

**SOCIO-ECONOMIC FACTORS INFLUENCING IN-PATIENT SATISFACTION WITH HEALTH CARE AT THE UNIVERSITY OF BENIN TEACHING HOSPITAL (UBTH), BENIN CITY, NIGERIA**

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**ABSTRACT:** *Previous studies have focused largely on waiting time, cost of treatment and not much has been documented on in-patient outcome of health care seeking in a tertiary institutions from the point of view of the patient themselves. This study, investigates the socio-economic factors that determine in-patient satisfaction with care at the University of Benin Teaching Hospital (UBTH), Benin City, Nigeria. The Sick Role Model, and Social Action theories guided the study and the research design was cross-sectional survey. A Multistage sampling technique was used to select 420 respondents from the five units of the hospital. A semi-structured questionnaire was used to obtain relevant information from the respondents. Fifteen In-depth interviews (IDIs) were also conducted. Quantitative data were analysed using descriptive statistics and Chi-square while the qualitative data were content analysed. Findings show that, 61.4% were female, 70.0% were married, 42.0% had secondary school education, and 90% were Christians. Ninety-five percent indicated moderate level of satisfaction from the use of health care. Forty-seven percent indicated that economic constraint has influence on their use and satisfaction with the health care provided. Also, cultural beliefs, recipients' age, spousal roles, access to multiple doctors, and staff-patient relationship, health education, income and occupation influenced their satisfaction. It is recommended that socio-economic factors as they affect outcome of in-patients' and utilization of the available health care services be integrated into their medical services in the hospital organization providing health care services especially in teaching hospital. It is important for health care professionals to give consideration to cultural beliefs and economic issues of recipients who are seeking health care in the teaching hospital.*

**KEYWORDS:** Cultural Beliefs, Income, In-Patient Satisfaction, Health Care,

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## **INTRODUCTION**

From time immemorial the peoples' expectations and desires to receive health care in a way that gives them satisfaction with the issues of health care remains an important course of action at all times when faced with illness management. Patient satisfaction is an increasingly important issue both in evaluation and in the shaping of health care services for any Nation. Patient satisfaction generally refers to the fulfillment of patient's desires and expectations from healthcare interaction (Mylod & Kaldenberg, 2000) Patients who are satisfied with health care services from health facilities generally behave differently from those who are dissatisfied especially in the developing countries (Wilson, McNamara, 1982; Linn, Linn, Stein 1982). However, there are indications that services provided at public health facilities are generally perceived by the members of the public as being very poor (Afolabi and Erhun 2003). Patients' expectations and desires to receive health care in a way that gives them satisfaction with the health care in the tertiary hospitals have received negligible attention. Only few studies have

been conducted so far on in-patient satisfaction in the tertiary hospitals in Nigeria. Illiyasu, Abubakar, Abubakar, Lawani, and Gajida (2010) did a cross-sectional study on Patient satisfaction with services obtained at the Aminu-Kano Teaching Hospital in Kano, Northern Nigeria. The study focused mainly on waiting time, cost of treatment including course of treatment. However not much has been documented in the area of patient satisfaction with health care services as it relates with socio-economic factors on the Levels of satisfaction as outcome of health care utilization in the tertiary hospital in Edo State, Nigeria from the point of view of the patients themselves.

Several factors have been implicated in the utilization and outcome of health care services. Available reports reveal that patients' satisfaction is associated with physician's advice and treatment, explanation provided and their listening abilities. Black, and Gruen (2009) identifies among others, factors that influence people's choice of care options in hospitals to include social cost, availability of care options, economics, beliefs and referral mechanisms.

In African society and in Nigeria, the belief system influences the views and opinions of causation and cure of diseases and illness and invariably satisfaction with health care services. According to Oke (2002) illness is commonly believed to be due to evil mechanisation of witches, sorcerers, deities and ancestors. These views, opinions and beliefs influence utilisation and continuity with health care in tertiary hospital. The meaning of illness is not clear-cut because of the immense diversity of meaning and actions that occur in response to similar experience of symptoms. The traditional opinion of man as to the etiology of disease is very comprehensive. Owumi (1989) observes that the etiology of a disease especially as it incorporates the orthodox definition which has a great implication on the management of illness in the hospital and patient not having his expectations met in teaching hospital. Outside of the teaching hospital, the definition of disease is based on assessment confined within social values and norms of the people before hospitalisation. But in the teaching hospital setting, the diagnosis is based on history obtained from a patient, physical observation/examination of the nude body, clinical investigation, laboratory test, availability of result, closely followed by administration of treatment prescribed with various routes of administration.

In certain cultures in African community, the traditional or folk doctors are relied upon in preference to medical practitioners. This is perhaps so because of the subjective interpretation and understanding of illness. This differs in response and recognition according to ethnic differences, socio ecological condition and even education of the people (Igun, 1994).

In Nigerians, the socio-economic and living condition of many and how it impacts on assessment of outcome of health care use cannot be overemphasized. Nwokocha (2004) summed up the living condition as precarious socio-economic condition in which the Nigerian workers find themselves. According to him, this is attributed to a number of factors including poverty, general insecurity and poor political leadership.

Review of previous studies in literatures show that socio-economic factors influence the use of health care services (Dutton, 1978; Mechanic, 1978; Owumi, 1989, Jegede, 1998). Differences between income group with regards to where people seek care are obvious and consistent (Dutton, 1978 and Cockerham, 1992). Cockerham (1992) argues that people with higher income are more likely than those with lower income to have received medical service especially in private doctor's office and group practice or over the telephone. National Centre for Health Statistics (NCHS) (1991) reports that people with lower income are more likely to contact hospital out-patient or Emergency room. Although people of all income groups are

seen to use each source; private and public health care system, a clear pattern emerges of a dual health care system:- a private system with a greater proportion of the higher income groups and a public system with a preponderance of lower income groups. Cockerham (1992) notes that a patient in the public system is likely to receive less quality medical care, spend longer period in the waiting room and cope with more bureaucratic agencies. Similarly, studies on occupational status (Dairo & Owoyoku, 2010), households' income (Iyaniwura & Yussuf, 2009) and demographic factors (Obemeyen, 1993) have proven to be strong predator of women likelihood of using reproductive health services. Generally, economic factors cannot be separated from societal values, for example, a mother's economic status and the father's economic status form important societal values which invariably influence the use and satisfaction with health care services. A mother's economic status makes her submissive to her husband who is traditionally or culturally regarded as the bread winner. In a study of the Ika people of Delta State, Jegede (2010) reported that even with free immunisation services, mothers still need to obtain permission from their husbands before taking their children for immunisation in a patriarchal society where the men's cultural domination is jealously guarded. The decision to use modern healthcare services in the teaching hospital is still an issue in many families.

The corporate existence of Africa society sometimes removes the burden of treatment cost from women, even when there is no husband. The husbands to a large extent are more economically viable. In the Ekiti village study of Orubuloye, and Caldwell (1975) findings show that men played a greater role than one might find meeting the cost in over half of the identified treatment for their children and wives. Evidence from this village is that men usually earn more than women, largely because of their control of land.

Jegede (2010) observes that user' charges are another factor that discourages people from using health facilities. Over the years, this has been one of the advantages of traditional medicine over modern medicine. While in traditional medicine, the charges are very moderate and low in most cases. Users have access to no-credit facilities but in the modern medicine the reverse is the case; charges usually follow standardised rates or government in charge of such health facility (Owumi, 1989; Jegede, 2010).

Socio-cultural factors influence the way in which illness is interpreted, perceived and responded to. In the same vein, age, sex, ethnicity and socioeconomic status influence the use of health care services (Erinosho, 2005). In Sauerborn, Adams, and Hien (1996) on the strategies adopted for coping with the cost of utilising healthcare services, different coping strategies were identified which include the use of cash and previous savings, sales of assets, free care and gift. They note that some individuals sold their livestock as a main coping strategy in order to be able to settle the cost of healthcare. They equally observed that the individual abilities within the population studied varied from group to group. Thus the ability to afford and utilise health care services is likely to depend on the conditions of the social and economic environment of an individual in the society. Review of literature also shows that socio-cultural factors influence the use and consequently, patient satisfaction with health care services. Oke (2012) observes that there is inextricable association between socio-cultural/economic factors and the use and non-use of health services.

As Benjamin and Miller (1955) have pointed out:

The habits and beliefs of the people in a given community are not separate items in a series but elements

of cultural systems. The elements are not all equally integrated some are central to the system, other peripheral. Hence, some cultural elements can be altered or replaced with little efforts, others only apply great force.

Benjamin and Miller (1955) cited in Amadasun (1987) suggested that, for the health services to be improved upon and utilisation of available health resources to become meaningful and satisfying to any given community like the Edo people, efforts should be made to evolve a health policy based on mutual understanding between health care providers armed with Western thoughts and the people (in-patients) armed with their traditional and cultural/beliefs since they are expected to be the beneficiary of such services. Hence its main objective was to investigate the influence of socio-economic factors on patient satisfaction with health care services in the teaching hospital Benin City, Nigeria with a view to integrating into the medical services in the hospital organization providing health care services socio-economic and cultural factors especially in teaching hospital.

### **Theoretical Framework**

Sick role and social action theories provided the theoretical guide for explaining outcome of the use of health care in terms of patient satisfaction with health care services. The combination of perspectives, assumes that people have abilities and are capable of subjective evaluation. Talcott Parsons advanced Sick role model which emphasis the social dimension of illness (sick role) and social expectations.

In applying the theory to the users of health care services and in the role of patients, the individual who is sick (patient) and members of the public also, enter into a social relationship with the medical and health professionals-(the doctors and nurses). Thus the application sees the pattern of behavior characteristics of the sick persons during illness management such as willingness to use and continue with the use of tertiary health care services, the assessment or evaluation of health care received and readiness to recommend to other people as determined within the context of social and cultural norms, beliefs and values of the people. Owumi, (2012) noted that there is an inextricable relationship between socio-economic and socio-cultural factors in the use and non-use of health care services in illness management.

A major expectation concerning the sick individual in our society particularly in Nigeria is to seek health care services and advice and also co-operate with the professionals. According to Parsons, patients, doctor and nurses are acting out prescribed roles.

According to the theory, the role of the sick person is deemed to be undesirable; patients are expected to want to get better, to voluntarily seek professional health advice and cooperate fully with the doctor. By engaging in illness management, with the behavior of acceptance and cooperation in using the health care services s/he becomes involved with the role of the professional Doctor/Nurse in a complementary but asymmetrical role relationship as one of compliance with expected norms.

The roles of the patients/doctor or patient/nurse are also characterized by rights and expectations. Doctors/Nurses are expected to use their skills and expertise for the benefits of their patients. In the performance of their duties they have the right to conduct physical examinations and ask patients question about their physical health and personal circumstance.

Health care services (Hospital Services) in the teaching hospitals are oriented towards a supportive/creative notion of patient welfare. The sick or injured persons, following admission into the different wards are organized into various patient categories namely (emergency, medical, surgery, ophthalmic, hematology, neurology, orthopedics, urology, pediatrics, maternity/obstetrics and gynecology and psychiatrics). Thus this organization reflects the medical staff definition of their illnesses.

Max Weber proposed the use of subjective method as a means of understanding causal relationship behind action and reactions. According to Weber, Social action is an action which takes place when the acting individual attaches a subjective meaning to it (Haralambos and Holborn 2008; Olutayo and Akanle 2013). The theory is based on the understanding that the social exchange of action is only possible when interpretative understanding takes place, which of course, occurs when the parties involved ascribe meaning to each other's action. This implies that a patient will take health related action such as cooperation and acceptance of health related instructions in interactions with doctors, undressing for physical examination, acceptance of drugs/treatment administered and the food served in the context of present analysis, when the patient understand the action of the health professionals by interpreting the action provision of care services) and attaching meaning. Their interpretation, subjective meaning and understanding of action produce a willingness to continue to reuse or discontinue with using the hospital as outcome of their subjective evaluation. The patient/care givers ascribe meaning to the different activities of care provisions by the medical and health care professionals which were oriented to bring about better health in the patient's life who is admitted into the hospital. Weber believed that the set of ultimate ends for which actor could strive was potentially infinite. Human beings act to achieve goals in situations to solve problems that confront them at any time.

The position of this Social Action theory which focuses on the individual's subjective assessment/evaluation of the outcome of health care especially with regards to using health care services in the tertiary teaching hospital is that through interpretative understanding, meaning and subjective judgment in human action social order and survival and maintenance of the society would be achieved. Their cooperation with doctors/nurses (interpersonal relationship) and compliance with treatment regimen are all subjective actions. In the same way, actions taken by the healthcare providers are forms of rational actions by a segment of the society and are all undertaken in accordance with shared value and normative dictates (Isiugo-Abanihe, 2002). Weber's social action theory tends to suggest that human actions can be explained as subjective behavior. Thus the patient, following the use the facility may express satisfaction with the health care services received from the professionals therein in their designated service areas as they contribute to patient care.

## **MATERIALS AND METHOD**

The University of Benin Teaching Hospital is strategically located on a large expanse of land (a 150-acre site) in Benin City and along the Benin Lagos Highway in Edo State. It is a Federal Tertiary Teaching Hospital with highly qualified professional health team members and state-of-the-art facilities provided by the federal government. It is one of the centres of excellence in health care delivery in Nigeria.



## Research Design

This study was exploratory and cross-sectional in design. The focus of this study was on all the patients admitted into the University of Benin Teaching Hospital (UBTH), Benin-City.

## Study population

The study population comprised all in-patients admitted into the teaching hospital. This population is spread into five units/categories/wards according to the classification of illness types organization in the hospital and this consisted of 26 wards and categorized into Units (1) Medical unit (2) Surgical unit (3) Obstetric and Gynaecological unit (4) Paediatric unit and (5) Emergency unit. The bed occupancy is a total of 578. The inclusion of both adult male and female patients was confined to those admitted into the wards for not less than forty-eight hours and well oriented to time, place and person in-patients who are conscious. Relations/care givers were allowed to stand proxy in the paediatric Unit because they were equipped with relevant information. Also only in-patients who gave their consent were included. In-patients who have received care for less than forty-eight hours, those who are unconscious and those patients who refuse to give their consent to participate in the study were excluded.

## Research Instrument

The research instrument for the study comprised of questionnaire and in-depth interviews (IDIS) guide in order to compensate for the weakness of the other. Robust information was generated from the assessment of the outcome of health care services received as well as their expectations about the service.

## Sample Size

The calculated sample size was 420 after giving consideration to attrition using Lemeshow et al., (2006) formula for estimating minimum sample size in descriptive health studies and also findings from a previous studies for a population survey with 95% confidence interval.

$$n = Z^2 \frac{P(1 - P)}{E^2}$$

Where n= sample

z= standard normal score corresponding to 95% confidence level=1.96

P= the estimated proportion of the factor to be studied (or P= the prevalence rate of medical research studies) assumed 50%

E= Sampling error that can be tolerated 5%

Z= 1.96, P=0.5 or 50%, E= 0.05, n=456, N=587 = Total bed complement in the hospital.

The estimated minimum sample size assuming 50% maximum satisfaction response variability is 384.16 and giving consideration to attrition this was increased by 10% = 38.416

## Sampling technique

A Multistage sampling technique was used to select the respondents from the five units of the hospital. The first stage of the selection commenced with purposive selection of the wards providing different care: medical care; surgical care; obstetric and gynecological and ante-natal care, pediatrics care and emergency care were purposively selected. Next, was the systematic selection which involved proportionate selection in percentage of respondents across the units providing variety of health care. The proportion in percentages in the different units were as follows: medical care; 86 (20 percentage), surgical care; 86 (20 percentage) pediatrics care ; 89 (21 percentage), obstetric and gynecological; 87(20 percentage), and emergency care;74(19 percentage) respectively to each unit stated above). The final selection involved simple random selection using balloting for those who took part in the study.

## Data Collection

Data for the study was collected through a combination of qualitative and quantitative methods. The independent variables were built around such factors as: Place of resident, age, sex, income, marital status, level of education, knowledge of socioeconomic issues.

*socio-economic factors* – refers to in-patients' socio-economic status on the basis of the individual's occupation, income, and level of education attainment that derives from a feeling of wellbeing while *socio-cultural factors* — refers to occupation, level of education and beliefs about health care services and also values that are related to health care use. Dependent variable is a discrete indicator of patient satisfaction.

1. Fieldwork for the study began with the qualitative aspect of the research which provided important insight for the investigation of the study area. This was significant and was done to facilitate the design of the questionnaire. For the quantitative data, a cross-section of the inpatients were selected as respondents using a multi-stage sampling technique. In all, 420 questionnaire were administered. Structured questionnaire was used which consisted of both open ended and close-ended questions of elicit important information. It addressed the socio-demographic characteristics of the respondents and their experiences with the use of health care services in a teaching hospital setting.

Specifically, qualitative data for the study was elicited through in-depth interviews (IDIs), in-depth interviews (IDIs) were undertaken using interview guide which ensured appropriate discussions following the specific objectives of the study and were transcribed.

## Data Analysis

Analyses were carried out at different levels. The data generated through the questionnaire were analysed at the univariate and bivariate levels. At the univariate level demographic characteristics of the respondents were described using largely descriptive statistics such as frequencies and percentages. Bivariate analysis examined the relationships among variables. The resulting qualitative data were content analysed.

## Ethical Permission

The international standard ethics for research was strictly adhered to in this study. Ethical approval was sort and approval was given by the ethical committee of the University of Benin Teaching Hospital to conduct the study. This was preceded by thorough explanation of the aim

and objective of the study. Participation was based on informed and voluntary consent. Respondents for the study were informed of their right to withdraw from the study at any time they deemed necessary. They were fully assured of their confidentiality and anonymity. Throughout the field work, ethical consideration was emphasized. The questionnaire that was administered to the in-patients was prefaced with a consent form requesting consent of the respondents before participation in the study.

## RESULTS

The sex distribution of the respondents indicates that the male respondents constituted 38.6 percent of the respondents while the female constituted 61.4 percent of in-patients on admission at the time of the study. More than 80% of the in-patients were under the age of 50 years. The findings suggest that most in-patients receiving health care services are in their biological and social reproductive phases of life.

The attributes of the in-patients concerning level of education reveal that only 6.7% had no formal education, while 22.3% had primary school education and 42.4% had post primary/secondary school education. There were 28.6% of the respondents that possessed post-secondary education (tertiary) (e.g. colleges, polytechnic and university degrees and other additional qualifications).

Data on distribution of the respondents by occupation indicate that civil servants make up to 16.4% while self-employed make up 44.0% which is the highest proportion and clergy men and women made up 0.7%, housewife make up 8.8%. Findings show that 9.0% were college/university teachers or lecturers. Additionally, 21.0% of the respondents were unemployed. The personal monthly income distribution of respondents shows that more than half of the respondents (54.5 percent) had less than ₦20,000.00 monthly income, also 17.6percent had ₦20,001.00-40,000.00 and 10.2 percent had ₦40,001.00-60,000.00. Other monthly income of respondents shows that only 6.0 percent had ₦60,000.00-800,000.00, while 3.8 percent had ₦80,001.00-100,000.00 and 7.9% above ₦100,000.00. The findings on personal income show that most of the responds (82.3 percent) earned less than ₦60,000 monthly and only 17.7% earned above ₦60,000. Critically speaking, income determines many things in human's life. It defines the quality of life and life chances.

Multivariate results

## DISCUSSION

In Nigeria like many other developing countries, the socio-economic and socio-cultural factors influence the outcome of the use of the teaching tertiary hospital. Therefore this paper investigated the socio-economic factors that influence with the outcome of the use of the teaching tertiary hospital in terms of in-patient satisfaction.

Socio-economic and socio-cultural factors associated with in-patient satisfaction have been investigated including; revealed to play important role in the healing process of in-patients. From the univariate analysis, it was identified that age, level of education, income and occupation were the factors that ensured that in-patients received emotional bond, attachment



and care from their family members and friends. This transformed into positive outcome for in-patients as they were able to develop hope to get well as quickly as possible. Findings indicate that there were 61.4 percent female and only 38.4% of male respondents. There were differences in the proportion of males and females respondents. The preponderance of female could be attributed to health challenges related to maternal issues which tend to affect females' utilization of health care services. This finding supports the views of Jegede, 2010; Otite & Ogionwo, 2006 that more women than men in Nigeria engage in the utilization of hospital services for themselves and other members of the family especially the care of the young ones within the family setting.

The findings of this study on the relationship between socio-economic factors and the outcome of the use of the teaching tertiary hospital are in line with the outcome of use health care facility in the study by Jegede, 1989; That more than 80% of the in-patients were under the age of 50 years suggest that most in-patients receiving health care services are in their biological and social reproductive phases of life. The finding also corroborates the views that majority of health care users in both developed and the developing countries are in their reproductive phases of life (Iliyasu et al.; Japipaul & Rosenthal, 2003). Only 3.3% of the respondents aged 60 and above patronised the services of the teaching hospital. This may have some socioeconomic undertones. It could be inferred from the age distribution of the in-patients that participated in the study above that were concentrated in the biological reproductive age of life.

The attributes of the in-patients concerning level of education reveal that only 6.7% had no formal education, while 22.3% had primary school education and 42.4% had post primary/secondary school education. There were 28.6% of the respondents that possessed post-secondary education (tertiary) (e.g. colleges, polytechnic and university degrees and other additional qualifications).

On the basis of the distribution, it can be inferred that majority of the respondents possessed academic qualifications of different categories which had influence on the patronage of tertiary health care services. This finding upholds Iliyasu *et al.*, (2010) that the majority of the users of the tertiary health care services possessed both secondary and tertiary levels of education. It can be surmised on the basis of the findings that the in-patients are largely literate as only few respondents had no primary education.

Data on distribution of the respondents by occupation indicates that civil servants make up to 16.4% while self-employed make up 44.0% which is the highest proportion and clergy men and women made up 0.7%, housewife make up 8.8%. Findings show that 9.0% were college/university teachers or lecturers. Critically speaking, 21.0% of the respondents were unemployed. This suggests that they have no regular or source of income. This may as well affect the nature and outcome of health care services they received.

Access to desirable health care services and its utilization is one of the life chances people desire. It appears that few people especially in the context of the study area may not have such advantage because of the income earned on monthly basics. Looking at income reported by respondents especially in Nigeria context the standard and cost of living, it can be stated that most respondents were on low income, although they could still utilise health care services available in a tertiary hospital. Majority of the people were of limited means of income. It is expected that this will in one way or the other have influence on outcome of use. It could be inferred from the income distribution above that most respondent that participated in this study were people of limited means of income. It is expected that this will in one way or the other

have influence on outcome of use. This could be that patients in the study area get donors and philanthropists to offset their medical bills. Limited means of income is a challenge as well as access to health care facilities.

Multiple regressions shows predisposing factor of in-patient satisfaction with health services in the teaching hospital. There is a significant linear relationship between the criterion variable of sex and the following predictor variables age, income, marital status, level of education, knowledge of socio-economic issues, *socio-economic factors*—the individual's occupation, income, and level of education attainment. Hence in-patient's age, and others are predisposing factors that can influence their satisfaction with health care services. Hence the individual inpatient's occupation, income, and level of education attainment are the predisposing factors that influence use and satisfaction outcome with health care services. The level of income on the treatment use behaviour of health care seekers has been explained by Igun, 2009. According to him, users of health care commonly display their understandings and explain their behaviours in response to illness management in terms of available income. He affirms that the popular economic interpretations of their access and use of the teaching hospitals by the low socioeconomic class in the society portends danger to member of the family and invariably the health care sector of the economy. Recent findings suggest that the socio-economic status of different households which is determined by the occupation of the households' heads is very important in determining the outcome of health care use for illness management particularly in the teaching hospital.

Examination of the relationship between respondents' locations and their satisfaction with health care services shows that the in-patients do not just attend and use the health care services of the teaching hospital facility in vain but have expectations and with the realisation of their expectations they express their associated feelings of satisfaction with the health care services. It also indicates that there is no consistent relationship between the dependent and independent variables.

However, majority of the respondents (81.4%) from urban and 18.6% from rural areas expressed moderate satisfaction with health care services. This variation also occurs for high and low satisfaction with health care services in urban and rural area settings.

The implication is that satisfaction with western medical services is enormous in urban setting than it appears to be in rural area. The reason for this is not unconnected with the fact that in rural area, cultural beliefs give much credence to traditional method of herbal medicine which people are attached to in the cure of illness (Owumi, 1989; Erinosh, 2005). Therefore utilization of hospitals in most cases in the rural areas is perceived as secondary and ancillary health services. This finding upholds Erinosh,(2005) that the majority of the users of the tertiary health care services have the belief that traditional methods of herbal medicine which people attached to cure of illness is important (Erinosh, 2005). Findings reveals that although the (Chi-square 1.503 P<0.826) was not significant, those who had high knowledge 94.0% and were aware of health care services achieved higher levels of satisfaction. Thus, the cross-tabulation Chi-square=1.503 P-value=0.826 shows that level of education has no significant association (P<0.05) with level of satisfaction with health care service.

On whether respondents' level of satisfaction achieved had any relationship with marital status, it is evident that there is a strong association between respondents' marital status and level of satisfaction achieved and also shows that there is a statistically significant relationship. The cross-tabulation Chi-square=14.006, P-value = 0.030 shows that marital status has significant

association ( $P < 0.05$ ) with the level of satisfaction with health care services. This may be explained by many episodes of contacts of married persons with health care providers either during pregnancy or child care. This suggests that level of satisfaction with health care service is contingent on marital status. This supports the findings of Owumi, 1989 and Alluyi, and Oduwole, 2005, that health care provision during the reproductive phase of married women has significant relationship with the outcome of care received. Specifically, the findings revealed that married respondents compared to singles who reported high levels of satisfaction achieved with health care services received. Meanwhile, the table shows that occupation, sex and age are not statistically significant as shown in relationship between levels of satisfaction achieved with health care services from health care services received and sex, age, income, educational attainment and occupation at ( $P > 0.05$ ). This implies that levels of satisfaction achieved with health care services from health care services received is not contingent on sex, marital status, income, education attainment and occupation.

## CONCLUSION

The main purpose of the study was to investigate socio-economic factors that influence in-patient satisfaction with health care use at the UBTH Benin City, Nigeria.

This study has shown and observed that several socio-economic factors play important role in healing process of in-patients during the period of utilization for illness management in a teaching hospital. These factors also ensured that in-patients received emotional bond, attachment and care from their family members and friends. This transformed into positive outcome for the in-patients as they were able to develop hope to get well as quickly as possible. The main purpose of the study was to investigate socio-economic factors that influence in-patient satisfaction with health care use at the UBTH Benin City, Nigeria.

## RECOMMENDATION

The recommendation here is that every hospital organization providing health care services especially in teaching hospital like UBTH should integrate into their medical services socio-cultural factors as they affect outcome of in-patients' and out-patients' utilization of the available health care services. Attention should be to be given to socio-cultural factors which significantly affect in-patient satisfaction with health care services. This suggests that tradition, beliefs, kith and kin of patients should not be taken for granted during process of health care delivery.

**TABLE 1: Gender distribution of Respondents**

SEX	Frequency N=420	Percent
Male	162	38.6

Table 1 below shows that 38.6 of the respondents were male while 61.4 female.

**TABLE 2: Respondents distribution based on Marital Status**

MARITAL STATUS		
Single (unmarried)	90	21.4
Cohabiting	8	1.9
Married	293	69.8
Separated	11	2.6
Divorced	5	1.2
Widowed	13	3.1

Table 2 shows

**TABLE 3: Respondents distribution based on Age**

AGE RANGE		
20-29	161	38.4
30-39	129	30.7
40-49	59	14.0
50-59	57	13.6
60 and above	14	3.3

**TABLE 4 : Respondents distribution based on Marital Status**

EDUCATION	Frequency	Percent
No formal education	28	6.7
Primary school	94	22.3
Post primary	178	42.4
Tertiary	120	28.6

**TABLE 5: Respondents distribution based on Occupation**

OCCUPATION		
Unemployed	86	21.5
Civil servant	69	
Housewife	37	
Self employed	185	16.4
Traditional rulers	3	8.8
Teacher/lecturer	2	44.0

**TABLE 6: Respondents distribution based on Marital Status Occupation**

RELIGIOUS AFFILIATION		
African traditional religion	7	1.7
Islam	8	1.9
Christianity	405	96.4

**TABLE 7: Respondents distribution based on Personal Monthly Income**

PERSONAL MONTHLY INCOME (IN NAIRA)		
Less than ₦20,000	229	54.5
₦20,001- 40,000	74	17.6
₦40,001- 60,000	43	10.2
₦60,001- 80,000	25	6.0
₦80,001 and above	49	11.7

**Table 8 Respondents' Level of Satisfaction Achieved by Socio-Economic Factors N= 420**

Table 8 presents summary information on the significant differences of association between

Socio-economic factors	Level of satisfaction achieved				X <sup>2</sup>	Df	P
	Low	Moderate	High	Total			
<b>Sex</b>					<b>2.392</b>		<b>0.122</b>
Male	11(2.6%)	151(35.95%)	--	162(38.57%)			
Female	9(2.1%)	249(59.28%)	--	258(61.42%)			
<b>Total</b>	<b>20(4.76%)</b>	<b>400(95.23%)</b>		<b>420 (100%)</b>			
<b>Marital status</b>					14.006		0.030 sig
Single (unmarried)	10(2.4%)	80(19.4%)	--	90(21.42%)			
Married	9(2.1%)	284(67.6%)	--	293(69.76%)			
Separated/Divorced	--	15(3.60%)	--	11(2.65%)			
Widow/Widower	19(4.5%)	13(3.09%)	--	13(3.09%)			
<b>Total</b>	<b>38 (9.0%)</b>	<b>392(93.3%)</b>		<b>420 (100.0%)</b>			
<b>Education</b>					1.503		0.826 not significant
No formal education	2(%)	26(6.2%)	--	28(6.7%)			
Primary school	3(%)	91(21.7%)	--	94(22.4%)			
Post primary	8(%)	170(40.5%)	--	178(42.4%)			
Tertiary	7(6.0%)	113(26.9%)	--	120(28.6%)			
<b>Total</b>	<b>20(4.8%)</b>	<b>400 (95.2%)</b>		<b>420 (100.0%)</b>			
<b>Occupation</b>					3.929		0.686 n/sig
Unemployed	6(1.4%)	80(19.0%)	--	86(20.4%)			
Civil servant	4(1.0%)	65(15.5%)	--	69(16.5%)			
Housewife	2(0.5%)	35(8.3%)	--	37(8.8%)			
Self-employed	5(1.2%)	180(42.9%)	--	185(44.1%)			
Traditional rulers	--	5(1.2%)	--	3(1.2%)			
Teacher/lecturer	3(0.7%)	35(8.3%)	--	38(9.0%)			

Levels of satisfaction achieved and socioeconomic variables. On whether respondents level of



MONTHLY INCOME					7.219		0.205
Less than N20,000	11(2.6%)	218(51.9)	--	229(54.5%)			
N20,001- 40,000	1(0.2%)	73(17.4%)	--	74(17.6%)			
N40,001- 60,000	2(0.5%)	41(9.8)	--	43(10.2%)			
N60,001- 80,000	2(0.5%)	23(5.5%)	--	25(6.0%)			
		1					

satisfaction achieved from health care services have relationship with educational attainment with high level of education,

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