

Causes and management of poor healthcare services delivery in Kwara state, Nigeria: students' perception

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Abstract

The present study sought to investigate the perception of students on the causes and management of poor healthcare services delivery in Kwara state, Nigeria. Primary data were collected from 360 students in the higher institutions meant for training healthcare professionals in Kwara state. A cross sectional survey using 200 students from College of Health Sciences, University of Ilorin and 80 students each from School of Nursing, Ilorin and College of Health Technology, Offa randomly recruited, participated in the study. We designed questionnaire with questions divided into two subject areas: causes and management of poor healthcare services delivery. Self completion questionnaire was used to gather data from the 360 students. Low salary, shortage, dissatisfaction and burnout of healthcare givers, etc. were the causes of poor healthcare in the state. Management strategies including increasing salary, continuous recruitment, flexible scheduling of duties and decentralizing decision making by bedside care givers etc. were also identified. In conclusion, Hospital management, governmental and non-governmental organizations have various specific roles to play in improving the quality of healthcare services delivery in Kwara state. Further studies are needed to access the perception of healthcare givers.

Keywords: Healthcare, Poverty, Kwara, Nigeria.

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Introduction

A well-functioning health care system requires a robust financing mechanism; a well-trained and adequately-paid workforce; reliable information on which to base decisions and policies; and well maintained facilities and logistics to deliver quality medicines and technologies (WHO 2012). Its provision in Nigeria is a concurrent responsibility of the three tiers of government in the country (Rais, 1991). However, because Nigeria operates a mixed economy, private providers of health care have a visible role to play in health care delivery. The federal government's role is mostly limited to coordinating the affairs of the university teaching hospitals, Federal Medical Centres (tertiary health care) while the state government manages the various general hospitals (secondary health care) and the local government focus on dispensaries (primary health care), (FMC Abeokuta, 2011).

Available statistics indicate that poverty has become endemic in Nigeria and is on the increase, with the likelihood of being poor being increased by resident in north central zone where Kwara state is located. The total poverty head count rose from 27.2% in 1980 to 65.6% in 1996, an annual average increase of 8.83% over the 16-year period. However, between 1996 and 2004, the head count declined by an annual average of 2.1% to 54.4%. The fact that over 50% of total population is officially poor should be of great concern to policy makers (NBS, 2005; 2006).

The CBN and NBS socio-economic survey of 2006 showed that a substantial proportion of Nigerians still lives on less than N20, 000, with 18 states, including Kwara, recording lower per capita incomes than the global standard of less than \$1.25 per day. Because healthcare services delivery is not free in the Nigeria, the striking poverty in the country has noticeable adverse effects on the healthcare services delivery (CBN, 2005; NBS, 2006a).

Increasing access to affordable, accessible and quality healthcare which is a major contributor to human capital development, increased employability and higher labour

productivity, was part of the planned strategies to reduce poverty and inequality. This was done by the introduction of a national primary healthcare strategy, the reinvigoration of the federal Primary Health Care Development Agency (PHCDA) and the pioneering of a National Health Insurance System (NHIS). Despite the various reforms in the health sector, the progress of the impacts of the reforms on health and child poverty was reported to be slow on infant mortality rate, malaria prevalence rate and tuberculosis prevention rate; and worsening number of child orphaned by HIV/AIDS, total population with access to safe drinking water, maternal mortality ratio, just to mention a few (MDG, 2008).

Study is scanty on the causes and management of poor healthcare services in Nigeria. The present study sought to access the perception of students on the causes and management of poor healthcare services delivery in Nigeria, taking Kwara state as a case study.

Materials and method

The study design was a cross sectional survey using self completion questionnaires. The study was carried out in the three higher institutions for training healthcare professionals in Kwara state. This study was limited to the healthcare students based on the assumption that they have better understanding of healthcare plan and challenges in the country. Three hundred and sixty students consisting of two hundred people from College of Health Sciences, University of Ilorin, Ilorin (COHSUI) and eighty people each from School of Nursing, Ilorin (SON) and College of Health Technology, Offa (COHT), were randomly recruited to participate in the study. Medical students were sampled among other students in the COHSUI. At the COHT, students across various departments including Medical Laboratory Science, Environmental Health, Medical Record, etc. were sampled. Though there are limited data for the healthcare data in the state, it is regarded as one of the states in Nigeria with low healthcare service delivery by Nigeria standard.

Questionnaires were developed by the research team with questions divided into two subject areas: causes and management of poor healthcare services delivery in Kwara state. Questions were drawn from previously identified potential causes of poor healthcare services delivery in various other studies and developed specifically for the study. The draft questionnaire

was piloted among 30 students of other tertiary institutions not used for the study and modifications were made accordingly. Students completed the questionnaire anonymously under examination conditions. They gave verbal and written consent to participate in the study. They were given the explicit option to refuse though none did. Respondents were encouraged to complete the questionnaire themselves but researchers assisted where necessary. This study got institutional ethical approval prior to its commencement.

Statistical analysis

Data were entered and analyzed using the SPSS version 16.0 statistical software. Frequency distributions of the variables were done. Binary logistic regression was used to compare and calculate odds ratios from the 'yes' and 'no' responses. The regression model was also used to adjust for the cofounders' institution, age, sex, ethnicity and religion. For the purpose of testing if there is institutional difference in the students; responses, data were transformed to quantitative data and the significant differences between them were determined by student's t-test. Values were expressed as frequency (percentage) unless otherwise stated. Values with P-value < 0.05 were taken as statistically significant.

Results

Characteristics of the study population (table 1)

There were completed questionnaires from three hundred and sixty participants, a 95% response rate based on the completion of selected key variables. The sociodemographic composition is given in table 1. More than half of the respondents were from Yoruba ethnic group. Moreover, majority of the respondents practice Islamic religion. Majority of the students in school of nursing and college of health technology were females, explaining the female preponderance among the study subjects.

Table 1: Characteristics of the study population

	No	%
Institution		
College of Medicine, University of Ilorin, Ilorin	200	55.6
School of Nursing, Ilorin	80	22.2
College of Health Technology, Offa	80	22.2
Age (year)		
15-20	32	8.9
21-25	176	48.9
26-30	123	34.2
31-35	29	8.0
Sex		
Male	157	43.6
<i>Female</i>	203	56.4
Ethnicity		
Yoruba	211	58.6
Others (e.g. Igbo, Ebira, etc)	149	41.4
Religion		
Islam	209	58.1
Christianity	151	41.9
Traditional		

Causes of poor healthcare services delivery (table 2)

More than three quarter of the respondents favoured the facts that low salary, shortage, dissatisfaction and burnout of healthcare givers were the causes of poor healthcare services delivery in Kwara state. Moreover, more than three quarter of the respondents supported the facts that poor access of patients to medicine and unaffordable costs of healthcare services by patients are part of the causes of poor healthcare services delivery in the state. However, about half of the respondents supported the facts that downstream health services research and policy approach innovation, production of incompetent healthcare givers by the training institutions, inadequate

medical equipment and facilities, and lack of use of the skills of non-medical healthcare services professionals are other causes of poor healthcare services delivery in the state. Significant differences ($P < 0.05$) were found for all questions on the causes of poor healthcare services delivery except for questions concerning ‘production of incompetent healthcare givers by the training institutions’ and ‘lack of use of the skills of non-medical healthcare services professionals’ ($P > 0.05$). There was no significant difference between the responses of participants across the three institutions.

Table 2: Participants responses to the questions on the causes of poor healthcare services delivery in Kwara state

Can poor healthcare services delivery in Kwara state be caused by:	Yes, n (%)	No, n (%)	Adjusted OR (95% CI), P value
Low healthcare givers salary	270 (75.0)	90 (25.0)	24.9 (18.4-43.8), < 0.001
Shortage of healthcare givers	290 (80.6)	70 (19.4)	30.2 (16.9-134.9), 0.01
Healthcare givers’ dissatisfaction and poor organizational features	270 (75.0)	90 (25.0)	24.9 (18.4-43.8), < 0.001
Healthcare givers’ burnout	330 (91.7)	30 (8.3)	57.3 (20.7-196.3), <0.001
Poor access of patients to medicine	300 (83.3)	60 (16.7)	40.2 (21.3-142.4), <0.001
Downstream health services research and policy approach innovation	210 (58.3)	150 (41.7)	20.1 (17.3-22.5), 0.01
Production of incompetent healthcare givers by the training institutions	190 (52.8)	170 (47.2)	16.5 (15.9-17.5), 0.104
Unaffordable costs of healthcare services by patients	274 (76.1)	86 (23.9)	21 (17.6-28.6), <0.001
Absence of/Inadequate medical equipment and facilities.	201 (55.8)	159 (44.2)	17.3 (16-20.4), 0.04
Lack of use of the skills of non-medical healthcare services professionals	198 (55.0)	162 (45.0)	15.7 (15.4-16.3), 0.291
Low awareness on and participation in the health insurance program	259 (71.9)	101 (28.1)	21.0 (19.3-23.8), <0.001

Table 3: Participants responses to the questions on management of healthcare service

Can poor healthcare services delivery in Kwara state be managed by:	Yes, n (%)	No, n (%)	Adjusted OR (95% CI), P value
Improvement of healthcare givers salary	325 (90.3)	35 (9.7)	54.6 (25.2-193.1), <0.001
Encouragement of the study of medical and health related courses with attractive incentives	301 (83.6)	59 (16.4)	41.4 (21.9-142.5), <0.001
Maintain a participatory organizational features	259 (71.9)	101 (28.1)	21.0 (19.3-23.8), <0.001
Continuous recruitment of healthcare givers	296 (82.2)	64 (17.8)	34.3 (20.6-55.2), <0.001
Flexible scheduling of healthcare givers duties	200 (55.6)	160 (44.4)	17.3 (16-20.4), 0.03
Supplementary prescribing by nurses and pharmacists	189 (52.5)	171 (47.5)	13.9 (11.8-17.5), 0.056
Donation of drugs to hospitals by governmental and non-governmental organization	299 (80.1)	61 (19.9)	40.2 (21.3-142.4), <0.001
Promotion of health-related research by governmental and non-governmental organization	285 (79.2)	75 (20.8)	27.5 (20.8-46.3), 0.006
Educational reform to restructure and correct anomalies in the curriculum in various health training institutions	237 (65.8)	123 (34.2)	22.3 (19.4-30.1), <0.001
Making healthcare services free for all citizens	310 (86.1)	50 (13.9)	43.4 (36.8-56.6), <0.001
Provision of medical equipment and facilities by governmental and non-governmental organizations	253 (70.3)	107 (29.7)	20.7 (12.9-29.7), <0.001
Decentralizing decision making by bedside care givers	279 (77.5)	81 (22.5)	26.0 (11.9-22.8), <0.001
Increasing the awareness and coverage of health insurance program	257 (71.4)	103 (27.6)	20.9 (13.5-30.1), <0.001
Organizational assessment of healthcare	199 (55.3)	161 (44.7)	17.3 (16-20.4), 0.04

Management of poor healthcare services delivery (table 3)

More than three quarter of the respondents supported the idea that healthcare services delivery in Kwara state could be managed by improvement of healthcare givers salary, encouragement of the study of medical and health-related courses with attractive incentives, continuous recruitment of healthcare givers, donation of drugs to hospitals by governmental and non-governmental organizations, promotion of health-related researches by governmental and non-governmental organization, making healthcare services free for all citizens, and decentralization of decision making by bedside care givers. Moreover, more than half of the respondents supported the opinion that poor healthcare services delivery in the state could be managed by flexible scheduling of healthcare givers duties, supplementary prescribing by nurses and pharmacists, educational reform to restructure and correct anomalies in the curriculum in various health training institutions, and provision of medical equipment and facilities by governmental and non-governmental organization. Significant differences ($P < 0.05$) were found for all the questions on the management of healthcare services delivery except than on 'Supplementary prescribing by nurses and pharmacists' ($P > 0.05$). There was also no significant difference between the responses of participants across the three institutions.

Discussion

The present study investigated the perception of students on the causes and management of poor healthcare services delivery in Kwara state, Nigeria. A question relating to how much to pay staff led to the introduction of physicians practice's first-ever staff survey. Wide disparities were found in pay based on region, and on whether the practice is in an urban, suburban, or normal setting. Urban areas tend to pay higher than suburbs and rural location as reflecting cost of living difference (Kellie, 2009). In the present study, low healthcare givers salary was also identified in Kwara state, which is a relatively suburban setting.

Low quality of healthcare in Kwara state was also found to be associated with shortage of healthcare givers, which consequently lead to increment in patients' waiting time (Cooper, 2008). This is similar to the previous report in United State, England, Scotland and Germany (Blendon et al., 2001). In these countries, high level of nurses' dissatisfaction has previously been identified as one of the causes of poor healthcare services delivery (Aiken et al., 2000; Davidson et al., 1997). This present study showed similar result in Kwara state in Nigeria.

Poor access of patients to medicine and lack of use of the skills of non-medical healthcare services professionals (Cooper et al., 2008) and downstream health services research and policy approach to innovation (Lehoux, 2006) were also identified in the present study as part of the causes of poor healthcare services delivery in the state.

Various managerial reforms have been undertaken to improve productivity in the hospital sector. These initiatives have taken different form, some focusing on new organizational arrangement such as vertical and horizontal integration of services, mergers and regionalization of services and others on process re-engineering and work design (Leatt et al., 1997; Walston et al., 2000; Burke and Green, 2000). Previous studies identified set of organizational attributes to attract and retain professional healthcare givers as flat organizational structure, decentralized decision making by bedside caregivers, inclusion of the chief nurse executive in the top management decision making, flexible scheduling, unit self governance, and investment by management in the continuing education of nurses (Kramer and Schmalenberg, 1988; Aiken et al., 1994). Similarly, the present study identified strategies like maintaining a participatory organizational feature, decentralizing decision making by bedside care givers, and organizational assessment of healthcare as ways to improve healthcare services delivery in Kwara state.

It was reported that nurses constitute the on-going surveillance system in hospitals for early detection of adverse occurrence, complications and errors. Early detection and patient outcomes is affected by nurse-to-patient ratios and nursing skill mix (the proportion of nursing personnel who are registered professional nurses). The earlier the problem is detected and managed, the lower the probability of a poor outcome (Flood, 1994). Moreover, nurses in the worst-staffed hospitals were 1.3 times as likely as those in the best-staffed hospitals to report dissatisfaction and burnout, and rate the quality of care in their unit as fair or poor (Aiken et al., 2000). Therefore, continuous recruitment of healthcare givers and encouragement of the study of medical and health related courses with attractive incentives were rightly suggested by the participants in this study.

With aims of improving patients' access to medicines, making better use of the skills of non-medical healthcare professionals and reducing waiting times (Cooper et al., 2008), supplementary prescribing (SP) is considered particularly suitable for the many patients with long-term conditions such as asthma, diabetes and hypertension. Furthermore, patients appear to have valued pharmacist SP and also received more medicines information and longer consultations from their SP pharmacist than their doctors (Cooper et al., 2008). In UK, use of SP

among a sample of nurses and pharmacists was shown to be 44% (Courtenay and Carey, 2008) and 49% (George et al., 2007) respectively. Furthermore, SP has also been introduced for several other allied health professionals such as chiropodists, podiatrists, physiotherapists and radiographers (Department of Health, 2005). Though not significant, majority of the participants agreed that supplementary prescribing by nurses and pharmacists would improve healthcare delivery. This may be because the idea of supplementary prescribing is not yet practiced in Nigeria.

Promotion of healthcare research and policy approach innovation by governmental and non-governmental organization was also suggested in this study as a management strategy for healthcare service delivery. From a healthcare system perspective, a desirable innovation is a technology that is equally or more effective and costs less than its current alternative, can be used safely and effectively by less skilled and less costly personnel, and in any kind of setting, solves a health problem permanently or produces diagnostic certainty, does not trigger side effect or reduce patients mobility and does not raise ethical dilemmas (Lehoux, 2006). Innovation designers rarely tap into the knowledge generated by health services researches, while health services researchers often fail to provide key insights about the comparative value of emerging innovation, such as their significance within the broader universe of desirable healthcare interventions. As a result, after decades of research, there is an acute lack of knowledge about ways to promote the design of more valuable innovations (Lehoux, 2006). It was suggested that part of the solution was to develop a new collaboration policy oriented research agenda that can bridge design processes, and health care needs and priority. This idea is beginning to be recognized by academics and high-level policy makers around the world (Reiss et al., 2003).

Making healthcare services free for all citizens, increasing the awareness and coverage of health insurance program and donation of drugs to hospitals by governmental and non-governmental organizations were also suggested as other key ways to improve healthcare services delivery in the state. These ideas would remove the financial barrier to access proper healthcare service delivery by the citizens. While provision of sophisticated medical equipment and facilities by governmental and non-governmental organizations was highly necessary, this might not produce desired effect if educational reform to restructure and correct anomalies in the curriculum in various health training institutions was not done. The latter will ensure production of manpower that will have expertise in delivering quality healthcare service with the aid of modern medical equipment.

In conclusion, hospital management, governmental and non-governmental organizations have various specific roles to play in improving the quality of healthcare services delivery in Kwara state.

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