



Research Article

Pre-consultation waiting time in a Nigerian public Eye facility- a source of patient dissatisfaction.

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Received 18 March, 2013; Accepted 8 April 2013

Abstract

In order to determine subjective responses of ophthalmic patients to pre-consultation waiting time, a cross-sectional study was carried out with pretested questionnaires. Statistical Package for Social Sciences version 15.0 was used for descriptive analysis. In the research a total of 251 patients were analyzed comprising 139 males (55 percent) and 112 females (45 percent), in the ratio of 1: 0.8 respectively. Their ages ranges from 17 to 92 years with a mean of 37.2 years \pm 15.6 Satisfaction with overall quality of services was 80.1 percent; only 25.5 percent were satisfied with waiting time. Bivariate analysis (validated by multiple logistic regressions of confounding variables) of waiting time and overall satisfaction showed a result of $X^2 = 44.586$ and $p\text{-value} = 0.0001$. It is thus concluded that Pre-consultation waiting time is a major source of patient dissatisfaction to our facility.

Key words: waiting time, dissatisfaction, public, patient, Nigeria.

INTRODUCTION

The consumers' movement of 1960s gave birth to growing interest in assessing patient satisfaction (Reeder, 1992; Linn et al., 1992; Hulka et al., 1990; Ware et al., 1993; Hertz and Stamp, 1987). Though services provided at public health institutions are generally perceived by Nigerians as being poor, only few studies have involved patients in measuring satisfaction or defining health services standards (Olawoye 2008; Illiyasu et al., 2010). This has implications on how health care services are ultimately perceived or utilized (Dos Santos et al., 1994; Fernandes et al., 1994).

The efficiency of a health care would include issues like pre-consultation waiting time and duration of consultation (Santillan, 2000). In this era of high patient demand for health care excellence and growing awareness of individuals' rights, patient satisfaction surveys are veritable avenues to generate information that can be used for program planning and quality improvement efforts.

MATERIALS AND METHODS

Study setting

Our centre is one of the units of a federal teaching hospital located in the heart of a state capital. Being a public referral centre, it attends to different categories of ophthalmic patients making it appropriate for a study that bothers on satisfaction to public health facilities.

Study population

The study was carried out among registered adult patients. Two sets of patients were conscientiously recruited. Registered clinic patients coming for the first time (new patients) and registered clinic patients that have come at least once before (old patients). This was to assess satisfaction on heterogeneous groups of patients with varied experiences with the hospital facilities.

Design of the study

This was an observational qualitative descriptive study carried out between March and May, 2012. The questionnaire was validated through a pre-test study that lasted one week at the eye clinic of a Comprehensive Health Centre attached to our hospital. This was to test research tools and to train data collectors in order to minimize inter and intra-observer variations. Ethical approval was obtained from the Ethics Committee of our centre. Written and oral informed consents were sought from every participant with study's protocols in keeping with the tenets of Helsinki declaration.

Sampling technique

Two hundred and thirty nine patients inclusive of 10% attrition rate was the calculated minimum sample size. Inclusion criteria of the study were age more than 16 years, patients who were duly registered in our eye clinic and have been seen by a doctor at least once. Children (UNICEF definition of a child is 16 years and below) were deliberately excluded in this response-based study to enhance reliability (WHO, 1999). Adults' appreciation of service provided is more likely to be objective.

Methodology

The study was based on primary information collected through pretested questionnaire from 267 consecutive patients of which only 251 questionnaires were found suitable for research work. All ratings were made on a modified 6-point Likert-type scales. Client satisfaction questionnaire (CSQ-8) was adopted and modified to suit study's objectives. It is a widely used instrument with published data on reliability and validity (Greenfield and Atkinson, 1989). Questions contained in the questionnaire included socio-demographics characteristics and issues that bothered on promptness of accessing services. Questionnaires were filled by literate patients while medical students, specifically trained in the conduct of interviews assisted illiterate patients. It took an average of 12 minutes to fill a questionnaire while the illiterates who were assisted took slightly longer time. Communication among respondents was discouraged to check undue interferences.

To ensure patients were not forced to tick options not peculiar to them, options such as undecided or non-applicable were included in the structured questionnaire. Patient indicated their level of satisfaction by the following options: agree, strongly agree, disagree and strongly disagree. Those who chose disagree and strongly disagree were considered dissatisfied while those who selected agree and strongly agree were considered satisfied. Focus Group Discussions using (FGD) held in batches during clinic sessions so that grey areas were cleared to the patients. Also, questions and options ambiguous to the patients were painstakingly clarified.

Data management

The data from questionnaires were coded, entered and analyzed using SPSS (Statistical Package for Social Sciences) version 15.0 software in form of frequencies and percentages. Bivariate and multiple logistic regressions tests were used to assess and compare the effect of different variables on overall patient satisfaction. In all analyses p-value <0.05 was considered statistically significant.

RESULTS

The total of 251 patients analyzed comprised 139 males (55.4%) and 112 females (44.6%), with age range of 17-92 years and a mean of 37.2 years + 15.6. Majority of the subjects were between 17-40 years old. Age categorization as used in the present study was on the premise that each group shares similar ideologies and not on any statistical prejudice.

This was considered beneficial considering the research instrument that relied on subjective responses. The Table1 below shows the demographic characteristics of the patients studied. More than 70% of the participants attained at least secondary education.

TABLE1: Socio-demographic characteristics of the 251 respondents

Age(Yrs)	Male	%	Female	%	Total	%
17-40	79	31.5	80	31.9	159	63.3
41-60	47	18.7	23	9.2	70	27.9
>60	13	5.2	9.0	3.6	22	8.8
MARITAL STATUS						
Single	59	23.5	56	22.3	115	45.8
Married	78	31.1	47	18.7	125	49.8
Divorce	1.0	0.4	0	0	1.0	0.4
Widow	1.0	0.4	9.0	3.6	10	4.0
OCCUPATION						
Civil servant	59	23.5	36	14.3	95	37.8
Student	39	15.5	36	14.3	75	29.9
Business	19	7.6	10	4.0	29	11.6
Farming	12	4.8	12	4.8	24	9.6
Pensioner	3.0	1.2	2.0	0.8	5.0	2.0
House wife	2.0	0.8	11	4.4	13	5.2
Artisan	4.0	1.8	5.0	2.0	9.0	3.6
Driving	1.0	0.4	0	0	1.0	0.4
EDUCATION						
Primary	11	4.4	12	4.8	23	9.2
Secondary	41	16.3	33	13.1	74	29.5
Tertiary	78	31.1	53	21.1	131	52.2
Not educated	9.0	3.6	14	5.6	23	9.2

The **Figures** obtained showed nearly equal sex distribution of new and old patients with p-value of 1.47, which was not statistically significant. Statistical significance was also not noted when experience (whether new or old patients) was cross-tabulated with responses on waiting time and overall satisfaction. The computed overall patient satisfaction with all services was 80.1%. A bivariate analysis of waiting time and overall satisfaction showed $X^2 = 44.586$ and p-value = 0.0001. This was statistically significant and validated by multiple logistic regressions to obviate effects of confounding variables

DISCUSSION

The age distribution of the patients showed that majority, 159(63.3%) were between the ages of 17 and 40 years in conformity to a similar study in Kano (Ilyasu et al, 2010). The mean age of 37.2 years was similar to that reported in Sokoto, Nigeria (Umar et al., 2011) but much lower than the 45 years reported in Karachi, Pakistan (Jawaid et al, 2009). This could be attributable to different patient selection. Patients from the present study were recruited from an eye clinic unlike the Pakistani study which recruited patients from surgical outpatient clinic. There were more males than females in this study with a ratio of 1:0.8 in consonance with a similar southern Nigerian study on patient satisfaction (Olawoye, 2008).

The finding of youthful predominantly male population taking advantage of public health facility might be because they are the working class and more likely to afford incurred expenses than their female counterparts who often depend on them, being from lower socioeconomic status in developing countries.

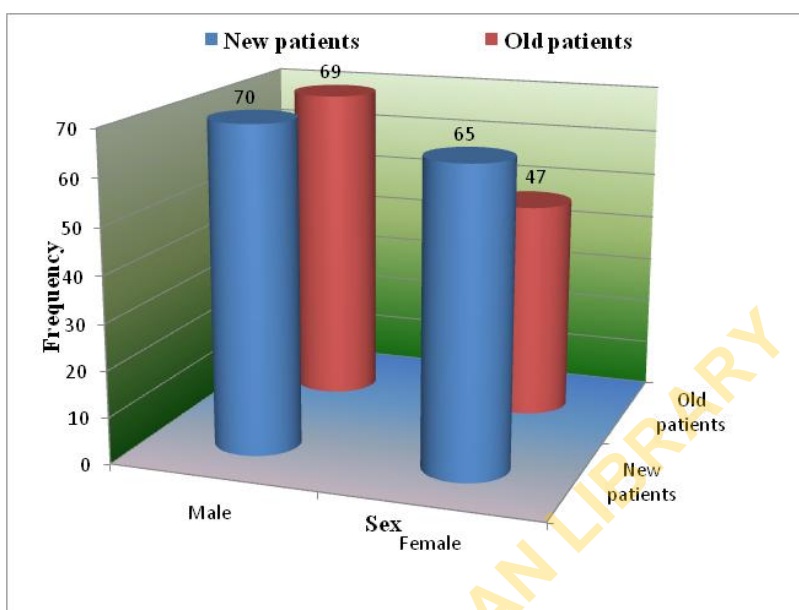


Figure1: Sex distribution of patients' visit

There have been inconsistencies in the figures obtained from patient satisfaction surveys across Nigeria in the order of 84% (Ofili and Ofovwe, 2005), 83% (Iliyasu et al., 2010), 75% (Olusina et al., 2004), and 53% (Eze, 2006). While the overall satisfaction of 80.1% of this study falls comfortably within this range, the reasons for varied figures are multifactorial. These would include individual study's methodology, setting and the target patients (population). Others are patients' expectation and socio-cultural differences. These studies (Ofili and Ofovwe, 2005; Iliyasu et al., 2010; Olusina et al., 2004; Eze, 2006) cut across multi-ethnic religious Nigeria with variegated opinions and inequality in the distribution of basic amenities. The diverse satisfaction figures reported are thus not unexpected.

In the present study, pre-consultation waiting time was the single most important source of patients' dissatisfaction (74.5%). This is the trend reported in several Nigerian studies (Umar et al., 2011, Thatcher, 2005; Ayeni et al., 2005, Afolabi and Erhin, 2003). This has been a major impediment to accessing health care services in Nigerian public health system (Umar et al., 2011). The 50% rates of dissatisfaction on waiting time reported by Umar et al., (2011) has been dwarfed by 74.5% found in the current study. Unfortunately, there are no local data addressing specifically waiting time of ophthalmic patients in outpatient clinic with which to compare our study. The much higher dissatisfaction recorded in this study could be traceable, at least in part, to the multiple eye clinic procedures: taking vital signs, visual acuity testing, intraocular pressure determination, dilated funduscopy, minor treatment room procedures etc. This is bound to increase the time a patient stays with the doctor and the time it takes the next patient to be seen. Medical or surgical outpatient routines are often not as tortuous. Patients' experience with services appeared to play no role with regards to satisfaction. Both old and new patients were equally dissatisfied.

Long pre-consultation waiting time seems less of a problem in the western world where patients are seen on appointments and the doctor-patient ratio is higher. Lopsided doctor-patient ratio has been alluded to as a cause of long wait to see the doctor (Umar et al., 2011). The present ratio in Nigeria is still a far cry from the recommendation of the World Health Organization (WHO). Other reasons identified as responsible for prolonged waiting time are lack or non adherence to appointment time, patients not seen in the order of arrival ('shunting queue'), inherent clinical challenges in seeing referred cases and paucity of clinic facilities like electricity and modern equipments to fast tract clinic activities and shorten consultation time.

This study is not without peculiar limitations. The spectrum of patients being questioned varied and so could have been their responses. Although multiple logistic regressions were used to account for confounding variables, a homogenous population could have obviated biases introduced by confounders such as literacy level, travels and socio-economic status. Hospital-based studies have inherent selection biases to which this study could not be said to be immune. The perception of satisfaction cannot be measured quantitatively while the qualitative alternative employed could be difficult to interpret.

CONCLUSION AND RECOMMENDATIONS

There is large proportion of dissatisfied patients accessing our eye care facility predominately as a result of undue long pre-consultation waiting. Therefore, it is recommended that exit suggestion boxes should be strategically located at patients' departure points to solicit suggestions on how services could be improved upon. The option of giving appointment and timing to patients as practiced in developed nations to cut pre-consultation time seems practicable and cost effective. Television stationed at waiting rooms would serve a twin function of health promotion and entertainment. To cut down on unnecessary clinic visits, e-consultation should become available for patients to reach doctors through electronic media and phone calls. This modality ensures that only critical cases need come to the hospitals. Additionally, providing grievances redressal system in the unit for aggrieved patients to access is a pragmatic step of showing genuine concern for improving patient satisfaction. Finally, periodic patient satisfaction survey should be institutionalized to provide feedback for continuous quality improvement.

ACKNOWLEDGEMENT

We are grateful to the Medical students who assisted in data collection

FINANCIAL DISCLOSURE(S)

The authors have no proprietary or commercial interests in the materials discussed in this article.

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