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Evaluation of Health Care Quality in Public and Faith Based Hospitals in Kiambu and Nairobi Counties, in Kenya: A Comparative Study

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Abstract
Quality is attribute that satisfy the consumer's needs and receiving quality health care is necessity. Health gaps within countries globally have widened, due to inequality in the absorption of new technology as well as unequal distribution of new and re-emerging health problems (Africa ranked 50%) and poverty (estimated population of Sub-Sahara Africa living in absolute poverty (54%). Currently, the Kenyan health care system is hampered by many obstacles that hinder quality health care provision for example culture, new technology, poverty (those below national poverty line constitute (52%), illiteracy among many others. This study was designed to evaluate the health care quality offered to patients admitted into faith based and public hospitals of Level four hospitals in Kiambu and Nairobi Counties in Kenya. The study adopted both exploratory and explanatory study designs, where qualitative and quantitative data were collected. A sample size of 384 of hospitalized patients was calculated. Systematic sampling, every 4th patient discharged was used to select the subjects to be interviewed. Questionnaires, in-depth interview guides, assessment checklists and observation checklists were used for data collection. Inferential statistics; Chi-square (x^2) tests, ANOVA, equivalent of independent sample T-Test and correlation at $p \leq 0.05$ was used for analysis. The results show that the dimensions for patient's satisfaction were; availability of drugs, services & equipment, cost of treatment, appealing Physical structure, clean environment and adequacy of staff (infrastructures 39.5%), responsiveness**,** communication, courtesy, reliability and equity (process 44.5%) and outcome of treatment to patient satisfaction that included; positive outcome (15.7%) of treatment and reduced morbidity and mortality. The dimensions that influence patient's choice of hospital were outcome of medical treatment (72.3%) in faith based and cost of service (50.7%) in public hospitals. The Chi-square (x^2) is significant at $p \leq 0.05$ hence there is a relationship between service dimensions and patient choice of hospital. Patient's perceived high satisfaction with health care service in faith based hospitals. At the $p \leq 0.05$ level of significance, there is a difference in perceptions between the four hospitals and type of facilities except cost of services whose $p > 0.05$. Public and faith based hospitals do not comply with Ministry of Health Quality Standards. The patient's perceived higher satisfaction with health care services in faith based hospitals as compared to public hospitals. The findings of this study would be relevant and valuable to all stakeholders in health care sector including health system developers, policy makers and more importantly to hospital management team to understand areas of improvement. Hospital top management would apply research findings to design and prioritize hospital strategies for improving service quality. This research results would further help healthcare providers to understand customer‘s preferences by measuring the service quality dimensions that contribute to patients satisfaction.

Keywords: health care quality; kiambu; Nairobi: exploratory and explanatory study designs.

INTRODUCTION

Quality is the ability to deliver services that satisfy the consumer's needs, providing quality healthcare is an ethical obligation of all healthcare providers (Zineldin, 2006) and receiving quality care is a right of all patients (Pickering, 1991). Service quality was defined as the ability to meet or exceed customer expectations (Pui-Mun *et al.,* 2006). Evaluation is the use of scientific method, rigorous and systematic collection of research data to assess the effectiveness of organization services and programmes (for example health service interventions) in achieving predefined objective (Bowing, 2002). The health gaps within and between countries have widened, due to inequality in the absorption of new technology as well as unequal distribution of new and re-emerging health problems (Von-Schirnding, 2002). Each year, many people are lost as a result of inequalities in health care provision and problems are worst in Africa where finance are least available; those who need more care have the least access to quality health care service (Gwatkin *et al.,*2000). Consequently, it is evident that this study was carried out to evaluate the situation of quality of health care in Kiambu and Nairobi Counties, Kenya. More than 50% of African populations do not have access to

modern health facilities, High levels of maternal, child, and infant mortality and low rates of immunization, are symptomatic of poor quality health service (World Bank, 2006).

Kols and Serman noted that patients' needs are dynamic and are continuously influenced by cultural, economical, demographic, social and environment factors. For health services to satisfy these needs health systems need to undergo continuous transformation in accordance to prioritized needs of consumers (Kols and Serman, 1998). In recent decades, carrying out an evaluation on quality health care has been found to be the most useful approach for getting patients' views on how to provide care (Sajid, 2007). This is based on two major principles: patients are the best source of information on quality of health services provided and patients' views are the determining factors in planning and evaluating quality of health care. Inappropriate provider's behaviour, insufficient case management capacity, referral and communication failures were identified at the service delivery level as some of the weaknesses leading to poor health care. Recent systematic reviews have highlighted quality failings in both public and private care settings in developing countries (Berendes *et al*., 2011) and have added power to earlier calls to standardize and assure the quality offered by private providers (Patouillard *et al.,* 2007). According to the World Health Report, 2000, Sub-Saharan Africa where Kenya falls is ranked among the lower 50% in terms of health systems performance where infectious diseases contributed to high mortality and poor quality health care. This demand well developed performance health systems to efficiently and effectively address this challenge (WHO, 2000). It is therefore important to evaluate the health care quality offered to patients admitted into public and Faith Based hospitals in Nairobi and Kiambu Counties in Kenya.

PROBLEM STATEMENT

Currently, the Kenyan health care system is hampered by many obstacles that hinder quality health care provision for example culture, new technology, poverty, illiteracy among many others. Each year, we are losing millions of people as a result of poor quality in health care provision and problems are worst where resources are least available; those who need more care have the least access to quality health service (Gwatkin *et al.,* 2000). The Human Development Report (UNDP, 2004) and the World Bank World Development Report of 2006 estimated that 54% of the total population of SSA is living in absolute poverty; this poverty limits access to quality health services.

According to the World Health Report, 2000, Sub-Saharan Africa where Kenya falls is ranked among the lower 50% in terms of performance of health systems where infectious diseases contributed to high mortality (WHO, 2000) Kenya like most developing countries is experiencing a double pattern of disease: These demand well developed performance health systems to efficiently and effectively address this challenge. The health systems, as organized today, are not adequately addressing the increasing burden of disease due to limited health service quality in health institutions (Kaseje, 2006). Ministry of health (MOH, 2002) quality standards are not actively implemented by hospitals. It is therefore important to evaluate quality of health care services accorded to patients.

METHODOLOGY

Background Information of the Study Area

Kiambu County is located in the Central highlands of Kenya in the former Central Province, close to Kenya's capital, Nairobi. Kiambu town is the commercial and administrative capital of Kiambu County, its proximity to the city of Nairobi (16 kilometers). Kiambu county is situated in Nairobi, Kenya, its geographical coordinates are 1° 19' 1" South, 37° 21" 33" East. Nairobi city is located at the Nairobi River in the highlands, in the south-central part of the country. Nairobi lies on the central Kenyan plateau at an altitude of about 1,680 m (5,500 feet), its geographical coordinates are 0°26"56" South, 37°6' 14" East. Nairobi County has a population of 3,138,369 while Kiambu County has a population of 1,623,282 according to Kenya Bureau of statistic, 2009.

This study adopted both exploratory and explanatory study designs by adapting mixed quantitative and qualitative approach it is expected to improve the accuracy of judgments by collecting different kind of data relating to the same phenomena. Exploratory study is a valuable way of finding out new insights by asking questions and assessing a phenomenon in a new way this was done through qualitative in-depth interviews. While the research was explanatory in nature as it explained patient perception on services quality through quantitative approach.

The study's population was made up of 384 (sample Size) of hospitalized patients above 18 years, who attended health services in public and faith based hospitals in Kiambu and Nairobi counties in 2012.

SAMPLING PROCEDURE

The sample population was selected from two faith based and two public hospitals of level four in Kiambu and Nairobi counties were selected by simple random sampling this was done by writing all the names of level four hospital and the numbers were placed in a container as per county and categories and picking any number in a random (Mungenda and Mugenda, 1999). This formed the first cluster that is two faith based hospitals and two

public hospitals and different wards in each hospital were selected as the second cluster. Sample size in each cluster was determined according to the proportion of hospitalised patients as per ward. Systematic sampling was used to select every fourth patient to be interviewed on discharge and the questionnaires were completed by the interviewer for quantitative study. Interviews were carried out on all days other than Sundays. The sample design for key informant was purposive (Newman, 2003) small numbers of 40 patients with specific characteristic were selected. Patients who had stayed in the hospital from one week and above and had attained tertiary education were eligible; ten patients were selected by use of registration number from each hospital for qualitative study. According to (Curry and Sinclair, 2002) stated that few patients possess sufficient medical skills to evaluate staff knowledge and expertise, even after their questions have been answered or the treatment given that is why those with high level of education were used as criteria and those who experienced the services in the hospital for at least a week.

Exploratory study was carried out by use of in- depth interviews to identify dimensions that contribute to patient satisfaction. Interview guide in the form of list of questions to be explored in the course of interview was prepared. The guide provided topics areas within which the researcher was free to explore, probe and ask questions to elucidate and illuminate particular subjects.

For explanatory a questionnaire was developed for perception of patients on service offered and the influence of patient's choice of hospital. The questionnaire contained structured or closed questions that required respondents exercise judgment. A five-point Likert scale was used to ask respondents for scoring (items) ranging from 1= strongly agree to 5 = strongly disagree. Twenty five instruments were modified from SERVQUAL method to reflect the environment in which the study was undertaken; the use of scaling comparable to previous research provides greater reliability for questionnaire.

To confirm the compliance by public and faith based hospitals to quality standards as set by the ministry of health (2002), facility assessment checklist consisting 25 items was used to evaluate sample units against ministry of health checklist whether they are there and their reliability maximum score 4 and minimum score 0. Selected basic diagnostic equipment that included questions about whether the units were available and in working condition maximum score 9.09 and minimum score 0. Also observation checklist on health providers containing 10 items was observed and the score was 10 all the score were to earn 100%. To comply to quality standards the score was to be 100% since either health service is quality or poor.

DATA COLLECTION

Qualitative and quantitative methods of data collection were used. Primary qualitative data was collected using, in-depth interview guides. Representative of four hospitals that comprises 40 in-depth interviews provided data relating to dimensions that contribute to patient's satisfaction with probing questions where necessary. These were administered to selected patients in study hospitals as key informants. Interviews were conducted using unstructured or open-ended questions to solicit information on dimensions that satisfies patients on health care service and the feelings of the patients on the nature of services currently being offered to them; their views and recommendations on how they would want the services improved in order to be satisfied and served better and achieve the aspects of quality. The interviews were conducted on patients who had been admitted for one week and more in the wards during study period.

Primary quantitative data was collected using self-enumeration matrix questions rated on a Likert scale and response graded with different values ranging from 1-5 strongly agree scoring 1 and strongly disagree scoring 5 and assessment checklists were used with scoring marks 4 being maximum and 0 minimum score. Quantitative study that examines the perception of patient on service quality, a questionnaire was also developed to ascertain the influence of service quality dimensions on patient choice of hospital and determine the patient's perception as in the literature and specifically the SERVQUAL dimensions. The questionnaires were administered at discharge point.

DATA ANALYSIS

Completed study tools were checked for accuracy daily by the researcher and where necessary possible follow- ups and corrections made. The recorded interviews were transcribed and the data systematically analyzed. The analysis was done in three steps, first was sorting and classifying data. Following a review of interview transcripts and related documents, data was then categorized or labeled to identify units of data. Categorization took place during the process of open coding, the aim of open coding is to discover, name and categorize phenomena in terms of their properties and dimensions. The content categories were chosen and labeled with particular reference to service quality concepts. Data was recorded on spread sheet to represent categories identified in each interview. All these codes were then noted down in a notebook, a data entry frame sheet was prepared in the computer, and numerical values of all the responses, key punched systematically into the computer and

analyzed using SPSS. The results were presented in graphs, pie charts, tables, percentage, cross tabulation and frequency.

Descriptive statistics were derived and analyzed by use of percentage, cross tabulation and frequencies. Inferential statistical analysis was undertaken to enhance further insights of the data. Various methods were used; Chi-square (x^2) tests: were used to identify differences between groups of all categorical variables. The Kruskal–Wallis one-way analysis of variance by ranks is a non-parametric method for testing whether samples originate from the same distribution. It was used for comparing two or more samples that are independent. Mann–Whitney U test was used to test the difference in means between two groups and this is an equivalent of independent sample T-Test. Correlation: was used to measure the similarity in the changes of values of interval variables but was not influenced by the units of measure.

STUDY LIMITATION

Due to limitation of time and resources (funds), the researcher was not in position to take a large sample and cover all the departments in the institutions looking at all the elements that affect or influence quality of health care. When based on exit interviews (as used in this study), there are unavoidable elements of self-selection bias among patients, that is, patients who choose to go to a particular facility are more like to be satisfied with the quality of care than the population as a whole, since those who are not satisfied are more likely to have sought care elsewhere (Levin *et al.,* 2003).

RESULTS

Service Quality Dimensions That Contributes To Patient's Satisfaction

The following attributes in Table 1. below were mentioned by the respondents as what makes them happy and satisfied with health care service offered in health care institutions. When patients were asked what affects health service in hospital they mentioned several items as they included poor interpersonal relationships 13.4%, shortage of staff 12.2%, lack of drugs 9.8%, low standards of caring 7.3%, insufficiency standards 7.3%, discrimination 6.1%, high cost 7.3%, poor diet 4.9%, untidy environment 4.9% and many others.

Dimensions	**Percentage (%)**	Total
Infrastructure		39.5%
1. Availability of drugs, services & equipment	9.1	
2. Cost of treatment	5.2	
3. Appealing Physical structure	6.3	
4. Clean environment	13.2	
5. Adequacy of staff	5.7	
Process		44.8%
1. Responsiveness	17.2	
2. Communication	15.5	
3. Courtesy	3.5	
4. Reliability	5.7	
5. Equity	2.9	
Outcome		15.7%
1. Positive outcome of treatment	11.4	
2. Reduced morbidity and mortality	4.3	
Total		**100%**

Table 2. Rating of health care quality by type of hospital

		How do you rate health care quality of services provided in this hospital?					
		Poor		Good		Very Good	
		Count	Row N %	Count	Row N %	Count	Row N %
Type of facility	Faith Based	1	5.0%	18	90.0%	1	5.0%
	Public	18	90.0%	2	10.0%	0	0.0%

Table 3. Rating of health care quality of services

		Responses	
		N	Percentages
Rating of health care quality of services	Poor	19	47.5%
	Good	20	50.0%
	Very Good	1	2.5%
Total		40	100.0%

Influence of Service Quality Dimensions on Patient Choice of Hospital

The results indicate that the cost of the services influences patients to choose public hospital for medical treatments. Generally the results show that outcome of medical treatment influence patient's choice of hospitals for medication. The results below indicate that interpersonal relationship and information provision on treatment do not influence patients' choice of hospital.

Table 4. Influence of service quality dimensions on patient choice of a hospital

		What makes you choose this hospital for your medical treatment?					
		Physical facilities	Cost of the services	Interpersonal relationship	Information provision	Outcome of medical treatment	Total
Which type of hospital you usually receive your medical treatment?	Public hospital	19 13.0%	74 **50.7%**	3 2.1%	0 0.0%	50 34.2%	146 100.0%
	Faith based hospital	11 5.9%	34 18.1%	6 3.2%	1 .5%	136 **72.3%**	188 100.0%
	Private hospital	3 6.3%	11 22.9%	1 2.1%	3 6.3%	30 62.5%	48 100.0%
	Other clinics	0 0.0%	0 0.0%	0 0.0%	0 0.0%	2 100.0%	2 100.0%
Total		33 8.6%	119 31.0%	10 2.6%	4 1.0%	218 56.8%	384 100.0%

Perception of Patients on Public and Faith Based Hospitals Service Quality

In Table 5. the H_o there is no difference on health care provider's behaviour among the type of facility. At $p \leq 0.05$ we reject the null hypothesis; hence we conclude that there is a difference in health provider's behavior among the type of facility. Mann–Whitney U test was used to test the difference in means between type of facility and this was an equivalent of independent sample T-Test. Across the factors on perception of health provider behavior they were significant at $p \leq 0.05$ as indicated in the Table 4.5 below.

Table 5. Perception of patients on health provider behaviour

	Doctors give sufficiency attention to the patients	Doctor has given satisfactory time to narrate the illness	Do health providers give proper medical care	Attitude of doctor is satisfactory	Behavior of nursing staff is good	You do not receive prompt service from employees in this hospital	Staff services and level of care is good	The providers seemed concerned about your needs	You can trust employees of this hospital	Food served as per suggestions of the doctor
Mann-Whitney U	5,486.500	6,474.000	4,073.500	11,587.500	5,536.500	4,915.000	3,158.000	3,313.500	4,015.500	2,522.000
Wilcoxon W	16,217.500	17,205.000	14,804.500	22,172.500	16,267.500	15,646.000	13,889.000	13,898.500	14,600.500	13,253.000
Z	-11.920	-10.939	-13.098	-6.090	-11.650	-12.171	-13.939	-13.713	-13.128	-14.510
Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000

In Table 6. H_o: There is no difference in cost of service among the type of facility.

At $p \leq 0.05$ we reject the null hypothesis; in this case we accept the null hypothesis and conclude that there is no difference in cost of services among the type of facility given $p > 0.05$.In general, it was concluded that there is no difference in perception of patients in regard to cost of services among the type of facility.

Table 6. Perception of patients on cost of the service

	The cost of services received in this hospital is reasonable
Mann-Whitney U	15,830.500
Wilcoxon W	44,271.500
Z	-1.513
Asymp. Sig. (2-tailed)	.130

In Table 7. the $H_{o:}$ there is no difference in admission procedure among the four hospitals. At $p \leq 0.05$ we reject the null hypothesis; hence we conclude that there is a difference in admission procedure among the four hospitals. In general it was concluded that the perception of patients in regard to admissions was different among four hospitals. Kruskal-Wallis H test (one-way analysis of variance (ANOVA) was used to compare mean difference in perception ratings among the four hospitals. Across the factors on perception of admission they were significant at $p \leq 0.05$ as indicated in the Table below.

Table 7. Perception of patients on admission procedure

	The admission procedure of this hospital is good	People at the registration counter are helpful	Is there a delay at admission	On the whole, registration procedure is good
Chi-Square	103.232	89.055	13.650	166.196
df	3	3	3	3
Sig.	.000	.000	.003	.000

In Table 8. the $H_{o:}$ there is no difference in infrastructure among the four hospitals. At $p \leq 0.05$ we reject the null hypothesis; hence we conclude that there is a difference in infrastructure among the four hospitals. In general it was concluded that the perception of patients in regard to infrastructure was different among four hospitals. Kruskal-Wallis H test (one-way analysis of variance (ANOVA) was used to compare mean difference in perception ratings among the four hospitals. Across the factors on perception of infrastructure they were significant at $p \leq 0.05$ as indicated in the Table 4.8.

Table 8. Perception of patients on infrastructure

	Physical facilities are visually appealing	Cleanliness in the ward/room is high	Toilet facilities are clean	Hospital linens are clean	Diagnostic services are available and reliable	The hospital has adequate health service providers	The medicines are available in this hospital
Chi-Square	137.826	247.191	272.356	232.851	111.480	88.109	122.728
df	3	3	3	3	3	3	3
Sig.	.000	.000	.000	.000	.000	.000	.000

Mean Ranks of Patients by Type of Facility

The ranking by hospital faith based hospitals scored the highest among all the 25 factors where patients perceived service quality to be satisfying in faith based as compared with that of the public.

Compliance by Public and Faith Based Hospitals to Ministry of Health Quality Standards

The results shows that both public and faith based hospital do not comply with ministry of health quality standards to comply with the standards both faith based and public hospitals has to have all the items assessed and score 100%.

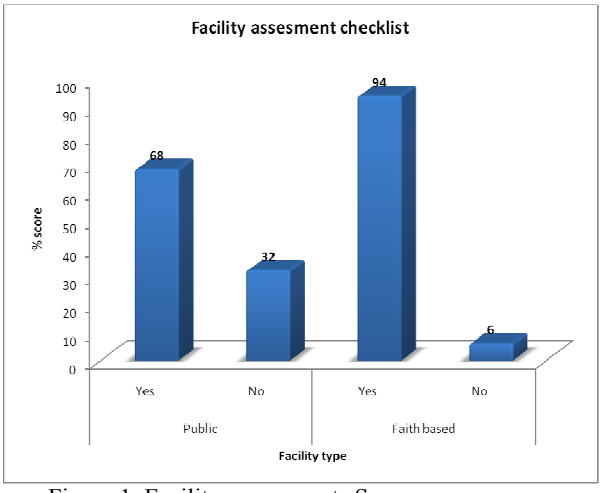

Figure 1. Facility assessments Score

DISCUSSION

Service Quality Dimensions That Contributes to Patient's Satisfaction

The results from qualitative data shows that several dimensions of the infrastructure contributes to patients satisfactions that were mentioned by key informant they included availability of drugs, services & equipment, cost of treatment, appealing Physical structure, clean environment and adequacy of staff. This finding agrees with (Wodon, 2013) that satisfaction is related to more partnership building, cleanliness of facility, drug availability and availability of equipment. This is also in agreement with the study done by (Prattana *et al.,* 2013) in Thailand indicated that the current service quality in term of tangibility is high whereas the service quality of the assurance dimension is low.

Results from this study have also shown several aspects of process contributing to dimensions of patient's satisfaction they included; **r**esponsiveness**,** communication, courtesy, reliability and equity. These findings were also recorded in studies done by (Wodon, 2013) show that satisfaction is related to more partnership building, more social conversation, courtesy, clear communication and information, respectful treatment, length of consultation and waiting time. This confirms findings of (Lemessa and Salomon, 2001) which showed significant association between satisfaction and perceived length

of time spent with health care provider for physical examination and consultation, with longer time spent associated with higher satisfaction level. The results of this study supports (Sajid, 2007) findings that patient waiting time before consultation, duration of consultation time spent with the doctor to attend to a patient subsequently quick response to emergencies, quick dispensation plays role in patient satisfaction.

The results also have shown the contribution of the dimension of outcome of treatment to patient satisfaction that included; positive outcome of treatment and reduced morbidity and mortality. This finding agrees with (Hibbard *et al.*, 2005) argument that if a hospital reputation is affected due to some attributes like high mortality, increased infection among admitted patients or no improvement in symptoms or mobility these results in reduction of market and dissatisfaction of patients.

Influence of Service Quality Dimensions on Patient Choice of a Hospital

The results of this study therefore, highlights quality dimensions that influence patients' choice of hospitals were outcome of the treatment and cost of the services. This findings agree with (Cheraghi *et al.,* 2008) statement that the costs of the services influence the choice of health care provider. Other studies similar to the current study reported that outcome indicators such as mortality or pressure sore rates had a strong influence on patient choice of health care provider (Groenewoud *et al.,* 2008, Marang- Van-De,*et al*., 2010). Additionally, outcome indicators influence the advice they would give to friends, whereas they did not have a strong influence on their own previous choices (Exworthy & Peckhan, 2010). Although in a different study indicates that interpersonal factors and availability of information, (Morrison *et al.,* 2003) influences patients choice of hospital that contradicts these results.

Perception of Patients on Public and Faith Based Hospitals Service Quality

The findings of this study indicate that the patient's perception on service quality rated faith based higher satisfaction across all twenty five factors assessed the perception of the patient on service quality. This confirms findings of other studies done previously in Tanzania (Mwabu *et al*., 2004) indicating that government owned buildings were rated as the worst when compared with those owned by religious organisation and individuals.

This observation was also recorded by (Levin *et al.,*2003) carried out a study in three countries the (6) faith- based facilities generally score higher on process indicators and client satisfaction than did the (6) public facilities. Another baseline survey was done by (Lindelow *et al.,* 2003) show that satisfaction was found to be higher in private non-profit facilities (many of which are faith-inspired) than in public facilities in areas such as friendly service, information about ailment, prompt attention, and information about medication. These results contradicts a study done on maternal/newborn (Widmer *et al.,*2011) noted that health services provided by FBOs were similar to those offered by governments, the quality of care received and the satisfaction were reported to be better.

CONCLUSIONS

The study revealed that service quality dimensions that contribute to patients satisfaction were; availability of drugs, services & equipment, cost of treatment, appealing Physical structure, clean environment and adequacy of staff (infrastructures), responsiveness**,** communication, courtesy, reliability and equity (process) and outcome of treatment to patient satisfaction that included; positive outcome of treatment and reduced morbidity and mortality.

The study revealed the highest dimensions that influence patient choice of hospital were the outcome of the medical treatment followed by cost of services and the least dimension that influences patient choice of hospital was the information provision.

The study revealed that patient's perception of public and faith based services quality, they rated higher satisfaction in faith based as compared to public meaning there is difference in service quality among the type of facility. There is a difference in the median perceptions (and, hence, the mean perceptions) among the four hospitals and type of facilities except cost of services whose alpha level is greater than 0.05. On assessment of the study hospitals the results revealed that both public and faith based hospitals do not comply with Ministry of Health Quality Standards.

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