Conundrum of bureaucratic processes and healthcare service delivery in government hospitals in Nigeria

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Abstract

Purpose – Bureaucracy to a large extent entrenches orderliness and productive means of achieving goals in both public and private organisations across the world. However, bureaucracy is not suitable in the management of hospitals due to its peculiar nature of operations. This study investigates the conundrum of bureaucratic processes and health-care service delivery in government hospitals in Nigeria.

Design/methodology/approach – The study surveyed 600 outpatients and attendees visiting tertiary and government hospitals in Nigeria using descriptive design to obtained data from the respondents. A research instrument, questionnaire, was used to gather data. Out of the 600 outpatients visiting the 20 hospitals in government and tertiary hospitals, 494 responses were returned from the attendees. The study employed random sampling strategy to collect the information.

Findings – The findings of this study were that service delivery in government hospitals were in adverse position on all the four constructs of bureaucratic dimensions as against quality of service delivery in hospitals in Nigeria. It discovered that bureaucratic impersonality cannot impact on the quality of service delivery in government hospitals in Nigeria. Separation and division of labour among health workers have no significant effect on quality service delivery in government hospitals. Formal rules and regulations (administrative procedure, rules, and policies) prevent quality service delivery in government hospitals in Nigeria. Also, patient's waiting time was not significant to the quality of service delivery in government hospitals.

Research limitations/implications – The results are constrained with dimensions of bureaucratic processes. Thus, the implication of this study is that bureaucracy in the Nigerian public hospitals is an unnecessary marriage which should be carefully separated and de-emphasised for quality service delivery in the hospitals to thrive.

Practical implications – Largely, this study is practical essential as it unearths the irrelevant operations procedure that hinder progress in Nigerian hospitals.

Originality/value – The study accomplishes recognised importance to survey how bureaucracy impedes quality service delivery in government hospitals. This study has provided a vital clue to elements that will

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Data Availability Statement: The data that support the findings of this study are available from the corresponding author, (Akinwale, O. E.) upon reasonable request.

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bring rapid attention to patients'outcome in Nigerian hospitals and health-care facilities which hitherto has not been emphasised. The study has contributed to the existing body of knowledge associated to healthcare service quality in developing country.

Keywords Bureaucracy, Patients' waiting time, Impersonality, Division of labour, Administrative rules and policies, Health-care service quality, Nigeria

Paper type Research paper

1. Introduction

Rapid and quality service delivery is crucial in health-care management, especially in hospitals in Nigeria given the prevailing socio-economic situation. As the popular adage says, health is wealth, so also is prompt and quality service delivery essential to human existence. This has been a challenge in the Nigerian health sector for over a long period of time and it calls for urgent intervention. Obtaining reliable services and prompt attention in government-owned hospitals have been a plague confronting most patients visiting hospitals when the need arises. The first point of call in our public hospitals in Nigeria is the record unit, where patients' files are kept. Right from this point down to the pharmacy where drugs are administered to patients, are characterized by an ineptitude service offering and delay processes. The ineptitude nature and delay have its root in bureaucratic management dimensions of the hospitals. On the account of the bureaucratic tendency, majority of the health-care workers have a poor attitude to work and this has an overbearing adverse effect on service quality to patients and their health systems. In the same vein, the bureaucratic processes and poor attitude to work have bedevilled the entire public sector of our national economy. From observation, not only the health-care sector, but virtually all public parastatals, ministries, and agencies are symbolic with delayed and slow attention when it comes to quality and efficient service delivery, and the Nigeria health-care system is not an exemption.

The challenge of bureaucratic processes of delaying patients that needed urgent attention is evident in the investigation of Segel (2017) which supports the above explanations, and argued that bureaucratic is deterring health-care from getting better. The inefficiency in health-care service delivery is pervasive especially in tertiary hospitals in Lagos State as well as the entire country. So many factors like patient-related, health worker-associated and employer-associated factors interrelate and adversely negate the quality health-care delivery being obtained in the country (Iloh *et al.*, 2013). The perceived challenge across all government established hospitals, and health-care facilities in the country, is the difficulties of poor response and attention in the cause of their visit to hospitals and this has caused a lot of damage to the citizens' health systems. Some have been consciously and unconsciously killed patients in the process of delay in giving prompt attention to the patients in the name of the bureaucratic pattern of work. Most times, the bureaucratic nature is extended more than usual and it has turned to neglect and abuse of the profession, and ethics of the business by health-care workers.

In furtherance of this discourse, the general inefficiency, ineffectiveness and poor service delivery in the Nigerian public service are as a result of poor procedural rules, excessive bureaucratic processes, political interference, poor working conditions, poor work ethics, among others, which have interacted to adversely affect service delivery in public sector organizations and particularly the health-care sector (Ezeani, 2014). The poor service delivery of public bureaucracy is sometimes criticized on its principle of impersonality, it nonetheless, creates a hole between the bureaucratic organizations and the populace. Furthermore, studies have revealed that bureaucratic processes are taking too much time

and unproductive, prevent innovative ideas and improvement, frosty and unconcerned, hindered hierarchical control, permeated with red-tapism, and subject to considerable goal displacement which is termed "bureaucratic dysfunction" (Maduabum, 2014; Ibietan and Oni, 2013; Irfan, 2016). It is this highly routined operating structure that most times adversely influence quality health-care service delivery in government-owned hospitals and tertiary institutions health centres which this study is evaluating in line with public opinion and perception of the health workers in Nigerian government hospitals.

Another pervasive issue that informs this study is that several challenges have emerged in the Nigerian health-care industry in relation to service quality. Through observations and interactions, patients' health systems have been thwarted as a result of the delay in response and the lackadaisical attitude to work. What could have been done headlong by one personnel to avert possible frustration of attendees in the hospital would be extended to more than three personnel before patients could comfortably obtain health-care attention in Nigerian public health-care facilities. The deplorable conditions of service delivery due to bureaucratic dimensions in tertiary and public hospitals were further argued in the study of Nwankwo *et al.* (2015) whose findings established that bureaucratic line of authority; division of labour, administrative procedural rules, impersonality and waiting time are the major adverse influence to achieving quality service delivery in Nigerian public hospitals. This situation is worrisome in Nigerian public health systems which call for vehement intervention. Thus, this study is set to add value to patients' health-care system by looking at the existing literature of Nwankwo *et al.* (2015) and Ezeani (2014), along Max Webber dimension whose studies established some dimensions of bureaucracy as line of authority, division of labour, administrative procedural rules, impersonality and waiting time in Nigerian government hospitals by proffering solutions to the deplorable states of service delivery in government-owned hospitals and bring succour to the patients and attendees health nature. The gap in the literature is that studies of this nature were conducted, in the past, on the management and employees of health-care facilities alone. Whereas this present study has taken it futher to survey the attendees and patients directly which are the major people concern for investigating quality service delivery which will elicit significant information for the study.

1.1 The scope of the study

This paper investigates the effects that bureaucratic components have on quality service delivery in tertiary hospitals and government hospitals in Lagos State. The rationale for choosing government hospitals and tertiary hospitals in Lagos State is due to the perceived challenges among the citizens in the area of health and Lagos State is a nerve centre in Nigeria with enormous health issues. Lagos State is believed to have over 21 million populations, the largest population in Africa and so also is the health challenge (World Population Review, 2018). According to World Population Review (2018), 66% out of a total 21 million population residents of Lagos live in slums and reported that, these residents have no access to clean water and good waste disposal which makes the citizens vulnerable to quality health systems. This is the major reason why Lagos State is chosen for the study. The sample was drawn from patients/attendees visiting tertiary and public hospitals in Lagos State.

2. Literature review

2.1 Theoretical framework

2.1.1 Bureaucratic theory. The bureaucratic theory emerged from a ground-breaking postulation of Max Weber on bureaucracy (1958). Weber agreed that his philosophies of

bureaucracy in government organisations assist in the understanding of why the contemporary bureaucracy was discovered in the industrialised western nations enabled them to accomplish optimum performance. The proposition of Weber is that for any vast and complex organisation to operate very well, formalised rules and procedures are necessary (Jatoi *et al.*, 2018). However, the proposition of Max Weber is that what makes bureaucratic organisation is that, it carries elements of essentials that include, operating under a hierarchical control, authority, underscoring meritocracy and not inherited rights or ownership, while the decision-making process follows a well-defined chain of command. Weber postulated that, given the complexities enmeshed in the operations of contemporary firms, the bureaucratic theory is the most logical and model solution to the administration of such, organisations (Oyelaran-Oyeyinka, 2006).

Ujo (2008), however, present features of the concept of a logical bureaucratic theory conceived by Weber as follows:

(1) official business is operated on a regular term;

(2) an administrative agency tasks in line with specified rules and is considered by three inter-associated features:

- the powers of the tasks of each official is delimited in terms of impersonal measures;
- the official is given corresponding authority to perform his duties; and
- the means of compulsion at his disposal are largely restricted and conditions that authenticate their contract is well stipulated.

(3) every individual member in the office is part of hierarchical authority, higher officials or offices supervise while sub-offices and officials have access to appeal;

(4) bureaucrats do not have the resources required for performing the duties, yet they are responsible for official resources. Official business and private undertakings, official and private profits are largely divided;

(5) offices cannot be adopted by the official as private property which can be sold; and

(6) the administration is concluded on the basis of written documents (Ujo, 2008; pp. 32-33).

The theory of bureaucracy of Max Weber's classic formulation of bureaucratic philosophy serves as the point of departure for those skewed towards a documentation-driven to understand the hierarchy that lies in the process of record keeping establishments. The work of administration involves establishing and re-establishing institutional objectives, resolving conflict on the use of authority, and managing the outcome of policy variabilities. This entails the application of rules and guidelines in making informed decisions. Inspite of their divergent dimensions, several scholars who have studied administrative processes whether sociologists, analysts of public administration, political scientists, or historians have confirmed Weber's work on bureaucracy (Adler and Borys, 1996; Meier and Krause, 2003; Page and Wright, 1999). While the administrative function has been a persistent attribute of all societies (ancient, primitive and contemporary), Weber was one of the earliest advocators to spot the distinguishing feature of bureaucracy in the contemporary period. Weber was a pioneering movement that conceptualises a model for analysing administrative systems and he serves as a forecaster in echoing the concern regarding the psychological penalties to any individual found in the pool of contemporary corporate organisations. Till today, Weber's inventions are still relevant and significant in helping organisations to better understand the all-encompassing political-economic systems: capitalist, socialist, and communist (Styhre,

2007). This theory resonates this study succinctly on the premise of the dimensions of bureaucracy. It is a good fit for the identified variables of this study. The theory addresses bureaucratic impersonality, division of labour, administrative procedural rules and waiting time of processing quality services.

2.1.2 Public choice theory. Public choice theory resonates the direct dimensions of bureaucracy in the modern-day business environment and it directly underpins the study logically. Public choice theory is a division of social economies that evolved from the aspect of taxation and public expenditure. The proponents of this theory are Buchanan and Tullock (1962), and they employ using economic devices to solve conventional issues of political science, and its contents consist of the study of political behaviour (Buchanan and Tullock, 1984). In political science, public choice theory happens to be a positive political theory that explores self-interest of agents such as politicians, political jobbers, bureaucrats as well as voters in relation to their social relationship. The theory takes an identical principle that economists employ to evaluate an individual's actions in the marketplace and applies them to people's actions in a shared decision-making atmosphere. The economists who understudy behaviour in the private marketplace presume that such individuals are driven solely by self-centred interest. Although, from their expression, majority of people premise their actions on their concern for others whereas in the true sense of it, the predominant idea in their actions whether they are employers, workforce or consumers is the concern for themselves (Schwartz, 1994). Therefore, Buchanan (1986) resolved that government is not efficient, and not purely selfless entities that effortlessly correct market deficiencies. Instead government are combined individuals inclined to focus on private rather than public interest via the mechanism of tax laws and regulations, and this is observed as government failure (Mueller, 2003).

However, these private interests introduce wasteful lobbying efforts called rent-seeking behaviour. Again, the public choice analysts have argued on rent-seeking and directly unproductive profit-seeking actions (Mueller, 2015; Shermeta, 2015; Tollison, 2012; Tullock, 1980). These are the avenues for realising profits and gains from activities that fail to add value to the social existence of human in society. They create goods and services that have no utility. Favourable Illustrations of direct unproductive profit-seeking exercise are tariff-seeking lobbying, producing insincere monopolies that create rents, as well as smuggling activities (Paldam, 2015; Varian, 1989). The implication of this is that it exhausts resources to generate profits but create no results at the expense of the masses in the society. This is largely true in all aspects of humanity, either socio-economic or political. The basic assumption that public choice analysts aver is that situations should not be evaluated from a public interest point of view but from an individual gain-maximising perspective. Everyone in social organisations (politicians, bureaucrats, voters, employers, employees, consumers, and stakeholders) act to optimise their own gains (Mbuku and Mwangi, 2015).

In furtherance of the above discussion, the theory is relevant to this study because it speaks directly to the dimensions of bureaucracy and inefficiency in producing results. Quality service delivery is the focus of this study and the theory suitably supports it. Bureaucrats are characterised with wasteful and possess the nonchalant attitude to output and result in as much as they earn their salary at work. Therefore, offering quality service delivery may likely not be their primary goal. All the four variables with the dependent variable of this study are hinged on public choice theory. Bureaucratic impersonality, division of labour, administrative procedures, rules and policies, and waiting time are all stimulated by public choice theory.

2.2 Conceptual review and hypotheses formulation

2.2.1 Bureaucratic impersonality and quality service delivery. Impersonality has been one of the attributes of bureaucratic virtue from the time of Max Weber. However, it has enabled the concept of bureaucracy turning to the epitome of red tape, poor initiative and lack of creativity, hence, poor service delivery in public sector (Galanti, 2011). The idea of impersonality in Weber's bureaucratic, organisation was centred on productivity via hospitable conduct of an individual and firm compliance to formal regulations governing the policies of the organisation, it entrenches perfection or near perfection, for the organisation to function effectively and help stimulate quality service delivery to the masses. However, in the majority of public organisations, impersonality has turned to undesired Frankenstein monster, with harms like unfair adherence to status-quo and inefficiency, which has rendered the original purpose irrelevant. In Nigeria, according to Ajibade and Ibietan (2016), bureaucracy has a negative influence on the quality of service delivery in the public sector. This dysfunctional feature of bureaucracy is evident in the Nigeria situation and it has eaten deep into her national fabrics. This dysfunctional nature has branded public service with hatred, loathing and jealousy, rather than fostering a spirit of oneness, cooperation and teamwork to achieve a goal of delighting members of the public when it comes to offering public services. This attitude of hatred and loathing occurs among peers, superiors and subordinates in Nigeria public offices as well as hospitals (Maduabum, 2014), and this precludes the workers from giving quality services to the members of the public. In addition to this, the Nigeria bureaucracies are marred with corruption, inefficiency and overstaffed offices (Lawal *et al.*, 2013). This confirms the report of Udoji of 1974 in Nigeria which reproaches Nigerian bureaucracies of prejudice and favouritism, ethnic fidelity and affinity, dishonesty, incompetency of boss to entrust and assign tasks and duties to subordinate, incompetence among young staff in carrying out delegated assignments, lack of necessary skills, knowledge in coordinating public services, inability to stick to deadlines and ineptitudes in productivity. Therefore, the study predicts that public organisations may likely not have desirable quality service delivery compared to privately-owned organisations. Thus, in view of this, explanation under this conceptual review, this study postulates that:

H1: Bureaucratic impersonality does not favourably impact on quality service delivery in government hospitals in Lagos State

2.2.2 Division of labour and quality service delivery. The concept of separation and division of labour has become one of the earliest concepts in the social sciences. It shows a stable corporate organisation, managing individuals or teams that are working on different but integrated tasks. The origin of division of labour has its root in a classical political economy, the precedent to contemporary day economics (Gupta *et al.*, 2015). The division of health-care personnel has a hierarchical component inherently fused in the organisation. One purpose of separation of health workers or dividing job functions according to skill sets and the experience is to apportion work to people who have the competence and can better handle such a job function effectively. Studies have shown the merits of careful consideration of the efficient separation of medical workers and workflow (Hughes, 2015). In regard to division of labour in health-care management, it would appear that the delivery of health care service is susceptible to striking a balance between public demand for quality service and the supply of the right workforce (Schoenfelder *et al.*, 2011). Division of labour is appropriate but a situation whereby an aspect of the workforce is posing a challenge in giving timely attention to a patient will cause dissatisfaction and patients with urgent medical needs may develop complication or their condition might worsen due to delay in

giving prompt attention from a division of the workforce (Turkki *et al.*, 2017). The delay in progress as a result of division of labour is connected with the service delivery in health care has made bureaucracy unacceptable to members of the public. It is this delay that has made the division of health-workers' tasks in the hospital becoming too cumbersome and challenging for patients to be satisfied with the management of hospitals and this has rendered quality service inaccessible. Moreover, the division of labour among health-workers gives room for over-dependence on a particular division especially when the team is not available at a given time or partial non-visibility occur when a patient wants to access them. A favourable example in support of this is the record division of the hospital. At times, when the staff on duty is absent for a known reason and a patient is willing to consult a medical doctor, without the record unit to fetch-out the patient file, accessing medical treatment becomes difficult. Also, if a medical doctor is not on the desk when a patient's file is passed forward, to see a doctor may also be quite difficult for such a patient. Therefore, this study predicts that the concept of division of labour hinders progressive service delivery in public hospitals in Nigeria. Thus, a division of healthworker in modern-day government-owned hospitals is a mirage. Hence, the authors would like to propose a hypothesis that:

H2: Division of labour among health workers has no significant effect on the quality service delivery in government hospitals in Lagos State.

2.2.3 Administrative procedure, rules and policies, and quality health-care service delivery. Administrative procedures in health-care centres, tertiary hospitals, rules and policies have its significance on the quality of service provided to patients. These are usually found in all bureaucratic organisations. Administrative procedures, policies and rules are crucial such that virtually every health-care worker manifest the administrative designation in their job descriptions. Carefully constructed policies are fashioned-out, maintained, and passed on to all health-care workforce and strict adherence is authorised. Regular orientation to these administrative procedures of bureaucratic processes is mandated, and job task is frequently defined by these policies and rules (Egeberg, 2012). Administrative procedures, rules and policies aspect of bureaucracy is argued by several contemporary thinkers as being diametrically opposed to innovation and creativity. Administrative rules and policies are not sufficed to elicit quality service delivery in health-care management. Such a situation needs flexibility in attending to patients as different strokes for different folks. Within bureaucratic firms, rules are the major features of formal organisations, where formal rules and regulations are employed to stipulate what individuals in corporate firms have to do (Knill and Grohs, 2015). However, the idea of adhering to formal rules streamlines the chances open to health-care staff to not only be involved in the formulation of objectives and goals but also even to use their own initiative on the possible means of conducting their job task. Therefore, this has an overbearing effect on the quality of service delivery to patients being attended to. As the rules have its attendant difficulty on health employees so also it hampered the satisfaction of patients and attendees visiting the hospitals. For this reason, health-care workforce in bureaucratic firms could be inhibited by the bureaucratic practice of control, which impede the multiplicative tendencies of the workforce and suppress their capabilities in producing innovative ideas and this has a resultant effect in the delivery of quality service to patients visiting the hospitals (Trondal and Veggeland, 2013). Therefore, this study predicts that administrative procedure, rules and policies may likely deter quality service delivery in hospitals in Nigeria. Hence, this study hypothesized that:

H3: Administrative procedure, rules, and policies prevent quality service delivery in government hospitals in Lagos State

2.2.4 Patients' waiting time/turnaround period and quality service delivery. Another component of bureaucratic processes in tertiary and government hospitals is the waiting time or turnaround moment in delighting patients/attendees visiting the health-care centres. Patients visiting hospitals for medical attention exhaust an extensive period of time in the clinics waiting for services to be delivered by physicians and other health-related professionals. The rate at which health consumers are not satisfied with the care obtained is strongly associated with the waiting time experience. Health-care organizations that seek to deliver *par excellence* services must be keen to manage their clinics' waiting time (Ballini *et al.*, 2015). Inability to integrate consumer/patient-focused components into the structure of the waiting experience could result in patient dissatisfaction. Waiting time is expressed as the amount of time a patient spends in the clinic before being attended to by any of the clinic health worker (Oche and Adam, 2013). Patients clinic waiting time is a critical pointer of quality services delivered by hospitals (Chen *et al.*, 2010). The amount of time at which a patient waits to be attended to is determinant element that influences the utilisation of health-care services. Patients see protracted waiting time as a challenge to offering quality services in hospitals. Keeping patients waiting pointlessly may lead to tension and anxiety for the patient. Waiting time is one of the parameters in which health workforce quality service delivery is determined, even more than their competence, knowledge, and skill.

Given the attributes of bureaucratic organisations, going by impersonality dimension, division of labour, administrative procedures, rules and policies of bureaucratic processes, waiting time on outcome patient in hospitals may not witness the improved process and outcome. Studies have discovered that several times in public hospitals, patients may have to wait for a very long period of time before getting the attention of doctors and pharmacists. This may not be unconnected with the paucity of the employees available to the hospitals at a given time (Kamil and Lyan, 2013; Sun *et al.*, 2017; Yahya *et al.*, 2015). Further argument by several authorities established that patients' dissatisfaction alongside the astronomically high waiting time, poor service quality, drugs that are not relevant for the treatment of ailment complained upon, and poor treatment are increasingly attracting serious concern from experts and several other world health organisations. This is the fall-out from public service that is not backed up by strong laws but hampered by bureaucratic processes (Carson *et al.*, 2014). Therefore, this study envisages that turnaround time and patient's waiting time does not reflect on quality service delivery in hospitals in Nigeria. With the review of the literature on the concept of waiting time/turnaround time in hospitals, this study further hypothesized that:

H4: Patients' waiting time/turnaround period of attending to patients does not impact on quality service delivery in government hospitals in Lagos

2.3 Bureaucratic dysfunction in Nigeria public sector

The dysfunctional features of bureaucracy in Nigeria are as a result of the self-centeredness of the individuals in various public offices and the leadership challenge which have pervaded the entire socio-political environment of the Nigeria polity. The Public Service Review Commission, therefore, observed that the Nigerian public services are marred with the spirit of hatred, dislike and jealousy rather than collaborative spirit and cohesive teamwork. Above all, corruption has also characterised the Nigeria public services (Lawal *et al.*, 2013). This spirit of bitterness and hatred among public servants has further been obvious among subordinates and superiors in the public sector. The animosity becomes very tense when a superior get a clue that a subordinate is creative and innovative and may

out-perform him/her in an office environment. Thus, to circumvent the actualisation of innovative ideas that come from subordinate or superior officers, either of them will firmly stick to the adherence to rules and policies, and regulations which often are antithetical to innovation and flexibility, and productivity (Ogundiya, 2011). In a clear reference to the state of affairs in Nigeria public sector, the public commission review, in its main report, found that many of employees do not see themselves as part of public service commission and they take a narrow view of their tasks. As established earlier, the Nigeria public service has undergone several reforms which indicate that it had not yet fulfilled societal expectations in terms of service delivery. Part of the reforms as articulated in the review commission of Udoji Review (1974) and the Obasanjo Renewal Programmes found the Nigerian bureaucracies with nepotism, corruption, the incompetency of both the senior and junior personnel, poor ability to use their skills, poor time management skills, and general inefficiency (Alabi and Fashagba, 2010). This adversely affect the quality of service delivery to members of the public.

Furthermore, public service staff owned-up to focusing on procedures, rules, and regulations rather than generating and creating new ideas to perform their statutory obligations in order to become highly productive. While these rules are not suitably optimistic, they are devised not to satisfy the requirement for meeting their job functions and the progress of the government. This is the reason the public sector is usually perceived as a space whereby without offering the officials a kick-back, they may not adequately give members of public the desired attention. Officials in the Nigeria public sector are driven by rights and gratuities, bonuses, incentives than performing their job functions; great concern for job security and protection of their rights and privileges than innovation, creativity, and productivity (Ahmed, 2016). Civil service employees conduct themselves as individuals who oversee the affairs of the rules and its application. Resistance to innovation has been a major impediment to quality service delivery in the Nigeria public sector. Eme and Ugwu (2011) did pinpoint resistance to innovative ideas as one of the elements that distinguishes the Nigerian public sector from its private organisations. Public administration is associated with public sector while effective management of the business is associated with corporate organisations in Nigeria (Awosika, 2014). Hence, the possibility to circumvent innovative ideas is on the increase in the public sector. This should have been ameliorated from the transformations which, the public service sector in Nigeria had passed through from time to time. Other reasons established by Eme and Ugwu (2011) which are intricately connected with resistance to innovation are survival, maintenance of status-quo, risk and mistake avoidance, self-protection and self-interest, fear of jeopardy, and retrospective. Another indication of scuttling innovation especially where such innovative concepts evolve from subordinates in the Nigerian public service is offered by a study team on the structure, staffing and operations of the Nigerian Federal Civil Service headed by Professor Dotun Philips (Maduabum, 2014). In its report, the study team discovered that informed decision procedure and its execution processes in Civil Service have been subjected to criticism from both the public and government as bureaucratic, rigid, slow, too confidential and secretive, and not progress-driven (Eme and Onwuka, 2010). A decisive reason for the above-mentioned issues, according to the report, is the lack of autonomy and incompetence of the senior officers to take decisions unless approval is sought from superior officers in whom control resides with. The discovery of the study team concluded that lack of autonomy to take certain decisions by senior officers unless approval is given does not only lead to time-wasting but also prevents initiative and discretion of subordinates in public sector of Nigeria which leads to frustration and erodes self-reliance and confidence in the capability of the junior officers in taking certain decisions that will lead to the progress and development

of the sector (Rasul and Rogger, 2015). The Study Team, thus, provided a panacea to this protracted process of decision making by restricting formulation of policies to the management and directorate hierarchy alone, that is, grade levels 13 to 17 alone. This belief would preclude the causes of bureaucratic barriers in decision making and stimulate innovative ideas in public service in Nigeria public sector.

3. Research methods

This research focuses on investigating the effects of bureaucratic processes on quality health-care service delivery in tertiary and government hospitals in Lagos State, Nigeria. The study population for this study is patients/attendees visiting tertiary health-centres and government hospitals in the State. The research design for this study is a descriptive research design with a cross-sectional survey method on the population. The study examines the patients of the hospitals by administering a questionnaire to patients attending hospitals at one point in time in gathering data as regards to how satisfied they were in terms of services offered in hospitals. The essence of descriptive design is due to its popularity in health study in providing a glimpse of how widely spread a certain phenomenon affect a population at a single point in time and how to obtain an appropriate sample (Bryman and Bell, 2011). Another justification for using the descriptive design using cross-sectional survey is that it is useful in examining how many individuals are affected by one type of challenge and whether the occurrence of the incidence differs across groups or population features. It is also helpful to establish whether a condition is more likely to be connected with other features or events (Saunders *et al.*, 2016). The instrument for collecting data is a structured questionnaire on the 7-Likert scale. The choice of using a questionnaire is that it enables the researcher to obtained responses in a more standardised manner and it is objective in nature (Bird, 2009).

3.1 Measures

The research instrument used for patient waiting time and turnaround is adapted from the scale of Hawthorne (2006) and Hawthorne *et al.* (2006). The instrument was a short assessment of patients satisfaction with seven items in which four of the items were on waiting time to consult physicians. The SAPs contains seven items investigating the essential domains of patients satisfaction which consists of treatment satisfaction, waiting period before assessing medical facilities, time with the clinician, clinician care, participation in medical decision-making and satisfaction with hospital/clinic care. The short assessment scale has been substantiated in a clinical environment (Sansoni *et al.*, 2011) with an endorsement from the Australian Government Department of Health and Ageing. The language of the instrument was in its original English version. The responses scale are on 7-point scales with a high-reliability alpha coefficient of 0.81.

Quality service delivery in health-care instrument adapted was from Marshall and Hays (1994) psychometric properties scale of a short version of a-50-item patient satisfaction questionnaire III. Patients' satisfaction is a metric of quality service received in health-care facility, therefore patient satisfaction questionnaire is deemed suitable for the study scale. The short-form instrument, the patient satisfaction questionnaire, contains 18 items, and the scale has seven dimensions of satisfaction with medical care measured by PSQ-III. The seven dimensions are:

(1) general satisfaction;

(2) technical quality;

(3) interpersonal manner;

(4) communication;
(5) financial aspects;
(6) time spent with doctor; and
(7) accessibility and convenience.

The seven dimensions used by Marshal and Hays (1994) was adapted and collapsed into two of the dimensions of this study (quality service delivery and patients' waiting time/turnaround period). The language of the instrument was in its original English version. The responses are on seven-point scales with a high-reliability alpha coefficient of 0.85. Another research instrument used for both administrative procedure, rules and impersonality dimensions was taken from the scale of Vanhala *et al.* (2011). The scales adapted were from Vanhala *et al.* (2011) and consist of 18 and 13 items respectively. The instruments were developed by Vanhala *et al.* (2011). The Cronbach alpha for these scales are 0.82 and 0.82 respectively. On division of labour for health-care personnel in tertiary hospitals in Nigeria, due to the paucity of the scales in this domain, the study employed a self-constructed research instrument of 14-items measuring patients perception of division of health-care personnel tasks/jobs and responsibilities towards their quality service offering. The instrument was subjected to pilot test in another hospitals and health-care facilities using 65 patients to obtain its reliability, the alpha reliability for this instrument was 0.79 and its validity was measured through professional face and construct validity.

3.2 Population and sample size

The population of this study includes patients/attendees visiting tertiary hospitals and government hospitals in Lagos State. The population is considered large and so it is an infinite population. Government hospitals in Lagos State are over 20; 18 state government and 2 federal government hospitals (Adenuga and Ibiyemi, 2014), including Lagos University Teaching Hospital (LUTH) and the Lagos State University Teaching hospital (LASUTH), federal and state government established respectively. The reason it is considered infinite is that it is possible that one or more patients might be using two or more hospitals at a time depending on the accessibility and proximity to the attendee. This will make the population overlap. Moreover, records of patients will not be given in terms of population as this will negate the oath of secrecy from the medical practitioners point of view. Thus, it is considered as an infinite population. Given this premise, the study draws a sample size using Cochran (1963) formula for an infinite population:

$$n_o = \frac{Z^2 * P * q}{e^2}$$

where;

n_o = Sample size;
Z = Z-value (e.g. 1.96 for 95% confidence level);
P = Percentage of population picking a choice expressed as decimal; and
e^2 = Acceptable sampling error, desired level of precision, confidence interval expressed as decimal (e.g. 0.04 = ± 4 percentage points).

Therefore, the sample size for this study is derived using the formula above for widely spread hospitals' attendees and patients in Lagos State, Nigeria whose degree of variability

is not known. Assuming the maximum variability, which is equal to 50% (p = 0.5) and taking 95% level of confidence with ±4% precision level, the calculation for the required sample size is thus given as p = 0.5, hence q = 1–0.5 = 0.5; e = 0.04; z = 1–96. Thus, the sample size:

$$n_o = \frac{(1.96)^2 (0.5)(0.5)}{0.04^2} = 0.9604/0.0016 = 600.25$$

The total sample size for the study is 600 patients/attendees across all hospitals and tertiary health centres in Lagos State.

3.3 Sampling technique

A random sampling strategy was adopted to carefully taking those patients/attendees that participate in the study. A total number of 600 copies of the research instrument were administered to 20 general and tertiary hospitals in Lagos including LASUTH and the University of Lagos Health Centre. 2 Federal government-owned hospitals and 18 State government-owned hospitals in Lagos State. However, 494 copies were returned which represents 82.3% response rate. The basis for taking simple random sampling is that it reduces the chance of the sample biased or prejudice of the researcher taking the sample (Saunders *et al.*, 2012). Another reason for adopting simple random sampling is that it enables the individual selecting the sample to apply the findings to the entire population given its unbiased nature. And it gives the opportunity to analyse data that possess a relatively error margin (Babbie, 2013).

3.4 Validity and reliability

The validity of the research instrument is done using the content and criterion validity, discriminant and convergent validity using factor loading of the items in the research instruments. Item was raised and the criterion validity confirms if the instrument accurately evaluates what it ought to evaluate. The variables under study are impersonality; division of labour; patient waiting time/turnaround period; and administrative procedures, rules and regulations managing hospitals. Criterion validity examines the degree to which a measure is associated with an outcome. It is a measure of how appropriate the instrument predicts an outcome for another measure. A test is said to have this kind of validity if it is significant in predicting performance or behaviour in another situation (past, present or future) (Taherdoost, 2016). Therefore, the question items adequately addressed all the variables of measurement. The content validity of the instrument shows the degree of clarity and suitability of the question items in the questionnaire. Experts in both medical and management sciences were given the instrument and validation was done by the experts. Suggestions were provided on which question items to reject, change or retain. The reliability of the instrument, however, was done using internal consistency of cronbach's alpha and composite reliability as it shows consistency in all the parts of the measuring instrument (Huck, 2007). The scale is proposed to be consistent and reliable if the question items of the scale are cohesive, stable and evaluate the same construct (Oluwatayo, 2012). The most commonly employed internal consistency measure is Cronbach alpha coefficient and it is seen as the most suitable evaluation of reliability when using Likert scales (Bryman, 2012). The acceptable Cronbach Alpha coefficient on a minimum internal consistency coefficient of 0.70 was obtained on all the variables of interest. The higher value on impersonality (0.76), a division of labour (0.79); patients waiting time/turnaround time

(0.74) and administrative procedures, rules and regulations (0.71) had higher coefficient reliabilities.

3.5 Data analysis strategy

The analytical technique for the study is the bivariate analysis. It is used to determine if there is a relationship between two sets of values, usually involving variables X and Y. The bivariate analysis is done using a simple linear regression model. This data analysis strategy is chosen on the basis that it enables one to measure the strength and direction of the relationship that exists between two or more elements. It further helps to indicate if this association is a valid one (Kumar, 2014).

4. Results

4.1 Descriptive statistics

This includes mean, standard deviation and correlation among all dimensions of bureaucracy in health-care are depicted in Table 1. It can be noticed that correlation values between bureaucratic impersonality and quality health-care service delivery ($r = -0.0481$; $p \leq 0.01$) showing negative minor correlation and insignificant value higher than 1%. Division of labour and quality health-care service delivery ($r = -0.0382$, $p \leq 0.01$) was not significant with negative weak correlation. Administrative procedure, rules and policies and quality health-care service delivery ($r = 0.0212$, $p \leq 0.01$), and patient's waiting and turnaround time and quality health-care service delivery ($r = -0.0423$, $p \leq 0.01$) are all statistically insignificant and are in negative directions except for Administrative, Procedure, Rules and Policies with positive correlation yet very weak. The mean values and standard deviation for bureaucractic impersonality (5.25, 0.85), division of labour (5.72, 0.75), administrative procedure, rules and policies (4.95, 0.87), patient's waiting time and turnaround period (6.25, 0.79), and quality health-care service delivery (5.20, 0.79) are noted. Composite reliability also is noted in Table 1, conventionally, Cronbach's alpha is the measure of internal consistency for reliability coefficient. It produces an estimate of the reliability taking the inter-correlations of the observed indicator variables as earlier conducted for this study. Besides, it is recommended that Cronbach's alpha is employed as a traditional measure of internal consistency reliability as a result of its responsiveness to the number of items in the scale and its tendency to underestimate the internal consistency reliability. Consequent to these drawbacks, composite reliability is an appropriate measure of internal consistency reliability. The composite reliability varies between 0 and 1, where higher value shows a higher degree of reliability. Composite reliability values shoud be 0.70

				Correlations				
Factor	Mean	SD	CR	1	2	3	4	5
1. BIMP	5.25	0.85	0.775	*(0.841)*				
2. DL	5.75	0.75	0.795	−0.0241	*(0.826)*			
3. APRP	4.95	0.87	0.854	−0.0522	−0.0342	*(0.824)*		
4. PWT	6.25	0.77	0.825	−0.0392	−0.0244	0.0491	*(0.812)*	
5. QHSD	5.20	0.79	0.855	−0.0481	−0.0382	0.0212	−0.0423	*(0.795)*

Notes: $^{**}p \leq 0.01$. Square root AVE (bold values) are displayed in parenthesis showing discriminant validity. SD: Standard Deviation; BIMP: Bureaucratic Impersonality; DL: Division of Labour; APRP: Administrative, Procedure, Rules and Policies; PWT: Patient's Waiting and Turnaround Time; QHSD: Quality health Service Delivery; AVE: Average Variance Extracted; CR: Composite Reliability

Table 1.
Descriptive statistics, composite reliability, correlations and discriminant validity

or higher (Bagozzi and Yi, 2011). Therefore, the condition of higher internal consistency is fulfilled on the variables of this study as shown in Table 1, all the dimensions are higher than 0.70. Also, discrimant and convergent validity values are given in Table 1 for all the dimensions of bureaucracy. It ensures that the construct signifies something exceptional. Discriminant and convergent validity of the variables were measured by exploring the factor loadings, average variance extracted (AVE). The composite reliabilities confirmed the minimum benchmark at 0.60 (Asif *et al.*, 2019). While the estimates for the average variance extracted (AVE) moved beyond the limit of 0.50 (Fornell and Larcker, 1981) (see Table 1)

4.1.1 Data analysis and interpretation of results (see table 2). Table 2 indicates that 49% of the total population surveyed included male participants while 51% were

Profile	Frequency	(%)
Gender		
Male	242	49.0
Female	252	51.0
Total	494	100.0
Age		
20 – 30 years	164	33.2
31 – 40 years	180	36.4
41 – 50 years	120	24.3
Above 50 years	30	6.1
Total	494	100.0
Marital Status		
Single	205	41.5
Married	244	49.4
Divorced	45	9.1
Total	494	100.0
Self-Reported Health Status		
Poor	179	36.2
Fair	170	34.4
Good	80	16.2
Very Good	35	7,1
Excellent	30	6.1
Total	494	100.0
Frequency of Hospital Visits		
Once a Week	38	16.7
Several Times a Week	54	23.7
Once a Month	53	23.2
Several Times a Month	43	18.9
Several Times a Year	40	17.5
Total	494	100.0
Education		
SSCE	98	19.8
Undergraduate	150	30.4
HND/BSc.	200	40.5
Masters	30	6.1
Ph.D.	16	3.2
Total	494	100.0

Source: Field Survey, 2019

Table 2.
Respondents' demographic profile

female. This shows that the sample was not gender-biased as the relative score was fair, balanced, suitable and a valid study. Also, about 69.6% of the participants fall within active age range while the remaining 30% fall into the category of mid-age and above. Also, nearly half of the entire respondents were married which depicts that they were responsible. 41.5% were single while 9.1% of them reported being divorced. However, the reason for their present marital position at the time this report was filed was not probed further. Concerning their supposed health status at the time of visiting the clinics and hospitals, 36.2% and 34.4% of the respondents reported that their health status was poor and fair respectively. 16.2% of them were having good health status, 7.1% of them had very good health position, and 6.1% of them, had excellent health status. The reason for those that recorded well, very good, and excellent health positions visiting hospitals is peradventure for a holistic medical check-up to reduce the risk of experiencing serious health challenge. As regards the frequency of hospital visits, 16.7% said they visit the hospital once a week, 23.7% visit the hospital several times a week, 23.2% of the respondents visit the hospital once in one month, while 18.9% and 17.5% of the respondents stated that they visit the hospital several times in one month and several times in one year respectively. This makes the participants qualify to appropriately respond to the questionnaire and give valid information regarding the treatment experience in the cause of using the health-care facilities in Lagos State and tertiary hospitals. The educational status of the respondents show that 19.8% of them were holders of school certificate otherwise called ordinary level certificate, 30.4% of the respondents were undergraduates, they were university students undergoing one academic course or the other. 40.5% of them were holders of Higher National Diploma and Bachelor of Science Degree. 6.1% and 3.2% were holders of masters degree and doctorate (Ph.D.) degree respectively. The implication of this educational profile of the respondents is that all of them are suitable to give valid information that assists the study in making an informed decision.

4.2 Analysis of data and test of hypotheses

H1: Bureaucratic impersonality does not favourably impact on quality service delivery in government hospitals in Lagos State

The first hypothesis of this study is analysed in Table 3 (see Table 3). Given model summary analysis, R indicates that 5.5% strength of the relationship exists between impersonality and quality health-care service delivery among the hospitals evaluated. Also, R-square depicts that 0.3% of impersonality variations account for quality health-care delivery among the attendee's survey in the hospitals. This shows that 0.3% of total variability explains the degree of quality health-care service delivery and it is not fit in the analysis. The analysis of variance in Table 3 also shows 21.9% far above the accepted level

Variable	B	Beta	R	R^2	T-value	F-value	Sig.	Durbin Watson
Bureaucratic Impersonality	−0.042	−0.055	0.055	0.003	−1.231	1.515	0.219	0.776

Note: Dependent Variable: Quality Health-care Service Delivery ($P< 0.05$)
Source: Field Survey: 2019

Table 3.
Data analysis consideration for hypothesis one

of significance (0.05). This indicates that it is not statistically optimistic given the value of p = 21.9%. Thus, the null hypothesis is accepted, which states that bureaucratic impersonality does not favourably impact on quality service delivery in government hospitals in Lagos State. Standardised coefficient (Beta) value in Table 3 depicts that the independent variable is not statistically showing impact at −5.5% which is negative. It shows that there is an adverse impact of bureaucratic impersonality on quality service delivery in hospitals. The T-statistics which test relative error difference in comparison to the null hypothesis gives the negative value of −1.231. The implication of the T-value in this result is that there is a small negative value of T with large p-value and it depicts that the means of the hypothesis are not significantly different. Therefore, the null hypothesis is not discredited and is accepted (Gill, 1999). The Durbin Watson value shows that there is positive auto-correlation at 0.776

H2: Division of labour among health workers has no significant effect on quality service delivery in government hospitals in Lagos State.

Table 4 (see table 4) reports the analysis on hypothesis two of this study and shows that R at 4.8% has a very weak relationship when the division of labour of health-care worker is compared with quality service delivery in hospitals. On the other hand, R-squares is a statistical evaluation of how close the data are to the fitted regression line. It is a coefficient of determination. R-square is 0.2% which means that the model explains the total variability of the response data. This is an indication that 0.2% total variability of quality service delivery is explained by the division of health-care worker in the hospitals surveyed. However, it means a very minute variability which depicts that the model explains none of the variability of the regression model around the mean. The value for analysis of variance gives an insignificant value of 0.284 (28.4%) with F value at 1.515, which is above the alpha value of 5%. P = 0.284. Given the anova p-value, there is a ground to accept the null hypothesis which states that division of labour among health workers has no significant effect on quality service delivery in government hospitals in Lagos State. The Durbin Watson value shows that there is positive auto-correlation at 0.776

Table 4.
Data analysis consideration for hypothesis two

Variable	B	Beta	R	R^2	T-value	F-value	Sig.	Durbin Watson
Division of Labour	−0.024	−0.048	0.048	0.002	−1.073	1.515	0.284	0.776

Note: Dependent Variable: Quality Health-care Service Delivery ($P < 0.05$)
Source: Field Survey: 2019

H3: Administrative procedure, rules, and policies prevent quality service delivery in government hospitals in Lagos State

Table 5 shows the analysis of *H3* of this study. On the model summary path that gives R = 5.2%, this indicates that 5.2% strength of correlation exists between an administrative procedure, rules, and policies, and quality health-care service delivery. It depicts a very weak relationship. R-square gives 0.3% total variability which means that administrative procedure, rules and regulations do not explain any variability that occurs on quality service delivery. While analysis of variance in Table 5 is 0.244 which

means 24.4% is not significantly related to quality service delivery, F (1, 492) = 1.359, $P > 0.05$, P = 24.4%. Therefore, there is justification to accept the null hypothesis that states that administrative procedure, rules, and policies prevent quality service delivery in government hospitals in Lagos State. The Durbin Watson value shows that there is positive auto-correlation at 0.776

Variable	B	Beta	*R*	R^2	*T*-value	*F*-value	Sig.	Durbin Watson
Admin Procedures, Rules and policies	0.026	0.052	0.052	0.003	1.162	1.359	0.244	0.776

Note: Dependent Variable: Quality Health-care Service Delivery ($P < 0.05$)
Source: Field Survey: 2019

Table 5. Data analysis consideration for hypothesis three

H4: Patients' waiting time/turnaround period of attending to patients does not impact on quality service delivery in government hospitals in Lagos

Table 6 explains *H4* of this study. It shows R at 3.9% which means that 3.9% coefficient of correlation otherwise called strength of the relationship between patients' waiting time/turnaround period and quality health-care service delivery occur in the hospitals evaluated in Lagos State. R-square is 0.2% which shows how the regression equation accounts for variability in the response variable. The R-square indicates that 0.2% of the variance of quality health-care service delivery is explained by the patients' waiting time/turnaround period. Given the low value of 0.2%, absolutely means that it does not explain any variability that exists on quality service delivery. The analysis of variance which denotes decision had this value (P= 0.382; $P > 0.05$), portends that there is a justification to reject the alternate hypothesis and accept the null hypothesis which states that patients' waiting time/turnaround period of attending to patients does not impact on quality service delivery in government hospitals in Lagos. The Durbin Watson value shows that there is positive auto-correlation at 0.776

Variable	beta	B	*R*	R^2	*T*-value	*F*-Value	Sig.	Durbin Watson
Patient's Waiting, Time/ Turnaround Period	−0.020	−0.039	0.052	0.003	−0.875	1.765	0.382	0.776

Note: Dependent Variable: Quality Health-care Service Delivery ($P < 0.05$)
Source: Field Survey: 2019

Table 6. Data analysis consideration for hypothesis four

5. Discussion of findings

The study has exhibited significant outcome regarding all the results from the analysis conducted in relation to quality health-care service delivery in government-owned hospitals in Lagos State, Nigeria. Hypothesis one of the study demonstrates that there is no significant relationship between bureaucratic impersonality and quality health-care service delivery. By implication, this shows that impersonality and personal differences speak great volume on efficiency through impersonal conduct of an individual and firm adherence to rules and

regulations governing the policies of the organisation. However, in the 20 hospitals surveyed, majority, with their ineptitude nature and impersonality feature of bureaucracy that Weber proposed has turned to undesired Frankenstein monsters, with harms like unfair adherence to status-quo and inefficiency, and this rendered the original purpose irrelevant. Most of the patients confirmed that health-care employees are not eager to attend to most of them when it comes to giving medical attention and it has turned to personal differences and the service quality is affected. Health-care service is critical to human endeavour, the finding discovered that neglect is pervasive among health-care workers in those hospitals rather than giving patients quick attention but being public hospitals, all the workers, including medical doctors, believe that they cannot be over overstretched when it comes to attending to the needs of patients. The result depicts that bureaucratic impersonality does not favourably impact on quality service delivery in government hospitals in Lagos State. This finding is symmetrical with the study of Ajibade and Ibietan (2016), whose finding discovered that bureaucracy has a negative influence on the quality of service delivery in the public sector. Also, this study takes a similar position with the study of Maduabum (2014) which concludes that animosity and loathing among subordinates and superiors are the major challenges that affect bureaucratic impersonality in relation to quality service delivery in the Nigeria public sector.

Hypothesis two (H_2) of this study demonstrates the same contrary dimension to quality service delivery in the health-care system. The idea of separation and division of labour in hospitals is a good one which calls for effectiveness and productivity. This allows health-workers to maintain a coordinated task function divisible according to skills and competence. However, the study has discovered that separation and division of labour among health workers have no significant effect on quality service delivery in government hospitals in Lagos State. The study discovered that the division of labour in public hospitals in Lagos State usually brings about an unnecessary delay in giving medical attention to patients visiting hospitals. The study found out that division of labour has caused a lot of damage to attendees as some lower workers take their job with deserved priority. The study confirmed that in the record section of the hospitals, patients are usually made to queue indefinitely before being attended to. Another aspect is the pharmacy section where patients experience a great challenge for drugs to be dispensed to them. The study also discovered that separation and division of labour in health care centres and hospitals have caused over-dependence on a particular unit or individual. This finding takes a similar position with the study of Lavander *et al.* (2017) which concludes that challenges and issues in developing the division of labour were associated with personal experience, technical know-how, and firm's elements *vis-à-vis* attitudes, predispositions regarding competence and the restrictions and uncertainty of health-care labour.

Hypothesis three (*H3*) indicates that administrative procedure, rules, and policies serve as a deterrent to quality service delivery in government hospitals in Lagos State. The study revealed that formal rules and standard operating procedures in government-owned hospitals in Lagos State usually deter patients from experiencing quality service delivery. Formal rules and policies often lead to issues and challenges that outpatients encounter when visiting hospitals. The study discovered that formal rules and regulations cause red-tape as some of the official procedures usually lead to over-complication of an outpatients' health condition in the management of the hospitals in Lagos State. The study established that formal rules and regulations prevent health workers from being creative and innovative in the discharge of their duties. This finding resonates with Trondal and Veggeland (2013) who maintained that formal rules and regulations of bureaucracy inhibit and impede the multiplicative tendencies of the workforce and suppress their capabilities in producing

innovative ideas. This has a resultant effect on the delivery of quality service to patients attending the hospitals.

The final hypothesis four (*H4*) of this study is that outpatients' waiting time/turnaround period of attending to patients does not impact on quality service delivery in government hospitals in Lagos State. The study discovered that many of the outpatients who would desire an appointment with doctors usually spend an average of 55 minutes before obtaining medical attention from doctors, pharmacist and other related health-care workers. The study revealed that long waiting time was another challenge in assessing medical facilities in government-owned hospitals in Lagos State. It has been demonstrated that protracted waiting time is antithetical to quality service delivery in hospitals in Lagos State and therefore it must be taken care of very well if peoples' lives must be saved. This study further established that outpatients considered lengthy waiting time as an obstacle to visiting hospitals. Some have even claimed that they resort to alternative home remedy in treating themselves whenever health issue arises. It is gathered from the study that patients exhaust projected 1 hr. 25mins, in another hospital, waiting with lengthy time, most of this time spent at, the record units, registration and the pharmacy. This finding is consistent with the result of Sun *et al.* (2017) whose position was that several times in public hospitals, patients may have to wait for a very long time before getting the attention of doctors and pharmacists, as this may not be unconnected with the paucity of the employees available to the hospitals at a given time. Also, this finding is in consonance with the study of Carson *et al.* (2014) which held that patients' dissatisfaction alongside astronomically high waiting time, poor service quality, the absence of the prescribed drugs for the treatment of ailments complained of and poor treatment is not necessarily a result of inadequate laws but bureaucratic processes.

6. Conclusion and recommendations

Health-care services are contingent on time or less waiting time that patients use in seeing the doctor and get succour on their health situation. Bureaucratic tendencies in the Nigeria health-care systems is preventing the productive ability of the health-care workforce and anything termed "public service" inherently characterised with lackadaisical approach. Bureaucratic processes in Nigeria hospitals have engendered inflexibility and rigour, as formal rules and regulations in the bureaucratic management of hospitals in Lagos State are too rigid. Consequently, this compliance with formal rules and regulations rather put-off innovative ideas and introduces avenues for accepting responsibility for the failures of health-care employees. This is why, often times, when error occurs in hospitals, they never accept that the mistake was as a result of the negligence of the staff on duty. Also, impersonality in bureaucracy stresses a mechanical means of getting work done faster while organisational rules and regulations are given high precedence over an individual's emotions. The overall outcome of this study largely indicates that patients are not delighted and satisfied with the service provided in government-owned hospitals in Lagos State. The overall outpatients' experience with services offered was very poor on the basis of a bureaucratic enigma. All the characteristics of bureaucratic processes measured show insignificant values, impersonality, separation and division of labour; formal rules and regulations, as well as patients' waiting time at the hospitals, were all insignificant with quality customer experience from the findings. Thus, this study concludes that formal rules and regulations of bureaucracy and other features of bureaucracy are "unholy marriage" in the management of hospitals in the state. In view of the findings of this study, the study makes the following recommendations for improving the state of health-care position in Nigeria:

- The cost of bureaucracy and volume of bureaucratic directives should be drastically decreased in order for patients to have confidence in public hospitals. This is another reason some wealthy patients seek medical attention oversea due to prompt attention.
- Qualified and zealous personnel should be matched with certain units such as record point and pharmacy.
- The management of both federal and state-owned hospitals in Nigeria should allow and encourage patients' feedback after they have received medical treatment and attention. This will enable the management a clearer understanding of where improvement is required in service delivery.
- Emotional intelligence training should be given to all health-care employees. This entails awareness and understanding of emotions and applying them to behaviour and decision making. This will help in awareness and management of their own emotions and patients emotions. In the end, they will leave the patients better-off by treating them well with the right attitude and right spirit.
- The government should also motivate health-care workers by making the work environment conducive for them to work and adequately remunerated. This will prevent most of the doctors from running private hospitals, otherwise called employee moonlighting. Surprisingly, privately run hospitals in most cases are owned by qualified doctors working in government hospitals. It is therefore possible for these doctors to refer patients to their private hospitals, usually (although not by any reason always) to generate income. Therefore, when they are wholesomely remunerated, they would be more likely dedicated to quality service delivery.
- Government partnership and collaboration with foreign organisations should be encouraged in order to improve patients' experience

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