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Preferred Choice of Health Facilities for Healthcare among Adult Residents in Ilorin Metropolis, Kwara State, Nigeria

Abstract

Purpose: The choice of health facilities for healthcare by an individual is largely determined by several factors. This study aims to determine predictors of preferred choice of health facility for care.

Methods: In a descriptive cross-sectional study, pre-tested semi-structure questionnaire was administered to 366 adults selected through a multi-stage sampling technique in Ilorin metropolis. Data collected were analysed using Epi Info software version 3.4.1 and level of significance set at $p < 0.05$.

Results: The preferred health facility for medical care was private hospitals (35.2%) followed by pharmaceutical store (27.9%) and 17.0% for general/teaching hospitals and only 12.3% for primary health care (PHC). Quick service and availability of drugs were the major reasons for their preference which were said to be better in private hospitals. Sex, marital status, educational status, occupation and city area where the respondents dwell are all associated with the preferred choice of health facility for care.

Conclusion: This study has shown that the private sector is preferred to the public ones with regards to receiving healthcare and that within the public sector, the higher levels of health facilities are preferred to the primary health care centres. Improving the image and performance of the public health facilities especially the PHC is very important for appropriate utilization of health services

Keywords: Preference, Health Facilities, Public hospital, Private hospital

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Introduction

The choice of health facilities for healthcare by an individual is largely determined by his/her taste, satisfaction with service and the perceived quality of care provided [1-4]. The choice is however limited by factors such as availability, accessibility, affordability of services of the health facilities, cultural beliefs, the situation per time (i.e. urgency of care needed) and whether the kinds of services provided meet the need of the user [4-6]. The choice is also influenced by the users' understanding of the functions of the different levels of health facilities which ultimately result in the appropriate (or otherwise) utilization of health services.

In Nigeria, health care system comprises both public and private health facilities [7]. In the public sector, the facilities are in three levels (primary, secondary and tertiary) which corresponds to the three tiers of the government [7]. The primary health care (PHC) facilities which are the prerogative of the local government are often poorly managed [8] and funded as evidenced by lack of skilled and competent personnel, inadequate equipment, irregular drug supply and poor state of infrastructure in which many centres are actually in a state of dilapidation and waste [7,8]. For example, while less than half of PHC facilities in Nigeria provide antenatal care (ANC), a reproductive health resource inventory carried out by FMOH and WHO found that almost 60% of PHC offering ANC and delivery services had no midwives and another 17% had neither midwives nor senior community extension workers [9]. This has rendered them underutilized sometimes making the tertiary facilities overburdened [10].

Following the declaration of Alma Alta, the PHC was pronounced as the key instrument in achieving health-for-all for which reason it is supposed to be the entry point into the health system [7,8] but this is hardly so in Nigeria as in many other sub-Saharan countries. Self-medication and patronage of pharmaceutical shops (including the licensed and unlicensed patent medicine stores and drug peddlers) in place of clinics and hospitals is a common

occurrence in most developing countries including Nigeria. The under-utilization of the health services in public sector has been almost a universal phenomenon in developing countries. On the other hand, the private sector has flourished everywhere because it is said to focus mainly on 'public health goods' [11,12]. In addition, since profit depends on turning-over of clients and patients, hospital managements in the private sectors make use of social marketing strategies to attract patients [12].

Several factors have been identified for poor utilization of modern health facilities and especially the PHC. These include proximity, clients'/patients' affordability, staff attitude, availability of equipments and qualified personnel [1,4,6]. Ordinarily, a person would not use a product that does not meet his need unless he has no choice. Meeting these needs go beyond the goods and services alone but also include environmental conditions that are conducive [2,4]. There seem to be higher use of private health facilities attributed mostly to issues of easy access, shorter waiting time, longer or flexible opening hours, better availability of staff and drugs, better attitude and more confidentiality in socially stigmatized diseases [13]. However, in private hospitals, the quality of services, the responsiveness and discipline of the provider has been questionable [3,14-16]. Notwithstanding, the demand for public health facilities is tremendously high as compared to that of private health facilities in rural areas of the countries [3]. Although, utilization of health services and factors determining it has been largely studied, there is paucity of literature specifically on factors that determine preference for the type (public or private) and the levels of healthcare facilities visited first when ill especially when there are many options. More than before, positive concepts of patients' rights is being advocated for. In part, this has been a reflection of respect for persons and to equity in health as a policy objective in WHO member states. As a consequence, there is now greater emphasis on the encouragement of individual choice and the opportunity to exercise it freely, and the commitment of healthcare providers and all stakeholders in healthcare to build mechanisms for ensuring quality of care. Patients have been

said to have the right to choose and change their own physician or other health care provider and health care facilities, provided that it is compatible with the functioning of the health care system of the country [15]. The evolution of National Health Insurance scheme in Nigeria also gave allowance for beneficiaries to choose their preferred healthcare provider and change at will after a period of 6 months if they are not satisfied with services been offered [8]. One study in Zimbabwe showed that the community did not know the functional differences between a lower level health centre and a referral hospital; what was clearly known was the physical differences that exist between the two which is one of the reasons why the choice of a point of entry into the health care delivery system is not always correct [17]. Despite several attempts by different governments to improve health care services, the low use of the PHC still persists and is reflected in poor health seeking behaviour, including the use of self-prescriptions and patronage of patent medicine stores for complaints rather than purchase prescribed medicine from a medical personnel. It also leads to delay in seeking treatment and non-compliance with referral advice to public hospitals.

This study was carried out among adult residents in Ilorin metropolis to find out the determinants of preferred choice of facility for health care as well as their attitude and practice of utilization of peripheral health care services. It however excluded the patronage and utilization of all types of alternative medicines. The healthcare referred to in this study is self (i.e. respondents') and not for their children or other relative.

Methods

The study was conducted in 2007 in Ilorin, the capital city of Kwara State, Nigeria. The city metropolis is located in three local governments namely Ilorin West, Ilorin East, and Ilorin South. The city has several health facilities including a tertiary hospital (University of Ilorin Teaching Hospital), and some secondary health facilities. The total number of PHC facilities in the 3 LGAs is 52 with 21 in Ilorin West, 16 in Ilorin East and

15 in Ilorin South. The adult population of Ilorin from the 2006 census is estimated to be 460,244.

Sample size for this study was calculated using standard procedure to be 329 (using $p=29\%$ from a previous Nigerian Study) [18]. However, a total of 400 individuals were involved. Through a multi-stage sampling technique, respondents were drawn from the three local governments that are in the metropolis. This included all adult residents including students who lived in the city when their institutions were in session but excluded all non-residents (visitors). Selections were from both the inner and outer cores. For the outer core; 6 streets representing clusters were selected through balloting while 4 were selected for the outer core; 15 houses were selected through systematic sampling in each of the cluster. A maximum of 3 adults chosen by balloting were interviewed in the houses selected where there are more than 3 adults in a house but where there were less than 3, all the adults were interviewed. A total of 400 both self-administered and interviewer-administered (as appropriate) semi-structured questionnaires were administered to the selected participants by trained research assistants. The questionnaire sought information such as socio-demographic data, their usual choice of health facility as first point of call for care with reasons when there are more than one and also reasons why they will utilize a facility farther to them when there is one closer.

Results were analyzed with Epi Info software version 3.3.2 using descriptive statistics. Proportional data were analysed using Chi square or Fisher's exact test as appropriate while regression analysis was applied in determining association between variables. At 95% confidence interval, 2-tailed p values < 0.05 were considered to be significant.

Results

Of the questionnaires distributed, 366 were correctly filled, returned and therefore analyzed. Table 1 showed the demographic distribution of respondents. The age range was between 18 and 62 yr (33.62 ± 4.21 yr). Almost 80% of the

respondents fell were between 18 and 50 yr. Male:female ratio was 0.89:1. The single, married and widowed were 55.7%, 38.3% and 6.0% respectively. Only 15.0% of the respondents had no form of formal education. Most of the respondents were students (126, 34.4%) and this was followed by skilled workers (105, 28.7%) which included various forms of artisans while the civil servants while others such as professionals (bankers, lawyers, doctors, teachers), unskilled workers such as orderlies, petty traders were as shown in the table.

Table 1: Socio-demographic characteristics of respondents

Variable	No.	%
Age		
18 – 30	112	30.6
31 – 40	84	23.0
41 – 50	95	26.0
51 – 60	57	15.5
>60	18	4.9
Sex		
Male	172	47.0
Female	194	53.0
Marital status		
Single	204	55.7
Married	140	38.3
Widowed/separated/ divorced	22	6.0
Educational status		
None	55	15.0
Primary	106	29.0
Secondary	136	37.2
Tertiary	69	18.8
Occupational status		
Professional	41	11.2
Skilled	105	28.7
Unskilled	50	13.7
Students	126	34.4
Unemployed	44	12.0
City area		
Inner core	216	59.0
Outer core	150	41.0
Total	366	100

The preferred and usual choice of health facility as first point of call for medical care was private hospital (35.2%) followed by pharmaceutical or patent medicine store (27.9%). About 12.3% of respondents preferred to go to Basic Health Centers while only 7.6% said they did not have

any preference but will attend any hospital convenient for them at any time. However, among those that indicated preference for medical store and basic health center, 32% said they would change their mind if they felt the illness was severe in which case they would choose teaching hospital or private hospital for their care. Another 76% of the respondents reported that they can only utilize Primary Health Centres for immunizations and not for delivery or treatment (Table 2).

Table 2: Respondents' usual choice of health facility as the first point of call for care

Health facility	No.	%
Private Hospital	129	35.2
Pharmacy/Medicine Store	45	27.9
Basic Health Centre	62	12.3
General/Teaching Hospital	28	17.0
Any Hospital	102	7.6
Total	366	100.0

In seeking reasons for their preference and what they considered in choosing a facility for health care, quick service was the commonest reason given by 82.8% of all respondents and this was followed by availability of drugs (78.1%). Others reasons were availability of laboratory facilities (77.6%) and qualified personnel (65.6%) convenience and proximity (71.6%), privacy (58.7%), respect or good attitude by workers (69.9%), cheap service constitute (29.0%) and the fact that it was the family hospital (17.8%) (Table 3). Some other reasons provided were doctor being a family member, relative or friend, doctor

Table 3: Reasons for respondents' preference of choice of health facility for care

Reason	No	%
Cheap Service	106	29.0
Convenience/Proximity	162	44.3
Qualified Personnel	240	65.6
Quick Service	303	82.8
Privacy	215	58.7
Good Attitude of Staff	256	69.9
Equipments an Lab Service	284	77.6
Drug Availability	286	78.1
Family Hospital	65	17.8
Other reasons	174	47.5
No other Choice	212	57.9

being very patient, thorough and considerate. Some also felt that they have been too used to a particular hospital or that the doctors in such facilities knew their history well. Others felt they could have some leverage as regards mode of payment of fees/charge while some claimed they receive free treatment. Some of the respondents (184, 51.4%) felt that the staffs at the Basic Health Centers were not capable of treating them because they were not experts or because there were no qualified doctors. Other reasons provided for not utilizing the basic health centre were presumed lack of equipments and drugs. Some participants (395, 97.0%) said they would not be happy if teaching hospital would demand for referral letters from patients before attending to them because they believed people would suffer and die and that it is the duty of medical workers to treat everybody whether referred or not. Other reported that the choice of facility for health care service should be a personal thing and everyone should be given a free hand. In addition, 21.4% of the respondents felt that Basic health centers is meant for local and illiterate people and 33.9% felt it is for those who cannot afford the expenses in teaching hospitals or other reputed private hospitals.

In order to improve utilization of the basic and comprehensive health centers as well as cottage hospitals, the respondents felt the following should be put in place: good looking environment, modern facilities including laboratories, drug availability, geographical accessibility, availability of qualified medical personnel – doctors and nurses. Other qualities demanded were improved attitude of workers and affordable services. If these things are put in place, 72.5% of those who would not have loved to use the primary health centres claimed they would use it while 13.6% claimed they will still not use it despite the improvement and another 13.6% could not make up their mind yet.

Some respondents (314, 85.8%) reported that they usually skipped one or more health facilities close to them to attend their choice much farther away. The reasons given by the respondents why they would ignore a health facility close to them and utilize one that is farther are provided in

Table 4. For most of the respondents, no specific reasons was given.

Table 4: Reasons for respondents' non-utilization of a facility nearest to them (n=314)

Reason	No.	%
No 24 hr service	46	14.6
No equipment/laboratory service	158	50.3
Environment unkempt / not cozy	166	52.9
Staff poor relationship	124	39.5
No doctor in the clinic	65	20.7
Doctor not present most times	112	35.7
No doctor on call / night duty	108	34.3
Do not trust staff competence	85	27.1
Services are expensive	73	23.2
Do not like private hospital	29	9.2
Do not like government hospital	66	21.0
"It is not my hospital"	55	17.5
No particular reason	32	10.2

Our results indicated that sex, marital status, educational status, occupation and city area where the respondents dwell are all associated with the preferred choice of health facility for care (Table 5). The preferred health facility with the highest proportion for both sexes was the private hospital but whereas 33.1% of males would prefer the private hospital, it was 37.1% for the female gender ($p < 0.05$). The most common preferred facility for singles and married was the private hospital but it was primary health centre for the separated/widowed/divorced. Among respondents with primary or no formal education, pharmaceutical/medicine store was the preferred choice of health facility but it was private hospital for respondents with secondary and tertiary education. Respondents with higher educational status utilize the private and teaching hospital more than their counterparts with lower educational level ($p < 0.05$). Similarly, the unemployed respondents and those with skilled job such as the artisans would prefer medicine store for care than other facilities but students and professionals including respondents with unskilled job will prefer the private hospital than others. More respondents living in the inner core would rather patronize the medicine store while more of those living in the outer core would prefer the private hospital most.

Table 5: Relationship between selected socio- demographic characteristics and most common choice of health facility for care

Variable	PRIV*	GEN/TH*	PHC*	ANY*	PMS*	Total	P-value
SEX							
Male	57(33.1)	21(12.2)	22(12.7)	19(11.0)	53(30.8)	172	0.0475
Female	72(37.1)	24(12.4)	40(20.6)	9(4.6)	49(25.3)	194	
MARITAL STATUS							
Single	81(39.7)	20(9.8)	20(9.8)	8(3.9)	75(36.8)	204	<0.0001
Married	46(32.9)	21(15.0)	35(25.0)	15(10.7)	23(16.4)	140	
Separated	2(9.1)	4(18.2)	7(31.8)	5(22.7)	4(18.2)	22	
EDUC*							
None	11(20.0)	5(9.1)	10(18.2)	10(18.2)	19(34.5)	55	<0.0001
Primary	32(30.2)	9(8.5)	26(24.5)	5(4.7)	34(32.1)	106	
Secondary	46(33.8)	19(14.0)	22(16.2)	8(5.9)	41(30.1)	136	
Tertiary	40(58.0)	12(17.4)	4(5.8)	5(7.2)	8(11.6)	69	
OCCUP*							
Professional	21(51.2)	11(26.8)	2(4.9)	2(4.9)	5(12.2)	41	<0.0001
Skilled	15(14.3)	12(11.4)	10(9.5)	10(9.5)	58(55.2)	105	
Unskilled	16(32.0)	7(14.0)	11(22.0)	6(12.0)	10(12.0)	50	
Students	69(54.8)	8(6.3)	33(26.2)	6(4.8)	10(7.9)	126	
Unemployed	8(18.2)	7(15.9)	6(13.6)	4(9.1)	19(43.2)	44	
CITY AREA							
Inner Core	37(17.1)	23(10.6)	52(24.1)	20(9.3)	84(38.9)	216	<0.0001
Outer Core	92(61.3)	22(14.7)	10(6.7)	8(5.3)	18(12.0)	150	
<i>Total</i>	<i>129</i>	<i>45</i>	<i>62</i>	<i>28</i>	<i>102</i>	<i>366</i>	

* PRIV = Private Hospital; GEN/TH = General Hospital/Teaching Hospital; PHC = Primary Health Centre; ANY = Any Hospital Available; PMS = Pharmaceutical/Medicine Store; EDUC = Educational Status; OCCUP = Occupational Status

Discussion

Our study has revealed that private hospitals are the most preferred health facility for care. This result is similar to that reported in Pakistan where 34% of the patients preferred private hospitals for children emergencies compared to 25% who preferred public hospitals [11]. Similar results have also been reported in developed countries like United Kingdom where 30% of patients in Birmingham were reported to use private hospital because of perception of higher standard and better quality of care. However, our results are quite different from the situation reported in Germany where less than 8% of the population preferred using private health facilities [6]. In spite of the respondents' preference, it must be stressed that a study in Nigeria showed that quality of antimalarial treatment is generally poorer in private than in public hospitals [14]. Furthermore, the private hospitals are generally more expensive than the public ones as evidenced by previous studies [1,6,15] but this did not hinder the respondents in this study from utilizing these facilities. This also goes to show that users' satisfaction with service is not always in line with

most appropriate situation and their views are not always correct judgment of effectiveness of service. Despite all these, patients would still not mind patronize the private hospital because they (the hospitals) have a way of continuously attracting patients through providing an environment that is cozy which they (the respondents) claimed was lacking in most public hospitals.

Within the public sector, general and teaching hospitals (which are usually often in the secondary and tertiary health care levels in Nigeria) were chosen by the respondents in preference to PHC is often as a of the poor state of the PHC especially the comprehensive health centres which were expected to provide care to 60-70% of the Nigeria population [7] and ideally the entry point to the healthcare system. It could be obvious that this is the reason why the referral procedure has failed and referral letter has not been a prerequisite of utilizing the higher levels of healthcare.

Self-medication is permissible under the Nigerian Drug Policy and can sometimes offer the

advantage of providing quick/emergency relief from minor ailments especially where healthcare facilities are limited but there is a limit to the services that can be available for “Over the Counter drugs” stores [19]. More than a quarter of the respondents’ choice of pharmacy/medicine store as first point of call for healthcare in this study is result of self-medication and the patronage of chemists in pharmaceutical shops including the patent medicine stores and other drug hawkers as a common practice throughout the developing world but which is more regulated in the advanced countries. Without necessary control of the private pharmaceutical shops in Nigeria, their patronage will be associated with more harm than good.

It is surprising that less than half of the respondents in this study considered convenience/proximity as a reason for their choice of facility for healthcare. Previous studies showed that far distance to health facility is a major factor for non-utilization of health facilities [5,11]. In the same way, cheap service was not so considered as an influencing factor in this study as would have been expected ordinarily taking into account that almost $\frac{2}{3}$ of the respondents were from the inner core which is usually the poor community of a city. Nonetheless, the fact that more than half of them were gainfully employed could explain their action although this study did not find out income power of the respondents. Other findings in this study influencing choice of health facility such as personnel, privacy and staff attitude are consistent with earlier studies [1-6,15,17].

The significant effect of gender as a factor affecting choice is seen in the fact that females seem to be more careful in their choice because males have a higher tendency to patronize the patent medicine stores and would visit any health facility without any particular preference ($p<0.05$). The marital status also goes to show that singles have a higher propensity to practice self-medication than those who were ever married ($p<0.05$). The more educated the respondents were, the less likely they would utilize any available health facility and drug stores and the

more likely they would utilize the private, general/teaching hospital ($p<0.05$). This is probably to be due to the fact that the more educated ones would be more informed about dangers of self-medication and since they are also likely to be gainfully employed, they would more be able to afford hospital bill which is also reflected in the way occupation affected preference for health facilities.

Conclusion

This study has shown that the private sector is preferred to the public ones with regards to receiving healthcare and that within the public sector; the higher levels of health facilities are preferred to the primary health care centres. The choice is determined by satisfaction and the perceived quality of service.

Policy makers’ and all stakeholders’ attention ought to be drawn to improving the status and performance of the peripheral health facilities, improving the outlook image of the public health facilities and making them environmental friendly. Similarly, efforts to raise and keep the standards of practices in the private hospitals through continuous medical education and regular accreditation assessment by relevant bodies is imperative in providing quality healthcare services to the populace.

Contribution of Authors

We declare that this work was done by the authors named in this article and all liabilities pertaining to claims relating to the content of this article will be borne by the authors. Abodunrin Olugbemiga conceived the study and all the authors participated in the design, collection, and analysis of data including the preparation of the manuscript.

Conflict of Interest

The authors declare that they have no conflict of interest in this study.

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