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Factors Influencing Choice of Medical Care among Ill Patients Suffering From Chronic Diseases in Ebonyi State

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Abstract
The cross-sectional survey research design was used to the study the factors influencing choice of care among ill patients suffering from chronic diseases in Ebonyi State. The population of the study comprised 325 patients with selected chronic diseases such as diabetics' mellitus, cardiac and renal diseases who were undergoing treatment at the Federal Teaching Hospital (FETHA 1) Abakaliki. Since the population was of a manageable size the researchers decided to include the entire patients in the study. The instrument used for data collection was a 26-item questionnaire developed by the researchers. Data collected were analyzed using percentages in order to describe the data and chi-square ($\square^2$) statistic in order to establish whether there was any significant association between the independent variables of gender and level of education attained and the dependent variables, that is, the factors influencing choice of care among chronic disease patients. The results of the study showed that the association between gender and factors influencing choice of care is not significant except for culture, employer and strong hope of cure ($p < 0.05$). Secondly, the association between level of education attained by patients and factors influencing choice of care is significant except for finance, access to hospital, relationship with medical personnel and adequacy of hospital facilities ($p > 0.05$). The need for special clinics and hospitals for prompt treatment of chronic disease patients is advocated.
Keywords: Choice of care, chronic diseases, patients, Ebonyi State

Introduction

Illness has been conceptualized in many ways. For example, Abanobi and Ewuzie (2000) perceived illness as human response to disease process or the perception by an individual that he or she has some form of impairment. Similarly, British Medical Association (2002) noted that illness is the perception by a person that he or she is not well. The British Medical Association added that illness is a subjective sensation experienced by an individual who has some feeling of deviation from normal health. This subjective sensation, according to Patrick, Wood, Cravan, Rokosky and Bruno (2006), may have some psychological undertone. Urdang (2005) perceived illness as a disease of the body and mind or a condition of being ill.

A close observation of the definitions of illness presented above could show that they are similar in that they see illness as human response to disease process which is capable of making the ill individual exhibit a particular behaviour in reaction to his or her condition. According to Uzma, Underwood, Atkinson, and Thackrah (2012), disease episode could be acute or chronic. However, Ahmed, Chowdhury, and Bhuiya (2001) describe chronic disease as an illness or medical condition that lasts over a long period and sometimes causes a long-term change in the body. On their own part, Tipping and Segall (2014) perceived chronic diseases to mean those diseases that develop over time and require more than six or more months to heal, and some may persist indefinitely. They gave examples of chronic diseases to include tuberculosis, asthma, diabetes, hypertension and other cardiac problems, and kidney or renal diseases.

In the context of the present study, chronic diseases are described as those diseases that last over a long period and sometimes persist indefinitely. Therefore the behaviour of the patient experiencing any one chronic disease, such as diabetes, cardiac problems, and kidney or renal diseases identified by Tipping and Segall (2014) above were used in order to determine the factors influencing choice of care.

According to Fong, Bargman and Chan (2007), one of the most outstanding challenges to public health is the problem of the chronically ill. They noted that chronic illness affects almost every family and it has been estimated that about 25 million persons, or over one-sixth of the population of the developing world, have one chronic disease or the other. They further indicated that probably over 7 million of these chronic ill persons have an appreciable disability from their illness and at least a million and a half are invalids. The above submission concerned chronic disease patients in developing countries, including Nigeria. Important in the chronic illnesses are arteriosclerosis, high

blood pressure, mental disease, arthritis, heart and kidney diseases, cancer, tuberculosis, diabetes, and asthma (Fong, Bargman, & Chan, 2007). In only several of these categories, tuberculosis, heart or cardiac diseases, kidney or renal diseases and diabetes, has there been any development or provision for special care (Ahmed, Chowdhury, & Bhuiya, 2001). Since chronic disease causes nearly a million deaths each year and causes the loss of almost a billion days of productive activity, action against this group of diseases is most important and this action might probably be initiated when the factors influencing their choice of care during illness is determined. It is the expectation of every society that patients should seek care and get well. Variations exist in how individuals choose to seek medical care when they become ill. These variations in care seeking might result in individual's use and non-use of health care services, especially among the chronically ill patients.

The knowledge of care seeking behaviour during illness especially in terms of how ill people feel they are and their choice of care is very pertinent. This is of much importance in rendering care to the patients. Studies (Erinosho, 1979; Akinsola, 2003; Woods, 2003) have shown that individuals react to illness in various ways. What one individual may identify as illness may not be regarded as illness by another individual. Similarly, what one society may regard as illness may be seen by another society as normal. For instance, Abanobi (2004) observed that in developing countries like Nigeria, people with headache or fever go about their normal duties and are not regarded as sick while in developed countries like America or Britain, people with such symptoms as headache, might interpret the symptoms as serious warning signs of illness. This interpretation may affect the individual's behaviour towards the condition.

Studies (Conner & Norman, 1996; Tipping & Segall, 2014) demonstrate that choice or decision to engage or seek a particular medical channel is influenced by socio-demographic variables such as sex and level of education attained. These socio-demographic variables were examined in the study in order to determine the influence the variables exert on the behaviour of the patients with the selected chronic diseases in Abakaliki, Ebonyi State.

A patient, according to Urdang (2005), is a person receiving treatment from a doctor and or hospital. For Freeman, Levine and Reeder (2002) a patient is an individual whose incapacity disturbs performance of the social roles he or she is normally charged with and exposes him or her to the attention of medical personnel. The patient described above could be one suffering any chronic disease like diabetes, cardiac and renal diseases. In the context of this study therefore, a patient is perceived as one who is suffering any of the chronic diseases indicated above and the disease exposes him or her to the attention of a medical doctor.

The researchers have observed that chronic disease patients in Ebonyi State appear to lack the proper direction and behaviour towards their health care. While some embark on self medication, others prefer native healers and faith healing for reasons of affordability, some who have the courage to consult medical doctors in hospitals do that when it is already too late thus exposing themselves to deaths which ordinarily would have been prevented. The above scenario prompted the researchers to explore the factors influencing choice of care among patients of chronic diseases that attend FETHA in Ebonyi State.

Erinosho, Usman and Mkpume (1981) reported that majority of rural dwellers studied utilized the services of assorted traditional healers before and even after seeking care from modern health care and a good number of the rural sick engaged the services of patent medicine dealers. According to them, this behaviour sometimes results to irreversible complication or death that might have ordinarily been avoided. The situation described above concerned the sick in rural settings in Northern Nigeria and the situation in Ebonyi State may not be different especially among the chronically ill. Regrettably, the situation with regard to the chronically ill, probably, has not been explored in Ebonyi State. The problem of this study can be stated in a question form, thus: what are the factors influencing choice of medical care among ill patients suffering from chronic diseases in Ebonyi State? To provide answer to this question, the present study therefore was carried out to investigate the factors influencing choice of medical care among ill patients suffering from chronic diseases in Ebonyi State.

Methods

Design and Participants

The cross-sectional survey research design was used for the study. The population of the study comprised all patients with chronic diseases such as diabetics' mellitus, cardiac and renal diseases who were undergoing treatment at the Federal teaching hospital (FETH) Abakaliki. They included both out-patients in the special clinics of the hospital and those on admission during the period of the study. According to the medical record unit of the hospital as at December 2014, the number of patients with the selected chronic diseases who were receiving treatment in the hospital was 325 patients. This number comprised 183(59%) males and 142(41%) females. Since this number was not large, the entire patients were included in the study.

Instrument

The instrument used in this study was a 26-item Chronic Diseases Patients' Choice of Care Questionnaire (CDPCCQ) developed by the researcher. Items in the questionnaire were gathered from literature on chronic diseases. The questionnaire consisted of two sections; sections A and B. Section A contained four items on personal data of respondents. Section B contained 22 items that elicited information on factors influencing the patients' choice of care. Five experts from one institution of higher learning in Ebonyi State were used for validating the CDPCCQ. Fifteen chronic diseases patients of both genders who were undergoing treatment in one hospital in Enugu State were used for test of reliability. The data yielded a split-half reliability coefficient of 0.94. The reliability coefficient was higher than Ogbazi and Okpala's (1994) criteria of 0.60 acceptable for good instruments.

Data analysis

The returned copies of the questionnaire were cross-checked for completeness of responses .All the 325 copies of questionnaire distributed were properly completed making a hundred percent return rate and were used for data analysis . All the research questions were answered using percentages, because of the need for nominal data while the hypotheses were tested using the chi-square ($\square^2$) statistic. The hypotheses were tested at alpha level of 0.05.

Results

Table 1: **Factors Influencing Choice of medical Care**

S/N	Variables	N = 325	Responses	
			f	%
1.	Fear		222	68.3
2.	Frustration		212	65.2
3.	Past experience		153	47.1
4.	Personal motivation		236	72.6
5.	Culture		208	64.0
6.	Religion		228	70.2
7.	Finance		198	60.9
8.	Employer		197	60.6
9.	Spouse		224	68.9
10.	Children		187	57.5
11.	Friends		259	79.7
12.	Other relatives		215	66.2
13.	Knowledge of disease		106	32.2
14.	Degree of severity of illness		236	72.3
15.	Strong hope of cure		224	68.9
16.	Access to hospital		183	56.3
17.	Affordability of hospital expense		251	77.2
18.	Relationship with medical personnel		219	67.4
19.	Adequacy of hospital in terms of staffing		281	86.5
20.	Adequacy of hospital in terms of facilities		200	61.5
21.	Feeling of worth		211	64.9
22.	Feeling that the illness has no cure		124	38.2

Table 1 shows that the factors that influence choice of medical care among respondents include adequacy of staff in the hospital, friends, and ability to afford hospital expenses, severity of illness, religion, spouse and strength of hope. Other factors include fear the disease instilled in them, relationship with medical personnel who may have advised them, other relatives, feeling of worth and their culture, among other factors.

Table 2 below presents data on factors influencing choice of care by male and female respondents. As can be seen in the table, 63.6% of male respondents and 73.2% of female respondents are influenced by fear; 65.4% of the males and 64.9% of the females are influenced by frustration presented by the illness. On the other hand, 69.0% of male respondents and 76.4% of the females are influenced by personal motivation; 69.6% of males and 57.9% of females are influenced by culture. Furthermore, 66.8% of males and 73.2% of females are influenced by religion and while 54.1% of males and 58.5% of females are influenced by accessibility of the hospital, 75.5% males and 78.9% females are influenced by affordability of hospital expenses. When chi-square is run, it is observed that the association between gender and factors influencing choice of care by male and female respondents is not significant except for culture, employer and strong hope of cure ($p < 0.05$).

Table 2: **Factors Influencing Choice of medical Care by Male and Female Respondents**

S/N	Variables	Gender			
		Male (n = 168)	Female (n = 157)	χ^2- value	p-value
1.	Fear	63.6	73.2	3.425	0.064
2.	Frustration	65.4	64.9	0.009	0.923
3.	Past experience	48.8	45.2	0.419	0.517
4.	Personal motivation	69.0	76.4	2.226	0.136
5.	Culture	69.6	57.9	4.806*	0.028
6.	Religion	73.2	66.8	1.556	0.212
7.	Finance	59.5	62.4	0.286	0.593
8.	Employer	67.8	52.8	7.640*	0.006
9.	Spouse	75.5	74.5	0.050	0.823
10.	Children	60.7	54.1	1.436	0.231
11.	Friends	82.1	77.0	1.290	0.256
12.	Other relatives	64.2	68.1	0.542	0.462
13.	Knowledge of disease	29.1	36.3	1.882	0.170
14.	Degree of severity of illness	70.2	74.5	0.744	0.388
15.	Strong hope of cure	73.8	63.6	3.877*	0.049
16.	Access to hospital	54.1	58.5	0.648	0.421
17.	Affordability of hospital expense	75.5	78.9	0.529	0.467
18.	Relationship with medical personnel	70.8	63.6	1.882	0.170
19.	Adequacy of hospital in terms of staffing	86.9	85.9	0.058	0.809
20.	Adequacy of hospital in terms of facilities	61.9	61.1	0.020	0.888
21.	Feeling of worth	61.9	68..1	1.391	0.238
22.	Feeling that the illness has no cure	40.4	36.6	0.795	0.373

* $p < 0.05$

Table 3: **Factors Influencing Choice of medical Care according to Level of Education of Respondents**

S/N	Variables	Level of Education Attained					
		NFE (n = 71)	PE (n = 52)	SE (n = 70)	TE (n = 132)	χ^2- value	p-value
1.	Fear	59.1	82.6	78.5	62.1	13.458*	0.004
2.	Frustration	81.6	75.0	71.4	49.2	26.732*	0.000
3.	Past experience	47.8	32.6	30.0	61.3	23.345*	0.000
4.	Personal motivation	60.5	71.1	90.0	70.4	16.191*	0.001
5.	Culture	64.7	86.5	68.5	52.2	19.998*	0.000
6.	Religion	690	80.7	80.0	61.3	10.955*	0.012
7.	Finance	53.5	59.6	62.8	64.3	2.449	0.485
8.	Employer	60.5	71.1	75.7	48.4	17.240*	0.001
9.	Spouse	70.4	86.5	82.8	68.9	9.395*	0.024
10.	Children	64.7	59.6	64.2	49.2	6.642	0.084
11.	Friends	78.8	90.3	84.2	73.4	7.758*	0.051
12.	Other relatives	63.3	75.0	75.7	59.0	7.860*	0.049
13.	Knowledge of disease	14.0	23.0	24.2	50.7	35.951*	0.000
14.	Degree of severity of illness	69.0	80.7	84.2	64.3	11.388*	0.010
15.	Strong hope of cure	67.6	53.8	67.1	76.5	9.232*	0.026
16.	Access to hospital	50.7	57.6	55.7	59.0	1.372	0.712
17.	Affordability of hospital expense	80.2	90.3	82.8	67.4	13.971*	0.003
18.	Relationship with medical personnel	63.3	65.3	65.7	71.2	1.581	0.664
19.	Adequacy of hospital in terms of staffing	87.3	86.5	97.1	80.3	11.145*	0.011
20.	Adequacy of hospital in terms of facilities	61.9	57.7	54.2	66.6	3.353	0.340
21.	Feeling of worth	53.5	59.6	80.0	65.1	11.687*	0.009
22.	Feeling that the illness has no cure	56.3	42.3	25.7	33.3	16.220*	0.001

NFE = Non Formal Education, PE= Primary Education, SE = Secondary Education, TE = Tertiary Education

Table 3 presents data on factors influencing choice of care according to level of education of the respondents. The table shows that respondents with primary education (PE) are influenced by fear (82.6%), frustration (75%), past experience (32.6%), personal motivation (71.1%), culture (86.5%) and religion (80.7%). Other factors are finance (59.6%), employer (71.1%), spouse (86.5 %), friends (90.3%), other relatives (75%) and affordability of hospital expense (90.3%). On the other hand respondents with secondary level of education (SE) are influenced by fear (78.5%), frustration (71.4%), personal motivation (90%), culture (68.5%), religion (80%), finance (62.8%), employer (75.7%), spouse (82.8%) children (64.2%), friends (84.2%), and other relatives (75.7%) and while 84.2% respondents are influenced by severity of illness, 97.1% are influenced by adequacy of hospital staff.

Among those with tertiary education (TE), 62.1% are influenced by fear, 49.2% by frustration, 61.3% by past experience, 70.4% by personal motivation, 52.2% by culture, 61.3% by religion, 64.3% by finance, 48.4% by employers, 68.9% by spouse, 73.4% by friends, 76.5% by strong hope of cure and 80.3% staff of hospital. Furthermore, among those with non-formal education (NFE), 59.1% are influenced by fear, 81.6% by frustration, 60.5% by personal motivation, 64.7% by culture-induced, 69% religion, and 70.4% by spouse 70.4%, 66.7% by children, 78.8% by friends, 80.2% by affordability of hospital expenses and 63.3% by relationship with medical personnel. When chi-square is run, it is observed that the association between level of education attained by respondents and factors influencing choice of care is significant except for finance, access to hospital, relationship with medical personnel and adequacy of hospital in terms of facilities ($p > 0.05$).

Discussion

Results in Table 1 showed that in their choice of hospital to go for treatment, 86.5% were influenced by the quality of staff in the hospital they chose. Experience show that human beings go for wherever the best can be found especially as it affect health matters. This explain why out of the two tertiary health care facilities in Ebonyi State, one seem to be enjoying higher patronage than the other for reasons of quantitative staffing and their numerical adequacy. The results also showed that 72.3% of the respondents were influenced by the degree of severity of the illness. This finding is indeed expected owing to the value every human being attaches to his or her life. Any condition that is a threat to life had always been known to put the individual concerned on his or her toes in a bid to ensure survival.

These findings support the observations of Akinsola (2003) that what an individual regards as illness may be seen as normal by another individual. Abanobi (2004) added that in most developing countries like Nigeria, people with headache or fever go about their normal duties and are not regarded as sick until it becomes severe the implication of this is that people of the area do not go for treatment early enough. This is a risky behaviour that could expose the individual concerned to irreversible complication of his ailment or even death (Erinosho, Usman & Mkpume, 1981). The results further showed that 38.2% of the respondents were led into complacency by the feeling that the illness has no cure.

This finding is indeed very strange as it disagrees sharply with the assertion that every society expects her sick patients to get well. The patients who have the feeling that their ailment has no cure may consider going for treatment a waste of resources that could be spend on more useful things. He or she will relax and be waiting to die. This behaviour is very dangerous because, according to Nwafor (2011), if you sit and wait to die, you may not wait too long.

Results of the study on Table 2 showed that 86.9% of the male respondents were influenced by adequacy of hospital in terms of staffing in choice of care while the same applies to 85.9% of the female respondents. These findings are not surprising because it is personnel that make an institution. The findings also agree with the views of the Federal Ministry of Health (1996) who stated that the life wire of any institution especially health institutions is the quality of her personnel. According to her it determines its growth and societal acceptance. The results also showed that only 54.1% of male respondents had access to the hospital while 58.5% of the female respondents did. These findings revealed that poverty is a serious barrier to early and effective treatment within the area of study. At the bottom of the Table are 40.4% of male and 36.6% female respondents who had the feeling that the illness has no cure.

This feeling could be very dangerous to the patients who have it because it can lead to complacency which is a simple means of waiting to die. This finding clearly supports the observation by literature that individuals react differently to disease conditions (Abanobi, 1999).

Results of the study on Table 3 indicates that 90.3% of respondents with primary education were influenced by their friends, 84.2% of the group with secondary education indicated same while 73.4% of the respondents with tertiary level of education adopted similar influence. Those with non-formal education scored 78.8% influence. These findings support the earlier observation on the high influence of significant others in the life of people in the society with chronic disease patients inclusive. Among the respondents influenced by access to the hospital are 57.6% of respondents with primary education, 55.7% of respondents with secondary education and 59% of those with tertiary education while 50.7% of respondents with non-formal education were also influenced.

These findings revealed that many people in Ebonyi state do not have access to the hospital as a result of inability to afford its high cost. The likely reason for this may not be far from poverty, and high cost of medical services in Nigeria. At the bottom of the table are 23% of the respondents with primary education who were influenced by knowledge of diseases, 24.2% of those with secondary education and 50.7% of respondents with tertiary education. Among the respondents with non-formal education only 14% indicated they had knowledge of diseases. These findings clearly support the findings of Collier (2002) who stated that education of the citizenry is the best means of empowering them to tackle their health and social problems in the society.

Conclusion and Recommendation

From the findings of the study, it is safe to conclude that poverty and high cost of medical services in Ebonyi State in particular and the country in general is a serious barrier to access to medical health care. The same factor tends to encourage medical quackery and fake drug vending both in the state and the country at large. However ,the researchers recommends that special clinics for the treatment of patiants of chronic diseases should be established in public hospitals and their charge subsidized to encourage patients to freely go for prompt treatment willingly when the need arises.

References

Abanihe, M.A (1995). Stress: Exploring health implications. *Journal of Physical, Health Education and Recreation, 1*(1), 23-25.

Abanobi, O.C. (1999). *Diabetes Mellitus: Related diseases and risk factors.* Owerri: Onii Publishing House and Abanaheart Publications.

Abanobi, O.C., & Ewuzie, M.A (2000). *Health and illness: A behavioural approach.* Owerri: Mantle Publishers Nig.

British Medical Association. (2002). *Illustrated medical dictionary*: London: A Penguin Company.

Brown, A.N., & Baker, J.A. (2001). Hypertension and stress: A preventive approach. *Journal of Psychosomatic Research, 28*(2), 70-76.

Campbell, C. (2001). *Health education behaviour models and theories: A review of the literature, Part one.* Retrieved August 3, 2008, from http://www.11mscares. com/health/appal.htm

Collier, A.S. (2002). The economic of health care in Japan. *International Journal of Health Promotion, 12*(5), 64-618

Erinosho, O.A. (1979). An aspect of illness behaviour in Northern Nigeria and its implications. *Nigerian Medical Journal, 9*(2), 239-242.

Federal Medical Centre. (2010, June 24). *Statistics of chronically ill-patients.* Abakaliki: Records Units.

Federal Ministry of Health. (1996). *The national health policy and strategy to achieve health for all Nigerians.* Lagos: Federal Ministry of Health.

Fong, E., Bargman, J.M., & Chan, C.T. (2007). Cross-sectional comparison of quality of life and illness intrusiveness in patients who are treated with nocturnal home hemodialysis versus peritoneal dialysis. *Clinical Journal of American Society of Nephrology, 10*(2), 1195-1200.

Freeman, H.E., Levine, S., & Reeder, I.G. (2001). *Handbook of medical sociology.* New Jersey: Prentice Hall Inc.

Nwafor, J.N. (2011). *Illness behaviour of patients with selected chronic diseases at the federal medical centre, Abakaliki.* Unpublished MSc. Ed Dissertation, Ebonyi State University, Abakaliki.

Ogbazi, J.N., & Okpala, J. (1994). *Writing research report: Guide for researchers in education, the social sciences and the humanities.* Enugu: Press Time Ltd.

Tipping, S.A., & Segall, C. (2014). Situational obstacles to diction adherence for adolescents with diabetes. *Diabetes Education, 20,* 207-211.

Urdang, L. (2005). *Longman dictionary of contemporary English.* Edinburgh: Gate Harlow Publishing Company.

Uzama, J., Underwood, A.C., Atkinson R., & Thackrah, A.A. (2012). The patient reactions assessment: a brief measure of the quality of patient provider medical relationship. *Psychological Assessment, 4,* 346-351.

Woods, D.W. (2003). Towards developing a theory of spirituality. *Journal of Nursing Scholarship, 24,* 267-272.