

Original Article

A Survey of the Perception of the Quality of and Preference of Healthcare Services amongst Residents of Abeokuta South Local Government, Ogun State, Nigeria

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ABSTRACT

Background: The choice of healthcare facilities by individuals is determined in part by their taste, satisfaction with services, and the perceived quality of care provided. The aim of the study was to explore the healthcare preferences of residents of Abeokuta South Local Government Area (LGA) and their perception of quality of services received, and to determine the factors influencing their choice of healthcare facilities. **Materials and Methods:** A descriptive cross-sectional study design was used to assess perception of clients regarding quality of healthcare received and their choice of healthcare service delivery. Data were collected using a pre-tested interviewer-administered questionnaire, and analysis was done using SPSS version 17. Statistical significance was set at $P < 0.05$. **Results:** The mean age of respondents was 45.7 ± 11.7 years. Government-owned general hospitals were preferred for common health problems such as body pain and fever. Overall, about 73% of the respondents preferred government-owned facilities. Determinants of the preference of the government facilities were reduced cost ($P < 0.001$) and effectiveness of care ($P = 0.024$), whereas private facilities were preferred more significantly because of short waiting time and good attitude of staff ($P = < 0.001$). Almost 78% of the respondents were satisfied with the quality of care received. **Conclusions:** Government-owned general hospitals were the preferred source of health services and the quality of healthcare services received was generally perceived to be high.

KEYWORDS: Patient preferences, patient satisfaction, perception of quality

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INTRODUCTION

Quality of care can be defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”^[1] The dimensions of quality health service include availability and appropriateness, access and affordability, equity and equality, technical competence and skills, timeliness and continuity, safety and reliability, respect and caring (interpersonal relations), efficiency and effectiveness, and amenities.^[2] Thus, quality health service offers patients what they want and meets their need at the lowest cost.^[3]

Patient satisfaction hinges on whether the “service experience meets consumer expectations.”^[4] The client-focused definition of quality comes from Donabedian, Morgan, and Murgatroyd, who described a conceptual model that provides a framework for examining health services and evaluating quality of care.^[5] This model posits that information about quality of care can be drawn from three categories: “structure,” “process,” and “outcomes.”^[6] Structure describes the context in which care is delivered, including hospital buildings,

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staff, financing, and equipment. Process denotes the transactions between patients and providers throughout the delivery of healthcare. Finally, outcomes refer to the effects of healthcare on the health status of patients and populations.

Several studies have been carried out to assess patients' perception of the quality of health care received; a lot of these studies were hospital based. A study to assess patient's perception of quality of hospital services in Ekiti State, Nigeria, found that 75% of the respondents were satisfied with the quality of services received.^[7] Comparing patient satisfaction between developing and advanced countries showed that long waiting hours were identified as the main source of dissatisfaction in developing countries, whereas in advanced countries, interpersonal communication skills of physicians, respect for patient preferences, and involving patients in decision making were the main concerns far beyond clinical competence of health workers.^[8]

A study that assessed determinants of health-seeking behavior among rural residents in Ghana showed that quality of care and cost form a duality of the most important factors affecting health decision making.^[9] Another study in the same country on preference of health care for fever in children revealed private facilities and drug stores as the preferred sources of health care.^[10]

In Nigeria, private health facilities are more in number than public ones and are more utilized.^[11] A study among adult residents in Ilorin metropolis showed that the preferred health facility for medical care was private hospitals (35.2%) followed by pharmaceutical stores (27.9%), general/teaching hospitals (17.0%), and primary healthcare centers (12.3%). Promptness of service and availability of drugs were the major reasons for their preferences. Gender, marital status, educational status, occupation, and area of residence were associated with the preferred choice of health facility.^[11] This is partly because in private health facilities issues of easy access, shorter waiting time, longer or flexible opening hours, better availability of staff and drugs, better staff attitude, and more confidentiality in diseases associated with social stigma are important to their operators.^[12] However, despite these problems, studies have not shown the private sector to be more efficient, accountable, or medically more effective than the public sector.^[13] However, in Nigeria, there is a lack of monitoring system to identify and monitor the quality of health services provided by the private sector. Some of the private health facilities lack adequate numbers of and quality of personnel

needed to meet the health needs of the people and the few private facilities who can provide these personnel are very expensive and are not affordable by most people.^[14] These problems adversely affect overall utilization of orthodox medicine and has contributed to the poor health indices of the country.

The objective of this study was to explore the healthcare preferences of residents of Abeokuta South Local Government Area (LGA) and the perception of quality of services received, and to determine the factors influencing the choice of healthcare facilities. Thus, it is hoped that areas for possible interventions to help improve patient satisfaction may be identified and provide information that will be useful to policy makers, health planners, and other stakeholders in the goal of improving the quality of care offered to the citizenry.

SUBJECTS AND METHODS

Ogun State lies in the south West part of Nigeria. It has 21 local governments with a total population of about 3,751,140 (2006 census).^[15] It is made up mainly of people of Yoruba ethnic group. Abeokuta South Local Government occupies an area of 5735 km² with an estimated population of about 250,278 people (2006 population census) and has 15 wards.^[16]

The study population consisted of the inhabitants of Abeokuta South Local Government area. Majority of the inhabitants are civil servants, especially as the Ogun State seat of government is in the local government. Some of the inhabitants also engage in trading, pottery, mat weaving, and in the making of locally designed cloth materials called "kampala."

Sample size determination and selection of participants

The minimum sample size was determined using Fisher's formula, with a standard normal deviation at 95% confidence interval (1.96), a prevalence rate of 0.75 (proportion of residents who were satisfied with quality of care received from a previous study)^[7] and the error of precision at $\pm 5\%$ (0.05). The minimum sample size was 320 with an added attrition rate of 10%.

A multistaged random sampling method was used to administer interviewer-administered questionnaires to residents in selected wards of the local government. The first stage of sampling involved simple random selection by balloting of 3 wards out of the 15 wards in the local government. The sample size was proportionately allocated to each ward depending on the number of settlements. Each ward had an average of seven to nine settlements. The second stage of sampling was a random

selection of two settlements from each ward (through simple balloting) making a total of six settlements under study: Ake, and Oke-lantoro, from ward 1, Idi-aba, and Olokuta from ward 7, Isabo and Oke-yeye from ward 13. Each settlement had an average of 15 streets.

The third stage of sampling involved the selection of two streets through a simple random selection method. The fourth stage was recruiting 55 subjects, each from the four settlements in wards 3 and 13, and 46 subjects, each from the two settlements chosen from ward 7. Each street had an average of 50 houses. Twenty-six subjects were selected from each of the two selected streets per settlement, using a sampling interval of two ($50/26$); a subject was picked from every second house on the selected streets. Where a house had more than one household, the household occupying the first door nearest to the gate was picked. The household head or representative was recruited as the subject.

Study instrument, data collection, and analysis

The survey questionnaire was developed and adapted for this study from a review of relevant literature. The questionnaire was divided into three sections: section A elicited socio-demographic data of the respondents. Section B consisted of questions on respondents' preferences for health services viz a viz, their preferred facility for health care and the reason for their choices. It also determined their preferred health facilities in relation to disease severity, cost, and perceived quality of care. Section C consisted of questions on perception of quality and general satisfaction. Patient satisfaction was obtained by asking questions on their level of satisfaction using a 5-point Likert scale (very satisfied, satisfied, indifferent, dissatisfied, and very dissatisfied). The instrument was interviewer-administered.

The quality of care was determined following the Donabedian conceptual framework of structure, process, and outcome. Structural domains assessed the general cleanliness of the facility, the amenities available, adequacy of buildings and waiting areas, and privacy in the consulting room. The process domains assessed included the attitude of health workers, the ease of getting care and waiting time, interpersonal and communication skills, cost and payment for services. Outcome domains assessed effectiveness of care. Pre-testing of the questionnaire was done on 10 subjects randomly selected from Abeokuta North Local Government secretariat, and the questionnaires were interviewer-administered. The goal of the pre-test was to remove ambiguities in the instrument and to ensure that the instrument could meet the objectives

of the study. Face validity of the tool was assessed by the study supervisor. The findings of the exercise were incorporated into the final instrument for the survey.

Three research assistants were recruited to help with the distribution of questionnaires and collation of data. Data were collected between May and July 2015. Each respondent had the questions and response options read out to them. Data analysis was done using SPSS computer software version 17. Respondents who were either very satisfied or satisfied were classified to as being satisfied with their usual healthcare provider, whereas those who were very dissatisfied or dissatisfied were classified to be dissatisfied with their usual healthcare providers. Those who were indifferent constituted a very small number^[5]; they were therefore excluded from the data analysis. The chi-square test was used to determine statistical significance of observed differences in cross tabulated variables. The level of significance was set at $P < 0.05$.

Ethical considerations

A letter of introduction was presented at the Abeokuta South Local Government Secretariat. The Medical Officer of Health gave permission for the conduct of the study. Oral informed consent was obtained from respondents before the administration of the tool. They were informed on the scope, objectives of the study, and for confidentiality, all questionnaires were made anonymous.

RESULTS

Three hundred and twenty questionnaires were distributed to respondents and all were returned by the researchers who interviewed them.

Table 1 shows that most of respondents were in the age range of 40–49 and 50–59 (37.2% and 29.4%, respectively), with the mean age being 45.68 ± 11.75 years. Christians made up 68.1% of respondents. About half of the respondents were government employed (49.1%). About half of the respondents (48.1%) had at least secondary level of education and 28% of respondents had average monthly income of less than 50,000 Naira.

Most of the respondents preferred government-owned general/teaching hospitals for majority of the health conditions, including common cold, general body aches, for surgical operations (76.2%), maternal services (54.4%), and pediatric care (70.9%). Preferences for primary health centers and traditional health practitioners were mainly for maternity cases (13.4% and 10.3%, respectively). There was an almost equal preference of health service delivery between public and private

Table 1: Socio demographic characteristics of the respondents

Variables	Frequency (n =320)	Percentage (%)
Age (years)		
≤29	39	12.2
30–39	37	11.5
40–49	119	37.2
50–59	94	29.4
≥60	31	9.7
Gender		
Male	165	51.6
Female	155	48.4
Religion		
Islam	94	29.4
Christianity	218	68.1
Others	8	2.5
Marital status		
Single	83	25.9
Married	196	61.3
Separated/divorced	32	10.0
Widowed	9	2.8
Level of formal education		
Primary	20	6.2
Secondary	134	41.9
Tertiary	161	50.3
None	5	1.6
Employment status		
Unemployed	42	13.1
Self-employed	57	17.8
Employed in the private sector	45	14.1
Government employee	157	49.1
Others	19	5.9
Average monthly income (N)		
≤50,000	90	28.1
50,000–#99,999	48	15.0
100,000–#149,999	63	19.7
150,000–#199,999	79	24.7
≥200,000	40	12.5

facilities in cases where diagnostic tests had to be done such as scans and x-rays [Table 2].

Overall about 73% of respondents preferred government-owned facilities and reasons given for preference are shown in Table 3. Respondents significantly preferred public hospitals because of reduced cost, $P < 0.001$ and

effectiveness of care, $P = 0.024$. However, respondents preferring private hospitals did so because of reduced waiting time, $P < 0.001$ and pleasant attitude of healthcare providers, $P < 0.001$. Proximity to facility was a reason for choosing public facility; however, the association was not statistically significant. Respondent's level of education was also found to be

significantly associated with choice of health service delivery [Table 4].

In the assessment of perceived quality of care in relation to dimensions of quality and Donabedian's framework [Table 5], a significantly higher proportion of respondents reported public facilities as having good quality of service in the areas of cost/payment of service, $P = 0.003$, cleanliness of toilet facilities, consultation time, and effectiveness of care, $P = 0.027$, 0.021 , and 0.024 , respectively. Conversely, the private

facilities significantly provided better ease of getting care and better attitude of health providers to clients ($P < 0.000$).

The quality of care was generally perceived to be high with about 78% of the respondents being satisfied with quality of care received. Factors found to be significantly associated with being satisfied with the care received were marital status, educational qualification, and the use of public health facilities; see [Table 6].

Table 2: Preferred facility for common health conditions

Health condition	Preferred Health Facility					
	Government-owned general hospitals	Primary health center	Private hospitals	Drug store/ pharmacy	Para professionals	Traditional health worker
	n (%)	n(%)	n (%)	n (%)	n (%)	n (%)
Common cold	144 (45)	10(3.1)	76(23.8)	84(26.3)	3(0.9)	3(0.9)
Body pains	154(48.1)	18 (5.6)	76(23.8)	67 (21.0)	2 (0.6)	3 (0.9)
Diarrhea	186 (58.1)	17 (5.3)	69(21.6)	41(12.8)	2(0.6)	5(1.6)
Fever in adult	177(55.3)	6(1.8)	84 (26.3)	53 (16.6)	0 (0)	0 (0)
Fever in children	227 (71.0)	16 (5.0)	57 (17.8)	15 (4.7)	2 (0.6)	3(0.9)
Pregnancy/maternal healthcare	174(54.4)	43(13.4)	64(20)	1(0.3)	5(1.6)	33 (10.3)
Surgery	244(76.3)	5(1.6)	59(18.4)	4 (1.2)	2(0.6)	6(1.9)
Ultrasound scanning	174 (54.4)	4 (1.3)	130 (40.6)	11(3.4)	1(0.3)	0 (0)
Chest x-ray	178(55.6)	11(3.4)	112(35)	13(4.1)	0 (0)	6 (1.9)

Table 3: Reasons for choice of health facilities

Most preferred healthcare facility	Public facility	Private facility	Total	X2	P-value
Variables	n (%)	n (%)			
Cost of service					
Cheap	[178] (75.7)	[17] (20.0)	[195] (60.9)	79.16	<0.001
Expensive	[57] (24.3)	[68] (80.0)	[125] (39.1)		
Waiting time					
Short	[21] (8.9)	[52] (61.2)	[73] (22.8)	93.8	<0.001
Long	[214] (91.1)	[33] (38.8)	[247] (77.2)		
Proximity to residence					
Close	[175] (74.5)	[54] (63.5)	[229] (71.6)	3.15	0.076
Far	[60] (25.5)	[31] (36.5)	[91] (28.4)		
Attitude of Provider					
Pleasant	[12] (3.9)	[49] (57.6)	[61] (19.1)	101.3	<0.001
Not Pleasant	[223] (96.1)	[36] (42.4)	259 (80.9)		
Effectiveness of treatment					
Effective	[188] (80.0)	[57] (67.0)	[245] (76.6)	5.12	0.024
Noneffective	[47] (20.0)	[28] (33.0)	[75] (23.4)		
Payment mechanism					
Insurance	[43] (18.3)	[22] (25.9)	[65] (20.3)	1.77	0.18
Out of pocket	[192] (81.7)	[63] (74.1)	255 (79.7)		

Table 4: Association between socio demographic factors and choice of health facility

Variable	Type of Healthcare Facility			X ²	Df	P value
	Public facility	Private facility	Total			
	n (%)	n (%)				
Monthly income						
<50,000	67(74.4)	23(25.6)	90(28.1)	2.324	4	0.676
50,000–99,999	38(79.2)	10(20.8)	48(15.0)			
100,000–149,999	43(68.3)	20(31.7)	63(19.7)			
150,000–199,999	56(70.9)	23(29.1)	79(24.7)			
>200,000	31(77.5)	9(22.5)	40(12.5)			
Age						
<29	32(82.1)	7(17.9)	39(12.2)	4.13	4	0.389
30–39	26(70.3)	11(29.7)	37(11.6)			
40–49	89(74.8)	30(25.2)	119(37.2)			
50–59	69(73.4)	25(26.6)	94(29.4)			
>60	19(61.3)	12(38.7)	31(9.7)			
Marital status						
Single/divorced/separated/widowed	89 (71.8)	35(28.2)	124(38.8)	0.729	1	0.695
Married	146(74.5)	50(25.5)	196(61.2)			
Distance to healthcare facility						
<30 min	193(75.4)	63(24.6)	256(80)	2.028	1	0.079
> 30 min	42(65.6)	22(34.4)	64(20)			
Level of education						
Below secondary level	10(40)	15(60)	25(7.8)	13.74	1	< 0.001
Secondary level and above	225(76.3)	70(23.7)	295(92.2)			
Payment option						
Out of pocket	190(59.6)	65(40.4)	255(79.7)	0.494	1	0.482
Insurance scheme	45(69.2)	20(30.8)	65(20.3)			

Table 5: Association between choice of health facility and the dimensions of perceived quality of care provided by the respondents' usual healthcare providing facility

	Type of health facility			X ²	P-value
	Public facility	Private facility	Total		
Waiting time					
Short	78(33.2)	59(69.4)	137(42.8)		
Long	157(66.8)	26(30.6)	183(57.2)	31.985	< 0.001
Interpersonal/ communication skills					
Good	88(37.4)	53(62.4)	141(44.1)	14.716	< 0.001
Bad	147(62.6)	32(37.6)	179(55.9)		
Cost of Service					
Cheap	137(58.3)	33(38.8)	170(53.1)	8.741	0.003
Expensive	98(41.7)	52(61.2)	150(46.9)		
Facility toilet cleanliness					

Contd...

Table 5: Contd...

	Type of health facility			X2	P-value
	Public facility	Private facility	Total		
Clean	137(58.3)	37(43.5)	174(54.4)	4.909	0.027
Dirty	98(41.7)	48(56.5)	146(45.6)		
Adequacy of waiting area					
Adequate	85(36.2)	30(35.3)	115(35.9)	0.0002	0.99
Inadequate	150(63.8)	55(64.7)	205(64.1)		
Consultation time					
Short	179(76.2)	53(62.4)	232(72.5)	5.304	0.021
Long	56(23.8)	32(37.6)	88(27.5)		
Effectiveness of care					
Effective	[188] (80.0)	[57] (67.0)	[245] (76.6)	5.12	0.024
Noneffective	[47] (20.0)	[28] (33.0)	[75] (23.4)		

Table 6: Association between demographic variables of the respondents and respondents' level of satisfaction.

Variables	Level of satisfaction			X2	P-value
	Satisfied	Not satisfied	Total		
	n (%)	n (%)	n (%)		
Age					
< 29	33(13.1)	6(9.4)	39(12.4)	7.13	0.129
30–39	26(10.4)	11(17.2)	37(11.7)		
40–49	99 (39.4)	20 (31.2)	119(37.8)		
50–59	65 (25.9)	24 (37.5)	89(28.3)		
≥ 60	28 (11.2)	3(4.7)	31(9.8)		
Marital status					
Single/separated/divorced/widowed	84(33.5)	37(57.8)	121(38.4)	11,77	< 0.001
Married	167(66.5)	27(42.2)	194(61.6)		
Education					
≤ Primary	22(8.8)	3(4.3)	25(7.9)	10.37	0.006
Secondary	117(46.6)	13(24.6)	130(41.3)		
Tertiary	112(44.6)	48(71.1)	160(50.8)		
Family size					
1–5	179 (71.3)	43 (67.2)	222(70.5)	0.24	0.622
≥ 6	72 (28.7)	21 (32.8)	93(29.5)		
Employment status					
Unemployed	33(13.1)	9(14.1)	42(13.3)	0.88	0.643
Self-employed	48(19.1)	9(14.1)	57(18.1)		
Employed (govt./private)	170(67.8)	46(71.8)	216(68.6)		
Facility					
Public	169 (67.3)	61 (95.3)	230(73.0)	18.87	<0.001
Private	82 (32.6)	3 (4.7)	85(27.0)		

DISCUSSION

Consumers of healthcare services play a pivotal role

in healthcare quality assessment and monitoring. By expressing their preferences, they supply the valuations needed to choose between alternative strategies of care.

Patient satisfaction with healthcare services is important as it improves service utilization and patient compliance thereby improving the overall health outcome of the populace. This study sought to assess health service preference and quality of healthcare services available to residents of an urban settlement using client perspectives.

Public hospitals as opposed to private facilities were the preferred source of health care among residents of Abeokuta (72.5%). This contrasts with the findings of studies done in Ilorin metropolis^[12] and Sagamu,^[17] which showed more residents of those towns preferring private facilities. The reasons for the differences in preferences between the present study and those from these two towns are not clear to us.

This study revealed that preference of health service delivery was related to the perception of severity of illness with most of the respondents preferring public facilities when the illness was perceived to be major, for instance, involving surgical procedures, pediatric care, pregnancy, and maternal health services. This may be due in part to confidence in the quality of trained manpower available in government facilities. This finding is like the findings of the study from Nepal where the pattern of care-seeking indicates that public providers were most commonly consulted in any childhood illness episode.^[18] Furthermore, the choice may be influenced in part by proximity of residents to these facilities (although not significant, $P = 0.08$) as about half of them claimed that public hospitals were closest to their places of abode. This finding is like the findings of the study from Nepal which showed that 76% of respondents satisfied with care resided <1 hour from a health facility.^[18]

In addition, the choice of public facilities in the respondents was influenced by the lower cost of care and perceived effectiveness of care. This corroborates the findings of a recent multinomial logistic model assessment by Amaghionyeodime^[19] on the determinants of choice of facilities by households in Nigeria which revealed that cost was stronger than the distance in influencing accessibility to modern healthcare. In the same vein, a study among local government workers in south west Nigeria revealed reduced cost as a positive predictor for choice of public hospitals.^[20] In this study, respondents who preferred private hospitals did so because of reduced waiting time and pleasant attitude of healthcare providers. This is similar to findings in the study among local government workers in south west Nigeria where reduced waiting time was found to be a positive predictor in the choice for private facilities.^[20] The importance of waiting time in the choice of health provider has also been emphasized by most studies in other settings.^[8,10,12] Respondents' level of education (P

<0.001) was found to have significant association with choice of health service delivery by the respondents. This is important and may indicate that the citizenry has become more enlightened and more demanding of its rights than before.

The significant determinants of utilization of health facilities found by this study were perception of competence of health staff, effectiveness of therapy, proximity, and the overall perception of quality of service, whereas promptness of services and availability of drugs were the most important factors in Ilorin, Nigeria.^[12]

Perception of quality of care

Different domains of quality were assessed in this study using the Donabedian concept of structure, process, and output. Structure domains assessed included general cleanliness of the facility, where our respondents showed an average level of satisfaction, contrary to findings of the study at the University of Benin Teaching Hospital where the level of sanitation of environment of the facility was scored low.^[21] However, this study showed a relatively lower level of satisfaction with cleanliness of toilet facility in private hospitals as opposed to government hospitals. This may be because private hospitals utilized by respondents may be in buildings that were not purpose built and may not have adequate number of toilets or they may not have an adequate number of staff deployed for cleaning purposes. It is also possible that the respondents have higher expectations because of the higher costs of services in private facilities. Other structural domains measured included rating of waiting area, the quality of which was perceived to be low (36%) in both public and private facilities. This may be because most of the public hospitals in Abeokuta South Local Government Area were built in the 1970s and have not been adequately expanded to cater for the increasing population. It should also be noted that many private facilities operate in residential flats which have been converted for hospital use; therefore, adequacy of space may not be optimal.

Process domains assessed included waiting time, consultation time, and interpersonal communications. Consultation time was rated highest at 73%, whereas waiting time was rated lowest at 43%. This is similar to the findings in Benin, where consultation time was also rated high at 80.4%.^[21] Dissatisfaction with waiting time is similar to the findings of the study from Trinidad and Tobago where 48% of respondents were not satisfied with the waiting time.^[22] This study revealed that 66.8 % of respondents who preferred government facilities were dissatisfied with the waiting time, whereas only 30.6% of those using private facilities were dissatisfied. Chu-

weininger in 2006 found waiting time to be inversely and significantly related to satisfaction with care received.^[23] The low satisfaction with waiting time may be attributed to the high patient patronage in government facilities in relation to the number of available healthcare personnel, and the fact majority of the respondents patronized government-owned general hospitals even for minor health conditions. This has implication for the long queues and the long time it takes to receive care at the secondary care facilities, whereas primary healthcare facilities remain under-utilized.

The output domain assessed was in area of effectiveness of care which was generally rated high by 76.5% of respondents. However, this was rated higher by respondents preferring public facilities (80%) than those who preferred private facilities (67%). This is likely due to the presence of more experts in different fields of medicine in the government hospitals as opposed to private facilities. It is important to note that the bulk of the costs associated with the use of government facilities are borne by government and therefore the actual cost to the user is heavily subsidized.

General patient satisfaction

This study showed that there was a generally high level of satisfaction with healthcare received, the proportion of respondents satisfied were 78.4%, similar to findings in the study carried out in Ekiti where 75% of the respondents were satisfied with level of care,^[7] and 84% of pregnant women in Nnewi who reported a high level of satisfaction.^[24] Furthermore, a study in Sagamu showed much higher level of satisfaction with patient–doctor communication (90%) and may be because consultations in that area are partly done in the local dialect.^[17] The areas of care respondents were most satisfied with included effectiveness of treatment, consultation time, and communication skills.

Limitations to study

The main limitations to the study were those of recall and observer bias on the part of the respondents and the fact that people tend to remember unpleasant experiences more thereby using that to assess health facilities. The cross-sectional nature of the study makes it impossible to generate any specific causal relationship between the quality of care and the independent variables studies.

In conclusion, government-owned general hospitals were the preferred sources of health services and the quality of healthcare services received was generally perceived to be high. Areas of dissatisfaction with government facilities identified were long waiting time, poor interpersonal communication skills, adequacy of waiting areas, and cleanliness of facilities. We recommend that the government should improve on the

existing structures available at public-owned hospitals, and healthcare facilities to be built in the future should be larger to take care of structural inadequacies evident in the present facilities and be expandable to take care of population growth. This will help in accommodating the large turnover of patients thereby reducing waiting time and improving the perception of quality. Regular training of health workers especially in areas of interpersonal relations and patient communication should be conducted.

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Conflicts of interest

There are no conflicts of interest.

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