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Assessment of the Administration of Healthcare Service Delivery in Obafemi Awolowo University Teaching Hospitals' Complex, Ile-Ife, Nigeria

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Abstract

The study examined the structure and mode of administration in Obafemi Awolowo University Teaching Hospitals Complex Ile-Ife Nigeria; and also assessed the impact of the structure and mode of administration on the service delivery in the hospital. These were with a view to assessing the administration of healthcare service delivery in Nigeria. Primary and secondary data were used for the study. The primary data were collected through administration of questionnaire and in-depth interviews on the staff of Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC), Ile-Ife, The study population of 779 consisted senior staff members on levels 07 and above in OAUTHC, (a federal tertiary hospital) and SERVICOM office in the hospital. Stratified and random sampling techniques were used in selecting respondents with a sample fraction of 20% bringing the sample size to 155 out of 779 population frame. Interviews were conducted with 9 respondents including two (2) purposively selected Directors in the hospital, two (2) servicom officers and five

patients, who were randomly selected in the tertiary healthcare institution. Secondary data were collected from books, journals, reports, documents, official publications, and internet sources. Data collected were analysed using descriptive and inferential statistics (*t* test). The study concluded that the structure and mode of administration impacted negatively on the service delivery, efficiency and running of tertiary healthcare in OAUTHC Ile-Ife Nigeria.

Key Words: Efficiency and Effectiveness, Health and Healthcare, Health Expenditure, Hospital Management, Hospital Administration

Introduction

A health system consists all organisations, people and actions whose primary intent is to promote, restore or maintain health (WHO, 2007). It has as its main functions the delivery of health services, the creation of resources for health (investment in people, building and equipment), health financing (revenue raising, risk pooling, and purchasing of healthcare services) and stewardship (Carrin, 2004).

The revised National Health Policy (1996) provides for a three-tier structure compartmentalized into primary, secondary, and tertiary levels of healthcare service delivery. Responsibilities were allocated across the board to the local, state and federal government. Primary healthcare by policy arrangements is within the purview of local governments, based on residual operations of local government authorities (Ademiluyi & Aluko-Arowolo, 2009). Primary health structures are arguably the first points of call for the sick and injured persons. They undertake mild healthcare cases like malaria, fever, cold, nutrition disorder among others. They also handle infant, maternal and pregnancy matters. Other health issues in their care are family planning and immunization (Badru, 2003). At the primary level assigned to local government, the organisational arrangement for providing healthcare services to residents of the council areas are vested in the local government health committee headed by the council chairman with the supervisory councillor taking statutory responsibility for all health matters in the council area of jurisdiction. At this level the facilities include primary health centres, maternity homes, district and village dispensaries (Airhienbuwa, 2000). The state governments have responsibility for second tier health facilities like general hospitals, comprehensive health centres and are involved with not only prevention but also treatments and management of complex minimal cases. They also have provisions for accident and emergency unit and diagnosis unit including x-ray, scan machines and other pathological services (Badru, 2003). The apex healthcare organisations are essentially under the federal ministry of health. These include teaching hospitals, federal medical centres and specialised hospitals like psychiatric and orthopaedic hospitals (Airhienbuwa, 2000). They handle complex health problems or cases either as referrals from general hospitals or on direct admission to its own. It has such features as accident and emergency unit, diagnostic units, ward units, treatment unit and outpatient consultation unit. They are equipped with the necessary facilities and staffed by skilled personnel. (Health in Africa Initiative, 2011)

These health services are delivered in the context of guidelines, policies, legislation and laws with the specific goal of optimizing inputs to produce health. Health policies also outline priorities, roles and responsibilities for stakeholders in health. Policy and regulatory activities are the responsibility of health authorities. It covers the development of regulatory guidelines or rules to govern the operations of actors in the health system, as well as ensure compliance (NAS, 2006).

The health system in Nigeria, as ranked by the World Health Report 2000, is 187th out of 191 member states. Many factors are said to be responsible for this low rank of the health system

in Nigeria. This include poor organization, stewardship, financing and poor provision of health services. The primary objective of a health system is to improve people's health and therefore its chief function is to deliver health services. Health is seen as a basic right to be guaranteed by the state (Heidenheimer, 1976), as it is the most basic of all essential services (Collins, 2006) and their significance cannot be over emphasised.

The delivery of health service in Nigeria is faced with the problems of quality of care, inadequacy of healthcare facilities and systems, healthcare policies, standard operating procedures and inadequacy of the level and scope of care provided by the physicians and other health workers. There is also the problem with accessibility to care measured by the evaluation of the adequacy of the numbers of healthcare facilities and the proper distribution of these facilities to allow easy and immediate access to medical facilities, the affordability and the accessibility of quality healthcare to all patients (Nwangwu, 2013).

Despite financial allocation from government, external financing, insurance, individual donations, corporate donations, community financing, and user charges, our healthcare delivery has remained comatose with resultant array of poor health outcomes, high morbidity and mortality, inadequate manpower development and poor infrastructures, absence of basic facilities and worst employer-employee relations, making the future of Nigerian health industry seems hopeless.

The medical doctors contend that by virtue of their training and responsibilities, they are the natural heads of the sector, other paramedical health workers including nurses, pharmacists, laboratory technicians/technologists, radiographers, and practically every other non-physician staff argue otherwise (Umeha, 2015). The unfortunate situation such as bickering and intractable struggle for supremacy that have characterized the Nigerian health system would have been successfully nipped in the bud if the leadership has been proactive about the yearnings and aspirations of the various labour unions (Onwe, Sunday, Abah, and Nwokwu, 2015). The enabling environment for cooperation and coordination of efforts of the numerous professionals' groupings that contribute to the provision of healthcare, for smooth and optimal performance at all levels of delivery is lacking.

As the rivalry rages, the healthcare service delivery is worst for it. In other countries like the United Kingdom, it is not unusual for trained and seasoned managers, who are not necessarily medical practitioners to assume management positions with respect to public health administration (Oyewunmi, 2014). In the United Kingdom and the United States of America, most hospital executive officers (CEOs) are non-physician managers rather than physicians (Falcone and Satiani, 2008). Of the 6,500 hospitals in the United States only 235 are led by physicians (Gunderman and Kanter, 2009), and that only 5% of hospitals are led by a doctor, according to the American College of Physician Executives. In Japan Akira Nagatsuma who was appointed in 2009 as minister of health was not a medical doctor. Similarly, In India Mr. Ghulan Azad holds an M.Sc degree in zoology was also appointed a minister of health.

In Africa, Botswana has been rated by the World Health Organisation as having the best healthcare service. The current Minister of Health in Botswana is an Accountant, and he took over from Mrs. Motsumi, a physiotherapist who was Minister of Health between 2003-2009. Earlier on, Mrs. Joy Phumaphi, who holds a Master of Science degree in Financial Accounting and Decision Sciences was the Minister of Health from 1999-2002 (Ministerial Leadership Initiative, 2009) There has been a shift in advanced climes, from vertical to a matrix health management structure, as this approach seems to serve better the interests of all participants involved with the public healthcare delivery. This approach or any other one as

may be deployed depending on circumstances will only be effective if the “medical governance” structure is duly enforced and adaptable to the dynamics of tertiary healthcare delivery in Nigeria. In effect, it is the enforcement of the prevailing governance structure that would actually facilitate the integration of various medical disciplines that co-exist within the health sector (Oyewunmi and Oyewunmi, 2014).

With greater transparency and prudent administration of healthcare resources, increased accountability and managerial efficiency, less pressure on health administrators that would make health care services in the country generally efficient, accessible, and affordable is advocated for, hence this study.

Research Questions

1. What are the structure and mode of administration in the tertiary hospitals in Southwestern Nigeria?
2. What are the impacts of the structure and mode of administration on service delivery in the study area?

Research Hypothesis

H0: The structure and mode of administration in the teaching hospitals did not have significant positive

Review of Relevant Literature

Health and Health Care: Health has been perceived in different ways by different people. World Health (1946) defined health “as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity” (WHO, 2006). This definition of health entered in to force in 1948. However, the definition has the problem of implying a complete or perfect state of three components of health in forms of physical, mental and social well being which is not possible because no individual can be said to be completely well in all the three health components or domains (Miller and Price, 1998). There are four components of health; these are physical health, mental health, social health and spiritual health (Miller and Price, 1998).

Health Expenditure: Health expenditure refers to outlays for prevention of disease, health promotion, rehabilitation, personal and public health care Services; population programmes; nutritional activities; programme food aid; and emergency aid specifically for health (The World Bank, 1994). Health expenditure is the expenditure for which the primary objective is to restore improved health or prevent the deterioration of health status/outcomes. The primary objective may change under some circumstances and it means normal usage, not personal motivation. Health expenditure is also the final value of goods and services, capital investment, research and administrative costs in the public and private sectors of the economy (Hicks, Ballinger and Campbell, 2000).

National Health Services Systems which is known as tax-based financing or Government sponsored insurance is a health care services system that is owned by government (national ownership of health sector inputs) and are funded by the general government revenue such as income tax, value added taxes, import duties or earmarked (“sin” taxes) health care taxes, borrowing, sales of natural resources or state ownership of enterprises (Santerre and Neun, 1996; Folland, Goodman and Stano, 1997; Senior and Veveash, 1998; Irurzun-Lopez, 2003; WHO, 2004; the world Bank, 2006; Hou and Dulitzky, 2007; Shieber, et al, 2007; and or, Jusot and Yilmaz, 2008). The system has theoretical benefit of providing health care services

to the entire population without fee (with the exception of user fees). Government sponsored health care services came in at least public health programmes, such as targeted programmes for individuals with special like HIV/AIDS, tuberculosis, renal failure etc.; targeted programmes for selected populations groups, like the poor or the elderly; and complex national or provincial public health plans that provides universal and comprehensive coverage for all citizens (WHO, 2004, Dormont et al, 2007).

Health Services Evaluation: According to Faruqee, (1982), when evaluating the impact of health services, there are four major categories of indicators to be considered These are, (a) Environment which comprises socio-economic conditions and health policies measures like knowledge and skills about health etc.; (b) inputs (to health care), which includes measures of services offered physical accessibility of services, distance, time needed to travel, ability to pay for services cultural determinants; (c) outputs (outputs of health services received) which encompasses per capital use, distribution of use among target population, coverage of usage, number of doctors/nurses, number of children immunized, number of women with prenatal care e.t.c. and (d) outcomes (changes in mortality, life expectancy and nutritional status) which is the final impact of health services that reflect long run changes in health status.

Health Management and Administration: In any organization, management of resources and administrative style not only contribute to the quality of services, but also determine productivity level. Thus, administration cannot be overemphasized in service delivery, as it contributes immensely to national growth and development (Olaleye, 2008). In theory, management consists of four basic activities: planning, organizing, communicating and monitoring (controlling) In recent times, administration has been defined scientifically as the coordination of all resources of an organization through the process of planning, organizing, directing, controlling, staffing, coordinating, reporting and budgeting in order to attain organizational goals and objectives (Akanni, 1987). Today in modern health/hospital management, there is administrative concern for resource allocation, organization efficiency and institutional survival while the various professional groups see the hospital as the vehicle for the practice of their professional activities, under the supervision of their professional associations. In the discharge of functions in hospital setting, there exist occasional conflicts between the medics and non-medics over issues in their various autonomous units. According to Metiboba (2007), communication in the hospital flows vertically as well as horizontally. Relationship among doctors and the various professional groups is collegial. There is duality of structure in hospital administration and the professional groups. For instance the hospital administrators are non- medics but oversee administrative matters while the professional groups are medics with professional authority. Each profession has its rules and codes of practice.

Hospital Administration: Dorland's Illustrated Medical Dictionary defines a hospital as: an institution suitably located, constructed, organized, staffed to or any organized part of the complex requirements for the medical aspects of social ills. This is with functioning facilities for training new workers in many special professional, technical and economical fields essential to the discharge of its proper functions and with adequate contacts with physicians, other hospitals, medical schools and all accredited health agencies engaged in the medical schools including all accredited health agencies engaged in the better-health programme.

Hospital is the most complex of all administrative organizations considering the complexity of medical care and acceptance of the hospital as a service. Hospitals have many different groups of people interacting together in a complicated process to achieve the objectives of the institutions. As large organizations, large numbers of workers have to be supervised,

coordinated and controlled. Administration of Hospital and Health service therefore can be described as the process of mobilizing and deploying resources for the efficient provision of effective health care services while the health administrator is an individual who manages and conducts the affairs of the health facility or the institutions resources (Olumide, 1997).

Efficiency vs Effectiveness

Efficiency: Efficiency is doing things right and consistently. According to Nyarko (2014) it is getting the maximum output with minimum input (objective performance). Efficiency takes into consideration of the present state and focuses on the process.

Effectiveness: Effectiveness is doing the right things. It measures if actual output meets desired output. Nyarko (2014) is also of the opinion that effectiveness takes into consideration the long term strategy. It has the desires or innovative ways of working and focuses on the result.

Efficiency and Effectiveness are useful Management tools. Both concepts are very useful for monitoring and evaluating employees' output and helps to have a clear mind for creativity and innovative ideas. Both are performance indicators.

Methodology

The study is on Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC) Ile-Ife, a Teaching Hospital in Southwestern Nigeria. Primary and secondary data were used for the study. Primary data were collected through administration of questionnaire and in-depth interview. The study population (779) consists of senior staff members (level 07 and above) of the teaching hospital. Stratified and random sampling techniques were used in selecting respondents with a sample fraction of 20% bringing the sample size to 155 out of 779 population frame. Interviews were conducted with 9 respondents including two (2) purposively selected Directors in the federal tertiary institution and two servicom officers and five (5) patients who were randomly selected in the tertiary healthcare institution. Secondary data were collected from reports, documents, official publications, journals, articles, books and internet sources. The data collected were analysed using simple percentages and content analysis.

Discussions

This study examined the structure and mode of administration in the selected teaching hospital. Seven (7) structural items were investigated. The items include: (i.) organisational effectiveness; (ii.) administrative and managerial skills; (iii.) appropriateness of two-directorate system in the hospital; (iv.) the decision-making procedure; (v.) effective functioning of the system; (vi.) inclusion of all health professionals in the hospitals; and (vii.) peaceful co-existence among the professional groups in the hospitals.

It is only on item (ii) that the majority (63.1%) of the respondents agreed/strongly agreed that the management of the hospital were equipped with adequate administration and managerial skills. On the remaining six (6) items, respondents admitted structural defects in the hospital. The poorest is in the areas of effective functioning of the system, where (80%) of the respondents disagreed/strongly disagreed that the existing structure and mode of administration in the hospital promote effective functioning of the system. Closest to this is the decision-making procedure, where (73%) of the respondents disagreed/strongly disagreed that the procedure of making decision under this structure and mode of administration is highly efficient and effective. The distribution equally revealed the failure of the structure and

mode of administration in the areas of inclusion of all health professionals in the hospitals management and guaranteeing peaceful co-existence among the professional groups in the hospitals. In these areas, (53%) and (60%) of the respondents disagreed/strongly disagreed respectively with the efficiency and effectiveness of the structure.

It could be concluded from the above that the structure and mode of administration in the teaching hospital under the study fell far short of ensuring effective functioning of the system. This is clearly reflected where the average percentage of responses to the seven items in the questionnaire is given. According to the respondents, on the overall, (34.5%) agreed/strongly agreed that the structure and mode of administration in the hospital was okay for effective functioning of the institution. This was against the (65.5%), disagreed/strongly disagreed with the position that the structure and mode of administration in the selected institution guaranteed their effective functioning. Also, the impact of the structure and mode of administration in the selected tertiary hospital is assessed. In doing this, seven (7) expected administrative impacts were examined. These included: (i) improvement in Internally-Generated Revenue and healthcare service delivery in the hospital, (ii) reduction in the waiting time of patients, (iii) reduction in morbidity and mortality rates, (iv) increase in number of patients visiting the hospital, (v) improvement in staff attitude towards patients and service delivery, (vi.) standardized complaints procedure, and (vii) creation of adequate awareness in services rendered by the hospital. Responses obtained in respect of the expected impacts revealed that in none of the expected impact did the administrative structure of the hospitals produce satisfactory outcome. The poor/weak impact was not unconnected with the defective administrative structures in the selected hospitals as earlier established. The least impact was felt in the area of establishing a standardized complaints procedure in the hospitals, in which (69.4%) of the respondents disagreed/strongly disagreed that the hospitals' administrative structure established standardized complaints procedure.

Next to the above was the poor performance of the hospitals in the area of internally-generated revenue (31.7%) of the sampled respondents agreed/strongly agreed that the administrative structure improved the Internally Generated Revenue and healthcare service delivery in the hospitals. This was against (68.3%) that disagreed/strongly disagreed with the claim. This was followed by creation of awareness in services rendered by the hospital, where majority (64.3%) of the respondents disagreed/strongly disagreed with its adequacy. This was the trend across the seven examined impacts. Majority of the respondents disagreed/strongly disagreed with effectiveness of the examined impacts as follows: reduction in the waiting time of patients, (63.8%); reduction in morbidity and mortality rates, (55.3%); increase in number of patients visiting the hospital, (55.3%); and improvement in staff attitude towards patients and service delivery, (61.3%).

On the average examination, (37.4%) of the respondents considered the expected impacts as significantly felt. This was against (62.6%) that were on disagreement side, who did not see the expected impacts as significantly felt. Given the summary, one could justifiably conclude that the structure and mode of administration on the service delivery in the selected teaching hospital fell far short of producing the expected impacts.

Test of Hypothesis

A hypothesis is tested on the impact of the structure and mode of administration on health care service delivery as below. The test is carried out using the scores from the ratings by the respondents with the standard impact set at 60% and 95% confidence level. H₀: The

structure and mode of administration in the teaching hospitals did not have significant positive impact on health care service delivery

One-Sample Statistics

	N	Mean	Std Deviation	Std Error Mean
Impact	7	37.4857	5.64134	2.13223

One –Sample Test

Tes Value =60

	T	tcv	Sig (2-tailed)	Mean Difference	95% Confidence Interval of Difference	
					Lower	Upper
Impact	-10.559	2.306	6	.000	-22.51429	-27.7317

Impact	-10.559	2.306	6	.000	-22.51429	-27.7317	-17.2969
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Using a test value of 60, a t obtained of -10.559 with 6 degrees of freedom is significant at 95% confidence level. This is much far away from t critical value of 2.306. There is 0% chance of obtaining an insignificant positive impact on health care service delivery by error. At any level of the 7 areas of impact of the structure and mode of administration examined, significant positive impact was specifically lower at an average of -22.51 than the set standard. This therefore implies an acceptance of the hypothesis that the structure and mode of administration in the teaching hospital did not have significant positive impact on health care service delivery.

Conclusion

The results showed that the use of directorates, centralization of authority, centralized pattern of decision making and centralized decision making procedures are the structure and mode of administration in the hospital. The results also showed that centralized pattern of decision making as a structure and mode of administration in the hospital has significant negative impact on healthcare service delivery ($t = -10.559$, $p \leq 0.05$). The results further revealed that the use of directorates as a structure and mode of administration in the hospital has not improved healthcare service delivery (68.3%).

The study concluded that the structure and mode of administration in the teaching hospital under study fell far short of ensuring effective functioning of the system (34.5%).

References

- Adamolekun, L. (1983). *Public administration: A Nigerian and comparative perspective*. England: Longman Book Limited
- Adebayo, A. (2001). *Principles and practice of public administration in Nigeria*. Ibadan: Spectrum Books.
- Adebayo, A. G. (1987). Competitive modernisation, bourgeois accumulation and the revenue allocation controversy in Nigeria, 1946-86. Paper presented at the *National Conference on Nigerian Government and Society in the 21st Century* at the Ahmadu Bello University, Zaria, held on May 4-9, 1987.
- Ademiluyi, A. Aluko-Arowolo (2009). Infrastructural distribution of healthcare services in Nigeria: An overview. *Journal of Geography and Regional Planning* 2(5) 104-110
- Airhienbuwa, C. O. (2000). *Challenges of Health Care Management*. Benin City: Sunbasco Printing Press.
- Akanni, J. A. (1987). *Management concepts, techniques and cases*. Ibadan: Publishers Julab Publishers Limited.
- Badru, F.A. (2003). Sociology of health and illness relations in Olurode. Lai and Soyombo (eds.) *Sociology for Beginners*. John West Ikeja: pp 336-355
- Cordon, C. P.(2013). System theories. An overview of various system theories and its application in healthcare. *American Journal of Systems Science* 2(1): 13-22.
- Collins, R. (1986). *Max weber, a skeleton key*. Brevity Hills, Sage.
- Damanpour, F. (1991). Organisational innovation: A meta-analysis of effects of determinants and moderators. *Academy of Management Journal*, 34(3)
- Easton, D. (1957). An Approach to the Analysis of Political Systems. *World Politics* Vol. 9, NO.3, April, pp. 38-400.
- Greenberg, J. (2011). *Behaviour in organisation* (10th ed). Upper Saddle River, NJ: Prentice Hall.
- Gunderman, R., Kanter, S. L. (2009). Educating physicians to lead hospitals. *Academic Medicine*, 84: 1348-1351.
- Health in Africa Initiative (2011). *Private health market studies in Nigeria*. International Finance Corporation. World Bank Group.
- Lukas, A.O. & Gilles, H. M. (1979). *A short textbook of preventive medicine for the tropical*. United Kingdom: Holder and Stroughton Publisher.
- McMurtry, A. (2007). Reinterpreting interdisciplinary health teams from a complexity science perspective. *University of Alberta Health Sciences Journal*, 4(1), 33-42.
- Ministerial Leadership Initiative (2009). *Aspen global health and development*.
- Mintzberg, T. (2009). *Tracking strategies: Towards a general theory of strategy formation*. New York. NY: Oxford University Press.
- Meadows, D. H. (2009). *Thinking in systems. A primer*. London, UK: Earthscan.

- Merriam-Webster (2016). *Dictionary*. Retrieved October 01, 2016, from <http://www.merriam-webster.com/dictionary/system>
- Metiboba, S. (2007). *Issues in health sociology*. Ibadan: Nathadex Publication.
- Obansa, S. A. Orimisan, A. (2013) Healthcare financing in Nigeria: Prospects and challenges. *Mediterranean Journal of Social Sciences*
- Olaleye, A. (2008). *Essential readings in development administration*. Ado-Ekiti: PNL Publishers.
- Omoleke I. I. (2005). The primary health care services in Nigeria: Constraints to optimal performance. *Nigeria Journal of Medicine*
- Omoleke, I. I. (2009). *The administration of health and welfare services in Nigeria: Policies and issues*. Obafemi Awolowo University Press Limited.
- Onwe, S., Abah, E., Nwokwu, P. (2015). Motivation as a veritable tool for effective leadership in the Nigerian health sector. *Public Policy and Administration Research* Vol.5 No. 4
- Oyewunmi, O. A. (2014). *Collective bargaining in Nigeria public health sector*. Evidence for an inclusive approach. *Research on Humanities and Social Sciences*, vol. 4, no 23, 2014
- Raufu, A. (2002). Nigerian health authorities worry over exodus of doctors and nurses. *BMJ*
- Tonwe, D. A. (1998). *Public administration; An introduction*. Lagos: Amfit Book Company.
- Umeha, C. (2015). The good, the bad and the ugly of health sector. *Public Policy and Administration Research*. Vol. 5, no. 4.