
THE IMPACT OF INTERPERSONAL FACTORS ON QUALITY HEALTH DELIVERY IN KWARA STATE GOVERNMENT HOSPITALS

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ABSTRACT

In the health care system, quality is influenced by many factors including individual exchanges of Administrators, Board Members, Physicians, Nurses and other Medical Personnel and the way they interact with patients. The objective of this paper is to investigate the impact of interpersonal factors on quality health delivery in selected government hospitals in Kwara State. The Methodology used for this research was the development of fourteen factors that bothers on interpersonal factors in a questionnaire. Frequency counts and factor analysis were used for statistical analysis. Six of the fourteen factors were considered accounted for 61.13% and greetings ranked higher with 11.7%, complementary remark 10.17% and personal communication 10.18% listening 9.9%, handshake 8.7% and jokes 8.625%. The implication of these results is that the combination of all these factors will go a long way to affecting patients' satisfaction which is the quality goal of hospitals. The ANOVA technique was used to test the hypothesis of differences in application of interpersonal factors among the seven local governments in Kwara State.

Keywords: Healthcare, Interpersonal Relationships, Nigeria

1. INTRODUCTION

Total Quality Management (TQM) has had a major impact since its relatively recent development. It is now considered almost indispensable as a means of releasing the many benefits accruing from increased quality. During the Second World War, British Prime Minister of "blood sweat and tears" fame, Winston Churchill once said "there is nothing wrong with change if it is in the right direction. To improve is to change so to be perfect is to have changed often". To strive continuously for change and create willingness among people and to participate in the change is to practice TQM. TQM can then be defined as a cooperative endeavour which relies on the skills and capabilities of the human system for continually striving to improve the quality of products and services.

TQM leads to better human relations, greater intimacy with customer higher productivity and profitability and increase market share. The success of TQM implementation

in the manufacturing industry has made its application in service industry appealing. TQM promises an opportunity to achieve better outcomes with fewer resources thus TQM has become an important part of the hospital's competitive strategy. Hospitals in competitive markets are more likely to attempt to differentiate themselves from their competitors on the basis of greater service quality.

The U.S. Agency for International Development's Maximizing Access and Quality Initiative (MAQ) has identified 25 indicators of quality of care: 13 relates to providers' Job performances, eight (8) reflect conditions of the service delivery facility and three (3) reflect clients' participation in care, and one (1) pertains to other clinic staff. The implication of these indicators is that providers' job performance factors accounted for 52 percent of patients rating of service quality. These providers job performance are the interpersonal factors that come into play between the patients and service providers.

Mohanty, et al (1996) identified five factors that can influence the implementation of TQM as: organization factors, interpersonal factors, environmental factors, facilities factors, and economic factors. This study is interested in studying the interpersonal factors to verify how the factors positively impact on the quality of healthcare delivery. Adeoti (2008) identified three additional factors influencing quality of services in the health care sector. These are: employee involvement and funding, inventory of drugs, information technology and personnel quality. He argued that the involvement of the employee and ability to take initiative when the superior health professionals are not on the ground will go along way to improving the service quality in government hospitals. Since the financing of the hospitals is based on allocation from the state government, the amount of funding allocated to the hospital will determine the motivation of the employees and their commitment to quality as well as the facilities that will be on the ground.

The inventory of drug factors, information technology and personal quality factors accounted for about 17.6% of the total variance explained in the study. The objective of this study is to investigate the impact of interpersonal factors in total quality management practice in Kwara State Government Hospitals. The hypothesis tested is presented below:

H₀: There is no significant difference in application of interpersonal factors among the seven local governments.

H₁: There is a significant difference in the application of interpersonal factors among the seven local governments.

2. CONCEPTUAL FRAMEWORK

Understanding satisfaction and service quality have, for some considerable time, been recognized as critical to developing service improvement strategies. The inaugural quality assurance work of Donabedian (1980) identified the importance of patient satisfaction as well as providing much of the basis for research in the area of quality assurance in healthcare. In the healthcare sector, the importance of measuring patient satisfaction is well articulated (Lin and Kelly, 1995) with patient satisfaction having been studied and measured extensively as a standalone construct and in particular in quality care assessment studies (Sofaer and Firminger, 2005). Furthermore, the literature tells us that the concept of satisfaction is complicated (Heidegger et al., 2006), irrespective of the area in which it is studied. It is multidimensional concept; not yet tightly defined; and part of an apparently yet to be determined complex model (Hawthorne, 2006).

Significant divergence can be found in the recent healthcare literature, for example Gonzales et al. (2005) noted that satisfaction questionnaires have been the most commonly used method to survey patient perceptions of healthcare for more than 30 years, but only over

the previous five years, had studies tried to ensure that the validity of the instrument was well grounded. Yet in contrast, the main finding of a 2006 review of the patient satisfaction literature (Hawthorne, 2006) concluded that none of the instruments reviewed could be considered satisfactory. Hawthorne indicated that there were thousands of patient satisfaction measures available, which have been developed on an “ad hoc” basis, with insufficient evidence of their psychometric properties. Further, quality in healthcare has been studied largely from the clinical perspective, excluding the patient’s perception of service quality. According to Crowe et al. (2002), the subjective affective component of the patient satisfaction construct makes its measurement “probably a hopeless quest” and its study is largely fraught as it has lacked precision, at the expense of exact science, with many researchers having undertaken studies of a purely exploratory nature (Gilbert and Veloutsou, 2006). Mohanty et al (1996) classified factors that can influence the implementation of TQM broadly into five categories as listed below:

- (a) Organizational Factors: these are the basic components of any healthcare system and staff resources in terms of number, variety and level. Some of these resources are internal – the staff actually employed within a particular organization and some are external – additional staff resources which may have to be used in case of shortage of the primary internal resource.
- (b) Interpersonal Factors: Mohanty et al (1996) admits that all Health Care Systems are influenced by the interactions that engender between the hospital employees interaction are psychological in nature to the patients, yet it enhances the quality of service rendered to the patients.
- (c) Environmental Factors: The knowledge of these factors is necessary in order to predict the behaviour of the system, as these external variable changes over time. The elements under this are competition, prescribed standard, government policy, internal expectations, interest groups and language and communication.
- (d) Facilities Factors: These refer to the non-staff resources of the health care system. These could be medical technical and ancillary. The quality of health care as perceived by patients may be influenced strongly by non-medical facilities like catering services, location, maintenance, capacity, laboratory, radiology, surgery, pharmacy, records and laundry.
- (e) Economic Factors: These Factors determine the viability of the health care system and it is influenced by availability of funds, costs of services, disposable income, peculiarity of service *vis a vis* volume and the nation’s economy.

Liz et al (2009) summarized the theories of patient satisfaction in healthcare as below:

- (a) Discrepancy and transgression theories of Fox and Storms (1981) advocated that as patients’ health care orientations differed and provider conditions of care differed, that if orientations and conditions were congruent then patients were satisfied, it's not, then they were dissatisfied.
- (b) Expectancy-value theory of Linder-Pelz (1982) postulated that satisfaction was mediated by personal beliefs and values about care as well as prior expectations about care. Linder-Pelz identified the important relationship between expectations and the

variance in satisfaction ratings and offered an operational definition for patient satisfaction as “positive evaluations of distinct dimensions of health care”. The Linder-Pelz model was developed by Pascoe (1983) to take into account the influence of expectations on satisfaction and then further developed by Strasser et al. (1993) to create a six factor psychological model: cognitive and affective perception formation; multidimensional construct; dynamic process; attitudinal response; iterative; and ameliorated by individual difference.

- (c) Determinants and components theory of Ware et al. (1983) propounded that patient satisfaction was a function of patients’ subjective responses to experienced care mediated by their personal preferences and expectations.
- (d) Multiple models theory of Fitzpatrick and Hopkins (1983) argued that expectations were socially mediated, reflecting the health goals of the patient and the extent to which illness and healthcare violated the patient’s personal sense of self.
- (e) Healthcare quality theory of Donabedian (1980) proposed that satisfaction was the principal outcome of the interpersonal process of care. He argued that the expression of satisfaction or dissatisfaction is the patient’s judgement on the quality of care in all its aspects, but particularly in relation to the interpersonal component of care.

Interpersonal factors which are the focus of this article can be defined as health professionals – patient relationship. It is a predictive factor of patient satisfaction on the quality of health. If the health professionals – patient relation is cordial, it is believed it will affect the satisfaction of patients with respect to quality health delivered.

Adeoti (2011) identified five interpersonal factors. They are: (a) Supervision (b) Assurance (c) Empathy (d) Awareness of Users and (e) Feedback to health workers. Levin (2008) in his study of the role of interpersonal factors in dentist treatment of patients identified the following interpersonal factors in dentistry: Greetings of the patient by name, complimentary remark, personal comment on patients; No interruption when the patient is talking, smiles and shake of hands. According to Levin, strong interpersonal skills are crucial to success in any service business. He conceded that dentists are selling trusts rather than products or services. The better a patients feels about a dentist, the more they will trust him/her.

Campbell et al, 2000 described interpersonal care as the social and psychological interactions that happen between the patient and the physician or other care givers. Several researchers have already pointed out that the quality of interpersonal care is one of the most important determinant of patient satisfaction and their perception of service quality (Dagger et al, 2007, Gill and White, 2009, Li and Benton, 1996, Naidu, 2009). Effectiveness in the context of interpersonal care is whether the interactions were efficacious and appropriate (Flood et al, 2000). The delivery of health care is a complex endeavour (Sheffield, 2008). The primary organizations for health care delivery are the health care providers although inter-organizational relationships with other players provide a foundation. Though similar service organizations, healthcare delivery organizations differ from other organization in many aspects. Shortell and Kaluzny (2000) states some important differences between healthcare delivery organizations such as work is variable and complex and can also be of an emergency or non-deferrable nature and there is very little tolerance for ambiguity or error.

Jeffries (1996) opined that enhanced profitability, reduction in costs, innovation, accountability and conducive working environment are the derivations of effective TQM implementation. Newsome et al, (1999) said interpersonal factors are attributes upon which

patients are fully capable of passing judgment and are consistently reported as being among the most important traits dentist should provide.

Corah and O'shea pointed out that evaluation of technical competence (measured by asking patients to respond to statements such as: "The dentist was thorough in doing the procedure and I was satisfied with what the dentist did") are based on interpersonal factors such as communication, caring and information giving. Kristina Lantis et al, says providers are health workers such as doctors, health aides, and midwives who deliver family planning and reproductive healthcare services in clinics, hospitals and communities through outreach services and community-based activities. They work in both public and private settings and at various levels of the health care hierarchy and may have different levels of education and supervisory responsibility. Providers are also clients of the healthcare system, in that their work requires the infrastructure, supervision, equipment, and physical setting that system supplies. In addition, providers, like their clients, are influenced by the local culture, reflecting and often being constrained by local beliefs and biases regarding status, gender, ethnicity, and other social factors.

Chakraborty et al, used conjoint analysis to assess patient preference and to examine the trade off that occurs between various attributes. Preferred dentist were those who 'respond to their pain', discuss their fears, and help to overcome them. Communication skills have also been shown to be important in limiting patient dissatisfaction.

3. METHODOLOGY

Kwara State has 16 Local Government Areas. Seven Local Governments fall within the Kwara South Matrix. They are Ifelodun, Irepodun, Isin, Ekiti, offa, Oke-ero and Oyun L.G.A's. The 16 local government areas is the population of study but the seven local governments are the samples. Fifty patients each were served the questionnaire in each of the selected local governments. As at the time of collation, the numbers of questionnaire returned.

With reference to the above demographic statistics 47 percent of the respondents were male while 52.9 percent were female. The increase in the figure of the female patients over and above the male patients, as a result of female – related sicknesses which is rampant at the time of obtaining the result of this study. About 81.8 percent of the respondents fall within the age of 18 and 65 years. In other world, the bulk of the patients are youth and adult which show that, they understand the import of interpersonal factors on the quality of healthcare delivered by the providers. The marital status of the respondents shows that 46.8 percent were married, 40.4 percent were single and about 12.9 percent of the respondents were either divorced or widow.

On the educational attainment of the respondents, 36.4 percent of the respondents have first school leaving certificate, 26.8 percent are school certificate holders and 17.9 percent are graduate.

The majority of respondents were civil servants which explain why they patronized government hospitals rather than private hospitals. The factors analysis was used to identify which of the fourteen factors were critical in quality health delivery in Kwara State Government State Hospitals. Six interpersonal factors accounted for 61.13% of variation in quality health delivery that is due to interpersonal factors. The remaining 38.7% of variations in quality health delivery is due to other factors that are not interpersonal.

4. FINDINGS

From the study, seven local governments fall within the Kwara South geopolitical zone. We discovered that interpersonal factors are crucial to the success of any service business like health care. From the analysis, the choice of persistent patronage and publicity of the

government hospitals is contingent on whether the patients were satisfied on their exit from the hospitals or they were dissatisfied. This paper found that interpersonal factors should be selected based on the recovery process of patients. For example a patient that is in a coma, handshakes or jokes will not mean anything to him. Secondly, hospital staff must be trained on how to psychologically help the healing process of the patients.

5. CONCLUSION

Health care is all about service to humanity. The way such service is rendered will go a long way to determining the survival of the health care systems and operators. The government must develop a means through which the services rendered could be monitored. Compliance to government directive should not be a matter of choice, the representative of the government or agency in the hospital must carry it out.

If the satisfaction of patients is the essence of hospital service organizations, then a combination of 2 or more interpersonal factors will achieve the objective of patients' satisfaction. Hospital employees must therefore be trained especially on courtesy and professional-patient relationship.

In view of the foregoing analysis and brief explanation of the findings, we recommend that hospital employees should be educated on how to relate with the patients interactively. Although the interpersonal relation is psychological to the patients, it will go a long way to redeem the image of the hospitals in terms of the hitherto hostility that characterize the employees- patients relationship of the hospitals; and, there should be continuous professional development in the form of in-house training that boarder on relationship with patients.

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