Journal of Engineering and Applied Sciences 14 (5): 1676-1681, 2019
ISSN: 1816-949X
© Medwell Journals, 2019

Healthcare Stakeholder's Perspectives of the Determinants of Quality Healthcare Services Provision in Nigeria

[1]Blessing Onyebuchi Asogwa, [2]Agnes E. Okafor, [3]Nnenna Lois Omaka-Amari,
[4]Chihurumnanya Alo and [1, 5]Uchenna Cosmas Ugwu
[1]Department of Human Kinetics and Health Education, Faculty of Education,
[2]Department of Social Work, Faculty of Social Sciences,
University of Nigeria, Nsukka, Enugu State, Nigeria
[3]Department of Human Kinetics and Health Education, Faculty of Education,
[4]Department of Community Medicine, Faculty of Medicine, College of Health Sciences,
Ebonyi State University, Abakaliki, Ebonyi State, Nigeria
[5]Department of Health and Physical Education, Faculty of Education,
University of Nigeria Nsukka, Enugu State, Nigeria

Abstract: People's health and wellbeing depend on the quality of healthcare services provided by healthcare organizations. This study aimed to investigate the determinants of the quality of healthcare services provided in Nigerian healthcare organization. The study was based on descriptive research design. The sample for the study consisted of 650 healthcare stakeholders selected from the 36 states of Nigeria. The 36 states constituted 36 clusters (cluster sampling techniques). The simple random method (balloting) was used to select 10 states out of the 36 clusters. A total of 65 healthcare stakeholders were chosen from each of the 10 states (clusters), using the simple random method of sampling. Overall, a total of 650 healthcare stakeholders were used for the study. The study showed the following results: the majority of the healthcare stakeholders were females (58.5%); between the ages of 31-50 years (41.5%); Possessed a degree as their highest educational qualifications (51%) were married (60.5%) and were healthcare providers (32.3%). Available data indicated that the determinants of the quality of healthcare services provision in Nigerian healthcare organizations included provider-related factors (91.0%), organizational-related factors (84.6%) and patient-related factors (63.4%). The quality of healthcare services provision in Nigerian healthcare organizations is determined by provider-related factors, organization-related factors and patient-related factors, respectively. The Nigerian health care system should support quality improvement activities, effective leadership and partnership development to ensure sustainability and effectiveness in the provision of quality healthcare services.

Key words: Quality, determinants, healthcare services, stakeholders, Nigerian healthcare organizations, quality

INTRODUCTION

Nigerian healthcare system is structurally organized to provide essential healthcare services to the population (Omoruan *et al*., 2009; Welcome, 2011). The provision of these services in Nigeria is tied to the roles of the three levels of government: federal, state and local governments (Omoruan *et al*., 2009; Adeyemo, 2005; NHIS., 1999). The primary healthcare system is manned by the 774 local government areas which receive support from their own state ministries of health and private medical practitioners (Omoruan *et al*., 2009). There are sublevels of primary healthcare in the villages, districts and local government areas. This is the foremost level of contact of the individual and community with the national health system, making health care to be very near to the people. The ministry of health manages the secondary healthcare system at the state level. Patients at this level are often referred from the primary healthcare. The secondary healthcare which comprises of laboratory and diagnostic services and rehabilitation, among others is the initial level of specialty services and is accessible at various parts of the state (Welcome, 2011). The tertiary healthcare is provided by teaching hospitals and specialist hospitals. At this level, the Federal government works with voluntary and non-governmental organizations and

Corresponding Author: Bleesing Onyebuchi Asogwa, Department of Human Kinetics and Health Education, Faculty of Education, University of Nigeria Nsukka, Nsukka, Nigeria

private practitioners (Adeyemo, 2005; Awosika, 2005; Akande, 2004). These functions performed by three tiers of government are in line with the aim of the Nigerian National Health Conference held in 2006 which stipulated that all Nigerians receive effective, qualitative, affordable and accessible health care beyond 2007 (Onwujekwe *et al*., 2010). As part of the efforts to ensure quality, healthcare services are provided for all Nigerian people in 2008 the Nigerian senate launched a bill for an act to provide a framework for the regulation, development and management of a national health system and set standards for providing health services in the federation and other matters connected with it (Anonymous, 2017a-c). In spite of an increase in development of the healthcare industry compared with the previous decades (Awosika, 2005; Akande, 2004; Anonymous, 2017a-c), there remains a great deal of work to be done (Omoruan *et al*., 2009; Adeyemo, 2005) to ensure quality, healthcare services are provided for all Nigerian people.

Ovretveit defined quality care as the provision of care which surpasses patient expectations and achieves the utmost clinical outcomes with the resources available (Ovretveit, 2009). He created a method for improving the quality of healthcare with regard to three quality dimensions: professional, client and management. In this context, professional quality is based on expert's perceptions of the extent to which professionally assessed patient needs had been met using the right methods and procedure. Client quality is defined as whether or not patients derive what they need from the services they receive. Management quality focuses on whether services are delivered in a resource-efficient way (Ovretveit, 2009). These dimensions were assessed in the present study considering available evidences that Nigerian health care system has suffered several setbacks (Onwujekwe *et al*., 2010; Anonymous, 2017a-c) which have affected the quality of healthcare services being provided in the country.

Quality health care requires providing patients with appropriate services in a professionally competent way which includes good communication, shared decision-making and cultural sensitivity. Recent statistics show that healthcare institutions rendering health care services in Nigeria include 33,303 general hospitals, 20, 278 primary health centers and posts and 59 teaching hospitals and medical centers (Omoruan *et al*., 2009). Approximately 90% of the Nigerian population has formal health insurance coverage and up to 95% of the rural people and almost the entire urban residents have adequate access to primary healthcare services (Welcome, 2011). This may account for the significant decrease in child and maternal mortality rates (NPC., 2009) and the remarkable rise in life expectancy at birth (WHO., 2013). The maternal mortality ratio is now 21 per 10,000 births (WHO., 2013), indicating that the Millennium Development Goal number five which is to improve maternal health targets to reduce by three-quarter, the maternal mortality ratio (WHO., 2005, 2009) was attained. Research evidence shows that maternal and child health services are available in Nigeria (Emmanuel *et al*., 2013). Concerning health indicators, 95% of the population also has access to safe drinking water. The 99% of children reaching their first birthday are fully immunized (WHO., 2013). The crude birth and death rates are 16.8 and 5.3% per 1,000, respectively (WHO., 2013). The total fertility rate is 1.6% per woman (WHO., 2005; Emmanuel *et al*., 2013). These represent significant achievements in the Nigerian healthcare system in the last few decades.

Despite the achievements, so far in the Nigerian healthcare system, the system still faces many challenges which seem to undermine the quality of healthcare services provided in many parts of the country. Although, similar situation abounds elsewhere (Mohammadi and Shoghli, 2009), little is known about the determinants of the quality of healthcare services offered in many regions. The current condition of the healthcare system in Nigerian has been described as unsatisfactory (Adeyemo, 2005). Ideally, quality healthcare services should be available, accessible, affordable, acceptable, appropriate and suitable for all. To our knowledge, no study has identified the determinants of the quality of healthcare services offered in Nigerian healthcare organizations. This study aims to investigate the determinants of the current quality of healthcare services provided in Nigerian healthcare organizations. We expect that the outcome of this investigation would expose the factors associated with the current quality of healthcare services provided in Nigeria.

MATERIALS AND METHODS

Ethical statement: This study was conducted according to the principles of the Declaration of Helsinki (World Medical Association, 2013). Ethical approval was obtained from Federal Ministry of Health, Federal Capital Territory, Abuja, Nigeria (Ethical Approval Code: FMHFCTERA.301FCTH9). This is one of the Institutional Review Board Committees that gives approval for studies of this kind. The participants were informed that participation in the study was completely voluntary and that they can withdraw at their own will. The identity of the participants was protected. No financial compensation was provided to the participants for their participation.

Table 1: Demographic characteristics of the respondents (n = 650)

Variables	F-values	Percentage
Gender		
Male	270	41.5
Female	380	58.5
Total	650	100
Age by birth		
Below 30	250	38.5
31-50	270	41.5
51+	130	20.0
Total	650	100
Highest educational qualification		
FSLC	101	15.5
WASSC/NECO	219	33.7
Degree	330	50.8
Total	650	100
Marital status		
Single	187	28.7
Married	393	60.5
Divorced	16	2.5
Widowed	54	8.3
Total	650	100
Specialization		
Healthcare provider	210	32.3
Policy-maker	110	17.0
Manager	140	21.5
Payer/Patient	190	29.2
Total	650	100

Design and sample: This questionnaire based study was conducted from July-December, 2017. The study used a descriptive research design which involved the following healthcare stakeholders: policy-makers, healthcare providers, managers and payers in Nigerian healthcare organizations. The sample for the study consisted of a total of 650 healthcare stakeholders selected from the 36 states that make up Nigeria. The 36 states constitute 36 clusters (cluster sampling techniques). The simple random method (balloting) was used to select 10 states out of the 36 states 65 healthcare stakeholders were chosen from each of the 10 states (clusters), using simple random technique making a total of 650 healthcare stakeholders used for the study (Table 1).

Instrument: The instrument for the data collection was a self-administered questionnaire designed for the study. The questionnaire-"Quality Healthcare Services Questionnaire-QHSQ" could be completed in approximately 15 min and was composed of two parts: A and B. Part A elicited information on demographic characteristics of the respondents while part B generated data on determinants of the quality of healthcare services provided in Nigerian healthcare organizations. These two parts (A and B) were bundled into one study package for the convenience of the respondents. Reliability testing indicated that the questionnaire had a strong internal consistency (Cronbach's α = 0.76). The questions were designed to allow responses from the respondents without any bias.

Data collection: The healthcare stakeholders who agreed to participate in the study received a questionnaire package which included a cover letter containing a summary of the research, the participant's rights and the researcher's contact information. In the cover letter, potential participants were requested to complete the questionnaire and return it to the researcher at the indicated address.

Statistical procedure: The returned copies of the questionnaire were checked for completeness of responses and were coded into statistical Software Statistical Package for Social Science (SPSS) for analysis. The descriptive statistics involved frequency and percentages were used to analyze the data.

RESULTS AND DISCUSSION

A total of 650 healthcare stakeholders were studied. Data in Table 1 shows the demographic characteristics of the respondents. Concerning gender, the study showed that majority of the healthcare stakeholders were females (58.5%) while the males were fewer (41.5%). Approximately 39% of the respondents were below 30 years of age by birth while about 41.5 and 20.0% fell between the ages of 31-50 and 51 years and above, respectively. Of all the respondents, only 15.5% possessed FSLC as the highest educational qualification, while approximately 34 and 51% had WASSC/NECO and degree as their highest educational qualifications. The marital status of the healthcare stakeholders varied greatly. Thus, the majority of participants were married (60.5%) while only 2.5% were divorced. Approximately 29% were single while about 8.3% were widowed. About 32.3% of the participants were healthcare providers. Other participants included policy-makers (17.0%), managers (21.5%) and payers (29.2%), respectively (Table 1).

As can be seen in Table 2, results on the determinants of the quality of healthcare services offered in Nigerian healthcare organizations indicated that 91.0% were provider-related factors. This was closely followed by organization-related factors (84.6%) and patient-related factors (63.4%) (Table 2). Provider motivation and satisfaction (93.8%), provider competence (knowledge and skills) (90.2%) and provider socio-demographic variables (88.9%) constituted the provider-related factors. Resources and facilities (95.7%), leadership and management (88.2%), healthcare system (81.8%) and collaboration and the partnership development (72.6%) constituted organization-related factor. Patient socio-demographic variables (74.9%), type of patient illness (61.2%) and patient cooperation (54.2%) constituted patient-related factors, respectively (Table 2).

Table 2: Determinants of the quality of healthcare services provision (n = 650)

	True		False	
Items	F-values	Percentage	F-values	Percentage
Provider-related factors				
Provider socio-demographic variables	578	88.9	72	11.1
Provider competence (knowledge and skills)	586	90.2	64	9.8
Provider motivation and satisfaction	610	93.8	40	6.2
Percentage average	591	91.0	59	9.0
Organization-related factors				
Healthcare system	532	81.8	118	18.2
Resources and facilities	622	95.7	28	4.3
Leadership and management	573	88.2	77	11.8
Collaboration and partnership development	472	72.6	178	27.4
Percentage average	550	84.6	100	15.4
Patient-related factors				
Patient cooperation	352	54.2	298	45.8
Patient socio-demographic variables	487	74.9	163	25.1
Type of patient illness	398	61.2	252	38.8
Percentage average	412	63.4	238	36.5

Most of the healthcare stakeholders surveyed were above 30 years of age by birth, married and highly educated. This finding was quite encouraging with implications. First, the healthcare stakeholders of this age bracket possessed a great deal of experience, regarding quality healthcare services and so, they could play significant roles in addressing the concerns related to the quality of healthcare services provided in Nigeria. Scholars in healthcare services have demonstrated that age is a significant factor in healthcare services (Emmanuel *et al*., 2013; NPC., 2009; Mpembeni *et al*., 2007). Married people usually access quality healthcare services, especially, maternal and child health services. Maternal and child health services encompass all of the services for mothers throughout the childbearing age as well as services for children from conception through adolescence (Indacochea and Leahy, 2009). The experiences in marriage and utilization of healthcare services could trigger a unique understanding of how best to improve the quality of healthcare services provided in healthcare organizations. Approximately 51% of the respondents noted WASSC/NECO and degree as their highest educational qualifications. These findings were in agreement with previous studies which have indicated that healthcare service quality is determined by factors associated with the healthcare service provider, the patient and the healthcare organizations (Mosadeghrad, 2014).

The study found that provider-related factors determine the quality of healthcare services provided in Nigerian healthcare organizations. The provider-related factors include motivation and satisfaction, competence (knowledge and skills) and socio-demographic variables. This finding did not come as a surprise. To begin, the healthcare providers who do not have the motivation and positive disposition for healthcare services being provided may not consider quality healthcare service a priority in healthcare organizations. Second, lack of adequate knowledge of and requisite expertise for quality healthcare services can undermine the provision of such services. Thus, the quality of healthcare providers affects the quality of healthcare services provided. Previous research has indicated that healthcare providers offer services differently because of the variations in individual factors (e.g., experience, individual abilities and personalities) (Mosadeghrad, 2012). Therefore, the quality of healthcare services provided in Nigerian healthcare organizations could be improved if healthcare providers were motivated, inspired and possessed adequate knowledge and the desired skills for quality healthcare services. Other studies have shown that provider-related factors influenced the quality of healthcare services provided by health care organizations (Mosadeghrad, 2012, 2014; Kaluzny, 2006). There is also evidence that satisfied and committed employees deliver better care which results in better outcomes and higher patient satisfaction (Yang, 2006).

The healthcare stakeholders also indicated that organization-related factors determine the quality of healthcare services provided in Nigerian healthcare organizations. The organization-related factors include all aspects of resources and facilities, leadership and management, healthcare system and collaboration and partnership development. This finding may be because almost all decisions regarding the structures, general goals, policies and even resource allocation in Nigeria are made at the central level by the Federal Ministry of Health (Omoruan *et al*., 2009; Welcome, 2011). A similar situation exists in Iran (Mosadeghrad, 2014). These factors may result in organizational barriers such as centralization, bureaucracy, severe dependency on government, styles of leadership, infrastructures, manpower challenges,

clinical training, standardized diagnostic instruments, etc. (Onwujekwe *et al*., 2010; Anonymous, 2017a-c). To overcome these obstacles, researchers have emphasized that healthcare organizations should provide their staff with the resources and support the need to deliver high-quality services (Mosadeghrad, 2014). Also, the organizational structures of the Nigerian healthcare system should be modified to support quality improvement activities and effective leadership and partnership development. The Nigerian health care system requires an overhaul, revitalization and specific projects designed to enhance cooperation and efficiency in quality healthcare services being provided.

Leaders should possess specific qualities such as personal motivation, enthusiasm, intelligence, conscientiousness, self-confidence, skill in dealing with people and capacity to motivate others in order to provide effective leadership in healthcare organizations (Glickman *et al*., 2007). This study also identified resources and facilities as organization-related determinants of quality healthcare services being provided. In this respect, prior studies demonstrated that health facilities health centers, personnel and medical equipment are inadequate in Nigeria, especially in rural areas (Anonymous, 2010).

Furthermore, the present study showed that patient-related factors determine the quality of healthcare services provided in Nigerian healthcare organizations. Approximately 75% of patient socio-demographic variables, 61% of the type of patient illness and 54% of patient cooperation constituted the patient-related factors. Thus, it is possible that a study may correlate a patient's desire for quality healthcare services in connection with their level of satisfaction with healthcare services provided. The outcome of this investigation would help to initiate a benchmark for best practices, delivering appropriate care and improving processes to reduce the frequency of problems associated with the quality of healthcare services.

The strength of the present study lies in its descriptive nature. However, some limitations need to be addressed in future studies. First, this study was not an in-depth qualitative research study. Rather, it was a representative survey based on quantitative data analysis. There is therefore a need to conduct a comprehensive qualitative research study regarding this phenomenon. Second, this study focused on healthcare stakeholders in Nigerian healthcare organizations; The result of the study cannot be generalized to other countrie's healthcare systems. Hence, future studies are recommended to identify factors that affect the quality of healthcare services in other countries around the world.

CONCLUSION

The quality of healthcare services provided in Nigerian healthcare organizations is determined by provider-related factors, organization-related factors and patient-related factors. The understanding of these factors is essential for initiating a benchmark for best practices, delivering quality healthcare services and amelioration of problems undermining the quality of healthcare services. The Nigerian health care system should support quality improvement activities, effective leadership and partnership development in order to ensure sustainability and effectiveness in the provision of quality healthcare services.

ACKNOWLEDGEMENTS

This study was conducted according to the principles of the Declaration of Helsinki (World Medical Association, 2013). Ethical approval was obtained from Federal Ministry of Health, Federal Capital Territory, Abuja. (Ethical Approval Code: FMHFCTERA.301FCH9). This is one of the Institutional Review Board Committees that gives approval for studies of this kind. The participants were informed that participation in the study was completely voluntary and that they can withdraw at their own will. The identity of the participants was protected. No financial compensation was provided to the participants for their participation. UCU, BOA and CA conceived the current study. UCU, AEO and NLO did the data acquisition, statistical analysis, interpretation and writing of manuscript. All the researchers did the final review and approval of manuscript for submission.

ABBREVIATIONS

LGA	=	Local Government Areas
FSLC	=	First School Living Certificate
WASSC/ NECO	=	West African Secondary School Certificate/National Examination Council
QHSQ	=	Quality Healthcare Services Questionnaire
%	=	Percentage

REFERENCES

Adeyemo, D.O., 2005. Local government and health care delivery in Nigeria: A case study. J. Hum. Ecol., 18: 149-160.

Akande, T.M., 2004. Referral system in Nigeria: Study of a tertiary health facility. Ann. Afr. Med., 3: 130-133.

Anonymous, 2010. Maternal mortality ratio. United Nations Population Fund, New York, USA. https://www.unfpa.org/maternal-health

Anonymous, 2017a. Maternal mortality in Nigeria. Center for Reproductive Rights, New York, USA. https://www.reproductiverights.org/feature/maternal-mortality-in-nigeria.

Anonymous, 2017b. Nigeria primary health care policies. Photius Coutsoukis, Nigeria. https://www.photius.com/countries/nigeria/society/nigeria_society_primary_health_care_~10006.html

Anonymous, 2017c. The library of congress country studies. Central Intelligence Agency, McLean, Virginia, USA. https://www.cia.gov/index.html

Awosika, L., 2005. Health insurance and managed care in Nigeria. Ann. Ibadan Postgraduate Med., 3: 40-51.

Emmanuel, N.K., E.N. Gladys and U.U. Cosmas, 2013. Consumer knowledge and availability of maternal and child health services: A challenge for achieving MDG 4 and 5 in Southeast Nigeria. BMC. Health Serv. Res., 13: 1-5.

Glickman, S.W., K.A. Baggett, C.G. Krubert, E.D. Peterson and K.A. Schulman, 2007. Promoting quality: The health-care organization from a management perspective. Intl. J. Qual. Health Care, 19: 341-348.

Indacochea, C.M. and E. Leahy, 2009. A case study of reproductive health supplies in Nicaragua. Population Action International, Ghana, West Africa.

Kaluzny, A.D., 2006. Continuous Quality Improvement in Health Care: Theory, Implementations and Applications. 3rd Edn., Jones and Bartlett Learning, Massachusetts, USA., ISBN-10:0-7637-2712-1, Pages: 679.

Mohammadi, A. and A.R. Shoghli, 2009. Survey on quality of primary health cares in Zanjan District health centers. ZUMS. J., 16: 89-100.

Mosadeghrad, A.M., 2012. A conceptual framework for quality of care. Mater. Soc. Med., 24: 251-261.

Mosadeghrad, A.M., 2014. Factors influencing healthcare service quality. Intl. J. Health Policy Manage., 3: 77-89.

Mpembeni, R.N., J.Z. Killewo, M.T. Leshabari, S.N. Massawe and A. Jahn *et al*., 2007. Use pattern of maternal health services and determinants of skilled care during delivery in Southern Tanzania: Implications for achievement of MDG-5 targets. BMC. Pregnancy Childbirth, 7: 1-7.

NHIS., 1999. Decree No 35: Laws of the Federation of Nigeria. National Health Insurance Scheme, Ghana, West Africa. http://www.nigerialaw.org/National%20Health%20Insurance%20Scheme%20Decree.htm

NPC., 2009. Nigeria demographic and health surveys 2008. National Population Commission Calverton; NPC and ICF Macro, Maryland, USA. https://www.dhsprogram.com/pubs/pdf/FR222/FR222.pdf

Omoruan, A.I., A.P. Bamidele and O.F. Phillips, 2009. Social health insurance and sustainable healthcare reform in Nigeria. Stud. Ethno Med., 3: 105-110.

Onwujekwe, O., C. Onoka, N. Uguru, T. Nnenna and B. Uzochukwu *et al*., 2010. Preferences for benefit packages for community-based health insurance: An exploratory study in Nigeria. BMC. Health Serv. Res., 10: 1-7.

Ovretveit, J., 2009. Does Improving Quality Save Money: A Review of Evidence of which Improvements to Quality Reduce Costs to Health Service Providers. The Health Found, London, UK., ISBN:978-1-906461-17-1, Pages: 103.

WHO, 2005. Make Every Mother and Child Count. World Health Report, WHO, Geneva, Switzerland.

WHO., 2009. The millennium development goals for health: Rising to the challenges. The World Bank, New York, USA. http://www.worldbank.org/

WHO., 2013. WHO: Life expectancy. World Health Organization, Geneva, Switzerland. https://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends/en/

Welcome, M.O., 2011. The Nigerian health care system: Need for integrating adequate medical intelligence and surveillance systems. J. Pharm. Bioallied Sci., 3: 470-478.

World Medical Association, 2013. World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. J. Am. Med. Assco., 310: 2191-2194.

Yang, C.C., 2006. The impact of human resource management practices on the implementation of total quality management: An empirical study on high-tech firms. TQM. Mag., 18: 162-173.