choice, Satisfaction

INTRODUCTION

The health care system in Nigeria has a blend of private and public health care providers. In the public sector health care providers are under the three tiers of government; federal (tertiary hospitals and some hospitals in federal institutions like universities), state (state specialist and general hospitals) and local government areas (primary health care centres and health posts). In the private sector, they are broadly categorized into those that provide primary care (general practitioners), those that provide secondary care and those that provide both primary and specialist care. There are also several non-governmental organizations and donor-owned and operated facilities. Unlike in many developed nations, health care in Nigeria is not universally free. According to the Nigeria

Demographic and Health survey 2008, majority of women and men have no health insurance coverage (98 and 97 percent, respectively), which means they pay for health care from their pockets.¹ Health care service consumers are therefore bound to make the choice of where to receive health care based on some factors. Typically, choice of health care providing facility is based on six types of information: quality of service provided, access to providers (both hospitals and physicians), out-of-pocket costs, health provider communication skills, courtesy, and administrative burden. However, patients perceptions of the quality of services provided is a key factor (along with cost effectiveness) in determining the use of the health care facility.²

An interplay of the availability and affordability of drug, geographical accessibility to the facility as well as appropriate opening hours are important contributors to choice of care providing facility.³⁻⁶ Other factors which have been documented to determine choice of facility utilized include: travel time, education, age, sex, level of education of household head, household size and perceived quality of care provided in the facility.^{7,8}

Determining the factors responsible for patient's choice of health care providing facility cannot be measured without considering several factors some of which the consumer of healthcare services cannot control. Therefore unlike making choices over tangible things like dresses or cars, accurately measuring how patients feel about their out-patient visit, hospital stay, medical procedure, or total health care experience can be a very difficult challenge.⁹

Several efforts have been made to identify which of service quality, service value and satisfaction has the most influence on choice of a service provider.¹⁰ In the health care system, patient satisfaction has emerged as an important component that determines consumer choice of a product or service.¹¹ However, quality of care as a determinant for choosing healthcare providers is gaining grounds over the past decade.^{8, 10, 12-14}

Several parameters have been used to measure quality of care and include; waiting time, privacy of the medical examination, cleanliness of the health facility, staff treatment and sufficient treatment time. Other parameters include staff-patient relationships; administration and management; patient care, vaccines and drugs; and, infrastructure (i.e. building and equipment situation).¹⁵

Unlike in developed countries, research on factors affecting patient's choice of health care provider in Nigeria has not been fully explored. It is not very clear what influences the household's choice of one or the other within a health system with many health care providing facilities. The behaviour of the patient which is made evident by their choice of health care provider may also give an insight into how these health facilities can improve on their service delivery, improve client satisfaction and by extension ensure a healthier population.

This study was conducted to investigate how demographic and socioeconomic factors, quality of care, and expenditure on health care, impact on patient's choices of public or private facilities as their health care providing facility. It also aimed to provide a better understanding of the role, magnitude and contribution of both the public and the private health care providers

and highlight the main factors determining choice of these providers in Ibadan, South West Nigeria.

METHODOLOGY

The study was a descriptive cross-sectional study among all 312 consenting staff of a randomly selected Local Government Area (LGA) of the 5 in Ibadan Metropolis. Only consenting respondents who were at work in the LGA Secretariat during the study period were interviewed. There are six major units in the LGA Secretariat (Health, Administration, Finance/revenue, Environmental health, Water and agriculture and Education). There are about 700 workers in the LGA, with about 120 of them working outside the LGA secretariat.

The study was conducted in the local government for the following reasons: They are a homogeneous group and a relatively stable population. The workers in the local government cut across varying age, sex and other demographic parameters. The local government workers unlike state and federal workers do not have marked differential scales of salaries and wages. The LGA workers have not been integrated into the National Health Insurance Scheme

The respondents for this study were LGA full-time workers working within the LGA secretariat. Excluded from the study were contract staffs of the LGA and National Youth Service Corp members working in the LGA.

Data was collected using a semi-structured interviewer assisted questionnaire developed for the study to obtain information on socio-demographic data, usual health care provider and health care utilization. The patient satisfaction and quality of care questionnaire was a modified version of the Primary Care Health Centre Program Patient satisfaction Survey questionnaire by the Health Resources and Services Administration of the United States Department of Health and Human Services and, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaire from the Research and Development (RAND) Corporation. This questionnaire was used to determine the level of satisfaction and quality of health care services provided at usual health care provider.¹⁵

The usual health care provider for the purpose of this study is the health facility (patent medicine dealer, public or private orthodox medical facility) where the respondents go to first to access primary care for common ailments they do not consider life threatening. A total of 312 questionnaires were administered, only 309 (99.0%) of the questionnaire were returned. Two respondents whose usual health care providers were

traditional healers were also excluded. Therefore, responses from 307 (99.4%) of the returned questionnaires were used for analysis although some parts of the questionnaire were not completely filled and this affected the total number during analysis.

Usual health care provider was stratified into public and private facilities. However, two of the 312 respondents reported traditional healers as their usual health care provider and were not included for further analysis. This was because the traditional healers were not registered under any regulatory agency. Patent medicine dealers on the other hand are regulated by their organization (Patent Medicine Dealers Association), State Ministry of Health and the National Drug Law Enforcement Agency (NAFDAC). To this end, private facilities included all privately-owned hospitals, clinics, maternity centres and patent medicine shops. Public facilities included all government-owned primary, secondary and tertiary health care facilities.

Patient satisfaction was obtained by asking a 5-point Likert scaled (very satisfied, satisfied, indifferent, dissatisfied and very dissatisfied) question 'How would you rate your satisfaction with the health services provided in the usual place you receive health care'. Respondents who were either very satisfied or satisfied were re-coded to as being satisfied with their usual health care provider while those who were very dissatisfied, dissatisfied or indifferent were re-coded to be dissatisfied with their usual health care providers. The Quality of care was also determined using a 5-point Likert scale (strongly agree, agree, Indifferent, disagree and strongly disagree) set of questions in four domains: ease of getting care and waiting time (7 questions with maximum obtainable score of 14); interpersonal and communication skills (6 questions with maximum obtainable score of 12); cost and payment for services (7 questions with maximum obtainable score of 14) and cleanliness of the facility (3 questions with maximum obtainable score of 6). For each question, two options were appropriate with the most appropriate scoring 2 points. One point was given to the next appropriate option while the others including indifferent were scored zero. The mean score of each domain and a total score for all the domains were computed. Respondents with scores less than the mean were said to have experienced poor quality of care while those who had a score above the mean had good quality of care.

Catastrophic expenditure on health was computed as 10 percent or more of respondent's monthly income on health. Respondents were therefore classified as those with 'catastrophic' and 'no catastrophic' expenditure on health.

Data was cleaned and analyzed using SPSS version 15. Chi square test was used to determine factors that were significant at a p- value of 0.05 and logistic regression was used to determine the predictors for choice of health care facility.

RESULTS

The mean age of the respondents was 38.6 ± 7.5 years with the highest proportion, 126(41.0%) of the respondents in the 40 – 49 years age group. Most of the respondents were females (55.0%), married (83.7%) and were from monogamous families (82.4%). The median family income of the respondents was ₦28, 000 (₦3,000 – ₦500,000), with 75(24.4%) of the respondents families' earning a monthly income of ₦21,000 to ₦30,000. Catastrophic expenditure on health was experienced by 162 (63.8%) of the respondents (Table 1).

Majority, that is 222 (72.3%) of the respondents usually obtain care from government-owned facilities. However, 60 (19.5%) of the respondents usually obtain care from private hospitals while 25 (8.1%) of them utilize patent medicine shops usually for their health care needs (Fig. 1).

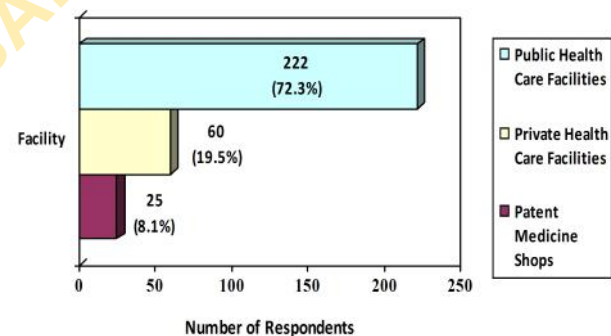


Fig. 1: Facilities where respondents usually access care

Table 2 shows socio-demographic factors associated with respondents' choice of usual health care provider. A higher proportion of respondents from polygamous families, (75.9%) usually access from public facilities while a higher proportion of respondents from monogamous families, (28.5%) usually access care from private facilities ($p = 0.513$). Also, a higher proportion of respondents with more than four members in the family, (76%) accessed care from public health facilities while those from families of 4 people or less, (31.0%) utilized private facilities more ($p = 0.210$). A significantly higher proportion of respondents whose monthly family income was less than ₦11,000, (64.7%) access care from public facilities compared to (35.3%) that use private health care facilities ($p = 0.002$). A higher proportion of families (71.0%) using public facilities spent 10% or more of their monthly income (catastrophic expenditure) on health earnings

Table 1: Socio-demographic characteristics of respondents

Characteristics (N = 307)	n	%
Sex		
Male	138	45
Female	169	55
Age (in years) * (N= 304)		
20 – 29	34	11.2
30 – 39	117	38.5
40 – 49	126	41.4
≥ 50	27	8.9
Marital Status		
Married	257	83.7
Not Married	50	16.3
Family Type		
Monogamous	253	82.4
Polygamous	54	17.6
Family Size** (N= 258)		
Four or less	129	50
More than four	129	50
Monthly Family Income*** (N= 277)		
Less than ₦ 11, 000	17	6.1
₦ 11, 000 – ₦ 20, 000	68	24.5
₦ 21, 000 – ₦ 30, 000	75	27.1
₦ 31, 000 – ₦ 40, 000	47	17.0
₦ 41, 000 – ₦ 50, 000	23	8.3
₦ 51, 000 and above	47	17.0
Expenditure on Health**** (N= 254)		
Catastrophic	162	63.8
No Catastrophic	92	36.2

* (N= 304), ** (N= 258), *** (N= 277), **** (N= 254)- Due to incomplete filling of questionnaire

Table 2: Socio-demographic factors associated with respondents' usual health care facility

Variables	Usual Health Care Facility		Total	Test Statistic	p-value
	Public	Private			
Type of family					
Monogamous	181 (71.5)	72 (28.5)	253 (100.0)	0.427	0.513
Polygamous	41 (75.9)	13 (24.1)	54 (100.0)		
Family Size*					
Four or less	89 (69.0)	40 (31.0)	128 (100.0)	1.574	0.210
More than four	98 (76.0)	31 (24.0)	129 (100.0)		
Average Monthly Family Income**					
Less than ₦ 11, 000	11 (64.7)	6 (35.3)	17 (100.0)		
₦ 11, 000 – ₦ 20, 000	58 (85.3)	10 (14.7)	68 (100.0)		
₦ 21, 000 – ₦ 30, 000	58 (77.3)	17 (22.7)	75 (100.0)	18.668	0.002
₦ 31, 000 – ₦ 40, 000	35 (74.5)	12 (25.5)	47 (100.0)		
₦ 41, 000 – ₦ 50, 000	13 (56.5)	10 (43.5)	23 (100.0)		
₦ 51, 000 and above	25 (53.2)	22 (46.8)	47 (100.0)		
Expenditure on Health***					
Catastrophic	115 (71.0)	47 (29.0)	162 (100.0)	0.249	0.618
No Catastrophic	68 (73.9)	24 (26.1)	92 (100.0)		

* (N= 257), ** (N= 277), *** (N= 254)- Due to incomplete filling of questionnaire

Table 3: Socio-demographic factors and usual facility with respondents level of satisfaction

Variables	Respondent's Level of Satisfaction		Total	Test Statistic	p-value
	Satisfied	Dissatisfied			
Usual Facility					
Public	214 (96.4)	8 (3.6)	222 (100.0)	17.491	<0.001
Private	70 (82.4)	15 (17.6)	85 (100.0)		
Type of family**					
Monogamous	237 (93.7)	16(6.3)	251 (100.0)	*	0.086
Polygamous	47 (87.0)	7 (13)	54 (100.0)		
Family Size***					
Four or less	120 (93.0)	9 (7.0)	128 (100.0)	0.795	0.373
More than four	116 (89.9)	13 (10.1)	128 (100.0)		
Average Monthly Family Income****					
Less than ₦11, 000	17 (100.0)	0 (0.0)	17 (100.0)	5.720	0.334
₦11, 000 – ₦20, 000	64 (94.1)	4 (5.9)	68 (100.0)		
₦21, 000 – ₦30, 000	69 (92.0)	6 (8.0)	75 (100.0)		
₦31, 000 – ₦40, 000	44 (93.6)	3 (6.4)	47 (100.0)		
₦41, 000 – ₦50, 000	22 (95.7)	1 (4.3)	23 (100.0)		
₦51, 000 and above	40 (85.1)	7 (14.9)	47 (100.0)		
Expenditure on Health*****					
Catastrophic	150 (92.6)	12 (7.4)	162 (100.0)	*	0.443
No Catastrophic	84 (91.3)	8 (8.7)	92 (100.0)		

* Fishers exact, ** (N= 305) , *** (N= 256) , **** (N= 277) , ***** (N= 254)- Due to incomplete filling of questionnaire.

on health compared to the 47 (29.0%) of families that use private facilities.

Table 3 shows factors associated with respondents' satisfaction with services of usual health care providers.

Composite score of the satisfaction with the usual health care provider showed that 284 (92.5%) were satisfied, while 23 (7.5%) were dissatisfied with the facility they access health care from.

A significantly higher proportion of respondents who were satisfied with the care they received usually access care from public facilities, 214 (96.4%) compared to

Table 4: Association between choice of health facility and the perceived quality of service provided by the respondents' usual health care providing facility

Variables (N = 307)	Usual Health Care Facility		Total	Test Statistic	p-value
	Public	Private			
Ease of getting care/waiting time*					
Good Quality	117 (52.9)	46 (54.1)	163 (53.3)	0.034	0.853
Poor Quality	104 (47.1)	39 (45.9)	143 (46.7)		
Interpersonal/ communication skills**					
Good Quality	111 (50.2)	30 (35.3)	141 (46.1)	5.509	0.019
Poor Quality	110 (49.8)	55 (64.7)	165 (53.9)		
Cost/ payment for service					
Good Quality	139 (62.6)	37 (43.5)	176 (57.3)	9.150	0.002
Poor Quality	83 (37.4)	48 (56.5)	131 (42.7)		
Facility cleanliness**					
Good Quality	104 (46.8)	27 (32.1)	131 (42.8)	5.382	0.020
Poor Quality	118 (53.2)	57 (67.9)	175 (57.2)		
Total Quality Score*** (N= 304)					
Good Quality	104 (47.3)	24 (28.6)	128 (42.1)	8.722	0.003
Poor Quality	116 (52.7)	60 (71.4)	176 (57.9)		

* (N= 306) , ** (N= 306) , *** (N= 304) - Due to incomplete filling of questionnaire.

Table 5: Logistic regression for factors associated with usual health care providing facility

Variable	Regression Coefficient β	p-value	Odds Ratio (95% CI)
Respondents satisfaction with health care provider	2.498	<0.001	12.163 (3.431 – 43.114)
Quality of ease of getting care/waiting time	-1.365	0.001	3.917 (1.755 – 8.742)
Quality of Interpersonal/ communication skills	0.222	0.621	0.801 (0.333 – 1.930)
Quality of cost/ payment for service*	- 1.095	0.009	0.347 (0.157 – 0.765)
Quality of Facility cleanliness	0.672	0.095	0.511 (0.232 – 1.123)
Total Quality	0.383	0.469	0.682 (0.242 – 1.924)

* Reference variable was private facility

those who were satisfied with care received in private facilities, 70 (82.4%) ($p < 0.001$). Also satisfaction with care received from usual care provider was higher among 237 (93.7%) respondents from monogamous families and those 120 (93.0%) respondents with family size ≤ 4 . These associations were however not statistically significant. Furthermore a higher proportion of respondents, 150 (92.6%) who were satisfied with their usual healthcare providers had catastrophic expenditure on health ($p = 0.443$).

Quality of care was measured in four domains ease of getting care and waiting time; interpersonal and communication skills; cost and payment for services and cleanliness of the facility. The total quality of care was also computed. Choice of either public or private facilities as the usual health care providing facility was determined using the respondents' perceived quality of care.

Table 4 shows the quality of service provided by the respondents' usual health care provider. A significantly higher proportion of public facilities were reported to have good quality of service in the area of interpersonal/communication skills, 111 (50.2%, $p = 0.019$); cost/payment of service, 139 (62.6%, $p = 0.002$); cleanliness of facility and its environ, 104 (46.8%, 0.020) and total quality score, 104 (47.3, $p = 0.003$). Conversely, the private facilities (46; 54.1%) provided good quality of service only with ease of getting care/waiting by respondents compared with the public facilities ($p = 0.853$).

Logistic Regression for Factors Associated with Respondents' Usual Health Care Providing Facility

Logistic regression for the factors associated with usual health care provider is as shown in Table 5. Respondents who are satisfied with their usual care providing facilities are 12.2 times more likely to have used public facilities than private facilities (95%, CI 3.431 – 43.114). Respondents who described the quality with ease of getting care/short waiting times as being good are 3.9 times more likely to have private facilities as their chosen health care providing facility

(95%, CI 1.755 – 8.742). Cost / payment for service is 2.9 times more likely to predict the use of public health facility as the usual health care provider.

DISCUSSION

This study sought to determine factors that influence choice of health care providers. The increasing awareness of individuals on the importance of obtaining appropriate medical care and the introduction of health insurance have contributed to the need for decision taking on clients choice of health care provider. Anderson and Newman illustrated how the interaction between societal factors, health service systems and individual factors determined the utilization of health services.¹⁶ Choice of care provider is often determined by affordability and availability of drugs, geographical accessibility and appropriate opening hours. Choice of a commodity (product or service) from consumer behaviour theories is determined by preference for that commodity, and preference for a commodity implies choice of that commodity. Satisfaction with services, quality of services and socio-demographic/socioeconomic factors are variables used to determine preference which will then lead to the utilization of the facility.¹⁷⁻¹⁹

In this study, logistic regression showed that satisfaction with services provided was a predictor for the preference for public facilities. This finding supports studies by Tembon in Cameroon who reported that several factors influence household's choice of health care and that the quality was the most important factor influencing choice of health care provider.¹³ Also a cross-sectional telephone survey conducted among residential households in the United States by Chu-Weininger *et al* to determine consumer satisfaction with primary care provider (PCP) choice and associated trust showed that satisfaction with services provided was significantly associated with choice of and trust in their PCP.²⁰ However, in a study to determine health care utilization among the urban poor in Thailand satisfaction was high but was not a predictor for utilization respondents' chosen healthcare provider.¹⁸

Concerning satisfaction between public and private facilities, studies have not been able to show either facilities as being most satisfactory but that they have their advantages depending on accessibility, availability and competence of health workers as well as cost of services and drugs.^{19, 21-29} This study also reported that users of government facilities were more satisfied with the health services they received. This supports findings by some researchers owing largely to the fact that individuals trade off price and quality, choosing the provider that gives them the highest satisfaction.^{30,31}

Quality of services was used in this study to determine preference and by extension choice. In this study, two domains of quality were found to determine choice of a health care provider. Ease of getting care/short waiting times was predictive for the choosing private facilities. On the other hand cost/payment for services were predictive for the choice of public facilities. These findings are similar to findings by Arhin-Tenkorang, where it was reported that cost which included opportunity cost of time wasted was a determinant to utilization of health facilities.³² In a study on the utilization of primary health care (PHC) facilities in rural southwest Nigeria prompt attention and appropriate outpatient services were found as the determinants of utilization of PHC while high cost of services, lack of drugs and availability of a physician were barriers to utilization of PHC facilities which are government facilities.³³

A study conducted in Kogi State, Nigeria on the effect of distance on the utilization of healthcare services showed that public facilities compared to private facilities were preferred on account of cost of accessing health service. Cost was also suggested as a major factor for utilization of public rather than private facilities by respondents in their economically productive years.²² However Okafor in studying the factors affecting the frequency of hospital trips reported that proximity of a health facility was not a guarantee for its utilization.³⁴ This therefore underscores the need for a holistic approach to making healthcare available, accessible and affordable to a vast majority of the population.

CONCLUSION

Choice of health care providing facility is an important decision that involves the interplay of several factors. Unlike decision making for other commodities, the decision making process involved in the choice of health care providing facility is determined by factors external to the clients such as quality of services provided by the health care facilities. Satisfaction of services provided is a perception by the clients and

must be considered by managers of health institutions when decisions to improve health facility services are to be made.

RECOMMENDATION

There is a need to ensure that patients have easy access to health care by ensuring that health personnel are available when needed. Long waiting times should be discouraged by identifying areas in the health care delivery system that is prone to causing long waiting times with a view to developing alternate health systems that will eliminate long hours of stay in public facilities.

This can be achieved by involving consumers of health care in government facilities in decision making process to make the facility more customer oriented.

Periodic evaluation of the quality of care provided by the health facilities should be conducted where clients of the facility are asked to rate the quality of care.

LIMITATION

The following were limitations to this study: Information on average monthly family income may not have been precise since some of the respondents were not the main breadwinners in their respective households. The information on monthly expenditure on health may have been over or under estimated since it was primarily due to recall. Level of satisfaction and quality of service questions may also have been biased since respondents are more likely to remember unpleasant experiences which are then used to access the facilities.

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