UNIVERSITY OF GHANA

PATIENTS SATISFACTION WITH QUALITY HEALTHCARE IN GHANA: A COMPARATIVE STUDY BETWEEN UNIVERSITY OF GHANA AND UNIVERSITY OF CAPE COAST HOSPITALS

BY

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DECLARATION

I here-by declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

…… ……......

KOFI ADUO-ADJEI **DATE**

(1044307)

CERTIFICATION

I here-by declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University of Ghana.

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DR. ALBERT AHENKAN DATE

(SUPERVISOR)

DEDICATION

This research work is dedicated to my Late mother Mrs Beatrice Adjei and my father Pastor Abraham Kwame Adjei.

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LIST OF ABBREVIATIONS

BI	Behaviour Intentions
CMS	Centre for Medicare and Medicaid Services
CRHD	Central Regional Health Directorate
ENT	Ear and Nose Therapy
FA	Factor Analysis
GHS	Ghana Health Service
IOM	Institute of Medicine
ISSER	Institute of Social Statistics and Economic Research
MOH	Ministry of Health
NHS	National Health Service
OPD	Out-Patients Department
OSQ	Overall Service Quality
SERVPERF	Service Performance
SERVQUAL	Service Quality
SOP	Standard of Operating Procedure
SPSS	Statistical Package for Social Science
UCH	University of Cape Coast Hospital
UGH	University of Ghana Hospital
UK	United Kingdom
WHO	World Health Organisation

ABSTRACT

Over the decades, Ghana's Ministry of Health has resolved to continuously improve the quality of healthcare and to enhance clients/patients satisfaction in the most cost-effective manner in Ghana. However, there are key challenges that confront the implementation of these objectives in some hospitals, according to the Ghana Health Service 2010 (GHS) evaluation report of patient's satisfaction with quality healthcare delivery. The purpose of this study was to examine patient's satisfaction with quality healthcare in Ghana, comparing healthcare services at the University of Ghana and the University of Cape Coast hospital.

A modified version of the SERVQUAL model was used as the data collection instruments, which was administered to a sample of 218 patients receiving healthcare at the OPD of the two university hospitals. A principal component analysis, multiple linear regression, independent Ttest and a manual thematic analysis were used in the data presentation and analysis.

The results show that empathy, communication, culture, tangibles and priority are key predictors of patients' satisfaction with quality healthcare. More so, in some interviews, the patients noted that timeliness, staff performance, service improvement and satisfactory services are relevant for ensuring service quality to patients at the hospital. A comparative analysis revealed that empathy, tangibles and priority were dimensions of service quality that pose a difference in healthcare delivery at the two-university hospital.

The author recommends that the university hospital management should develop policies based on the communication, empathy, culture, tangibles, and priority, which will ensure the patients' satisfaction with quality healthcare.

CHAPTER ONE

1.0 INTRODUCTION

Introduction

This chapter presents the background to the study, statement of the research problem, research objectives and research questions. The chapter further discusses the significance, the scope, limitations as well as the chapter organization of the study.

1.1 Background to the Study

In recent years, findings in developed countries on quality healthcare delivery have increasingly influenced developing nations in assessing the quality of their healthcare systems. Outcomes have received special prominence as a measure of quality healthcare (WHO, 2012). Assessing outcomes has merit both as an indicator for the effectiveness of different health interventions and as part of a monitoring system directed to improve the quality of care as well as to detect its deterioration (Epstein, 1990; Blumenfeld, 1993). Quality assessment studies over the decades usually measure one of three types of outcomes thus costs, medical outcomes and patients satisfaction (Turkson, 2009; Aldana et al, 2012).

Studies in healthcare have indicated that patients satisfaction has gained greater importance, specifically in developing countries. It is both a service quality indicator and a quality component. Strong healthcare systems enable healthcare providers to deliver better quality and value to patients (Radhika et al, 2007; Camgoz-Akdag & Zineldin, 2010). Again, patient satisfaction has become the latest trend of study. It has been realized, that in order to have a better competitive advantage or best practice in the healthcare industry, the perception of patients for quality has to be measured deeply and the quality strategies should be set as priority by management of healthcare facilities (Camgoz-Akdag & Zineldin, 2010).

According to WHO (2014), good service delivery is a pivotal element of any health system and is crucial to the achievement of health-related Millennium Development Goals. Therefore, service delivery is a necessary input to population health status, coupled with other factors, including social determinants of health. However, the preciseness of an organization and the content of health services differ from one country to another, thus in any well-functioning health system, the network of service delivery and provision should be characterized by the following: comprehensiveness, accessibility, continuity, co-ordination and efficiency. This signifies a systematic approach to health services organization in which the primary level is usually in the context of a local health system, which acts as a driver for the healthcare delivery system as a whole.

1.1.2 Patient satisfaction with healthcare

The perspective of the patient's view is becoming more integrated in the process of improving healthcare systems. Patient satisfaction is the level of contentment that patients experience having used a service (MOH, 2007). More so, patient care is the primary function of every hospital (GHS, 2010). It is one of the yardsticks to measure the effectiveness, where effectiveness of a hospital is related to the provision of quality care. Swamy (1997) indicates that patient satisfaction is the real testimony to the efficiency of hospital administration. As a hospital serves all the members of the society, the expectations of users differ from one individual to another because everyone carries a particular set of thoughts, feelings and needs. Hence, the determination of a patient's real feeling is very difficult to measure. Notwithstanding, it is the responsibility of hospital staff to create a conducive environment that will make the patient comfortable in receiving care (Wensing et al, 2012).

Generally, patient satisfaction is defined as the patient's view of services received and the results of the treatment (Kleinman, 2012). Some programme evaluators used service quality to enhance the healthcare provider's ability to render services that meet the patient's need. There is a uniform acknowledgement by society on the importance of the views of users in assessing services. The healthcare sector has used range of methods to identify the views of patients. Dansky and Milles (2007) state that from a management perspective, patient satisfaction with healthcare is important for various reasons. First, satisfied patients are more likely to maintain a consistent relationship with a specific provider. Second, by identifying sources of patient satisfaction, an organization can address system weaknesses, thus improving its risk management. Third, satisfied patients are more likely to follow specific medical regimens and treatment plans. Patient satisfaction measurement adds to important information on system performance, thus contributes to the organizations total performance index.

Moreover, patient satisfaction measures the gap between the service expected and experienced from the patient's perspective. It has become an instrumental part of the hospital/clinic management strategies across the globe. Moreso, the quality assurance and accreditation process in most countries require that the satisfaction of patients be measured on a regular basis (Fekadu et al, 2011). Competitiveness among healthcare organizations depends on patients' satisfaction, which is created by responding to patient views and needs (Zineldin, 2006).

There is an increasing need to improve quality in healthcare delivery. A study by Brent et al., (2013), indicates that the Centres for Medicare and Medicaid Services (CMS), hospitals, and insurance providers alike are striving to better define and measure quality of healthcare. A major component of quality of healthcare is patient satisfaction. They further indicate that patient satisfaction is critical to how well patients do; research has identified a clear link between patient

outcomes and service quality. Baltussen et al (2002) indicates that from the patient's perspective, the supply of drugs is a very vital determinant for the utilization of health service and healthcare quality in Burkina Faso.

In Ghana, the Ministry of Health in their five-year programme of work indicated that the patient's satisfaction is prime to health service delivery and quality care (MOH, 2006). The Ministry further identified that improving patient satisfaction and the quality of healthcare is one of its five key objectives of the health sector reforms in Ghana. Again, Turkson (2009), envisages that patients' satisfaction and quality of care might be improved through paying more attention to the perspectives of the patient, improving the competencies and skills of providers and improving the working environment by better management, provision of medical equipment, supplies and motivation of staff (Fekadu, 2011).

1.1.3 The context of patient satisfaction in quality healthcare delivery

Service quality is the pivotal force for business sustainability (Carlzon, 1987; Kumasey, 2014) in today's competitive global marketplace. Moreover, it is recognized that high quality service is instrumental for the success of the firm/industry (Rust and Oliver, 1994), when other factors have been considered, it leads to customer loyalty (Lewis, 1994) and higher profitability (Gundersen et al., 1996). Therefore, it is a key strategy for customer-focused firms to measure and monitor customer satisfaction.In the healthcare literature, different hospitals provide the same type of services, but they do not provide the same quality of services (Youseff et al., 1996; Lichtenberg, 2010; Yousapronpaiboon and Johnson, 2013). The quality of service, both technical and functional, is a key ingredient in the success of service organizations (Gronroos, 1984). In addition, customers today are more aware of alternatives being offered and rising standards of service. Over the years, these changes have increased their expectations (Lim & Tang, 2000),

coupled with the pressure of competition and the increasing necessity to deliver to the satisfaction of patients. Therefore, the elements of quality control, quality service and effectiveness of medical treatment have become vitally important (Friedenberg, 1997). Many service providers, with help from the research community, are beginning to realize that ensuring customer satisfaction is a key element in their marketing strategy and a crucial determinant of long-term viability and success (Andaleeb, 1998). Quality healthcare is difficult to measure owing to its inherent intangibility, heterogeneity and inseparability features (Conway & Willcocks, 1997). Butler et al. (1996) reiterate Zeithaml (1981, pp. 186-190) that patients' participating in production, performance and quality evaluations are affected by their actions, moods and cooperativeness. Healthcare is dynamic, considerable and the competition is increasing with time dimension as an influencing factor (Gilbert et al., 1992).

Some previous studies have indicated that service quality and satisfaction are distinct constructs in healthcare (Bitner, 1990; Aldana et al, 2001; Adrienne & Sinclair, 2002). Patient's satisfaction is influenced by two factors such as experience and expectations with service performance (Yin, 1990). Crosby et al., (1990), demonstrate that the decisions to have a continuing relationship with the service provider is influenced by customer's past satisfaction. Again, a satisfied customer/client tends to maintain their consumption pattern and will consume similar healthcare products or services. Thus, patient satisfaction has become an important indicator of quality and future revenue (Fornel, 1992; Andreassen, 1994). The healthcare delivery system in many developing countries are facing major challenges of quality care, however, Ghana faces three major challenges: improving quality, increasing access, and reducing costs (Owusu-Frimpong et al, 2010).

Over the years, the Ministry of Health (MOH) in Ghana has been concerned about quality of care, which has a strong resultant effect on client satisfaction, but the pace of improvements in the quality of care has been slow, partially because quality improvement activities have received inadequate priority. However**,** there have been efforts to research into quality of healthcare service, which has patient satisfaction as an indicator and institutionalization of quality assurance in Ghanaian health facilities (GHS, 2010). These were initiated through a project from 1993-1996 and then from 1998-1999 in the Upper West Region and in some facilities in the Eastern and Volta Regions as a result of complaints about the quality of care given by health workers and the level of satisfaction of patients. Poor quality of healthcare, and for that matter, low client satisfaction result in loss of patients' lives, revenue, material resources, time, morale, staff, recognition, trust and respect as well as individuals' and communities' apathy towards the health services, all of which contribute to lowered effectiveness and efficiency in the Ghanaian healthcare system (Turkson, 2009).

1.2 Problem Statement

Until recently, the establishment of quality standards was delegated to the medical profession. Not surprisingly, quality is defined in terms of technical delivery of care by clinicians (Bara et al. 2012). Analeeb (2001) reveals that the recent literature (in the developed countries) emphasizes the importance of the patient's perspective. However, hospital administrators, insurance companies, community groups and researchers have all begun to recognize the value of the insights that patients can provide (Shewchuk & Carney, 1994; Analeeb, 2001; Turkson, 2009; WHO, 2013).

In assessing healthcare service quality, criteria such as technical, functional (Babakus & Mangold, 1992; Hasen et al, 2008) or technical and process-related (Zeithaml & Bitner, 2000)

should be applied. Weitzman (1995) suggests that quality healthcare can be defined in relationship to (1) the technical aspects of care, (2) the interpersonal relationship between practitioner and patient, and (3) the amenities of care. If patient-centred evaluations are to be effectively used, especially in a technically complex sector such as healthcare that reflects credence-based services, (i.e., services that are difficult to evaluate by the patient), it may be unreasonable to expect patients to provide quality ratings based on technical merits of the service. Instead, subjective criteria must be used, understood, and translated into objective performance parameters. For developing countries, using any such criteria to assess service quality introduces additional challenges given the inadequate research and the variety of contextual factors that must be better understood (Best & Neuhauser, 2011). The sparse literature on the measurement of quality healthcare service in Ghana and in other developing countries has warranted this study.

Research on patient satisfaction with quality healthcare can be traced to the late 20th century. During this era the focus of most publications was on patient satisfaction as a condition to be satisfied in order to reach desirable clinical outcomes (Andaleeb, 1998).

Aldana et al (2001), studied client expectation, degree of satisfaction and quality healthcare provided in rural Bangladesh. A total of 1,913 persons chosen by a systematic random sampling were successfully interviewed immediately after having received care in government health facilities. The findings indicated that the most powerful predictor for client satisfaction with the government services was provider behaviour, especially respect and politeness. Furthermore, a reduction in waiting time (on average to 30min) was more important to clients than a prolongation of the quite short (from a medical standpoint) consultation time (on average 2 minutes, 22 seconds), it further indicated that 75% of clients were being satisfied.

Moreover, factors affecting patient satisfaction and healthcare quality were also studied which brought out some immediate factors that ensure client satisfaction (Zeithaml & Bitner, 2000; Tucker & Adams, 2001; Naidu, 2007). However, Zineldin et al., (2006), examined major factors affecting satisfaction and addressed the question whether patients in Kazakhstan evaluate healthcare similarly or differently from patients in Egypt and Jordan.

Again, extant studies have been done on service quality and patient satisfaction in a comparative approach of private and public hospitals (Leatherman & Sutherland, 2003; Bradshaw & Bradshaw, 2004; Hansen et al, 2008; Owusu-Frimpong et al, 2010). However, empirical literature indicates that little has been done on perception of patients on quality of service by hospitals (Duggirala et al, 2010; Suki et al, 2011).

In Ghana, many of the studies on healthcare quality have often focused on the quality award dimensions (GHS, 2003; Osei et al., 2005; MOH, 2007b; Atinga et al, 2011). Studies conducted in public hospitals over the years provide substantive evidence that the quality of health services is inadequate both by objective measures in the opinion of patients and by healthcare providers (GHS, 2008; MOH, 2007b). Moreover, research on quality healthcare has generally reported poor service delivery with respect to long waiting time, a frequent shortage of drugs and the poor attitude of health providers as factors militating against patients' satisfaction with quality healthcare in Ghana (Turkson, 2009; Atinga et al, 2011). In view of this, the continuous monitoring and evaluation of the policyholder's views on the quality of healthcare is necessary for quality improvement purposes, which will provide some kind of feedback to health professionals and policy makers (Bara et al., 2012). An extensive empirical search revealed that a single study has been conducted on patients' satisfaction with quality healthcare in a

comparative approach with focus on institutional facilities (University hospitals) in Ghana (Esiam, 2013). The novelty of this study is to assess patient's satisfaction with the university health service (university hospital), which is emergent in healthcare provision in Ghana. In this regard the purpose of this study is to examine patient's satisfaction with quality healthcare in Ghana, a comparative study between the University of Ghana and University of Cape Coast hospitals.

1.3 Study Objectives

1.3.1 General Objective

The main objective of the study is to examine the patient's satisfaction with quality healthcare in Ghana, a comparative analysis of the University of Ghana and the University of Cape Coast hospitals.

1.3.2 Specific Objectives

1. To assess key service quality dimensions that are good predictors of patient's satisfaction.
2. To determine the patient's perception on what constitute service quality in the two hospitals.
3. To compare patient perceptions of service quality dimensions at the two University Hospitals.

1.4 Hypotheses

1. Ha: Communication is a significant predictor of Patients satisfaction

   H_0: Communication is not a significant predictor of Patients satisfaction

2. Ha: Empathy is a significant predictor of Patients satisfaction

   H_0: Empathy is not a significant predictor of Patients satisfaction

3. Ha: Priority is significant predictor of Patients satisfaction

H_0: Priority is not a significant predictor of Patients satisfaction

4. Ha: Tangibles is significant predictor of Patients satisfaction

H_0: Tangibles is not a significant predictor of Patients satisfaction

5. H_a: Culture is significant predictor of Patients satisfaction

H_0: Culture is not a significant predictor of Patients satisfaction

1.5 Research Question

1. What constitutes perception of service quality among patients in the two university hospital?

1.6 Significance of the Study

The quality of service has a very strong significant influence on the patient's overall perception of quality care delivery. Service quality offers a healing environment where the patient is more likely to continue utilizing services provided by the provider (Fottler et al., 2002; Atinga et al 2011). Many studies on patient satisfaction with quality of care often place emphasis on communication, provider courtesy, support/care, environment of the facility and waiting time as important tools in measuring quality care. In recent times, many writers of service quality have been concerned with the nature and trend of customer-service provider relationship (Turner, 2011; Atinga et al, 2011; Steinwach & Hughes, 2012; Peprah, 2014;). This study reveals to service providers of the two institutional facilities the functional quality of their services, that is, it shows the patients' views of the quality of care they are receiving. This is important because even the best technical competence is worthless if it does not satisfy patients (Bielen & Demoulin, 2007). By understanding and documenting the patent's views, providers will be more aware of what is required of them.

The study also identifies the dimensions of service quality that are rated worst by the patients, thus indicating areas in which the service providers have weaknesses and the need to improve dimensions that are more highly rated.

Again, this study also emphasizes in which areas of service quality dimensions the two facilities differ, so that management and service providers can learn from each other's experiences and this will further provide a model that will be a working plan which will serve as a baseline policy for service delivery in institutional hospital facilities since it presents dynamics quite different from purely public and private health facilities.

The study contributes to health policy-making by documenting good practices to help hospital policy-makers pick out and apply lessons learned, to ensure a successful strategy of patient's satisfaction in all form of health service delivery.

Finally, it also adds to existing literature on patient's satisfaction and quality healthcare as well as the pool of knowledge on the healthcare literature (Baker et al, 2008).

1.8 Limitation of the Study

Despite its significance, the study has some limitations. First, the researcher could not interview all the targeted patients. This was due to difficulty in getting to them for an interview. Second, due to time and resource constraints, the study could not be carried out in other university hospitals in Ghana. However, the limitations mentioned did not affect the results of the study in anyway.

1.9 Definition of Terms

Patients: refers to people waiting at Out-patient-Department of the various units in the hospitals.

Satisfaction: is defined as the patient's experiences of services provided at the various hospitals.

Quality: refers to the patient's acceptable standards of care delivered to them at the various facilities.

Healthcare: refers service provision (delivery) to patients at the hospitals.

Dimension: Key service quality elements that predicts patient's satisfaction.

Tangibles: indicates the physical surrounding of the hospitals understudy.

Responsiveness: refers to the willingness of the staff to help patients and provide prompt healthcare service.

Reliability: refers to the ability of staff to provide service dependably.

Empathy: the caring attitude staff to patients at the hospital.

Culture: refers the language and religious barriers in healthcare delivery.

Assurance: refers to the knowledge and courtesy as well as the trust of staff to patients'.

Communication: this indicates the provider patients' interaction.

Priority: this dimension indicates how university staff are prioritize in health service provision

Affordability and Accessibility: this indicated the availability of the healthcare service in terms of financial access and proximity of facility to patients.

1.10 Chapter Organization

Chapter one introduces the entire study, beginning with a general background to the study, patient's satisfaction and quality healthcare. It covers the problem statement, objectives and research questions. This chapter also discusses the significance of study and the chapter dispositions of the study.

The second chapter of the study focuses on the discussion of theories relevant to patient's satisfaction and quality healthcare. An eclectic review of relevant empirical literature is also

contained in this chapter. The literature review conducted was based on the objectives of the study and this enabled the study to be grounded on empirical evidence in the literature so that cogent findings and conclusion were drawn based on the stands of existing literature.

In Chapter three, the researcher discusses the research methodology of the study. Again, this chapter explains and justifies the research paradigm under which the methods for the study were selected. It also covers sources of data, sampling techniques and the instrumentation, the study population and the scope of the study are explained in addition to the data gathering procedure and ethical considerations. This methodological chapter indicates the appropriateness of the methods to ensure a systematic approach that a scientific study of this calibre demands.

Chapter four presents findings together with the discussions; this enables readers to follow the connection between the objectives of the study and research questions, the literature review, theoretical framework and the responses from respondents. More so, the prominent factors that affect quality healthcare and these are made clear with the regression model.

The Chapter five of the study summarizes and concludes the entire study. The necessary recommendations are made to inform policy action and directives to ensure quality healthcare in Ghana.

CHAPTER TWO

2.0 THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Introduction

This chapter discusses theories in service quality that informed the conceptual basis for the framework of the study. It also contains review of empirical literature relevant to the study. This chapter has two main parts; the first part examines theoretical and the model foundations of the study as well as the selected model. The second part reviews empirical literature in accordance with the objectives of the study. This is to enable the researcher to meaningfully connect findings in the empirical literature to the findings from the field, in order to draw conclusions for the study. The overarching themes of the literature review are: the concept of service quality, the dimension of the service quality in relation to patient satisfaction and many more.

2.1Theoretical Evidence

In this section, the theoretical foundation for the study is laid in order to give an empirical theory base for the study.

2.1.1 Service quality

Firms, industries and hospitals provide services in order to reach customers with the needed products and services. However, Kotler and Keller (2009), define service as ‘any intangible act or performance that one party offers to another that does not result in the ownership of anything’. The service provided can be a tangible and an intangible offer by one party to another in exchange of money for pleasure and satisfaction.

Quality is an ideal characteristic that consumers look for in any service transaction and product sale (Solomon, 2009). Quality is also defined as ‘the totality of features and characteristics of a product or services that bear on its ability to satisfy stated or implied needs’ (Kotler et al., 2002).

Service quality in the management and marketing literature is defined as the extent to which customers' perceptions of service meet and/or exceed their expectations (Zeithaml et al. (1990) cited in Bowen and David, 2005, p. 340). Thus service quality can intend to be the way in which customers are served in an organization that could be good or poor. According to Parasuraman (1988), service quality is defined as the differences between customer expectations and perceptions of service. Again, he argues that in measuring service quality, the difference between perceived and expected service is a valid way that could make management identify gaps in what they offer as services. The overarching aim of providing quality services is to satisfy customers. Thus measuring service quality is a better way to dictate whether the services are good or bad and whether the customers will be or are satisfied with it. Furthermore, Haywood (1988) lists in his study: 'three main components of service quality, called the 3 "Ps" of service quality' (Physical facilities on processes and procedures, Personal behaviour on the part of serving staff, and Professional judgment on the part of serving staff) (Nitin et al, 2005; Gunawardane, 2011).

There are extant theories/models used in the studies on service quality which is applied to different field of study ranging from healthcare, corporate business, education, banking, telecommunication. A further empirical synthesis reveals that nine of these models have been used predominantly in the study of quality healthcare and these models are tabulated below.

Table 2.1: Synthesis of Quality Healthcare Models

No.	Quality Healthcare Models	Authors	Years
1	Technical and functional model	Gronroos	1984
2	The GAP model	Parasuraman, Zeithmal and Berry	1985
3	Synthesized model of service quality	Brogowicz, Delene and Lyth	1990
4	Performance only model	Cronin and Taylor	1992
5	The ideal value model of service quality	Matterson	1992
6	Model of service quality and satisfaction	Spreng and Mackoy	1996
7	Service quality, customer value and customer satisfaction model	Oh	1999
8	Internal service quality model	Frost and Kumar	2000
9	SERQUAL Model	Parasuraman et al, 1988	1988

Source: Author Reviews.

2.1.2 Technical and functional quality model

Gronroos (1984) proposed two key dimensions of service quality, which are the technical quality and the functional quality. He indicated functional quality as the result or the outcome of the service, while technical quality refers to the process or the way the service has been delivered (ACR, 2015). He further argues that technical quality is what consumer actually receives as a result of his/her interaction with the service firm and functional quality is how he/she gets the technical outcome. He indicates in his model that the corporate image is instrumental to service firms and this is built up mainly by the technical and functional quality of service including the other factors (tradition, ideology, word of mouth, pricing and public relations) (Gronroos, 1984; Nitin et al., 2005).

More so, this model has been applied in the study of quality healthcare, the accuracy of medical diagnosis, where the processes and procedures are defined as technical quality. In the stands of this purview, technical quality transcends patients' judgment while functional quality is overtly explained by the experiences of patients (Asubonteng et al., 1996; Yousapronpaiboon and

Johnson, 2013). However, some studies have indicated that most clients are not able to make justifiable assessment of the technical quality due to their lack of general technical knowledge on attributes (empathy, reliability, affordability and responsiveness etc) primary used in the evaluation of health service quality (Wiesniewski & Wiesniewski, 2005, Devebakan, 2005; Atinga et al, 2011). In spite of the popularity of the technical and functional quality models, it does not ensure effective representation of all views of patients; this led to the development of the GAP model (James, 2004; Bart Lariviere, 2014).

2.1.3 The GAP model

Parasuraman, Zeithaml and Berry (1985) propose that service quality is a key function of the differences between expectation and perception along the quality dimension. This model was developed based on a gap analysis. The various gaps in the model are visualized as:

i. Gap1: Difference between consumers' expectation and management's perceptions of those expectations, thus not knowing what consumers expect (Parasuraman et al., 1985; Nitin et al., 2005; Gunawardane, 2011).

ii. Gap2: Difference between management's perceptions of consumer's expectations and service quality specifications, thus improper service-quality standards (Dabholker et 2000, Drain, 2001).

iii. Gap3: Difference between service quality specifications and service actually delivered, that is the service performance gap (Groonroos 1984; Matterson, 1992; Nitin et al., 2005).

iv. Gap4: Difference between service delivery and the communications to consumers about service delivery, thus whether promises match delivery (Parasuraman et al., 1988; Groonroos, 1984; Nitin et al., 2005).

v. Gap5: Difference between consumer's expectation and perceived service. This gap depends on the size and direction of the four gaps associated with the delivery of service quality on the marketer's side (Parasuraman et al., 1988; Nitin et al., 2005).

Based on this model, service quality is a function between perception and expectation. They further refine their subsequent scale named SERVQUAL for measuring customers' perceptions of service quality (Parasuraman et al., 1988; Nitin et al., 2005). In this study, the original ten dimensions of service quality are collapsed in to five dimensions: reliability, responsiveness, tangibles, assurance (communication, competence, credibility, courtesy, security) and empathy, which captures access and understanding/knowing the customers. In 1991, the SERVQUAL model was revised with the focus of replacing 'should' word by 'would' and by reducing the total number of items to 21 in their 1994 study; however, the five dimensional structures remain the same. Furthermore, in this empirical research, the authors characterized and further delineated the four gaps identified in their research of 1985. This resulted in the extended service quality model; in this extended model most factors involve communication and control process, which was implemented in organizations to manage employees (Nitin et al, 2005; Frost & Kumar, 2000).

The Parasuraman et al., (1988) model was used in the study of service quality in the healthcare industry (Rose et al., 2004; Taner & Antony, 2006; Saunders et al, 2009; Peprah, 2013). In a study by Pena et al, (2013) aimed at studying the quality in health services with the objective to measure the satisfaction of users, adopted the parasuraman et al, (1985) Gap Model. This theoretical model was based on the analysis of perceptions and expectations of users of health services, based on the five dimensions: reliability, responsiveness, tangibility, empathy and assurance (Gonclaves et al., 2014). The study further indicated the difference between the

expected service and the received service. Gaps or shortcomings were derived that may be the main obstacles for users to perceive the provision of such services with quality. It was realized, by the use of the psychometric scale called Service Quality (SERVQUAL) in some studies about patient's satisfaction, very interesting results were obtained in the institutions in which it was employed. Furthermore, the findings revealed the essence of improving existing models of service evaluation and the importance of measuring patients' satisfaction with services of health institutions (Parasuraman et al,1985; Babakus & Mangold, 1992; Goncalves, 2014).

Again, a study by Owusu-Frimpong et al (2010) studied patients' satisfaction with access to private and public healthcare centres in London. The findings indicated that public patients were dissatisfied with the service climate factors as opposed to private counterparts (Kumaraswamy, 2012; Ramez, 2012). Generally, the study resolved that users of both public and private healthcare are faced with major problems in accessing healthcare. However, a study by Wisniewski and Wisniewski (2005) applied a modified SERVQUAL instrument, consisting of 19 variables, for a colonoscopy clinic in Scotland. The study resolved that even though patient overall satisfaction with the services was high, improvements were needed in specific dimensions of service, especially the reliability dimension (Ramez, 2012).

However, aside the fact that the SERVQUAL model (Parasuraman et al., 1985,1988, 1991) was applicable in most fields of studies, it has been criticized by some authors (Ramez, 2012). These criticisms are based on its conceptual and operational aspects. In their work, they proposed a SERVQUAL model based on the theory of conformation/disconfirmation, however, a number of researchers in marketing argued that both disconfirmation theory and the expectation scores have any substantial effect on customer satisfaction, (Carman, 1990; Cronin & Taylor, 1994; Teas, 1994; Buttle, 1996; Sharma & Gupta, 2004; Nai-Hwa et al., 2008). In contrast, the perception

scores (SERVPERF) have been extensively recommended for measuring service quality as it has a higher predictive validity of customers' satisfaction, (Cronin & Taylor, 1992; Babakus & Mangold, 1992; Cadott et al, 1987; Lee et al, 2000; Luk & Layton, 2004; Sharma & Gupta, 2004; Baumann, et al, 2007; Ramez, 2012; Kumaraswamy, 2012).

Furthermore, some researchers have questioned the dimensionality and universality of the SERVQUAL model. It is further argued that the instrument could not be a generic measure for all service industries. However, it needs to be customized to fit the nature of a specific service or a specific nation (Carman, 1990; Babakus & Mangold, 1992; Buttle, 1996; Mels et al., 1997; Andaleeb, 2001; Ramez, 2012; Kumaraswamy, 2012). On health service, Piligrimiene and Buciuniene (2005) note that the dimensions for measuring the quality of healthcare are proposed by various researchers. Coulthard (2004), in his study offered a comprehensive synthesis for the service quality researches since 1998. She further resolved that extant research is needed to control or inhibit the methodological, interpretative and conceptual biases of SERVQUAL instrument (Sharma & Gupta, 2004; Kumaraswamy, 2012).

Amidst the criticism of the validity and reliability of the SERVQUAL instrument, it is argued that it remains a vital model for measuring service quality (Buttle, 1996; Kumaraswamy, 2012). With respect to quality healthcare delivery, Babakus and Mangold (1992), reached the similar conclusion and indicated that the SERVQUAL model, is a standard instrument for measuring functional quality, which is reliable and valid for the hospital environment and variety of other service industries (Nitin et al, 2005; Sharma & Gupta, 2004; Kumaraswamy, 2012; Ramez, 2012; Bart Lariviere, 2014).

2.1.4 Synthesized model of service quality

Brogowicz, Delene and Lyth (1990), added to the gap model by postulating that a service quality gap may exist even when a customer has not yet experienced the service at delivery but learned about it through advertising or through word of mouth, or other media communications. Therefore, it was again added that there is a need to incorporate potential customers' perceptions on service quality offered as well as actual customers' perceptions of service quality experienced (Nitin et al., 2005) in measuring service quality. In this model there is an attempt to integrate a traditional managerial framework, service design, operations and marketing activities. The main focus of this model is to identify the key dimensions associated with service quality in a traditional managerial framework of planning, implementation and control (Nitin et al, 2005; Gunawardane, 2011). The synthesized model of service quality, in totality considers three factors, thus company image, external influences and traditional marketing activities as the factors influencing technical and functional quality expectations (Groonroos 1984; Nitin et al., 2005; Gunawardane, 2011). This model was adopted by Joshi et al., (2013) in a study to identify the components of primary health care service delivery models for populations and this model has been effective in improving access, quality and coordination of healthcare. Based on a systematic review of the literature, including published sources between 1990 and 2011, the findings indicate that healthcare services are affordable, appropriate and acceptable to the target groups. Specialist workers improved co-ordination between the different health care services as well as the service responding to the social needs of clients through case management. Quality of care was improved by training in cultural sensitivity and the appropriate use of interpreters. Therefore the elements of this model most frequently associated with improved access, coordination and quality of care were case management, the use of specialist refugee health

workers, interpreters and bilingual staff. These findings have implications for workforce planning and training. However, Cronin and Taylor (1992) criticize this model indicating that it needs empirical validation in the service quality literature. Furthermore, it was noted that this model ought to be reviewed for a different type of service settings. In this regard the performance model was conceptualized to study service quality in the healthcare industry.

2.1.5 Performance only model

The later part of the nineteenth century saw the immense effort of Cronin and Taylor (1992) to conceptualize and measure service quality, its direct relationship with consumer satisfaction and the intention to purchase. Since they argued the framework of Parasuraman et al. (1985), with respect to issues on conceptualization and measurement of service quality and developed the performance- only model noted as SERVPERF model. In their work, the computed difference score was compared with the perception score to conclude that perceptions only constitute a better predictor of service quality (Cronin & Taylor, 1992; Dabholkar et al., 1996; Dabholkar et al., 2000; Ladhari, 2008; Ramez, 2012). They further illustrate that service quality is the basis of consumer attitude and that the performance only measure of service quality is an enhanced means of measuring service quality.

Their study observed that SERVQUAL confounds satisfaction and attitude. It was therefore stated that service quality can be conceptualized as ‘similar to an attitude’, and can be fundamentally be operationalized by the adequacy-importance model (Zeithaml, 1981; Nitin et al., 2005). Particularly, they opined that Performance instead of ‘Performance-Expectation’ determines service quality. This model was adapted by Oslen et al., (2013), to compare the performance-only and the importance-performance model. Their study seeks to determine better predictors of pediatric healthcare quality and more successful methods for improving the quality

of care provided to children. Fourteen paediatric healthcare centres serving approximately 250,000 patients in 70,000 households in three West Central Florida counties were sampled for the study. Moreso, a cross-sectional design approach was used to determine the importance and performance of 50 paediatric healthcare attributes and four global assessments of pediatric quality healthcare. An exploratory factor analysis revealed five dimensions of care (physician care, access, customer service, timeliness of services, and healthcare facility) for effectively measuring healthcare quality. Again, the study indicated that the importance-performance multiplicative additive model was a better predictor of paediatric health care quality. That is, the importance-performance model is superior for measuring and providing a deeper understanding of paediatric quality healthcare and a better method for improving the quality of care provided to children and therefore indicated the performance only model was a better predictor of quality healthcare (Oslen et al, 2013)In a study by D' Souza and Sequeira (2012) they examined the performance only model using quality management factors, patient service quality factors and critical success factors on performance. The main findings revealed that there is a significant relationship between service quality factors and performance. Overall, the study recommended healthcare organization to improve their performance with respect to service quality that is patients-centred. However, this model has been criticized based on the fact that findings cannot be generalized for all types of service settings. More so, the quantitative relationship between consumer satisfaction and service quality need to be established with a model (Matterson, 1992; Nitin et al, 2005).

2.1.6 Ideal value model of service quality

This model was a follow-up to the performance model by Cronin and Taylor, 1992. The ideal value model of service quality was postulated by Matterson (1992), who indicated 'expectation is

essentially treated as belief about having desired attributes as the standard for evaluation'. However, Nitin et al (2005), argue for value approach to service quality, modeling it as an outcome of satisfaction process. Moreso, this model suggests the use of a perceived ideal standard against which the experience is compared. Again, the model indicates an implicit negative disconfirmation on a pre-conscious value level with satisfaction based on a higher attitude level. The negative disconfirmation is the key determinant of consumer satisfaction and the model's emphasis on the fact that more attention should be given to the cognitive processes through which service concepts are formed and measured by consumers. Steinwach and Hughes (2012) adopted the ideal model of service quality in the study of patient safety and quality based on empirical evidence from nurses. The study indicates that certain social factors thus financing systems as well as organizational structures and processes, health technologies and personal behaviours affect access to health care and ultimately quality and cost of healthcare. The study recommended the operational role of nurses in ensuring patient safety and general health quality in USA. The main challenge of the model is that fewer number of items are used for value and customer satisfaction. There is a need to define these items for all types of service settings when this model is applied in every service quality study (Dobholkar, 1996; Spreng & Mackoy, 1996).

2.1.7 Model of perceived service quality and satisfaction

Based on these key weaknesses of the ideal value model of service quality, Spreng and Mackoy (1996) conceptualize the perceived service quality and satisfaction model to enhance the understanding of the constructs on perceived service quality and consumer satisfaction. The model aims at modifying Oliver's (1993) model. The main tenets of the model outline the effect of expectations, perceived performance desires, desired congruency and expectation disconfirmation on overall service quality and customer satisfaction (Nitin et al., 2005). These

variables were measured based on a set of ten attributes of advising, which are: convenience in making an appointment, friendliness of the staff, the advisor listened to my questions, the advisor provided accurate information, the knowledge of the advisor, the advice was consistent, advisor helped in long-range planning, the advisor helped in choosing the right courses for career, advisor was interested in personal life, and the officers were professional. This model was adopted by Esian et al, (2012) to explore the application of the original SERVQUAL scale in the context of public health care services in Romania. The findings indicate that the tangibles dimension followed by responsiveness dimension and reliability dimension registered the biggest gap score. In contrast, Nitin et al (2005) and Oh (1999), indicate that findings need to be generalized for different self-service options. Again, demographic variables, price and physical environment are not considered in this model (Piper & Lamb, 2014).

2.1.8 Service quality, customer value and customer satisfaction model

Oh (1999), proposes an integrative model of service quality, customer value and customer satisfaction. The main focus of this model is on the post-purchase decision process; this model incorporated key variables as service quality, perception and quality, consumer satisfaction, customer value and intentions to repurchase. Furthermore, in this model, word of mouth communication is conceptualized as a direct combined function of perceptions, value satisfaction and re-purchase intentions. It presents empirical evidence that customer value has a significant role in customer's post-purchase decision-making process. It is basically an immediate antecedent to customer satisfaction and re-purchase intentions. The main findings indicate that perceived price has a negative influence on perceived customer value and thus have no relationship with perceived service quality. Haque et al (2012) conducted a conceptual survey using this model to study the impact of customer perceived service quality on customers'

satisfaction for Private Health Centres in Malaysia. In this survey, they indicate that patient satisfaction could be achieved through implementation of various support procedures as well as increasing the facilities that are patient-centered. The study further recommends that this conceptual model needs further investigation in the area of quality healthcare studies. Other authors criticize this model on generalization for different types of service settings and further indicate that the variables are measured through relatively fewer items (Frost & Kumar, 2000; Santos, 2003).

2.1.9 Internal service quality model

This model was developed by Frost and Kumar (2000); it is based on the concept of the GAP model (Parasurman et al., 1985). The model proposes the key dimensions and their relationships that determine service quality among internal customers (front-line staff) and internal suppliers (support staff) within a large service organization (Nitin et al, 2005; Gunawardane, 2011). The first internal gap shows the difference in support staff's perception (internal supplier) of front-line staff's expectation (internal customers). The second internal gap is the significant difference between service quality specifications and the service actually delivered resulting in an internal service performance gap. The third internal gap focuses on the front-line staff (internal customers). The gap is based on the difference between front-line staff's expectations and perceptions of support staff's (internal supplier) service quality. Gunawardane (2009) in an exploratory study in the health care management industry aimed at investigating whether the dimensions of internal service quality are dependent on the nature of the internal service relationship. The results revealed that in almost all surveys of external and internal service quality, 'Reliability' and 'Responsiveness' turned out to be the overall significantly leading factors in the internal service quality from the internal customer point of view. However, this

model was not generalized for all types of internal environments and the effect of changes from the external environment on the model was not considered thus the weakness of the model (Soteriou & Stavrinides, 2000; Zhu, Wymer & Chen, 2002).

2.10 (The Selected Model) SERVQUAL model

Parasuraman et al., (1988), developed the SERVQUAL model which is a multi-item scale used to assess perceptions of customers on service quality in service and retail businesses. This scale decomposes the notion of service quality into five main dimensions as earlier indicated. These dimensions are:

i. Reliability: The model defines this dimension, as weather the company is reliable in providing the service. Does it provide as promised? More so, reliability reflects a company's consistency and certainty in terms of performance. Again, reliability is the most important dimension for the consumer of services.

ii. Tangibility: In this regard, Parasuraman et al (1988) describes tangibility mainly as how the service provider's physical installations, equipment and people are. Since there is no physical element to be assessed in services, customers often trust the tangible evidence that surrounds it when making their individual assessment.

iii. Responsibility: The key issue raised here is whether company employees are helpful and capable of providing fast service. Furthermore, is it responsible for measuring company and employee receptiveness towards client.

iv. Empathy: This dimension deals with the capacity of a person to experience another's feelings. Again, it raises the question does the service company provide careful and personalized attention?

v. Assurance: With assurance, knowledge and courtesy of employees and their ability to inspire trust and confidence by customers.

This model has been applied in the study of healthcare quality in the healthcare literature. In a study to assess the quality of physiotherapy services, Curry and Sinclair (2002), used the SERVQUAL model in three physiotherapy services in Dundee, Scotland. In this study, they considered the ten original criteria for evaluation and combined them into five; tangibles, reliability, responsiveness, assurance (including competence, courtesy, credibility, and security) and empathy (including access, communication, and understanding). The findings indicated, that the services were highly appreciated by customers even though it was realized that the perception gaps were slightly negative and services could be improved. Their study proved that assurance and empathy were very important for quality healthcare.

More so, Jabnoun and Chaker (2003), in their study compared public and private hospitals in the United Arab Emirate. The Factor analysis of the results revealed five dimensions thus empathy, tangibles, reliability, responsiveness and supporting skills. The study found that there is significant differences between private and public hospitals in terms of overall service quality in empathy, tangibles, reliability and administrative responsiveness dimensions. Their findings indicate that public hospitals are perceived to be better than private hospitals on service quality.

Yesilada and Direktor (2010), used the SERVQUAL model to compare the quality of healthcare between public and private hospitals in Northern Cyprus. In their study they found that there were three critical quality dimensions; reliability–confidence, empathy and tangibles. Moreover, their study also observed that both private and public hospitals failed to offer the expected service quality but public hospitals provided a lower quality of care than the private hospitals.

They therefore recommended that for both public and private hospitals, further investigations should be made to find out the underlying causes of the underlying gaps identified within the organizations and suggest solutions to managers to close the gaps and provide high quality services to their customers.

Irfan and Ijaz (2011) conducted an empirical study to compare the quality of healthcare services delivered by the public and private hospitals to gain patient satisfaction in Pakistan. For this purpose the SERVQUAL instrument was used to measure the patients satisfaction about service quality delivered in these hospitals. In their work it is noted that private hospitals are delivering better quality of services to their patients as compared to public hospitals.

Ramez (2012), employed the SERVQUAL model to evaluate service quality of healthcare providers in Bahrain, the primary objective of the study was to ascertain the relationship between the dimensions of service quality and patients' satisfaction, analysing the behavioral intention of patients. He revealed that empathy, responsiveness and tangible dimensions had the largest influence on the overall service quality. He therefore concluded that there is a positive and significant relationship between overall service quality (OSQ) as well as patients' satisfaction (SAT) and their behavior intention (BI).

In a cross-sectional survey by Essiam (2013) the study adopted the SERVQUAL dimensions to examine the quality dimensions and patient satisfaction with healthcare delivery in a Public University hospital. The findings indicated that patients' satisfaction is best explained by perceived responsiveness, followed by perceived empathy, perceived assurance, perceived tangibility, and perceived reliability. The study further recommended that findings would be of interest to hospital administrators, policy makers, stakeholders and academics investigating the

main relationships between the SERVQUAL dimensions and patient satisfaction using the hierarchical regression model.

Aghamolaei et al., (2014), conducted a cross sectional study in the Bandar Abbas Shahid Mohammadi Hospital in the south of Iran. All 96 participants in this study were provided with a SERVQUAL questionnaire. Wilcoxon and Kruskal-Wallis tests were used to analyse the data. The findings indicated that service quality gaps were seen in all five-service quality dimensions and the overall quality of service. In this study, 56.1% of participants defined the quality of services as average. It was recommended that policy action must be taken to decrease the gap score between the perception and expectation of the patients.

2.2 Patients satisfaction and quality healthcare in the context of Ghana.

Ghanaians perceive the quality of health services as sub-standard and therefore choose alternative sources of treatment (Turkson, 2009). The trust and confidence is undermined by frequent shortages of drugs and medical supplies, long queues, the absence of emergency services and poor staff behaviour. This has resulted in low utilization of health services despite the substantial investment aimed at improving access to health services in Ghana (Shield Workpackage Report, 2007; Gyapong et al, 2007).

However, others perceive the quality of healthcare in Ghana to be high. Turkson (2009), looked at the quality of healthcare delivery in a rural district of Ghana and found that generally the quality of healthcare delivery was perceived to be high for most of the indicators used. That is ninety percent of the respondents were satisfied or very satisfied with the care given during their visit to the health facility. The participants however perceived poor attitude of some health workers, long waiting times, high cost of services, inadequate staff, policy of payment for health

services, frequent referrals to hospitals, and lack of ambulances at facilities as being detrimental to effective delivery of quality healthcare.

Furthermore, another study by Atinga et al (2011), examined how communication, provider courtesy, support/care, environment of the facility and waiting time significantly predict patients' satisfaction with the quality of healthcare in two hospitals located in northern Ghana. They observed that the five-factor model, support/care, environment of the facility and waiting time determine patients' satisfaction with quality of healthcare delivery. The explanatory power of the dependent variable was explained by 51 percent in the regression model.

Peprah (2014) conducted a study at Sunyani Regional Hospital in Ghana to assess patients' satisfaction using the SERVQUAL model by Parasuraman et al, (1998). The SERVQUAL instrument was adapted and modified to capture the relevant data. A total of 214 patients were sampled for the study. The study analysed for descriptive statistics and patients satisfaction were determined by the service quality gap. The study results indicate that the overall satisfaction of the patients concerning service quality of the hospital was good. Again, the study recommends policy action to improve service delivery in communication/interpersonal relationship, assurance and responsiveness dimensions. However, tangibility and empathy were esteemed high by patients in their satisfaction in assessing quality healthcare at Sunyani Regional Hospital.

2.3 Justification for the model selection

The selected conceptual framework explains basically the underlying process of service quality, which is applied to guide this study. Concentrating on the perception of the patient only, thus the expectation was removed from the modified model suited for the study. This is congruent with the fact that perceptions are usually a good measure of patient satisfaction with quality healthcare delivery (Pakdil & Harwood, 2005; Naidu, 2009; Drain, 2001). After defining the concept of

service quality, the researcher needed a model for measuring the quality level of services. The model was expected to spell-out the attributes that require improvement in order to enhance quality, identify the degree or amount of improvement required and identify how the impact of service quality improvement efforts can be assessed (WHO, 2014).

Again, this model can be used on a regular basis to track patients' perceptions of healthcare quality of a hospital compared with its competitors. Once data have been analysed they can be visually presented so that it is easier to identify strengths and weaknesses relative to competition. More so, it provides the opportunity for a firm (hospital) to assess its service quality performance on the basis of each dimension individually as well as the overall dimensions of service quality.

Furthermore, the model can be used in various service setting and provides a basic skeleton that can be adapted to fit the specific attributes of a particular organization (hospital). It is applicable across different empirical context, various countries and cultural backgrounds.

With these concerns the Parasuraman et al. (1988) SERVQUAL model was chosen and it was modified to include four-dimensions, making it nine dimensions for assessing healthcare quality. The four dimensions were added due to the operational service provision style of the university hospital that is predominantly focused on the university community. Decisions to modify the SERVQUAL instrument were based on the relevance of the questions to the context of university hospital services and on the ability of patients to respond to the questions without experiencing confusion or undue frustration.

2.3.1 CONCEPTUAL FRAMEWORK FOR THE STUDY

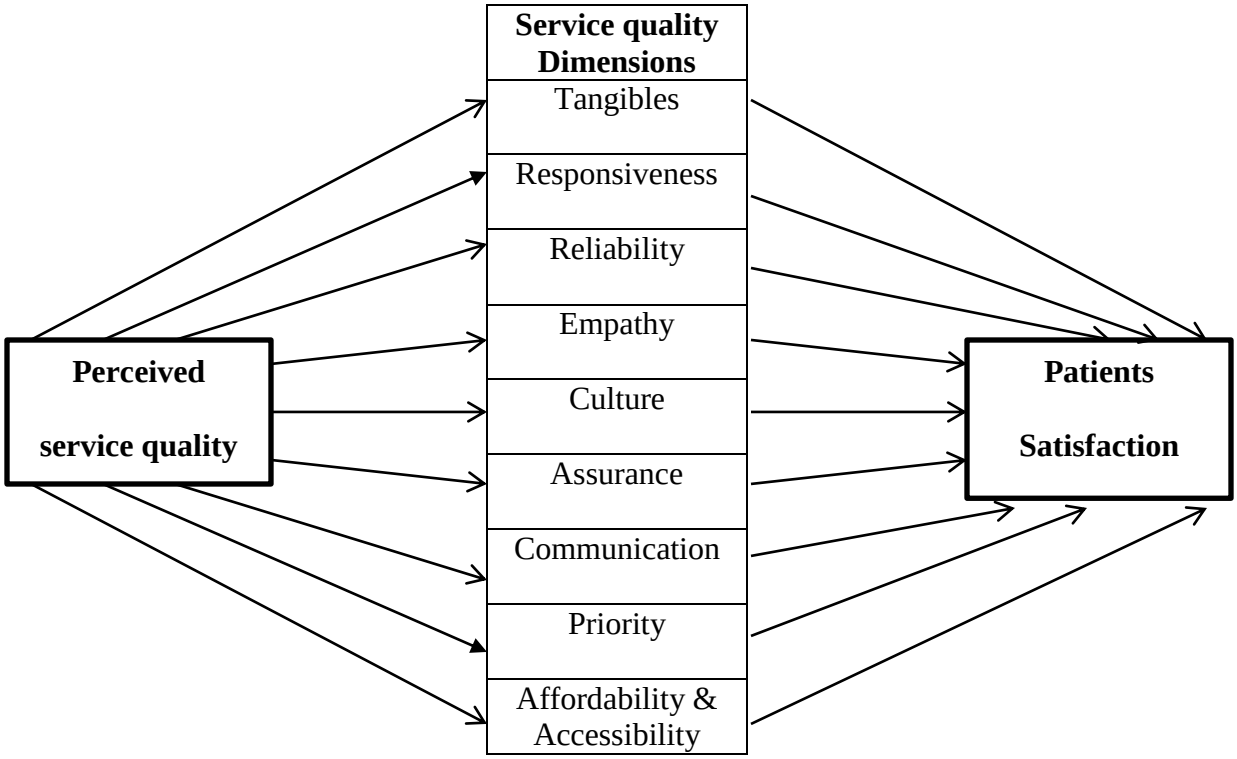

Fig. 1.0: Conceptual Framework for measuring quality healthcare
Adapted from the SERVQUAL MODEL
Parasuraman et al, 1988.

Figure 1.0 presents the conceptual framework for measuring quality healthcare of the study. Thus patients of the university hospital perceive quality healthcare based on the nine service quality dimensions in the model and these dimensions predicts patient's satisfaction with quality healthcare in the university hospitals. The model reveals direct relationship from perceived service quality towards the service quality dimensions and flows to patient's satisfaction.

2.3.2 Tenets to the Model

The main dimensions to this model are discussed below in terms of perceived service quality, tangibles, responsiveness, reliability, empathy, culture, assurance, communication, priority, accessibility and affordability as well as patient's satisfaction.

Perceived service quality: Patients has some perception on the healthcare service they receive, either based on experience or rumors. This variable measures the various perceptions of patients on quality health in the university hospitals.

Tangibles: This dimension measures the physical environment of the hospital in relation to the Out - Patient Department. The nature of the equipment used at the hospital.

Responsiveness: This dimension deals with the caring nature of the staff, meaning how helpful are the staff?

Reliability: It involves trust in the services, in terms of performing services according to the Standard of Operating Procedures (SOP's) and consistency in care delivery**.**

Empathy: Responsiveness involves the interest of the patients at the heart of the staff, it also answers the issue weather the staff have the interest of patient at heart.

Culture: Provision of service is hinged on culture, which is reflective of the language, ethnicity preference. This dimension looks at the culture paradigm that is entailed in healthcare delivery in the university hospitals.

Assurance: In assurance dimension the efficiency of the hospital is observed, it also measures weather the staff are well trained. The hospital has skilled staff to deliver services.

Communication: Communication is a tool for service improvement. It deals with whether staff gives adequate information about the process of healthcare delivery.

Priority: Priority is given to some patients in healthcare delivery and therefore this dimension is centred on the proper care given to students and university staff in the healthcare delivery at the university hospitals.

Accessibility and Affordability: The accessibility dimension looks at the geographical location of the hospital, the environment being friendly, patients-centred and the approachability of staff. This dimension also deals with the financial barrier that prevents patients from accessing healthcare at the hospital

Patient's satisfaction: Generally, this measures how satisfied patients are with the quality of healthcare service provided and the preparedness of patients to visit the facility again.

2.4 Healthcare

Healthcare is defined as the medical diagnosis, treatment, as well as prevention of disease, illness, injury, physical and other mental impairments in humans (WHO, 2008). Again, practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health and other care providers who deliver healthcare service adopt this definition. They refer to health as the work done in providing primary care, secondary care and tertiary care, as well as in public health. Furthermore, healthcare is conventionally regarded as an important determinant in promoting the general health and wellbeing of people around the world (WHO, 2010).

2.5 Quality Healthcare

The Institute of Medicine (IOM) in 2001, heralded the crusade to address the gaps between actual and recommended quality healthcare standards in the United States of America. This move coincided with a similar movement in the UK, which had been gathering pace since 1997 (Oliver, 2005). Initially, this quality healthcare approach was 'regarded as something best left to a few maverick enthusiasts' (Fillingham, 2008, p. 3) rather than an essential capability for all

healthcare staffs and patients. Today, the quality healthcare initiative theme is growing in stature after the WHO clarion calls for improved quality healthcare delivery in 2008 (WHO, 2008). This reinforces the continuous capacity building to ensure the best quality healthcare delivery in developing countries. Eccles et al., (2009) indicate that healthcare professionals are heterogeneous in the definition of quality healthcare, however, patients agree on the terms that any service improvement that satisfies patient demands, clinical needs, patient and carer wants are quality.

There have been some debates over the definition of quality healthcare in the literature whether defining quality healthcare should be in the perspectives of patients or the service providers (Yildi & Demirors, 2012). Collins and Joyce (2008), in an attempt to summarize the recent debates on quality healthcare definition and issues on the healthcare system in Ireland, which have come to the fore through media exposure, based their study on a systematic review of media opinion and reports. Their findings stipulate that quality healthcare definition should be patients centred, since the healthcare facilities are mandated to provide healthcare as a service. Once patients within the hospital are satisfied with services then quality healthcare is achieved. However, some studies have looked at quality healthcare from different perspectives and this is reflected below.

Spencer et al (2014) observed why hospitals vary in the quality of care delivered to patients in the USA. The study examined the Agency for Healthcare Research and Quality's innovative Inpatient Quality Indicators and pooled 2006–08 State Inpatient Database records from eleven states. The findings indicated that privately insured patients had lower risk-adjusted mortality rates than did Medicare enrollees for twelve out of fifteen quality measures examined. It further stipulated that Medicare patients appeared particularly vulnerable to receiving inferior care and

recommended that in order to help reduce care disparities, public payers and hospitals should measure quality healthcare for different insurance groups and monitor differences in treatment practices within hospitals. Again, Esian et al., (2012), explored quality healthcare improvement at individual, group and organizational levels and identified the restraining forces using formative evaluation, and the implications for current UK policy, particularly quality, innovation, productivity and prevention. A total of 11 multi-disciplinary groups drawn from the NHS England Healthcare Trusts (self-governing operational groups) were sampled. The results showed that there was a limited focus on patient-centred services in the eleven groups and therefore directed managers and policy makers to undertake an evaluative health policy to improve healthcare quality centred on patients' needs.

2.6 Patient Satisfaction

The advent of the patient's rights movement fuelled the debate over the relationship between patient satisfactions as a valuation of the process of care versus the standard of technical care (Williams, 1994). As a result, the use of patient satisfaction measures in the health sector became increasingly widespread. For example, assessing patient satisfaction has been mandatory for French hospitals since 1998; this is used to improve the hospital environment, patient amenities and facilities in a consumerist sense, but not necessarily to improve care (Boyer et al., 2006; Gill & White, 2009). However, it is extremely difficult to categorically define patient satisfaction due to the inconclusive evidence in literature (Larsson & Wilde-Larsson, 2009; Naidu et al, 2009; Peakash, 2010; Gosh, 2013). Crowe et al. (2002), in their work identify 37 studies investigating methodological issues and 138 studies investigating the determinants of satisfaction. They indicate that there is an agreement that the definitive conceptualization of satisfaction with healthcare has still not been achieved and that understanding the process by which a patient

becomes satisfied or dissatisfied remains unanswered. More so, they suggest that satisfaction is a relative concept and that it only implies adequate service. Furthermore, Crowe et al. (2002) and Urden (2002), separately point out that patient satisfaction is a cognitive evaluation of the service that is emotionally affected, and it is therefore an individual subjective perception. However, patient satisfaction is grounded as part of health outcome quality, which encompasses the clinical results, economic measures and health related quality of life (Heidegger et al., 2006; Gill & White, 2009).

2.6.1 The historical context of patient satisfaction

Hulka et al. (1970), took the initial steps to measure patient satisfaction in the healthcare area with the aim of developing the 'Satisfaction with Physician and Primary Care Scale. Ware and Snyder (1975), followed with their "Patient Satisfaction Questionnaire', targeted at assisting with the planning, administration and evaluation of health service delivery programmes. In the late 1970s, Larsen et al developed the 'Client Satisfaction Questionnaire'(1979) with eight-item scale for assessing general patient satisfaction with healthcare services; this scale was superseded by their 'Patient Satisfaction Scale' (1984) (Gill & White, 2009). Finally, Parasuraman et al., (1985), conceptualized service quality using a disconfirmation model that compares customer expectations and perceptions (Yousapronpaiboon and Johnson, 2013). Based on this model, Garvin (1988), used a much more aggressive and strategic approach by defining quality along eight dimensions; performance, features, reliability, conformability, durability, serviceability, aesthetics, and perceived quality to measure patient satisfaction with service quality. In addition, Anderson (1995) measured the quality of services provided by a public university health clinic, using a 15-item instrument representing the five dimensions of SERVQUAL. According to her findings, all the five dimensions measured negatively, assurance being most negatively

measured. Based on these results, Anderson made some recommendations for the budgeting of future quality improvement projects according to ratings to certain aspects of outpatient care than other inpatient services (Tangcharoensathienm et al., 1999; Yousapronpaiboon and Johnson, 2013). More so, some studies have been undertaken to assess perceived service quality in the hospital sector in different countries. Thus, Boshoff and Gray (2004) adapted this model for a study on customer satisfaction and loyalty among patients in the private healthcare industry in South Africa and revealed that SERVQUAL dimensions, namely nursing staff empathy, assurance and tangibles, impact positively on patients' loyalty. Cohen (1996) asserts that consumers of healthcare services frequently rank communication and interpersonal aspects of the healthcare experience highest in importance.

Rao et al., (2006) surveyed inpatients and outpatients who visited primary health centres, community health centres, district hospitals and female district hospitals in the state of Uttar Pradesh, the most populous state of India. They identified five dimensions of service quality – medicine availability, medical information, staff and doctor behaviour and hospital infrastructure. Patients' perception of service quality was found to be marginally better than average. For outpatients, doctor behaviour was the key determinant of patient satisfaction.

Kumari et al. (2009), examined patients attending the outpatient department (OPD) of government allopathic health facilities of Lucknow district, the capital city of Uttar Pradesh. Although the overall satisfaction of the patient was satisfactory, there were deficiencies in certain areas such as short OPD hours, availability of drinking water, availability of clean toilets and doctor–patient communication.

In addition, Nwankwo et al., (2010), found that public hospitals are providing largely unsatisfactory service to the patients in regards to doctor's responsiveness, length of getting an

appointment time, access to core treatment and hours of operation (Yousapronpaiboon and Johnson, 2013; Bisschoff and Clapton, 2014). Again, Zaim et al (2010) indicate the important criteria for measuring service quality in the hospitals in Turkey is the patient's view. The study confirmed that tangibility, reliability, courtesy and empathy are significant for customer satisfaction, while responsiveness and assurance were not. Sodani et al., (2014), measured the satisfaction of patients visiting the outpatient department (OPDs) of a district hospital, a civil hospital, a community health center and primary health center of eight selected districts of Madhya Pradesh, India. They observed an increase in the satisfaction of patients with the behaviour of doctors and staff at lower-level facilities compared to higher-level facilities.

Sharma et al (2004) assessed the patient satisfaction level visiting the OPD in a premier multi-specialty hospital of North India and concluded that the patients were satisfied with the doctor, nurses and paramedical staff. However, a certain percentage of patients opined that doctors had shown little interest to listen to patients' problems and often used technical terms to explain their illness or consequences. The majority of the patients in the survey were satisfied with the basic amenities, but the services were found costly. Nekoei-Moghadam and Amiresmaili (2011) examined the service quality in hospitals of Kerman University of Medical Sciences and found that the largest discrepancy between patients' expectations and perception were in the tangibles dimension. Responsiveness was the second followed by reliability, assurance and empathy. (Yousapronpaiboon & Johnson, 2013) According to Al-Hawary et al. (2011), hospitals in Jordan that had a high perceived quality was based on hospital staff (including academic/professional qualifications and sound medical experience), comfortable accommodations for in-patients and caring staff (including doctors, nurses, and health professionals) but that lower perceived quality at the hospital was due to an insufficient number of pharmacy outlets to dispense medicine as

well as long waiting times to see the doctor and expensive medicine. In reaction patients are most tolerant to factors related to the tangible dimension and least tolerant to factors related to the reliability dimension (Ariffin & Aziz, 2008; Yousapronpaiboon & Johnson, 2013).

Al-Hawary (2011), in an exploratory survey studied the health care services quality of hospitals in Jordan and Saudi Arabia and found that tangibles and accessibility were better provided in Saudi Arabia hospitals. Furthermore, tangibility was found to be perceived better in the hospitals in Jordan. Again, Ceelik and Sehribanoglu (2012), indicate that the tangible service quality dimension had the single largest effect on the contentment perception of patients in Turkey's hospitals; empathy and reliability were found to have lower effects in an experimental study. Zarei et al. (2012), through a cross sectional design studied service quality in hospitals in Iran and evaluated the service quality from the patients' view.

They found that the highest expectations and perceptions were related to the tangibles dimension and the lowest expectation and perception related to the empathy dimension. Mekoth et al., (2012), studied the OPD of a public hospital in Goa and observed the quality of physicians and clinical support staff as key determinants of patient satisfaction. However, the quality of non-clinical staff was not found to affect patient satisfaction.

Moreover, Yousapronpaiboon and Johnson (2013), indicated that SERVQUAL's five latent dimensions had a significant influence on the overall service quality. They further observed responsiveness had most influence; followed by empathy, tangibles, assurance and finally reliability. First, given that responsiveness was the strongest predictor of service quality, the policy implication is that hospital out-patient employees can exercise strong influence over perceived quality by giving sincere and detailed information about service conditions, by being willing to help and by offering fast and efficient service to out-patients. Senarath et al., (2014)

evaluated patient satisfaction using eight dimensions: interpersonal care, efficiency, competency, comfort, physical environment, cleanliness, personalized information, general instructions. The study revealed that patients were satisfied with interpersonal care, but less satisfied with comfort, environment, sanitation and general and personal instructions.

2.7 Patients perception on constituents of service quality

Perceptions are vital measures of health service quality in the context of patient satisfaction with healthcare delivery in Ghana. Improving service quality in health care has gained considerable attention in the past decade because proper delivery of care leads to better health outcomes for the patients. Generally, it is argued that patients' perception of actual services delivered determine the service quality of a hospital. Moreover, perceptions refer to the consumers' evaluation of the service provider. Therefore, if the customers' performance perceptions exceed the customers' expectations, the service provider provides quality service (Turkson, 2009; GHS, 2010; Yousapronpaiboon & Johnson, 2013). John (1991) noted that perceptions of service quality in hospitals could be improved through improving communication between patients and healthcare providers. Patients are the ultimate arbiters of quality and given that perceived quality is a key antecedent of perceived value and satisfaction judgments, hospitals are increasingly interested in conducting such quality assessments (Fornell et al, 1996; Yousapronpaiboon & Johnson, 2013). In quest by patients to assess the quality of healthcare delivery, Carman (2000), pointed out that perception of service quality is an attitude, and that the attitude is a function of some combination of attributes that a patient considers to be components of quality. The attributes can be divided into two sets, thus functional, which includes measures such as ambiance and provider attentiveness; and technical, such as outcome that describes how the service is delivered. Thus, there exists a link between perceived service quality and patient

satisfaction. More so, findings from Alrubaiee and Alkaaida (2011) and Ramez (2012) indicate that patient perception of quality healthcare has a strong and positive relationship with patient satisfaction.

Abdallah (2014), in his quest to understand how vulnerable lower income patients make health care decisions and define quality of care based on a survey and a focus group discussion in the United States indicates that perception and views of patient on service quality can be categorized into: patient-centred care, timely and efficient care, quality and range of services. Patient perception on patient-centred care noted that treating them in a hospital environment with respect and dignity as well as designing the service delivery to be equitable and fair are the building blocks on quality healthcare. Timely and efficient care was a key perception of patients on service quality: as the study revealed that quality care centred on structural elements of care rather than outcomes. Thus the study centered on a more service-oriented view of quality: were the services timely, efficient, well organized, and available when it was needed. Patients perceived quality and range of service as essential aspects of quality based on the physician's competence, which was judged based on thoroughness and a clear intent to help the patient. The physician's ability to communicate with patients was considered to be an essential aspect of quality, particularly the doctor's ability to explain things to the patients.

2.8 Conclusion

Historically, a number of studies have been conducted on patient satisfaction and quality healthcare delivery. The review of the relevant literature was hinged on the objectives of the study as well as on the broad spectrum of patient satisfaction in Ghana. In the area of dimension of service quality, various dimensions have been used in the measurement of service quality in relation to quality healthcare delivery. These dimensions are good predictors of service quality in

the healthcare industry depending on the significant contribution in defining patient satisfaction with quality healthcare delivery in Ghana.

On service quality constituents, the eclectic literature review indicated that patients have conceptualized service quality in their different jurisdiction depending on the service received.

The perceptions of the patients are vital in evaluating quality healthcare delivery in Ghana. The reviews stipulate that perceptions are varied but health providers should strategically provide services that are patient-centred.

CHAPTER THREE

3.0 METHODOLOGY

Introduction

This chapter discusses the methodological issues involved in the study. It begins by defining the broad paradigm within which the study is situated. This section further discusses the approach that was used to address the research questions. These methods are captured as the research approach, design, the sampling and sampling technique, sample size, study site, instrumentation, source of data, data collection procedure and analysis.

3.1 Research Approach

The mixed-method approach was adopted for the study**.** This approach ensured an in-depth explanation of the contextual dynamics of patient's satisfaction with quality healthcare in Ghana. Creswell and Clark (2007), note that the mixed-method research approach ensures a triangulated multilevel model that addresses different levels of analysis (macro and micro) within a system. According to Teddlie and Tashakkori (2009), mixed-method promotes a clearer and more explicit understanding of the social issue in relation to education, health, culture, and lifestyle.

3.2 Study Design

The main focus of the study is to compare patient's perceptions of the two facilities in service delivery, the process and the quality of services delivered to patients at the two hospitals. The study therefore adopted a comparative design. This selected design is appropriate for the study based on the fact that the study units are homogenous in nature. Thus comparing as well as contrasting their characteristics in the model makes it vital for policy implication on quality healthcare service in Ghana. This is grounded in Mills et al (2006), indicating that the underlying goal of comparative study-design analysis is to search for similarity and variance in the sample

of study either being heterogeneous or homogenous in characteristics. More so, imbedded in the work is the exploratory study design adopted for the quantitative approach. Gay (1992) states that exploratory design involves the collection of data in order to test hypothesis or answer research questions concerning the current status of the subject under investigation. Creswell (2007) indicates that exploratory research enables a researcher to gain familiarity with a phenomenon and acquire new insight in order to formulate a more precise problem or develop a hypothesis. The qualitative section identifies with Creswell (2007) and Neuman (2007) as it enabled the researcher identify the general assumption underlying quality healthcare from the perspective of the patients.

More so, the study adopts the case study design for the qualitative paradigm. This design refers to an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used (Yin, 1984: Barbie, 2004). As indicated by Barbie (2004), the leverage in using the case study design is that it enables the researcher to closely examine data within its real-life, natural context in order to obtain detailed understanding of the issues under study. The advantages of the case study design are congruent with the aim of the study in doing a detailed, micro-level analysis of patients in relation to quality healthcare delivered by the two institutional facilities under study.

3.3 Scope of the study

The study was defined within the scope of assessing patient satisfaction with quality healthcare at the two university hospitals. Within this scope, the study examined patient perception of quality healthcare. Moreover, it also explored what constitutes service quality in the context of

the two hospitals and also examined key service quality dimensions as an important measure of quality healthcare by the patients.

3.4 Study Population

The study purposefully centred on patients who are predominantly sick people from all walks of life with diverse professional, educational, religious and ethnic backgrounds. Since these facilities are all institutional-based, there was the possibility of capturing responses from students and staff accessing healthcare.

3.5 Study Setting

University of Ghana hospital (UGH) was established in 1955. It is currently located at the staff village community of the university campus. The facility provides general services to students, staff and the surrounding communities. The facility has staff strength of 120 professionals working in the various fields of healthcare delivery. The UGH have several sections: the Out-Patient Department (OPD), the Medical laboratory, the Male and Female ward. Again, utilization of the service is annually decreasing from 1,516 in 2011 to 1,203 in 2012 and 1,012 in 2013(OPD Annual Report, 2013). Service delivery within the University of Ghana hospital has been a great concern to students, faculty and the surrounding community. The quality of healthcare in this hospital has come under intense administrative and clinical scrutiny. Moreover, the service of the hospital was rated as not efficient according to Ghana Health Service Report on hospital service quality assessment (GHS, 2012). Therefore, there is the need to delve more into patients' satisfaction with the quality healthcare so that the hospital can know the best strategies to adopt in order to meet their old glorious image of efficient service delivered to the patients.

University of Cape Coast hospital is also located on the University of Cape Coast campus. The hospital was started in 1962 as a clinic located close to the female Adehye Hall. The hospital has several sections: the Out-Patient Department (OPD), the Medical laboratory, the Male and Female ward and provides service to both the university and the surrounding communities**.** The hospital has a staff strength of 128 professionals. Utilization by patients is increasing yearly from 2,045 in 2009 to 2,500 in 2010 and 3,540 in 2012 to 3,064 in 2013 (UCC Hospital Annual report, 2013). The University of Cape Coast hospital is selected because in their five-year strategic plan, the university has resolved to provide quality healthcare delivery to students, senior members and the surrounding communities and by the year 2017 this will be achieved with an extensive research on providing the services that is patient centred (DPQA, 2012). However, the performance appraisal by the regional health directorate rated the hospital as the best in service quality based on an assessment by patients in the region (GHS, 2012; CRHD, 2013). Based on this rating the study sought to compare the University of Ghana Hospital to University of the Cape Coast hospital.

3.6 Sampling

The study employed a two-stage sampling procedure based on stratified and convenient sampling techniques for the survey. Using the stratified sampling procedure for the first phase, it was helpful due to the stratification of the already existing units in the two facilities. Stratified sampling procedure ensures a uniform representativeness of all units in the two hospitals. Babie (2004) reveals that stratified sampling helps researchers to strategically avoid biases in the selection of study units. The two facilities have eight clusters and these are patients at the records section, pharmacy, maternal and child health, X-ray, physiotherapy, laboratory, E.N.T and the consultancy services clusters. From each cluster, patients were conveniently selected for the

survey. The selection was based on the existing survey approach (where patients after assessing the service could best explain and analyse the quality of the service delivered). However, perception informed the assessment of service delivered to the patient's. Records at the two Out-Patients Department (records section, pharmacy, maternal and child health, X-ray, physiotherapy, laboratory, E.N.T and the consultancy services) constituted 520 patients attendance on a daily basis (270 for the UGH and 250 for the UCH). With reference to these figures the researcher selected 218 patients based on the fisher formula for selection of sample size. Thus 110 and 108 respondents for UGH and UCH respectively.

In the interview (qualitative) approach, the purposive sampling procedure was adopted. Thus purposive sampling procedure enabled the study to have an intensive analysis of the study units. Neuman (2011) reveals that it is often used in comparative research to make a study informative due to the unique selection of cases appropriate for characteristics of the units under study. The average time for the interview was one hour each for fifteen (15) patients (7 patients from UG hospital and 8 patients from UCC hospital). Babie (2004), indicates that a sample size of 15 and above in a qualitative study is well grounded for theory and in-depth inductive analysis of the study units.

3.7 Data Collection Instruments

The quantitative approach used structured questionnaires. The use of questionnaires was relevant to this study because it is in sync with the view of Kerlinger (1973), which indicates that questionnaires are widely used for collecting data in research because it is developed to answer questions, it is an effective instrument for securing factual information about practices and decisions of subjects. The structured questionnaire was chosen due to the fact that it assisted the researcher to access vital information about what patients defined as quality in healthcare in

order to critically discuss the patient's perspectives on quality healthcare. Again, this instrument is predominantly used for quantitative surveys (Turner, 2011). The questionnaire was based on the SERVQUAL scale modified to suit the study. It was divided into two main sections. Section one dealt with demographic background of respondents while section two measured the service quality perceptions of patients. On the service quality dimensions, the questions were categorized into the nine dimensions of service quality as adopted for the study – Tangibility, Reliability, Responsiveness, Assurance, Empathy, Accessibility and Affordability, Priority, Culture and Communication. For the purpose of rating, a five-point likert scale was used, ranging from 'Strongly Disagree =1.0 –1.49, Disagree = 1.50 –2.49, Neutral = 2.50 –3.49, Agree = 3.50 – 4.49, Strongly Agree = 4.50–5.0'. This format has been recommended for healthcare surveys (Elbeck, 1987; Steiber, 1989; Scales et al, 2009).

The qualitative paradigm involved the use of an in-depth interview guide. This was constructed based on the research question. The in-depth interviews allowed the researcher to seek answers to the research question posed for the study. It also helped the researcher to grasp the perspectives and thoughts of patients regarding service quality in healthcare delivery. The instrument was carefully chosen for two reasons. One, it is qualitative data collection instruments and given the fact that the second objective of the study is rooted in the qualitative paradigm the instrument was appropriate. Two, the selected instrument is a useful tool in conducting explanatory and descriptive studies (Neuman, 2007). These tools allowed the researcher to extract the perspectives, thoughts and feelings of respondents in order to meet the objectives of the study.

3.8 Sources of Data

The primary source of data was the questionnaire administered to the patients in order to rate quality of service provision based on the Likert scale. The questionnaire was structured based on the hypothesis and the research question, which is reflective of the objectives of the study, and the interview guide also provided primary data from the sampled patients for the qualitative section of the study.

3.9 Data Analysis and Management

The data for the study was analysed both quantitatively and qualitatively. Thus data generated from the structured questionnaire was analysed with Statistical Package for Social Science (IBM SPSS Version 21). Statistical techniques such as the T-test were used to compare the means of the two facilities. A Principal Component Analysis was used to reduce the dataset in order to proceed with factor analysis. Thus factor Analysis (FA) which was consequently performed on thirty-two (32) variables and the output is presented in Table 4.2. As a prelude to employing the Factor Analysis in this study, the sampling adequacy and the factorability of the data were examined to ensure that all assumptions were met for the Factor Analysis. In ensuring the factorability of the data, the Bartlett's test of sphericity and the Kaiser-Meyer-Olkin (KMO) measures of sampling adequacy were examined. According to Tabachnick and Fidell (2001), the Bartlett's test of sphericity should be significant at ($p<0.05$) for the FA to be considered appropriate while the KMO index ranges from 0-1, with 0.6 recommended as the minimum value for a good FA. For this study, the Bartlett's test of sphericity was found to be very significant ($p=0.00$) while the KMO index of 0.919 confirmed the suitability of the data for Factor Analysis. Factors with eigenvalue greater than 1.00 and items with factor loadings greater than 0.50 have been recommended to be significant and included in the analysis. The Cronbach's alpha was

used to examine the reliability of the scale used and the extent to which the variables contribute in explaining a factor. This enabled the researcher have a full control of the key dimensions that relate to service quality in a regression model and to know the effect of the various independent variables (dimensions) on patient satisfaction being the dependent variable. A multiple linear regression has the ability to explore the relationship between one continuous dependent variable and a number of independent variables or predictors (usually continuous) (Pallant, 2005; Brant, 2007).

The transcribed data from the interviews were analysed manually using the thematic and cross-case analysis. This helped the study identify the various re-occurring themes that best explain the patient's decision and feeling on quality healthcare. The interview comprised fifteen patients, maximum of seven at each hospital. Among the fifteen patients who participated in the interview, seven were females and eight were males. Creswell (1998) has recommended that 10-25 participants can lead to a saturation point in phenomenological studies. Guest et al (2006), have observed that a sample of six interviews and more 'may [be] sufficient to enable development of meaningful themes and useful interpretations' (p.78). The recorded interviews were performed by the manual approach, where major emerging themes were identified for analyses and discussion.

To ensure effective management of data, the researcher adopted a data management plan. The data management plan comprised data recording, data coding and classification, data storage, and data security. In order to store data for the analysis, the researcher assigned unique codes to all data after recording. The purpose of the coding was for easy identification of responses.

Depending the on study units from which the data was collected, a coding system was generated. For the quantitative aspect data codes were indicated according to the questionnaire numbers (UCQ1 for data from UCH and UGQ1 for data from UGH). The transcribed data from UCH were coded as UCIDI and UGIDI for UGH respectively. On security of the data the interview responses were sky-derived into the personal account of the researcher and again it was backed-up on an external hard drive with protected passwords.

3.10 Pre- testing and Piloting of Instrument

The questionnaire and interview guide were pre-tested at Valley View university hospital with a sample of 20 patients, considerable attention was given to constructing clear and unambiguous questions. Valley View hospital was selected due to the fact that it shares identical characteristics with study area, being an institutional hospital. The instruments were refined based on feedback obtained and value loaded. More so, the pre-testing indicated that patients perceived some of the items included in the scale to be redundant. Because this redundancy led to frustration and low response rates, the researcher with input from the supervisor agreed to reduce the number of items. Furthermore, pre-testing the instrument was necessary based on the stance of Neuman (2007), noting that pre-testing of instrument checks for glitches in wording of questions, lack of clarity of instructions, in fact, anything that could impede the instrument's ability to collect data in an economical and systematic fashion.

3.11 Ethical Consideration

Ethical clearance and approval to conduct this research was obtained from the Ethics Committee on Humanities at the Institute for Social Statistics and Economic Research (ISSER), University of Ghana. More so, a copy of the research proposal, a cover letter, instruments and an introductory letter from my department was added to the request. The university ethically cleared

the study to be conducted at the designated hospitals. Participation was voluntary and the information provided was treated with the utmost regard for confidentiality and anonymity. Furthermore, since this survey was a low-risk research, consent was based on implied consent and did not require a written consent for the survey. However, a written consent was sought from the participant for the in depth interview. Patients involved in the interview were treated with the dignified privacy during the interview process and were made to consent to their participation before the process started.

3.12 Field Experience

Generally, the main challenge faced during the field data collection was the unwillingness of patients to respond to the questionnaire. This was largely attributed to the fact that patients had spent long hours at the hospital queuing at the OPD. Moreover, there were some respondents who dropped-out of the study along the course of answering the questions. These respondents felt the questions were too many and they could not stay any longer to complete them. The researcher printed and administered questionnaire in excess of 30, to make up for the non-response.

CHAPTER FOUR

4.0 PRESENTATION AND ANALYSIS OF RESULTS

Introduction

This chapter of the study presents the main results, thus the thematic areas of the presentation involve: socio-demographic characteristics of patients, service quality dimensions and patient satisfaction as well as comparative analysis of perceptions of UGH and UCH patients on quality healthcare.

4.1 Socio-demographic characteristics

A total of 218 respondents were sampled for the study as indicated in table 4.1. In all, 110 respondents representing 49.5 percent of the sample size were selected from the University of Ghana Hospital (UGH) and 108 respondents consisting of 50.5 percent were selected from the University of Cape Coast Hospital. Females constituted a larger proportion of the sample size (53.2%) and the males were 46.8 percent. The results indicate that 42.7 percent of the respondents are middle/senior high school graduates, while 28.9 percent and 15.1 percent were in the tertiary institution and Junior High School respectively. The results further revealed that 6.9 and 6.0 percent of the respondents had primary and non-formal education respectively. Again, the demographic results indicated that 45(20.6%) of the respondents were students, 17% were traders were traders (Businessmen) and 15.1% unemployed. However, farmers constituted 14.2 percent and 14.7 percent were Government employees. A total of 82.5 percent of the respondents were between 18 and 50 years. On the other hand, 10.6 percent were within the age 51 and 61years and 15(6.9 percent) were 62 years and above. A greater percentage of 74.3 had utilized the hospital between 2 and 4 times, more so, 18.8 percent had visited between 5 and 7 times and 6.9 percent had utilized the facilities over 8 times.

Table 4.1: Socio-demographic Characteristics of Respondents (N=218)

Demographic Variable	Categories	Frequency N=218	Percentage (%)
Hospitals	UCH	110	49.5
	UGH	108	50.5
	Male	102	46.8
Gender	Female	116	53.2
	None	13	6.0
	Primary	15	6.9
	Junior High/JSS	33	15.1
Educational Level	Senior High/Middle School	93	42.7
	Tertiary	63	28.9
	Other	1	0.5
	Unemployed	33	15.1
	Trader/Businessman	37	17.0
	Farmer	31	14.2
Employment Status	Government Employee	32	14.7
	Private Sector Employee	25	11.5
	Student	45	20.6
	Other Specify	15	6.9
	18-28 years	83	38.1
	29-39 years	57	26.1
Age	40-50 years	40	18.3
	51-61 years	23	10.6
	62 years and above	15	6.9
	2-4 times	162	74.3
Number of visits	5-7 times	41	18.8
	8 times and more	15	6.9

Source: Field data (2014)

4.2 Dimensions of service quality and patient satisfaction

Service quality in the healthcare literature is underlined by several attributes that decomposed into unique dimensions, which then significantly predict the outcome of the overall quality healthcare delivery based on patient satisfaction. These attributes were loaded on nine dimensions that eclectically underpin the overall service quality in the two University hospitals (tangibility, reliability, responsiveness, assurance, empathy, communication, culture, priority and accessibility and affordability). In order to extract relevant dimensions as good predictors of overall service quality, an exploratory factor analysis was performed in order to assess the best dimensions of service quality. The principal component analysis with varimax rotation was employed in ensuring the factorability of the data. The results of the dimension are presented in Table 4.2. The first factor (Factor I) measured the Empathy aspect of the healthcare service quality. The factor comprised issues as staff welcome patients weakness, staff has patients interest at heart, more so, staff are responsive, they understand patients specific needs as well as being caring to patients. This factor accounted for the highest variation with an eigenvalue of 10.6, which is equivalent to 38.2% of the total variance. The second factor captured issues on communication of staff to patients at the two university hospitals. The factor loadings under Factor II include doctor's willingness to answer questions of patients, giving adequate information on treatment and health condition of patients and patients receiving adequate information on test that they have to undergo. The factor accounted for an eigenvalue of 1.87, which amounts to 6.68% of the total variance. The third factor (Factor III) was termed as Culture, which is one key dimension to patient's satisfaction with healthcare service quality at the university hospitals. Items examined under this factor were; staff at the hospital use a language patients understands, they do not discriminate based on religion, as well as the location

being accessible to patients of different ethnic and cultural background. This factor explained 1.60(eigenvalue) of the variance, which represents 5.74% of the total variance. Factor IV, indicated the Tangibles dimension, determines patient's satisfaction with quality healthcare of patients in the university hospitals. Factors that loaded on tangibles included hospital having up-to-date facilities and also modern looking equipment. This factor explained 1.45 of the variance, which represent 5.17% of the total variance. The last factor (Factor V) measured issues related to Priority. The individual loadings here include university workers and students do not join queues to seek healthcare services, moreover, they are given special care at the hospital. This factor accounted for 1.25 of the eigenvalue, which is equivalent to 4.48% of the total variance.

Table 4.2: Dimension of Service quality on Patients Satisfaction

Factor	Statements	Loadings	Eigen values	% of variance explained	Cronbach alpha (α)
I	**Empathy**				
	Staff welcomes patients' weaknesses	0.78			
	Staff has patients' interest at heart	0.72	10.6	38.2	0.84
	Staff respond immediately when called by patients	0.70			
	Staff understand patient specific needs at the hospital	0.66			
	Staff at the hospital are caring to patients	0.63			
	Staff promptly deliver service	0.63			
II	**Communication**				
	Doctors are willing to answer questions relating to illness	0.79			
	Patients were given adequate information on their treatment	0.77	1.87	6.68	0.85
	Patients were given adequate information on their health condition	0.72			
	Patients received adequate explanation regarding any test undertaken	0.68			

III	**Culture**				
	Staff use language patients understand	0.75			
	Staff at the hospital does not discriminate based on religion	0.74	1.60	5.74	0.75
	Staff at the hospital does not discriminate based on ethnic background	0.66			
	Location of the hospital is accessible	0.55			
IV	**Tangibles**				
	The hospital has up-to-date facilities	0.80			
	The hospital has modern looking equipment	0.70	1.45	5.17	0.70
V	**Priority**				
	University workers and students do not join queues to seek healthcare services	0.84			
	University workers and students are given special care at the hospital	0.68	1.25	4.48	0.71
	Total Variance Explained			**60.3**	

Source: Field data (2014)

4.3 Predictors of service quality dimension on patent satisfaction

A multiple linear regression model was used to determine the predictive effect of the five dimensions of service quality (independent variables) from the factor analysis on patient satisfaction (dependent variable) using a $p<0.05$ as a statistical criterion. The model exhibited an adjusted R^2 value of 0.56. Thus this model is fitted in explaining 56% of the variations of the dimensions of service quality on patients' satisfaction. Consequently, all the five variables were good predictors of patient satisfaction with service quality in the university hospitals and their t-values indicated that these dimensions are strong predictors of patient's satisfaction. Results from Table 4.3 indicated that 'Empathy' (β=0.09) is statistically a significant predictor of patient satisfaction of both university hospitals since its p-value (0.003) does not exceed a significant P-

value of (0.05). Furthermore, communication, culture, tangible and priority are significantly good service quality predictors of patient's satisfaction of services of the university hospitals.

The relative importance of the significant predictors is determined by the standardized β values that are useful for comparing regression coefficients with respect to their impact on the dependent variable. The magnitude of these values shows the order of importance on patient's satisfaction. Analysing the results in the Table, the order of significance for the predictor of the service quality on patient satisfaction is 'Communication' (β=0.26, *p*=0.00), followed by 'Priority' (β=0.18, *p*=0.002). Culture is the third best predictor of patient satisfaction (β=0.17, *p*=0.008). 'Empathy' (β=0.14, *p*=0.003) is the fourth best predictor and the last predictor is 'Tangibles' (β=0.12, *p*=0.040).

Table 4.3: A multiple linear regression on dimension of service quality on Satisfaction

	Patient Satisfaction				
Predictors	*B*	SE	β	t-value	Sig
Empathy	0.18	0.09	0.14	2.01	0.003*
Communication	0.31	0.07	0.26	4.14	0.000*
Culture	0.26	0.09	0.17	2.66	0.008*
Tangibles	0.15	0.07	0.12	2.06	0.040*
Priority	0.17	0.05	0.18	3.12	0.002*
Constant	0.31	0.41		0.77	0.437

R^2 = 0.58 Adjusted. R^2 = 0.56; F-value= 26.17; p = 0.00, p≤ 0.05

Source: Field data (2014)

4.4 Constituents of service quality

An interview guide was employed to collect data from the patients on what they think and feel about what constitutes service quality in the university hospitals. The main key themes that emerged from the views of the patients on what constitute service quality were based on the nine dimensions, which were pinned on 'timeliness', 'staff performance', 'service improvement', and 'satisfactory services'.

Patients saw timeliness as a key determinant of service quality in the university hospitals. Thus they were of the view that time is an essential commodity to healthcare delivery and therefore indicated quality health service delivery hinges on time (time staff report to start work, time in accessing other essential care such laboratory tests, X-ray and the long waiting time at the OPD to take history). A greater percentage of the patients shared this view, as one noted:

> *"....time is money, we come and join this long queue for so many hours and they come only to order us around. They think we come here because we want, if not sickness what will bring me here. They should come to work early so this the queue can move fast"(Male patients, Taxi driver, Aged 25).*

Furthermore, patients outlined staff performance as another essential variable constituting quality healthcare in the university hospital setting. They noted that professional knowledge and in-service training boost performance of staff in providing quality healthcare to patients. A review of the findings revealed that staff with higher professional development are cautions in healthcare delivery as they ensure strict ethical and professional guidelines in the service delivery to patients. The majority of the patients stressed the need for excellent performance by staff. A respondent indicated:

> *"They need to work hard and perform all the medical procedure right, in fact their supervisors should also monitor them that they perform all the task according to the required procedure for quality healthcare delivery, they can do better, since they have the people" (Female, Housewife, Aged 34).*

Again, patients indicated that service improvement is an underlying component of quality healthcare. It was noted that quality of service is fueled by persistent improvement in services rendered by the various departments in the hospital, thus this improvement is reflective in the attitudes of service providers, the service delivery process, logistics provision and the

professional and ethical training of staff. Almost all respondents were of the view that service improvement is a necessity for patient satisfaction with quality healthcare.

> *".....they always do this assessment, but the service is the same, they should work to improve the service delivery, that is what we want"(Female, Seamstress, Aged 45).*

Finally, patients deemed satisfactory service as the crux of quality health service in the university hospitals. Thus, patients are of the view that service quality should be satisfactory in terms of the constituents of healthcare. They further indicated that staff at the university hospitals are averagely delivering service to the acceptable satisfaction of patients. A greater number of the patients were affirmative to this view as one observed:

> *"Well their service is normal compared to some government hospital in Ghana, but they can do more, since all the medical knowledge is produced in the university"(Male, Baker, Aged 39).*

4.5 Comparison of patient's perception on service quality

An independent t-test was used to compare the perception of patient's satisfaction on dimensions in service quality of University of Ghana (UGH) and University of Cape Coast hospital (UCH). Results from Table 4.4 indicate that there were significant differences between the mean perception of patients of UGH and UCH on empathy, tangibles and priority dimension at a p=value of 0.005. However, the mean perception of patients on communication and culture dimensions of service quality are not significantly different at a *p*=value of 0.005.

Table 4.4: An independent t-test Comparing of perceptions patients service quality dimensions that clearly predict patient's satisfaction of service at UGH and UCH.

Empathy	Mean	Std	t-static	p-value
UGH	3.41	0.83		
UCH	4.52	0.73	2.94	0.004*
Communication				
UGH	3.83	0.89	0.05	0.958
UCH	3.84	0.86		
Culture				
UGH	4.11	0.70	0.55	0.580
UCH	4.16	0.64		
Tangibles				
UGH	3.39	0.83	1.97	0.050*
UCH	4.56	0.81		
Priority				
UGH	3.04	1.06	5.60	0.000*
UCH	4.51	0.97		

Scale: Strongly Disagree =1.0–1.49, Disagree = 1.50–2.49, Neutral = 2.50–3.49, Agree = 3.50–4.49, Strongly Agree = 4.50–5.0

Source: Field data, 2014

CHAPTER FIVE

5.0 DISCUSSION OF RESULTS

Introduction

This chapter discusses the results of the study. The discussion takes into consideration the objectives of the study and its relation to literature that was reviewed with the modified SERVQUAL model. Again, the discussion was presented in the order of the following objectives: predictors of service quality and patient satisfaction, constituent of service quality and the comparison of the quality healthcare of UGH and UCH.

5.1 Demographic Background

The demographic findings indicate that females largely utilized the two hospitals in accessing healthcare services in diverse ways. This finding confirms studies by (Doyal, 2001; Say and Raine, 2007; GLSS, 2008; Abane & Adu-Gyamfi, 2013), who also observed that healthcare utilization is influenced by several factors all over the world and predominant among these factors are gender, educational level, economic status and age. Again, the result reveals that patients with higher levels of education thus those from the senior secondary school level upwards also utilized out-patients services of the University of Ghana hospital and University of Cape Coast hospital extensively. This corroborates the findings of Correa-de-Araujo et al (2005) Maurer (2006) and Nicholas et al., (2007), which suggest that there is a significant relationship between education level and health care utilization, with people of higher levels of education sharing higher levels of healthcare utilization. Thus, the highly educated persons in societies are conscious of their health and therefore make higher investment in their health.

However, majority of the patients are students due the fact that these hospitals are owned and managed by the universities. Therefore, most of the students access services due to the proximity of the hospitals to their campuses. Studies have indicated that residence is a strong determinant of utilization of health services. People close to health facilities are more likely to access healthcare on time (GDHS, 2008; Lahana, et al, 2011)

Furthermore, an approximated figure of 83 percent of patients were between 18 and 50 years, This result is a clear indication that age is a significant determinant in the utilization of healthcare as observed in previous studies (GLSS Report, 2008; GDHS, 2008; Arthur, 2012; Abane & Adu-Gyamfi, 2013).

In assessing quality of service the constant and persistent use of the service by customer is key to service evaluation (Porter et al., 2014). The demographic information revealed that seventy-four percent (162) of the patients have utilized service at the two university hospitals between 2-4 times, indicating that they are well-placed to assess the quality of services rendered by the hospital.

5.2 Predictors of service quality on Patient satisfaction

The multiple linear regression model gives adequate and significant results, indicating empathy, communication, culture, tangibles and priority are the significant predictors of patients satisfaction in the university hospitals in Ghana. This objective was designed to examine the best predictors of perceived service quality dimensions on patient satisfaction.

5.2.1 Empathy

Patients perceived empathy as a relevant service quality dimension that deals with how staff emotionally responds to the care of patients. Perceived empathy involves how staff welcomes the patient's weakness. This dimension clearly spells out how staff respond to patients needs and promptly deliver services on time. Again, it further defines how caring staff are to patients and have the patient's interests at heart. Patients perceived that empathy is a key determinant for patients satisfaction, thus patients are sensitive to how staff treat them and care for their ill health at UGH and UCH. This finding confirms studies by Zaim et al., (2010) who indicate that empathy is a significant service quality measure of patients satisfaction with healthcare delivery at public hospitals in Turkey. More so, Yousapronpaiboon and Johnson (2013), indicate that empathy is a one of the five latent dimensions that had significant influence on service quality. The regression model revealed that a unit increase in empathy by management of the university hospitals will increase the patient's satisfaction with quality healthcare by fourteen percent. In hypothesis II, empathy is noted as a significant predictor of patient's satisfaction.

5.2.2 Communication

The most important predictor of patient satisfaction in this study was the dimension 'Communication' which indicates how patients receive adequate information and explanations about the tests they had to undergo. Moreover, staff especially medical doctors give elaborate information on the treatment and health condition of patients. Communication is a key determinant of quality healthcare, since patients are able to engage with staff and effectively discuss personal health matters that affect their health. Through this approach medical staff are able to educate patients on how to make good choices affecting their health. The regression analysis indicates that a unit increase in communication will increase the patient's satisfaction

with service delivered in the university hospitals in Ghana by twenty-six percent as evidenced from both UGH and UCH. Furthermore, John (1991) alleged that service quality perceptions in hospitals could be improved through improving communication between patients and healthcare providers (Yousapronpaiboon and Johnson 2013). Again, Rao et al, (2006), Kumari et al, (2009) and Sharma et al, (2010), indicate that doctor-patients communication is a key determinant of quality healthcare and if upheld in hospitals will ensure patients' satisfaction. The university hospital serves the most elite class, who are senior members (lectures and senior administrators), senior and junior staff, dependents of the university workers, and the public around the university environment, they are therefore conscious about their health and engage doctors and medical staff in effective interpersonal communication on issues pertaining to their health.

Perceived communication was hypothesized to be a significant predictor of patient's satisfaction and the linear regression model revealed communication as a good predictor of patient's satisfaction.

5.2.3 Culture

Generally, in the Ghanaian context, culture is defined as the way of life of an individual and it includes clothes, food and societal arrangements. Osei and Addei (2012), state that culture comprises everything that a person in a community does. Thus, all activities of a community combine to create the culture of the people. Perceived culture as dimension of quality healthcare entails medical staff discriminating according to religion, language and ethnic background. Medical staff are sensitive to cultural standards in healthcare delivery to patients. Patients therefore indicated that staff uses language that they can easily understand in writing of medical history, and drug administration. It was further perceived by patients that there is no form of discrimination based on religion, class or ethnicity in the healthcare delivery at the university

hospitals in Ghana. Furthermore, studies by Schouten et al., (2008); Harmsen et al, (2010) reveal that patients with a culturally different background evaluate the received health care as quality indicator, as medical staff overcome all communication gaps to provide care to satisfy the patient's need of healthcare. This empirical finding is substantiated by the study.

Again, a unit increase in culture will increase patients' satisfaction by seventeen percent, this is thus a relevant factor, that the management of the university hospital needs to capitalize on this dimension to provide an excellent patient-centred service. Therefore, culture is a significant predictor of patient's satisfaction as based on the linear regression model.

5.2.4 Tangibles

Tangibles constitute the vital component that deals with the physical surrounding of the hospitals, thus the hospital should have up-to-date facilities, modern-looking equipment as well as adequate seating for patients. These facilities in some way influence the personal judgment of patients to perceive that healthcare delivery is of a quality standard. The patients revealed that physical facilities in relation to equipment and logistics ensure patients welfare hence perceived quality healthcare in the university hospitals. This finding is noted earlier in studies by Al-Hawary, (2011); Ceelik and Sehribanoglu, (2012); Senarath et al., (2014) that tangibility in terms of physical environment, cleanliness, seating and modern clinical equipment has a larger effect on perception of quality healthcare of hospital in Jordan and Turkey. Perceived tangibility is a significant dimension for patient satisfaction with quality healthcare delivery, as the model indicates a unit increase in tangibles will increase patients' satisfaction of service by twelve percent. Thus tangibility is a good predictor of service quality for patients' satisfaction with quality healthcare at the university hospitals in Ghana. Consequently, the alternative hypothesis

is upheld based on the linear regression, that tangible is a significant predictor of patients satisfaction.

5.2.5 Priority

Perceived priority is relevant for quality healthcare, as observed by the Agency for Healthcare Research and Quality (AHRQ) in 2005. Thus it was noted that in healthcare delivery, special care should be given to rural folks, those with low income, minorities, children and the elderly as well as those with special healthcare needs (MOH, 2007; GHS, 2008; Turkson, 2009). However, in this study 'priority' was captured as university workers and students do not join queues, and they are given a special service at the hospital based on the fact the hospitals were established to serve the university community. Patients perceive that priority care is significant for quality healthcare and therefore in these special environment (university compound) management should concentrate in providing senior and junior members with efficient and timely care to ensure effective teaching and learning. Andersen (1995) and Aghamolaei et al., (2014) confirm that priority care in specialized institutional hospitals promote a sense of ownership by staff and workers who always feel proud to utilize services at these hospital. Thus they are of the view that quality healthcare is delivered to them since the medical staff also understand the core mandate of the institution of which all are workers. Moreso, the multiple linear regression supports the alternative hypothesis that priority is a significant predictor of patient satisfaction. The model further reveals that a unit increase in priority will increase patient satisfaction with quality healthcare by eighteen percent.

5.3 Constituent patients perception on quality healthcare

There are various approaches to what is termed quality healthcare in the view of patients and in most instances these are operationalized on scales for evaluating service quality. However, the main drive of this objective is to allow patients express their views, natural understanding on what they perceive as quality healthcare based on a qualitative approach. The findings revealed four key headings for discussion based on the individual responses of the patients.

5.3.1 Timeliness

Patients were vociferous on time as a key element constituting service quality in the university hospitals. They emphasised that time is of essential value to patients and therefore staff should take note of the long waiting-time at the OPD, the pharmacy and the laboratory section. Patients stressed that staff should be consistent in service delivery as they express their dissatisfaction with what patients termed 'intentional delay' thus nurses at the OPD were found delaying patients intentionally with the excuse of reducing the pressure on the medical doctors.

> *"Sometimes we come very early in the morning, hoping to have early care but the nurses take a long time to set up the OPD section and taking of history too. Moreso, they bring their relatives and friends out of the queues and serve them first, keeping us here for a very long time, it is too bad for a university hospital to do that" (Female patient, Trader, Aged 36).*

Long waiting-time is a challenge to hospital management and patients, as patients become frustrated and always complain about how to make management aware of how such delays affect them. However, management are struggling to find out the best strategy in the delivery of services to avoid keeping patients for long at the hospital. Aldana et al., (2001) confirms that a significant reduction in waiting time is more significant to patients satisfaction in healthcare delivery. Moreso, Atinga et al., (2011) confirmed that waiting time is an important tool of

measuring perceived quality healthcare from the perspective of patients who utilize healthcare service.

5.3.2 Staff performance

Effective work performance in every organization is relevant for service delivery. In this regard, senior administrators and management boards provide the necessary logistics to make sure staff provide the needed service. Patients share this view, as they observe that quality healthcare is hinged on work performance by staff, thus the commitment of staff to duty and the task at the hospital is relevant for the delivery of healthcare. It was realized that some nurses at the OPD as well as the doctors are committed to patient care as they carefully engage them to know what really are their health needs. One respondent noted:

> *".....when they see the patients are in pain they try all possible best to help the patients. Some of the nurses who are willing to help, even go to the extent of calling others to help them to give some knowledge and assistance on how certain things are done in medical history writing. Some of the doctors consult a lot to help patients" (Male patients, Civil servants, Aged 54).*

Performance of staff at the hospital is deemed the centre of quality healthcare, most patients assess the quality of care based on the enthusiasm and the commitment that medical staff attach to care in the process of healthcare delivery. Crosby (1990) maintains that staff performance of service influences patients' perception of quality healthcare delivery in a hospital. Moreover, the performance model further indicate that staff performance and consumer attitudes are the prime measure of service quality (Cronin &Taylor, 1992; Ladhari, 2008; Ramez, 2012). Furthermore, Al-Hawary et al., (2011) observe that hospitals in Jordan with high-perceived service quality is based on hospital staff performance. This reveals that indeed the performance by staff at the hospital is key to measuring quality healthcare.

5.3.3 Service Improvement

In measuring quality healthcare, improvement in service delivery is relevant to patient-care at the hospital. Patients were of the view that university hospital management should intermittently evaluate the service that they provide at the OPD, the pharmacy and other departments and vary the services to satisfy the interest of patients. It was revealed that hospital management keeps outmoded equipment for a long time in providing services but a yearly replacement of some equipment will enable the staff to provide efficient service at the university hospital. The following narration illustrates typical views of the respondents:

> *".....they are good in service provision but there should be new and modern equipment such as digital thermometers to give the best of temperature figures, sometimes, their figures are not the correct figures after a second check"(Male patients, Teacher, Aged 45).*

Improvement in service is linked to measuring quality healthcare, some studies reveal that a customer-oriented service provides its service in the interest of the customers and therefore improves their activities based on the demands of the customer (Matterson, 1992; Nitin et al., 2005; Turkson, 2009; Yildi & Demirors, 2012). Alrubaiee et al.,(2011) and Ramez (2012) confirm that a patient's perception of service improvement has a strong contribution on quality healthcare resulting in patient satisfaction with healthcare delivery.

5.3.4 Satisfactory Services

Service satisfaction is the sole interest of every customer in accessing services of any kind. Thus, patients are of the view that a university hospital should provide service based on the patient's charter, where the needs of the patients are catered for in healthcare delivery. They further note that service provision should be satisfactory to patients, however it was revealed that patients

were satisfied with the services that staff provides at the OPD. In this stance, one respondent indicated that:

> *"The staff treat us well and fine, the doctors talk to as so well. Sometimes, if you want to use the washrooms, the nurses are ready to help you, show you the directions to the washroom. The nurses talk to you with respect and they show maturity towards their activity. I am quite happy with the service delivered" (Female patient, Trader, Aged 38).*

This finding is confirmed by some studies which indicate that satisfied patients will have a revisit intention to the facilities based on the service provided to them (Akbaba 2006; Spencer et al, 2014). However, Nwankwo et al., (2010) found that providing unsatisfactory service in regards to doctor's responsiveness, length of getting an appointment, access to core treatment and hours of operation could negatively impact a patient's satisfaction with quality healthcare (Yousapronpaiboon and Johnson, 2013).

5.4 Comparison of patient's perception on service quality of UGH and UCH

The key focus of this objective is to compare patient's satisfaction with healthcare service of the two university hospitals since their core-mandate is identical in service provision. In addition, it is aimed at identifying the strengths and weaknesses of either facility to serve as a policy guide to the University Health Services (UHS) in Ghana.

5.4.1 Empathy

The findings indicated that patients strongly agreed staff at the University of Cape Coast hospital (UCH) are more empathetic to patients' needs than medical staff at the University of Ghana Hospital (UGH). In addition, it is believed that majority of the OPD patients at UCH are from the surrounding communities of the university and these communities serve as social and clinical research laboratory for most departments in the university. Therefore medical staff show more care and ensure that their interest is at heart in welcoming their weakness in order not to breach

the community-university relationship. However, Peprah (2014) asserts that empathy was esteemed by patients in assessing service quality in his study conducted at Sunyani Regional Hospital. In contrast, patients at University of Ghana hospital were neutral when assessing staff empathy towards patients. They indicated that some of the medical staff especially some nurses and laboratory assistant are so rude and even do not give them the needed attention when patients are weak, as the nurses always say '*patients are never pleased so why worry'*. This was confirmed by Gyapong et al., (2007); Turkson, (2009) that poor attitudes of staff, thus not showing empathy can result in low utilization of health services despite the substantial investment aimed at improving access to health services in Ghana.

5.4.2 Tangibles

Patients at UGH remained neutral in noting that the physical surrounding, the medical equipment and the facilities at the hospital are not modern and up-to date. They revealed that a university hospital of such status should have efficient medical equipment to aid quality healthcare delivery since it is run as a private hospital by not subscribing to National Health Insurance Scheme therefore paying for the high cost of service means there should be better healthcare delivery aided with modern facilities and equipment. However, at UCH patients strongly agreed that, there is the need for improvement in the seating arrangement for patients. Moreso, they were of the view that the OPD is too crowded on Wednesday and Thursday due to hospital staff and management meetings on these days, which delay service provision with long waiting times coupled with floors and corridors cleaning. However, this finding is supported by the study of Nekoei-Moghadam and Amiresmaili (2011) which note that tangible is a significant predictor of patient satisfaction with quality healthcare at Kerman University of Medical Sciences hospital and recommended that management of the hospital should raise the face of the physical structure

of hospitals as it promotes the confidence of patients in quality healthcare delivery. Again, (Boyer et al., 2006; Zaim et al., 2010; Jaap van den Heuvel et al, 2013) confirm that tangible is a key determinant by patients in assessing quality healthcare.

5.4.3 Priority

Patients at the UCH strongly agreed that priority was given to university workers and students who access healthcare service at the hospital. Thus they indicated that they have special doctors who serve university staff on Mondays and Thursdays. Moreover, they do not join queues with non-university patients. At the pharmacy, there is a special section created for university workers and students to serve them with the drugs on time, this helps to reduce the long waiting time by staff of the university at the hospital in order for them to attend to other institutional demands. However, patients at the UGH who are university workers revealed that they were neutral on priority as a key dimension. They noted that only university lecturers and their families are given that special care which is even based on selectivity while other staff of the university are made to join the queues at the OPD, consulting rooms and pharmacy. It was realized that priority is not given to university workers and staff (Senior and Junior members) at the hospital. This finding collaborates with studies by Camgoz-Akdag and Zineldin (2011), who indicated that priority services are relevant for measuring quality healthcare and therefore significant for patient's satisfaction with healthcare delivery (John, 1991; Fornell et al, 1996).

5.5 Conclusion

The focus of the Ghana Health Service policy strategy on quality healthcare in Ghana is to provide patients with their healthcare-needs based on patient-care services. This chapter provided the discussion on the results of patients perceived service quality dimensions of UGH and UCH. The discussion focused on the predictors of service quality that influence patient satisfaction.

This discussion further revealed that communication, priority, empathy, tangibles and culture are key predictors of patient satisfaction supported by the empirical evidence on quality healthcare. Moreover, the natural assessment of service quality by the patients identified as timeliness, staff performance, service improvement and satisfactory service were discussed with the basis in literature. Finally, a comparative discussion of UGH and UCH revealed that empathy, tangibles and priority are significant in service delivery at the two university hospitals as the disparities in patients assertion of the service quality was discussed.

CHAPTER SIX

6.0 SUMMARY, CONLCUSIONS AND RECOMMENDATIONS

Introduction

Patient's satisfaction with quality healthcare is pivotal to healthcare delivery in Ghana. The Ministry of Heath together with service providers (Ghana Health Services, Teaching hospitals, University Health Services, Christian Health Services) are key-runners to achieving quality healthcare by providing patient-centred care to patients. This study was undertaken to first, assess key service quality dimensions that are good predictors to patients satisfaction with quality healthcare delivery in the university hospitals with the emerging restructuring of the University Health Service to a formal healthcare service provision agency in Ghana. Second, to determine patient's perception on what constitutes service quality in the two-university hospitals and lastly to compare perception of patients on quality healthcare thus, UGH and UCH.

Multiple theoretical views were synthesized to broaden the outlook of the study where quantitative and qualitative (questionnaires, in-depth interviews and content analysis) approaches legitimately combined or mixed in a single study to enhance an in-depth analysis of the study. Consequently, this resulted in a multi-method analysis, which helped to enhance the breadth and depth of the study. In this chapter, highlights on the summary of key findings, conclusions, contributions to knowledge and recommendations are presented.

6.1 Summary of main findings

Result from the study showed that females greatly utilize healthcare service at University of Ghana and University of Cape Coast hospitals. Furthermore, the majority of the patients accessing healthcare are educated to Senior High levels of education. However, students form a larger number of the patients who access OPD services at the university hospitals in Ghana.

Patients' satisfaction with quality healthcare is influenced by a number of service quality dimensions that is dependent on the type of facility under study (Zineldin, 2011). The study revealed that communication, empathy, culture, tangibles and priority are good predictors of patient satisfaction with quality healthcare in university hospitals in Ghana.

Furthermore, in-depth interviews with patients indicated that in their views what constitute service quality in the hospital are timeliness, where patients were of the opinion that there are long waiting-time at the OPD, the pharmacy and the laboratory sections. Staff performance in relation to effective duty and task delivery was highlighted as relevant for service quality in the university hospitals. Service improvement in healthcare delivery on timely basis and satisfactory services to patients were identified as key constituents for service quality in the university hospitals.

However, in comparing patients' perception of service quality dimension of the two university hospitals, it was realized that empathy, tangibles and priority were the significant dimensions that patients had varied perception, which were statistically different based on the healthcare provision at University of Ghana and University of Cape Coast hospitals. Respondents therefore indicated that addressing the differences could better place these hospitals in providing services that are patients-centred.

6.2 Conclusion

Patient satisfaction with quality healthcare in Ghana is one of the key objectives of the five-year programme of work (5YPOW) of MOH, GHS, teaching hospitals and university health service in providing a patient-centred care at the various hospitals in Ghana. In this view, there is a mandatory institutional requirement to publicly display the patient charter in order to keep

medical staff on their toes in providing patient-centred care, the commitment to this intervention seem unsatisfactory. There is the need to allow for stringent health system interventions which should include financing, planning, service delivery, monitoring and evaluation to effectively provide service that is centred on patients interest in the university hospitals in Ghana.

The findings further underscore the need for university health services to promulgate a specified patients charter in sync with the standards of Ghana Health Services and WHO patients' charter to assure their patients on how distinct services are provided to ensure patient satisfaction with healthcare delivery.

6.3 Contribution to Knowledge

First, this study is one of the first studies to have explored patient's satisfaction with quality health in Ghana employing a comparative analysis of two university hospitals. It therefore provides other researchers the opportunity to study service quality of both public and private university hospitals and the impact on the individual patient's satisfaction with quality healthcare in Ghana.

Existing studies on patient satisfaction with quality healthcare in Ghana had largely focused clinical quality (Bowers et al., 1994; Brown, 2007; Chahal & Kuamari, 2010; Delle, 2013). Others looked at hospital governance and the impact of patient satisfaction, however, there is limited evidence on the comparative approach to quality healthcare at hospitals in Ghana (Turkson, 2009: Atinga et al., 2011; Peprah, 2014). This study therefore adds to the expanding literature on the comparative approach to service quality strategies of hospitals in Ghana and the impact on patients' satisfaction with quality healthcare.

6.4 Recommendation

Drawing on the key findings of the study, it is recommended that the following could have implications for policy. First, the university hospital management should draw up policies based on the communication, empathy, culture, tangibles, and priority which will help ensure patients satisfaction with healthcare delivery at the hospital since the above five dimensions appear to be the best predictors of patients' satisfaction.

Again, while the university hospitals make efforts at improving the service quality at the hospitals, there is the need to make a conscious effort at also improving medical staff performance on the job, by conducting timely performance appraisals to evaluate work performance specifically at UGH. In addition, it will be relevant for management to provide services that are satisfactory to patients as well as to improve the quality of infrastructure, taking into account location of facilities and services at UCH.

Finally, priority care is a pillar for quality healthcare delivery and therefore UGH should considered this dimension in their service provision.

6.5 Limitations and opportunities for Future Research

Studies of this nature are likely to be limited in some respects. However, since academic studies are generally intended to contribute to, rather than terminate or consummate knowledge, the limitations of this study which are highlighted here present opportunities for further research in advancing knowledge on patients satisfaction with quality healthcare in Ghana.

The use of the SERVQUAL scale by Parasuraman et al (1988) in assessing service quality of the hospital is challenging, since the scale was developed for assessing service quality in marketing and it is eurocentric by nature. Therefore, there is the need for future studies to construct another scale to study the service quality in the university hospitals or preferably develop a standardized

scale that take into account the demographics of Ghanaian hospitals in assessing quality healthcare and the impact on patients satisfaction.

Finally, due to resource constraints, only two university hospitals were adopted for the study, however, future studies should concentrate on other private and public university hospitals in Ghana.

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APPENDIX A: SAMPLE QUESTIONARIES AND IN-DEPTH INTERVIEW GUIDE

UNIVERSITY OF GHANA SCHOOL OF BUSINESS

DEPARTMENT OF PUBLIC ADMINISTRATION AND HEALTH SERVICE MANAGEMENT

This questionnaire seeks to find out patient's satisfaction with quality healthcare in Ghana. I wish to assure you that this is an academic study and all information provided shall strictly be used for academic purposes. You are also assured of absolute confidentiality and anonymity. There is thus no right or wrong answer. Please respond to the questions by ticking [√] the answer that reflects your opinion.

SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. How old are you?.....
2. Gender. Male [ ] Female [ ]
3. Education. None [ ] Primary [ ]Junior High [ ]Senior High[ ] Tertiary [ ]

   Other[ ]
4. Number of visits to this hospital in the past 12 months…….....
5. Employment.

Unemployed [ ] Trader/Businessman [ ] Farmer [ ] Government employee [ ] Private sector employee [ ] Student [ ] Other please specify_____

PART II – SERVICE QUALITY DIMENSIONS AND MEASUREMENT.

For the following questions, Please choose from the options provided below, what best suits your response to the questions. Please Tick [√] where appropriate. On a scale of 1 to 5, rate the quality healthcare of the hospital based on strongly disagree to strongly agree.

Strongly Disagree (SD) = 1.0–1.49, Disagree (D)=1.50–2.49, Neutral (N)= 2.50–3.49, Agree(A)= 3.50–4.49, Strongly Agree(SA)= 4.50–5.0.

		SD	**D**	**N**	**A**	**SA**
No.	***Tangibility***					
6	The hospital has up to date facilities.					
7	The physical environment of the hospital is appealing.					
8	The hospital has modern-looking equipment.					
9	There is availability of adequate seating at the hospital.					
	Reliability					
10	The staff provides service on scheduled time.					
11	Doctors/staff are professional and competent.					
12	Medical procedures were performed correctly the first time.					
13	There is consistency in duty performance by staff at the hospital.					

	Responsiveness					
14	Hospital staff was helpful to the patients.					
15	The staff was responsive to patient needs.					
16	The staff responded immediately when called by the patients**.**					
17	Prompt service delivery without wasting time.					
	Assurance					
18	The hospital had skilled staff to provide healthcare delivery.					
19	The hospital staff treats patients with dignity and respect.					
20	The staff at the hospital possesses a wide spectrum of knowledge.					
21	The staff at the hospital was courteous.					
	Empathy					
22	The staff has my best interests at heart.					
23	The staff understands my specific needs at the hospital.					
24	The personnel give me special attention at the hospital.					
25	The staff welcomes your weakness in facility.					
26	The staff at the hospital was caring to patients.					
	Communication					
27	I received adequate explanation of any tests I had to undergo					
28	The doctors were willing to answer any questions relating to illness.					
29	I was given adequate information on my health condition.					
30	I was given adequate information on my treatment.					
	Culture					

31	The hospital Staff do not discriminate based ethnic backgrounds					
32	The Staff use language patients understand.					
33	The staff at the hospital does not discriminate based on your religion.					
	Priority					
34	University workers and students are given special care at the hospital.					
35	University workers and students are given special care at the hospital.					
	Accessibility and Affordability					
36	The location of the hospital is accessible					
37	The charge for services at the hospital is affordable					
	Patient Satisfaction					
38	I am satisfied with healthcare service delivered in this hospital.					

UNIVERSITY OF GHANA

SCHOOL OF BUSINESS

PARTICIPANT CONSENT FORM

I hereby declare, having understood the overview of the study and knowing the benefit as well as dis-benefit of the study, duly subject myself to the full participation of this research. Furthermore, noted that I can withdraw from this research at anytime, if I find out my continuous participation might be a detriment to my religious, professional, emotional and ethical stands, consent to partake in this study.

....

(Participant) (Researcher)

....

(DATE) (DATE)

IN DEPTH INTERVIEW

OVERVIEW

This interview seeks to find out patient's satisfaction with quality healthcare in Ghana. I wish to assure you that this is an academic study and all information provided shall strictly be used for academic purposes. You are also assured of absolute confidentiality and anonymity. There is thus no right or wrong answer. Please respond to the questions in this interview.

Socio-demographic Information

1. What is your age?

2. What is your religion?

3. Where do you come from?

4. How many times have you visited this hospital?

Service quality dimension

5.What constitute service quality to you in this hospital?

a. What is your view on the physical facilities and appearance of personnel; tools or equipment use to provide the Service? Probe

b. Is the service provided reliable? Probe

c. How responsive are the hospital personnel to care? Probe

d. Are you assured of quality healthcare? How? Probe

e. Are the staff empathetic to patients? How? Probe

f. Is the service provided accessible to you? How? Probe

g. Is the service also affordable to you? Why? How? Probe

h. Do the staff communicate with you during service provision? How Probe

6. How will you rate the overall healthcare quality of the hospital?

7. Can you make any recommendations to improve healthcare quality at the hospital

APPENDIX B: ETHICAL CLEARANCE

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)
P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

17th September, 2014

Mr. Kofi Aduo Adjei
Department of Public Administration and Health Service Management
University of Ghana Business School
Legon

Dear Mr. Aduo Adjei,

ECH 003/14-15 PATIENT'S SATISFACTION WITH QUALITY HEALTHCARE IN GHANA: A COMPARATIVE STUDY OF UNIVERSITY OF CAPE COAST AND UNIVERSITY OF GHANA HOSPITALS

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities and the following actions taken subject to the conditions and explanation provided below:

Expiry Date:	10/09/15
On Agenda for:	Initial Submission
Description:	21/08/14
ECH Action:	Approved
Reporting:	Bi-Annually

UG/ISSER/ECH VALID UNTIL 16 SEP 2015 APPROVED DOCUMENT

Please accept my congratulations.

Yours Sincerely,

Rev. Prof. J. O. Y. Mante
ECH Chair

CC: Director, ISSER