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Assessment of the Health Care Hassles in Patients with Long-Term Morbidity Seeking Care at a Tertiary Hospital in Nigeria

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Abstract
Background: *Patients with long-term conditions(LTCs) could face major challenges while using available healthcare. This study assessed health care system hassles encountered by patients with LTCs who accessed care at a tertiary hospital.*
Methods: *This descriptive, cross-sectional, study involved 500 patients with long-term communicable and non-communicable conditions, who seek regular care at the specialist outpatient clinic. Respondents were selected by stratified random sampling and administered the 16-item Perchman's hassles scale with each item coded on a 4-point response scale which was transformed to metrics of 0 to 100. Descriptive and inferential analyses were done using SPSS version 22 and P-values <0.05 were considered significant.*
Results: *Response rate was 89.2% and scale showed high internal consistency with a Cronbach's alpha of 0.88. More of the respondents were aged 40 – 60 years (46.6%), female (54.5%), married (62.1%), in paid employment (75.8%) ,visiting for non-communicable LTCs (65.2%). The most severe hassles interference of medical appointments with patients' usual work (68.9), side effects of medications (67.7) and long waiting time for laboratory investigations (61.1).The least were attitude of health workers to patients' concerns (25.7) and uncertainty about how medications should be taken (29.1). Patients' with better perceived health status, shorter length of treatment for LTC, single long-term morbidity and those on free treatment fared significantly better.*
Conclusion: *The findings on the key healthcare hassles faced by patients with LTC calls for the redesign of the healthcare system to ameliorate the difficulties faced by patients with LTC.*
Keywords: *Long-term morbidities, health care hassles, communicable diseases, non-communicable diseases, UPTH.*

Introduction

There has been a profound change in the pattern of illness and the perception of what healthcare should be over the years. Rather than sticking to the single disease framework on which many healthcare services are configured, people are now commonly faced with multiple long-term conditions (LTCs) which could accompany sufferers over a number of years[1]. It is now common knowledge that care for people with multi morbidity demands a completely different approach to that which served as the basis for the design of most health systems and traditional working processes[1].

Long-term morbidity is a major challenge facing the global health economy. The World Health Organization estimates that non-communicable diseases which are often long-term in nature, account for more than 60% of deaths worldwide[1]. Although in the time past, long-term morbidity is believed to comprise only non-communicable, communicable diseases like HIV/AIDS and tuberculosis have also become long-term illness because new drugs used now to manage them could sustain the patients for year.

Non-communicable LTCs imposes a large health, financial and economic burden on nations' health systems and households (Anderson I). Besides

accounting for a preponderance of appointments which could be up to 50% of GP Appointments and 70% of inpatient hospital stay. LTC such as heart disease, stroke, cancer contribute greatly to the mortality statistics globally and these mortalities are disproportionately skewed towards low and middle-income countries and among the adult productive population[2]. The existence of LTCs was also reported to be one of the predictors of catastrophic health expenditure in a study of local households conducted in Yenagoa, Nigeria[3].

The improved level of control of acute conditions and the lengthening of life expectancy achieved by humans in the 20th century is now reinforcing the global epidemic of long-term morbidity. LTCs often develop slowly, progressively and often presents as multimorbidity[4]. In 2012, it was estimated that there were 8.6 million new cases and 1.3 million deaths from tuberculosis[5]. In Nigeria, the prevalence of HIV at the population aged 15-49 was 31% in 2012. (commonwealthhealth.org/Africa/Nigeria) Also in Nigeria, NCD are estimated to account for 24% of total deaths with the probability of dying from between age 30 70 years from 4 main NCDs – cancers, diabetes, cardiovascular disease and chronic respiratory disease is 20 %.[6].

Interventions aimed at curbing morbidity and mortality from LTCs could be of immeasurable values to countries across the world. A previous goal of additional 2% annual reduction in LTCs was estimated to have the potential of averting 36 million deaths and ushering a cumulative gain of 500 million years of life over a period of 10 years from 2006 to 2015[2]) Nigeria with an approximate population of 160 million has an estimated proportional mortality attributable to cardiovascular disease of 12[7].

Hassles are experiences and conditions of daily living that have been appraised as salient and harmful or threatening to the endorser's well-being" Included within these hassles was dealing with the consequences of fatigue, immobility or the difficulties in managing cumbersome equipment[8].

Health care hassles are troubles or bothers that patients experience during their encounters with the health care system[9]. They are the ordinary challenges of daily life[10]. Most conceptualizations of hassles in disease specific research tend to focus on problems that occur outside of the health care system. However, qualitative focus group data suggest that problems during interactions with the health care system are a major concern for patients with chronic illnesses. Recent research has investigated the relationship between measures of clinical complexity for people with chronic illnesses and various outcome measures, including utilization of services, cost of care, barriers to self-care, psychological distress, physician communication, and technical quality of care (see, for instance,[9]). Hence, this research to identify the health hassles experiences by patients with LTCs and identify some of the predictors of these hassles among these patients that seek care at the medical outpatient clinic of the University Teaching Hospital.

Methodology of the Study

Study Area

The study was carried out in the Department of Internal Medicine in the University of Port Harcourt Teaching Hospital (UPTH). It was founded by the federal Government in 1980 and was officially commissioned by federal government in 1985. It is located along the East-West road in Rivers State with geo-coordinate of 4° 53′ 58″ N, 6° 55′ 43″ E. The hospital is a Federal tertiary health institution that provide specialised clinical services as well as undertakes training of all cadres of health professionals and medical research in most clinical specialties. The Internal Medicine department is made up of the following units which run outpatient services on specified days of the week. The units are:

The Infections diseases unit which runs clinics every day of the week and handles endemic and

epidemic communicable diseases. Others medical outpatient's clinic schedules are the neuropsychiatric unit (majorly on Mondays, Wednesday, and Thursdays; the gastrointestinal unit (Monday), cardiology unit (Tuesdays); endocrinology unit (Wednesdays); nephrology (Thursday); dermatology (Thursday) and neurology unit (Friday). First time visitors are often referred from other clinical units within and other the hospital or are self-referred. Such initial and subsequent encounters with the units often follow the typical patient flow system in outpatient clinics as shown in Figure 1[11].

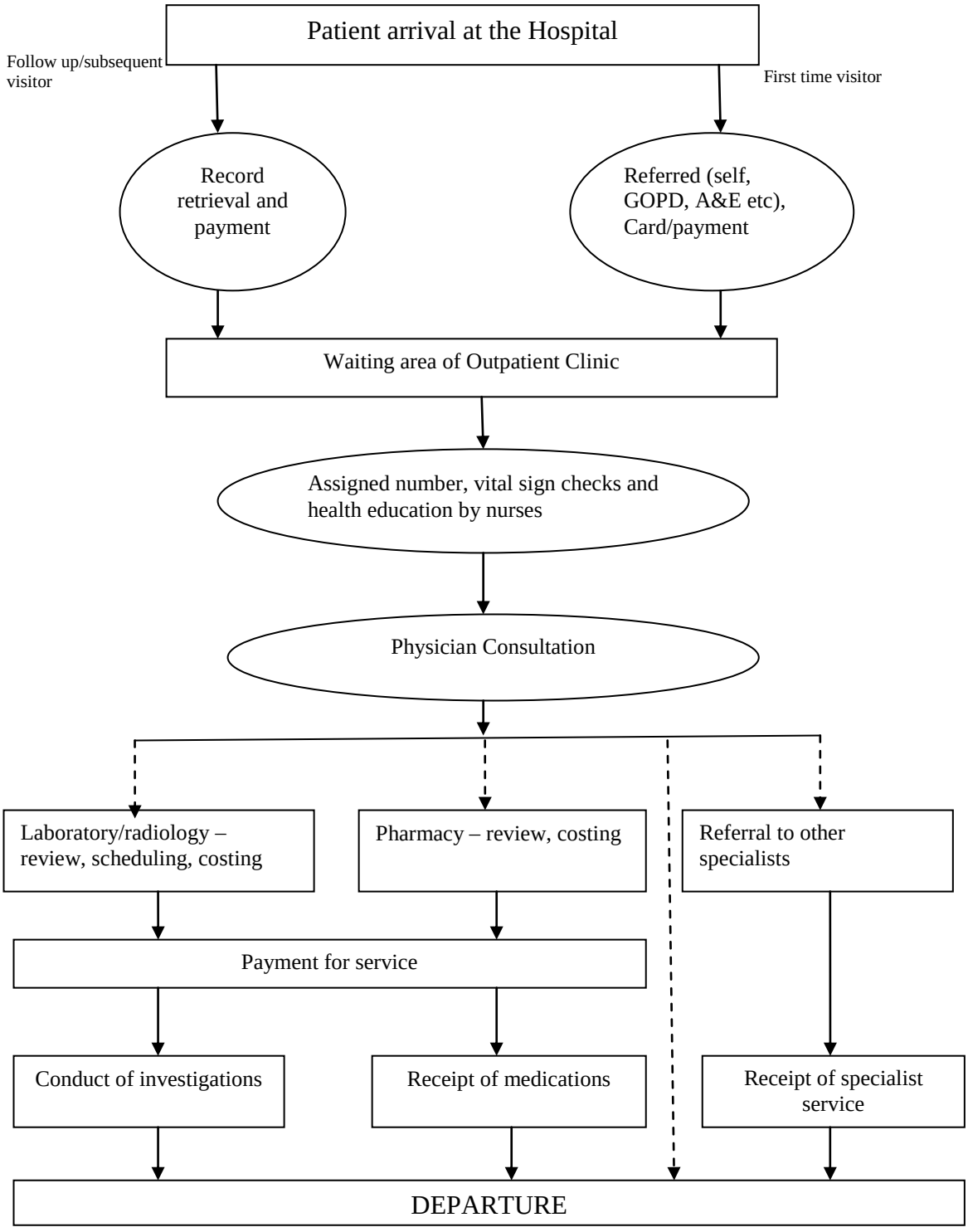

Figure 1 Patient flow at the Outpatient Clinic

Study Design

This is a descriptive cross-sectional study

Study Population

The population of this study are patients with different long-term communicable and non-communicable morbidities who were accessing care in UPTH. The eligibility criteria were - at least a previous visit for the management of their long-term condition before the index; long-term condition must have been diagnosed and managed for at least 4 weeks; cases must be ambulatory.

Sample Size

The minimum required sample size of 433 patients with LTMCs was calculated using the formula for single proportion n= $\frac{z^2(1-P)P}{D^2}$\ with p assumed to be 50% (to provide maximum sample size); Z=standard normal variance where confidence level is 1.96 at confidence interval of 95%; D=absolute precision or error margin (5%) and a 10% assumed non-response rate.

Sampling Method

The research used a stratified sampling where a list of all the units in internal medicine was obtained and the required number of respondents were disproportionately allocated to these units. All the units were visited on their clinic days and the patients selected randomly using numbers assigned to them on arrival. Questionnaires were administered to all patients that met the criteria after getting informed consent

Research Instrument

The study used the Parchman's hassle scale which was developed to assess health care hassles following patients' encounter with the health care facilities[9]. This tool had been used to assess hassles faced by general practice patients with LTMCs in the United Kingdom[12]. The instrument comprises three parts: Section one explored the socio-demographic characteristics of the respondents like age, sex, marital status, address. education, occupation and religion. Section two probed the clinical conditions of the patients including the number of LTMCs, illness and treatment duration and access to care. The last section explored respondents' ratings on core items in the health care hassles scale by choosingone of four options indicating 0 (note a problem at all, 1 (not quite a problem, 2 (it is a problem), 3 (it is a big problem), 4 (it is a very big problem. The face and content validity of the instrument was determined by experts and patients with LTCs to assure the comprehensiveness, comprehensibility and suitability for use in the medical outpatient units. The internal consistency reliability of the instrument was also assessed through the calculation of the Cronbach;s alpha of the scale.

Data Collection

The validated version of the instrument was directly administered by the research team to eligible respondents as they took their sits at the waiting area. Literate respondents were allowed to complete the self-administered questionnaire on their own while those that could neither read nor write were assisted by a member of the research team.

Data Analysis

The dependent variable in this study were the hassles patients face and the ordinal ratings were later transformed into percentages scores using a recommended approach shown below.

$$Percentage\ score = \frac{(Patient'rating - minimum\ scale\ rating)}{(Maximum\ scale\ rating - minimum\ scale\ rating)} X\ 100$$

This was to allow for the use of more robust parametric statistical techniques. The independent variables in this study were the patient's socio-demographic and clinical characteristics. The raw data was entered into SPSS version 20.0 First, a descriptive statistic of the socio-demographic, clinical and hassles characteristics were determined and later, a bivariate and multivariate

analyses were conducted to ascertain the relationship between hassles and other independent variables. The results were presented in Tables and Charts and p-value less than 0.05 were considered significant.

Ethical Approval

The ethical approval for the study was obtained from the University of Port Harcourt Research Ethics Committee. Permission was received from the department of Internal Medicine and individual consents were obtained from all patients who voluntarily participated in this research.

Results

A total of 500 questionnaires were shared for this study by the researcher and out of these a total of 446 was retrieved representing a response rate of 89.2%. The Cronbach's alpha for the entire scale was 0.88.

Table 1 Descriptive statistics on the Socio-demographics and Clinical Characteristics of Respondents

Characteristics	Frequency (%)	Mean overall hassles (95% CI)
Age in years		
<40	162 (36.3)	43.07 (40.07 – 45.69)
40 – 60	208 (46.6)	46.43 (44.41 – 48.36)
>60	76 (17.0)	52.06 (47.40 – 56.06)
Gender		
Male	203 (45.5)	46.83 (44.68 – 48.93)
Female	243 (54.5)	45.62 (43.59 – 47.71)
Marital status		
Never married	108 (24.2)	46.40 (42.78 – 49.47)
Married	277 (62.1)	45.86 (44.10 – 47.40)
Widow/divorced	61 (13.7)	47.18 (42.72 – 51.86)
Level of schooling		
No formal education	32 (7.2)	50.49 (45.25 – 55.48)
Primary	56 (12.6)	45.98 (41.79 – 50.00)
Secondary	113 (25.3)	39.87 (36.82 – 42.75)
Post-secondary	245 (54.9)	48.56 (46.41 – 50.42)
Employment status		
Not employed	108 (24.2)	49.68 (46.27 – 52.89)
Employed	338 (75.8)	45.05 (43.24 – 47.75)
Number of LTCs		
Single morbidity	138 (30.9)	41.13 (38.21 – 43.69)
Multi-morbidities	308 (69.1)	48.42 (46.50 – 50.41)
Category of LTCs		
Communicable only	77 (17.3)	35.57 (31.50 – 39.45)
Non-communicable only	291 (65.2)	49.58 (48.04 – 50.97)
Mixed	78 (17.5)	43.91 (39.80 – 48.73)
Self-rated health status		
Poor-fair	144 (32.3)	50.79 (47.07 – 54.18)
Good-excellent	302 (67.7)	43.97 (42.27 – 45.78)
Contact with clinic		
Less than 3 months	85 (19.1)	47.37 (43.84 – 50.53)
3 months and more	361 (80.9)	45.89 (44.10 – 47.49)
Payment for treatment of LTCs		
Free	108 (24.2)	37.63 (34.26 – 40.92)
Insurance	23 (5.2)	61.96 (54.06 – 69.50)
Paid	315 (70.6)	47.95 (46.28 – 49.52)
Time taken to reach clinic		
<30 minutes	64 (14.3)	48.98 (44.62 – 53.31)
30 minutes or more	382 (85.7)	45.70 (44.19 – 47.75)

Table 2 Hassles Trend among Respondents

Hassles	Trend – Frequency (%)				
	0	1	2	3	4
Information about medical condition	69 (15.5)	198 (44.4)	96 (21.5)	62 (13.9)	21 (4.7)
Information about treatment options	56 (12.6)	92 (20.6)	195 (43.7)	72 (16.1)	31 (7.0)
Information about medication	82 (18.2)	228 (51.1)	72 (16.1)	42 (9.4)	22 (4.9)
Problem getting medications	44 (9.9)	199 (44.4)	72 (16.1)	77 (17.3)	54 (12.1)
Uncertainty about taking medications	111 (24.9)	233 (52.2)	47 (10.5)	28 (6.3)	27 (6.1)
Side effects from medications	40 (9.0)	62 (13.9)	35 (7.8)	161 (36.1)	148 (33.2)
Information about referral	78 (17.5)	118 (26.5)	175 (39.2)	47 (10.5)	28 (6.3)
Waiting time for appointment	46 (10.3)	73 (16.4)	80 (17.9)	186 (41.7)	61 (13.7)
Poor communication between doctors	46 (10.3)	112 (25.1)	204 (45.7)	43 (9.6)	41 (9.2)
Disagreement between doctors	80 (17.9)	135 (30.3)	146 (32.7)	53 (11.9)	32 (7.2)
Agreement on laboratory test	64 (14.3)	128 (28.7)	71 (15.9)	150 (33.6)	33 (7.4)
Delayed laboratory results	37 (8.3)	69 (15.5)	68 (15.2)	203 (45.5)	69 (15.5)
Difficulty getting medical advice	48 (10.8)	84 (18.8)	182 (40.8)	79 (17.7)	53 (11.9)
Inadequate consulting time	53 (11.9)	180 (40.5)	77 (17.3)	92 (20.6)	44 (9.9)
Ignored concerns	208 (46.6)	126 (28.3)	42 (9.4)	32 (7.2)	38 (8.5)
Appointment interfere with work	48 (10.8)	51 (11.4)	46 (10.3)	118 (26.5)	183 (41.0)

Note 0 (note a problem at all, 1 (not quite a problem, 2 (it is a problem), 3 (it is a big problem), 4 (it is a very big problem.

From the study, majority of the respondent fell within the age group 40-60. And female where more in number (f =243) than male (f=203). The longer the length of treatment in the university teaching hospital, the less the reported hassle and this was statistically significant. Also 282 of the respondent representing 63.2% paid their medical bills with their own money from their pocket. The most reported hassles by the respondents where medical appointment that interfere with my work, family or hobbies, lack of information or side effects of medication, having to wait long to get specialist appointment, having to wait long to find out the result of lab investigation and X-ray while the least reported hassles where having my concern ignored or overlooked by my health care provider, lack of information about my medical condition, lack of information about why my medication was prescribed to me, uncertainty about when or how to take my medication. It was discovered that there was a relationship between mode of payment and the reported hassles. The table below shows the frequently encountered long term morbidity among patients in UPTH.

Table 5 Predictors of Health care hassles among patients with LTCs in Port Harcourt

Independent variable – reference group	Mean hassles	Bivariate analysis		Multivariate analysis	
		B (95% CI)	p-Value	B (95% CI)	p-Value
Age in year - <40	43.07	-			
40 – 60	46.43	3.36 (-0.12, 6.83)	0.058	3.10 (-0.93, 7.13)	0.131
>60	52.06	8.98 (4.37, 13,59)	0.000	3.96 (-1.32, 9.24)	0.141
Gender – Male	46.83	-		-	
Female	45.62	-1.21 (-4.41, 1.99)	0.458	-0.32 (-3.30, 2.66)	0.832
Marital status – never married	46.40	-		-	
Married	45.86	-0.54 (-4.36, 3.28)	0.782	-1.80 (-6.01, 2.41)	0.401
Widow/divorced	47.18	0.79 (-4.61, 6.18)	0.775	-1.15 (-6.86, 4.56)	0.692
Level of schooling – none	50.49	-		-	
Primary	45.98	-4.51 (-11.79, 2.78)	0.225	-2.74 (-9.77, 4.30)	0.445
Secondary	39.87	-10.62 (-17.21, -4.04)	0.002	-6.45 (-12.87, -0.04)	0.049
Post-secondary	48.56	-1.93 (-8.11, 4.25)	0.540	-0.60 (-6.64, 5.43)	0.845
Employment status – not employed	49.68	-		-	
Employed	45.05	-4.63 (-8.33, -0.94)	0.014	-2.24 (-5.00. 1.51)	0.241
Number of LTCs – single morbidity	41.13	-		-	
Multi-morbidities	48.42	7.29 (3.91, 10.67)	0.000	3.05 (-0.62, 6.72)	0.104
Category of LTCs – communicable only	35.57	-		-	
Non-communicable only	49.58	14.01 (9.90, 18.12)	0.000	8.36 (2.78, 13.94)	0.003
Mixed	43.91	8.34(3.19, 13.49)	0.002	3.11 (-2.81, 9.03)	0.302
Self-rated health status – poor/fair	50.79	-		-	
Good-excellent	43.97	-6.83 (-10.17, -3.48)	0.000	-4.56 (-7.96, -1.12)	0.009

Contact with clinic – less than 3 months	47.37	-		-	
3 months and more	45.89	-1.48 (-5.54, 2.57)	0.473	1.04 (-2.99, 5.01)	0.611
Payment for treatment of LTCs – free	37.63	-		-	
Insurance	61.96	24.33 (17.04, 31.62)	0.000	14.93 (7.07, 22.79)	0.000
Paid	47.95	10.32 (6.78, 13.86)	0.000	2.09 (-2.73, 6.92)	0.395
Time taken to reach clinic - <30 minutes	48.98	-		-	
30 minutes or more	45.70	-3.27 (-7.81, 1.26	0.157	-3.97 (-8.19, 0.26)	0.066

B – unstandardized coefficient explains the effect from moving from one category (baseline) the others would cause to the dependent variable (hassles)

Unemployed have significantly higher hassles than the employed (t = -0.74, B-4.63, 95%CI: -8.33 to -0.94, p = 0.014). patients who were covered by social insurance (t = 6.56, p = 0.000) and those who paid (t = 5.72, p = 0.000) for their management of their LTCs had significantly higher hassles that those that received free care. The introduction of patients' socio-demographic and clinical variables captured in this study could only explain 21.0% of the variance of health care hassles in this population. The regression model containing all these variables was statistically significant in explaining healthcare hassles experienced by patients with LTCs (F = 6.68, p = 0.000).

Table 2 Showing the Common long- term Morbidities among the Respondents (n=446)

Chronic Disease	Frequency	Percentage (%)
Cardiovascular disease	144	32.3
HIV	79	17.7
Diabetes Mellitus	50	11.3
Arthritis	22	4.9
Stress Disorder	18	4.0
Migraine	16	3.6
Dermatological Disorder/Acne	15	3.4
Depression	15	3.4
Chest Infection/Pneumonia	14	3.1
Tuberculosis	14	3.1
Anxiety	14	3.1
Kidney Disease	13	2.9
Thyroid Disease	12	2.7
Asthma	11	2.5
Panic Disorder	9	2.0

Discussion

Firstly I set out to identify the common long- term condition among patients with long term conditions accessing care in UPTH .from my findings I discovered that cardiovascular diseases was the first followed by HIV and diabetes, but surprisingly I noticed that the combined together the neuropsychiatric disorders were also had a high percentage this can be connected with the current high level of hardship prevalent in the country. Comparing this result with the work of. It can also be seen that CVS was the leading with cancers following. The[13] Global burden of disease study the results also showed cardiovascular disease as the leading cause of NCDs deaths Secondly I tried to identify the common hassles reported by the patients with long term morbidity accessing care at UPTH .From our findings, the most reported hassles were Side effects from my mediations, Having to wait a long time to get an appointment for specialist consultation, Having to wait long to find out the results of the lab tests or x rays, Medical appointments that interfere with my work family or hobbies. This was in contrast to the findings of [12] where the most reported hassles were uncertainty about how to take my drugs, problems getting my mediation refilled on the medical appointment, lack of information on why I have been referred to a specialist hospital, lack of

information about my medical condition, poor coordination between different doctors, having to wait long time to get an appointment for specialist doctor.

Thirdly I also wanted to find out if there was a relationship between the number of long term morbidity and the reported hassles my study found out that there was an increase in hassles as we moved from single morbidity to multi- morbidity this was statistically significant, also the same increase was recorded by[12]. This increase in the level of hassles could be deduced from the fact that a patient with two or more long term morbidity, will have more contact with the system as they may be required to visit the hospital more than once in a week to see the various specialist handling their case, due to the current system of care that is fragmented in nature .e.g. cardiology clinics is on Tuesdays and neurology is on Friday. A patient with hypertension and a stroke will have to come to the hospital on Tuesday for cardiology clinic and on Friday for neurology clinic.

Fourthly this study set out to ascertain if there was a relationship between the nature of illness and the reported hassles and we saw that there was a relationship as people with non-communicable diseases reported more hassles than people with communicable disease this is because the attention of the world is still on communicable disease with little or no effort being made to restructure the current health system that was built on management of acute epidemic diseases. This has led to the rise in global death burden from NCDs .Long-term morbidity is a major challenge facing the global health economy. The World Health Organization estimates that non-communicable diseases account for more than 60% of deaths worldwide[1] on this premise it will be adduced that that people with non-communicable disease s deserve more attention than is been given.

Finally I observed that the predictors of hassles among my respondents were health status, contact time mode of payment .as we move from poor health status to fair thee hassles reduced this was statistically significant. This is true as patients with poor health status are more likely to perceive more hassles due to the state of their health and the psychological trauma of ill health, in that state having to go through the registration process can be very challenging.

Less contact time predicted more hassles than long contact time. this is true because the more you make contact with an institution the more informed you are on the workings of the institution this in turn reduces the hassles one has to go through. Mode of payment was also a predictor of hassles with hassles worst with those on the health insurance scheme this as observe was with the administrative bottlenecks of getting approval for treatment which sometimes takes days to weeks irrespective of the patient's condition.

Implication of Researh for Policy, Clinical Practice and Future Research

Research evidence has shown that many older patients visits the hospital with long term morbidity as seen in the age distribution analysis where majority of the respondents were between the ages of 40-60 and greater than 60 years , this has highlighted the need to develop ways of improving health care service delivery to meet the needs of these patients. This work has contributed to developing such models by identifying the key hassles and the patents groups who are most at risk of the experience.

This study also discovered that people in health insurance and prepaid services reported higher level of hassles, which is understandably true due to the bureaucracies and administrative bottle necks inherent in the system. Again this research has provided a basis for a total review of the Nigerian health insurance scheme to reduce the hassles people using it go through as this will go a long way in encouraging others to make us of it. While the NHIS is a welcome development to health care, financing its impact is yet to be felt by the ordinary Nigerian as many are not even aware of the existence of a social insurance scheme and

the few that are aware are scared of using it due to the reported unpleasant experiences of others.

This study also highlighted the need for a revival of the primary health care in Nigeria as people still travel far to asses quality care. The PHC should be overhauled to make them capable of managing some long term conditions leaving the teaching hospitals to handle the severe cases. The belief that long term conditions is a disease of the elderly alone was found not to be true as some of the respondents under 40 years also had long term conditions in fact most the respondents in this study were of the age range of 30-60 years and above unlike that of Charles[12] where the age ranges was (71±10years) hence showing that the younger generation are more affected in this study. The implication of this is that more should be done in the area of prevention rather than curative, there should be health promotion activities incorporated into the health care policy of the nation with a view of reducing some of the risk factors for long term morbidities like cigarette smoking, alcohol abuse, sedentary lifestyle, obesity. Thus health promotion should be aimed at lifestyle naming.

This study highlight lack of information on the side effects of drugs as one of the most reported hassles, this is very important, and policies should be tailored to that direction with the view of making a discussion on the side effect of drug part of the doctor- patient interaction. This will go a long way in taking down drug nitration rations and other rations.

Future research is suggested in the following area

1) Utilization and uptake of the NHIS in Nigeria;
2) Long term morbidities among health workers in UPTH;
3) Management of long term morbidity the way forward for Nigeria

Conclusion

In the word of Mr. Vazques NCDs are the world leading avoidable killers but the worl s no doing enough to avoid them. We have to ask ourselves if we want to condemn future generation to dying too young and living lives if ill-health and loss of opportunities. The answer is ‘no’ bit there is so much we can do to safe guard and care for people from protecting everyone from tobacco harmful use of alcohol, unhealthy foods and sugary drinks, to giving people the health service they need to stop NCDs in their tracks (premium times February 16, 2018). Many lives can be saved from NCDs through early diagnosis and improved access to quality and affordable treatment as well as step to reduce the main risk factors[14].

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