

Satisfaction with Quality of Care Received by Patients without National Health Insurance Attending a Primary Care Clinic in a Resource-Poor Environment of a Tertiary Hospital in Eastern Nigeria in the Era of Scaling up the Nigerian Formal Sector Health Insurance Scheme

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Abstract

Background: The increasing importance of the concept of patients' satisfaction as a valuable tool for assessing quality of care is a current global healthcare concerns as regards consumer-oriented health services. **Aim:** This study assessed satisfaction with quality of care received by patients without national health insurance (NHI) attending a primary care clinic in a resource-poor environment of a tertiary hospital in South-Eastern Nigeria. **Subject and Methods:** This was a cross-sectional study carried out on 400 non-NHI patients from April 2011 to October 2011 at the primary care clinic of Federal Medical Centre, Umuahia, Nigeria. Adult patients seen within the study period were selected by systematic sampling using every second non-NHI patient that registered to see the physicians and who met the selection criteria. Data were collected using pretested, structured interviewer administered questionnaire designed on a five points Likert scale items with 1 and 5 indicating the lowest and highest levels of satisfaction respectively. Satisfaction was measured from the following domains: patient waiting time, patient-staff communication, patient-staff relationship, and cost of care, hospital bureaucracy and hospital environment. Operationally, patients who scored 3 points and above in the assessed domain were considered satisfied while those who scored less than 3 points were dissatisfied. **Results:** The overall satisfaction score of the respondents was 3.1. Specifically, the respondents expressed satisfaction with patient-staff relationship (3.9), patient-staff communication (3.8), and hospital environment (3.6) and dissatisfaction with patient waiting time (2.4), hospital bureaucracy (2.5), and cost of care (2.6). **Conclusion:** The overall non-NHI patient's satisfaction with the services provided was good. The hospital should set targets for quality improvement in the current domains of satisfaction while the cost of care has implications for government intervention as it mirrors the need to make NHI universal for all Nigerians irrespective of the employment status.

Keywords: Nigeria, Non-NHI patients, Quality of care, Satisfaction

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Introduction

The tertiary hospitals in Nigeria operate in a society made up of people with various sociodemographic backgrounds. These tertiary hospitals are often seen as authorities in several issues relating to health thereby creating high expectations and quality of care in the society. In the tertiary hospital organization,

several factors such as patients-related, employee-related and employer-related factors interact to affect the quality of care the patients received.^[1,2]

Traditionally, assessment of quality of care in Nigerian hospitals tends to look only at cure. However, there are aspects of care that are not measured by this approach such as interpersonal dynamics like patient-staff relationship, patient-staff communication and service delivery. Patients' satisfaction evaluation measures health gain and what actually happen to the patients who interface with the hospital unlike most of the other clinical measures of quality of care used traditionally such as cure rates, infection rates and adverse events.^[3] Patients' satisfaction studies are therefore increasingly being considered an important dimension of quality of care and the extent of utilization of health services.^[4]

Patient satisfaction refers to the extent to which the patients perceived that their needs and expectations are met by the service provided.^[5] It means the best health outcomes that are possible given the available resources and should be consistent with patient values and preferences. Several methods of assessing quality of care have been described.^[6,7] However, there is no universally accepted method of measuring quality of care but there is growing consensus that measuring quality of care should be based at least on patients' satisfaction studies.^[8]

Research has shown that patients' evaluation of quality of care in developed countries cannot be favorably compared with that of developing countries such as Nigeria.^[9] However, users of health facilities in Nigeria differ in their assessment of quality of hospital services.^[10,11] The attitude of the health workers, long patients' waiting time, cost of care, hospital bureaucracy and easy access to alternative medical practices are important barriers to the uptake of orthodox medical services by the Nigerian society. Patients that are satisfied with the quality of care are likely to seek medical consultation in the hospital, to adhere to treatment plan, to maintain a continuous relationship with the hospital, to recommend the hospital to others in the community, to make a more informed choices about the health care providers and to encourage a continuous quality improvement in the hospital.^[1]

In Nigeria, health services have been a social issue in the recent past.^[12,13] The increasing health awareness and easier access to information on health matters in Nigeria is expected to make consumers of health services play active roles in decision concerning quality of care rendered to them. If satisfaction with structural, process and outcome of care are critical elements of quality of care, then the way in which care is delivered should be evaluated through the eyes of the patients.^[6] The preparedness of Federal Medical Centre, Umuahia to meet this challenge necessitates this study on patients' satisfaction with the quality of care they received at the Family Medicine clinic that provides primary care for both NHIS and non-NHIS patients. This type of study has not

been done at the study center. It is envisaged that this study will provoke inquiry by patients without NHIS, health workers and hospital management on the quality of care provided with the aim of achieving excellence in patients care. This study was therefore generally aimed at assessing non-NHI patients' satisfaction with quality of care and specifically ascertaining their satisfaction with some selected quality of care indices like patient waiting time, patient-staff communication, patient-staff relationship, cost of care, hospital bureaucracy in a primary care clinic in a resource-poor environment of a tertiary hospital in South-Eastern Nigeria.

Subject and Methods

Study design

This was a cross-sectional study carried out on 400 non-NHI patients from April 2011 to October 2011 at the department of Family Medicine of Federal Medical Centre, Umuahia, a tertiary hospital in Umuahia, Abia state, South-Eastern Nigeria.

Study setting

Umuahia is located in Abia state, South-Eastern Nigeria. It is about 2 hours drive to the two commercial cities in the South-East and South-South Nigeria namely Onitsha and Port Harcourt respectively. It is endowed with abundant mineral and agricultural resources with supply of professional, skilled, semi-skilled and unskilled manpower. Economic and social activities are low compared to industrial and commercial cities in Nigeria like Lagos and Port Harcourt in Nigeria. Umuahia metropolis is undergoing rapid industrialization. There has been increasing number of banks, construction companies, hotels, schools and federal government ministries, departments and agencies within the metropolis in recent times.

Federal Medical Centre, Umuahia is located in the metropolitan city of Umuahia, capital of Abia state. It is a tertiary hospital established with the tripartite mandate of service delivery, training and research and serves as a referral center for primary and secondary public health institutions as well as missionary and private hospitals in Abia state and neighboring states of Imo, Ebonyi, Rivers and Akwa Ibom States of Nigeria.

The department of Family Medicine serves as a primary care clinic within the tertiary hospital setting of the Medical Centre. All adult NHIS and non-NHIS patients excluding those who need emergency health care services, pediatric patients and antenatal women are first seen at the Family Medicine clinic where diagnoses are made. Patients who need primary care are managed and followed up in the clinic while those who need specialists care are referred to the respective core specialist clinics for further management. The clinic is run by consultant family physicians and postgraduate resident medical doctors. The relevant and sensitive service windows

of the hospital for the study included medical records, nursing services, revenue collection, laboratory and investigation, and pharmacy services.

Study population and selection criteria

The study population consisted of non-NHI patients who met the inclusion criteria. The inclusion criteria included adult non-NHIS patients aged 18 years and above who gave informed verbal consent and had accessed care at the Family Medicine clinic and specific sensitive and general service windows of the hospital like medical records, nursing services, laboratory and pharmacy services. These patients must have accessed these services all together for at least six visits at different occasions. This would have afforded the patients the opportunity to have passed through all the most relevant and sensitive service windows offered by the hospital. The exclusion criteria included critically ill patients, antenatal patients, pediatric patients, staff and their relations and all the patients used in pretesting of the questionnaire who may be influenced by their previous interaction with the content of the questionnaire.

Sample size and sampling technique

Sample size estimation was determined using the formula^[14] for estimating minimum sample size for descriptive studies when studying proportions with entire population size >10 000. The estimated minimum sample size assuming 50% maximum satisfaction response variability was 384. This minimum sample size was however increased to 400 to improve the precision of the study.

The sample selection was by systematic sampling using every second non-NHIS patient that registered to see the clinicians on each consulting day during the study period and who met the selection criteria. This systematic sampling method does not require prior listing of subjects with particular attributes of sample frame, sample fraction and sample interval.^[14]

Data collection tool and process

Data were collected using pretested, structured interviewer administered questionnaire designed by the authors using information from literature review and previous studies on patients' satisfaction and quality of care.^[6,7,10,11,15] The questionnaire tool contained information on basic demographic variables such as age, sex, marital status, level of education, and occupation. The dimensions of care evaluated included patient waiting time, cost of care, patient-staff relationship, patient-staff communication, hospital bureaucracy and hospital environment. Each satisfaction item was scored on a five points Likert scale as follows: excellent = 5 points, very good = 4 points, good = 3 points, fair = 2 points, and poor = 1 point.

Pretesting of the questionnaire was done internally at the Family Medicine clinic of Federal Medical Centre, Umuahia.

Twenty non-NHIS patients were haphazardly used for the pretesting of the questionnaire which lasted for three days. The pretesting was done to assess the applicability of the questionnaire tool internally. All the patients used for the pretesting of the questionnaire instrument gave valid and reliable responses confirming the clarity and applicability of the questionnaire tool and questions were interpreted with the same meaning as intended. The questionnaire was administered by three resident doctors who were recruited and trained for the study. The questionnaire was administered once to each eligible respondent when the respondent came for follow up clinic visit at the Family Medicine clinic rooms designated for the interview.

Operationalization of terms

Operationally, overall satisfaction was defined by the authors as the average score of 3 points and above in all the domains evaluated while overall dissatisfaction refers to the score of less than 3 points. Specifically, satisfaction refers to the score of 3 points or more in specific domain of care evaluated. Patient-staff relationship refers to the staff attitude including listening and response to questions from the patients while patient-staff communication refers to giving information to the patients after they have explained their problems. Patient waiting time refers to the perception of the service delay by the patient in the area where he/she waited more than expected. Cost of care refers to the price of the hospital services such as consultation, cards, folders, drugs and laboratory tests. Hospital environment refers to the cleanliness of the rooms of the selected service windows of the hospital and surrounding environment of the hospital while hospital bureaucracy refers to the official procedures and processes involved in accessing care ranging from paying for cards, obtaining cards, consultations, investigations and obtaining medications.

Ethical approval

The study was approved by the Ethics Committee of Federal Medical Centre, Umuahia and informed verbal consent was obtained from the participants.

Statistics

The results generated were analyzed using software Statistical Package for Social Sciences (SPSS) version 13.0, Microsoft cooperation, Inc. Chicago, IL, USA for the calculation of mean, frequencies and percentages.

Results

The age of the respondents ranged from 18 to 86 years with mean age of 46.4 (11.3) years. Majority of the respondents were middle-aged adults (40-64 years) (187/400) (46.8%) followed by the elderly (≥ 65 years) (113/400) (28.2%) and then young adult (18-39 years) (100/400) (25.0%). There were 174/400 (43.5%) males and 226/400 (56.5%)

females with male to female ratio of 1:1.3. Majority of the respondents were married (56.8%) (227/400), had secondary education (51.5%) (206/400) and were Abia state public servants (27.2%) (109/400) [Table 1].

Generally, the overall average satisfaction score of the respondents was 3.1. Specifically, the respondents expressed satisfaction with patient-staff relationship which was ranked first and highest with average score of 3.9 for the domain with medical doctors rated highest (4.6) and medical records staff the lowest (3.3). This is followed by patient-staff communication which was ranked second with average score of 3.8 with medical doctors rated highest (4.5) and medical records staff rated the least (3.3) while hospital environment was ranked third with average score of (3.6) with cleanliness of the hospital service windows rated highest (3.7) and hospital ambient the lowest (3.5). Satisfaction with patient waiting time (service delay) was ranked the least with average score of (2.4) for the domain with medical record section rated lowest (1.9). This is followed by hospital bureaucracy which had a satisfaction score of 2.5 and then the cost of medication which had average score of 2.6 for the domain with the cost of medications (2.3) and

the consultation fees (2.8) recording lowest and highest satisfaction scores [Table 2].

The average score obtained by each domain of care evaluated were ranked. Patient-staff relationship had highest score and was ranked first. This was followed by the patient-staff communication while patient waiting time was ranked the least [Table 3].

Table 1: Basic socio-demographic characteristics of the respondents

| Characteristic | Frequency | Percentage |
|---------------------------------|-----------|------------|
| Age (years) | | |
| 18-39 | 100 | 25.0 |
| 40-64 | 187 | 46.8 |
| ≥65 | 113 | 28.2 |
| Total | 400 | 100.0 |
| Sex | | |
| Male | 174 | 43.5 |
| Female | 226 | 56.5 |
| Total | 400 | 100.0 |
| Marital status | | |
| Single | 108 | 27.0 |
| Married | 227 | 56.8 |
| Separated/divorced | 12 | 3.0 |
| Widowed | 53 | 13.2 |
| Total | 400 | 100.0 |
| Educational status | | |
| None | 27 | 6.8 |
| Primary | 68 | 17.0 |
| Secondary | 206 | 51.5 |
| Tertiary | 99 | 24.7 |
| Total | 400 | 100.0 |
| Occupation | | |
| Public servants (Abia state) | 109 | 27.2 |
| Traders | 72 | 18.0 |
| Farmers | 60 | 15.0 |
| Artisans | 55 | 13.8 |
| Students/apprentice/house wives | 49 | 12.2 |
| Retired | 31 | 7.8 |
| Drivers | 24 | 6.0 |
| Total | 400 | 100.0 |

Table 2: Patients satisfaction with selected domain of care in the hospital

| Care parameter | Average score |
|---|---------------|
| Patient-staff relationship (attitude) | |
| Medical doctors | 4.6 |
| Pharmacy staff | 4.0 |
| Nursing staff | 3.9 |
| Laboratory staff | 3.8 |
| Revenue collection staff | 3.5 |
| Medical records staff | 3.3 |
| Average score | 3.9 |
| Patient-staff communication (information) | |
| Medical doctors | 4.5 |
| Nursing staff | 4.1 |
| Pharmacy staff | 3.8 |
| Laboratory staff | 3.8 |
| Revenue collection staff | 3.4 |
| Medical records staff | 3.3 |
| Average score | 3.8 |
| Hospital environment | |
| Service windows | 3.7 |
| Ambient | 3.5 |
| Average score | 3.6 |
| Cost of care | |
| Consultation fees | 2.8 |
| Card/folder fees | 2.6 |
| Laboratory/investigation | 2.6 |
| Medication fees | 2.3 |
| Average score | 2.6 |
| Hospital bureaucracy | 2.5 |
| Waiting time | |
| Medical doctors section | 2.9 |
| Nursing service section | 2.8 |
| Pharmacy section | 2.6 |
| Laboratory/investigation section | 2.3 |
| Revenue collection section | 2.0 |
| Medical records section | 1.9 |
| Average score | 2.4 |
| Overall average satisfaction score | 3.1 |

Table 3: Ranking of the domains of care

| Care parameter | Average score | Rank |
|-----------------------------|---------------|-----------------|
| Patient-staff relationship | 3.9 | 1 st |
| Patient-staff communication | 3.8 | 2 nd |
| Hospital environment | 3.6 | 3 rd |
| Cost of care | 2.6 | 4 th |
| Hospital bureaucracy | 2.5 | 5 th |
| Patient waiting time | 1.9 | 6 th |

Discussion

This study has shown that the overall patients' satisfaction with the quality of care they received was good despite other domains of dissatisfaction. However, studies have shown that users of health facility differ in their satisfaction with the quality of care.^[10,11,16] Although, overall patients satisfaction score in this study was good but it was skewed to the lower end of the satisfaction ordinal scale. This score is lower than the overall satisfaction score of 83% reported in Kano, Northern Nigeria,^[11] 3.4 reported in Eastern Ethiopian study^[16] and excellent rating reported in Trinidad and Tobago.^[17] This finding of overall good satisfaction score could be attributed to the staff-related dynamics such as patient-staff relationship, patient-staff communication, and the hospital environment. In addition, the presence of medical specialists and absence of industrial action by the staff of the hospital when compared with the state-owned general and specialist hospitals are also contributory. Satisfied patients are likely to recommend the hospital to others in the society as it is known that information travels faster and are more believed by patients when coming from their relations than from the health worker who is considered part of the hospital. To improve on the quality of care, the hospital should recognize these dimensions of care with the aim of sustaining and improving them.

The satisfaction of the patients with the staff relationship was good on the ordinal scale. Although, the attitude of the medical doctors were rated highest and this finding is similar to the report from Benin City, Edo state^[18] and is dissimilar to the low rating of patient-provider attitude reported in Ilorin^[19] and Eastern Ethiopia.^[16] The findings of this study could be attributed to the activities of the management of the hospital through its public relations and SERVICOM units which emphasize the display of professional attitude in relating with the patients and their relatives.^[15] It is therefore necessary to sustain and improve on this aspect of patient-staff relationship since reports have shown that good patient-staff relationship improves compliance and adherence to treatment, illness behavior and coping mechanisms and overall quality of life of patients.^[20,21]

This study has demonstrated that patients were satisfied with communication with the staff. This finding is at disparity with low rating of patient-staff communication reported in Ilorin^[19] and Eastern Ethiopia.^[16] This good patient-staff communication in this study helps the patient appreciate the bureaucratic processes and procedures in the hospital. The patient is made familiar with the expectations of what service that is delivered, entitlement to quality service delivery and the recourse when service delivery fails. This is in agreement with the documentation that patient-staff communication results in greater patients' satisfaction.^[19-21] This finding could be attributed to the impact of SERVICOM Charter which is predicated on information which begets communication and professionalism and invariably staff attitude to work and the patients.

The patients were satisfied with the sanitation and cleanliness of the hospital service windows and environment. This finding is similar but lower than the report from Kano, Northern Nigeria where majority (87%) of the respondents were satisfied with the hospital environment,^[11] and in South Trinidad where the rating was very good.^[20] However, the finding of this study was at disparity with finding from Eastern Ethiopia^[16] where the patients were least satisfied with the cleanliness of the health facility. This finding has buttressed the fact that environmental factors may influence perception of quality of care and patients' satisfaction.^[16,17] The finding of this study is expected considering the efforts of the hospital management in upgrading and renovating the existing hospital infrastructure and maintaining clean hospital environment through the efforts of the staff of the department of environment of the hospital in collaboration with Abia State Environmental Sanitation Authority.

The finding of this study has shown that patients were not satisfied with the cost of all the selected essential and highly sensitive services in the hospital. This finding is dissimilar to the report from Kano Northern Nigeria^[11] where majority (73%) of the patients were satisfied with the cost of care. The finding of this study could be a reflection of the socioeconomic characteristics of the people accessing care in the study area. In addition, most of the patients accessing care from the study center must have spent some money at other private and public health facilities, complementary and alternative medicine facilities, patent medicine dealers and vendor outlets, and private medical laboratories before presenting to the medical center for care. More so, the absence of public and private sector national health insurance scheme for these patients and the need for immediate payment of services may make the cost of services seem expensive even if it is comparatively reasonable. Costs of care play a vital role in satisfaction studies as non-NHIS patients who live on a fixed or variable income would most likely be able to predict how much that would be spent on medical care. It is therefore obvious that many potential patients will not attend the hospital due to direct and indirect cost of care while those who attend are likely to afford the cost of care.

This study has shown that patients were not satisfied with the hospital bureaucracy. This is attributed to the officialdom involved in obtaining and paying for hospital goods and services. These bureaucratic procedures could be a reflection of the tertiary hospital as a complex organization with departmentalization of services that allows various cadres of health personnel to contribute to the process of patient care. Specifically, despite these bureaucratic processes, patients were generally satisfied with the quality of care they received in the hospital. These patients will nevertheless continue to patronize this hospital because they can hardly find any other facility in the study area with better quality of care. In addition, the incessant industrial action by hospital staff in the state owned hospitals has led to the interruption and disruption of their

services thereby dissatisfying their patients who probably are prepared to face the bureaucratic processes of care at the study center.

This study has demonstrated that patients were not satisfied with the waiting time at all the selected service windows in the hospital. Although, the actual patient waiting time at the evaluated service windows was not measured quantitatively but patients' perception of the waiting time at the service windows was subjectively and qualitatively assessed. This subjective assessment of the waiting time personalizes the interpretation of the waiting time and its consequences.^[22] Dissatisfaction with waiting time by patients has been reported in Kano, northern Nigeria,^[11] Benin City, Edo state,^[18] Ibadan,^[22] and Eastern Ethiopia.^[16] The long waiting time in the clinic and the service windows could be attributed to the growing number of patients accessing care in the hospital. This hospital as a tertiary center received patients who could have been attended to at the primary and secondary levels of care and this is compounded by the near moribund state of Abia state owned hospitals. In addition, the location of the hospital strategically in Umuahia municipal has led to easy access and rapid influx of patients from within and outside the state leading to the increase in patient load. Furthermore, the clinic appointment system used in advanced countries is yet to work in the hospital despite its introduction. This has led to patients coming to the hospital long before opening hours and waiting for long hours before accessing care in the hospital. Although, patient waiting times are inevitable in a bureaucratic organization such as tertiary hospitals but their reduction should be an important social marketing strategy in a milieu of competitive health care delivery. Time is money, so says an adage. Time is therefore a scarce resource which should not be wasted. Efforts should therefore be made to make the clinical and supporting services in the hospital timelier because patients that wait too long may not come back.^[23]

Study implications

Patients are the primary consumers and beneficiaries of health services provided in tertiary hospitals. In a period of fiscal constraints and health sector reforms, patients globally are demanding greater quality on the health services they receive. Measuring quality of care from patients' satisfaction concept will assist in planning how to promote change and how to overcome barriers to positive changes in the process and outcome of care. Improvement in the quality of care is unlikely unless government, hospital managers and other stakeholders especially the staff help create the feedback necessary to ensure improved quality of care. To support and sustain these critical care elements, hospitals must continually and periodically assess their quality of care in order to ensure that the health care consumers are satisfied.

Study limitations

The limitations of this study are recognized by the authors. First and foremost, the sample for the study was drawn from

general outpatients' clinic of the hospital. Hence, the findings of this study may not be general conclusions regarding other outpatient clinics, in-patients, and emergency room patients. However, this study gave some useful insight into the magnitude of the patients' satisfaction since these outpatients clinics, in-patients, and emergency room patients utilize the same sensitive and supporting services at the medical records, pharmacy, laboratory, and revenue collection units of the hospital. This study, therefore, provides useful baseline information for consultation and comparative purposes. Second, the study was based on interview method and may be prone to information bias on satisfaction by the respondents since some respondents could not clinically and socially give acceptable and true responses in questions related to satisfaction with quality of care. However, their effects were minimized by structuring the questions as well as assuring the respondents of confidentiality prior to the conduct of the interview. Furthermore, the questionnaire was pretested internally for clarity and acceptability. Although, the language used in the questionnaire was English language but Igbo language was used to explain verbally to the patients who could not understand English language adequately. This limitation of misinterpreting the questionnaire was recognized by the researchers, though pretesting of the questionnaire did not reveal language bias. However, their effects were minimized by training the researchers and research assistants on the Igbo translation of the questionnaire.

Conclusion

The overall non-NHI patient's satisfaction with the services provided was good. The hospital should set targets for quality improvement in the current domains of satisfaction while the cost of care has implications for government intervention as it mirrors the need to make NHI universal for all Nigerians irrespective of the employment status.

Further researches are suggested to determine the effect of socioeconomic and demographic variables on satisfaction with quality of care and comparison of satisfaction with quality of care between NHIS and non-NHIS patients in the hospital.

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