EFFECT OF MOTIVATION ON SERVICE QUALITY: MODERATION ROLE OF EMPLOYEES COMMITMENT AMONGST HEALTH PROFESSIONALS IN THE GREATER ACCRA REGION

BRENYAH CHRISTOPHER KWAKYE

(PG 2109514)

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF A MASTERS DEGREE IN BUSINESS ADMINISTRATION

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF BUSINESS

DEPARTMENT OF MARKETING AND CORPORATE STRATEGY (STRATEGIC MANAGEMENT AND CONSULTING OPTION)

SEPTEMBER 2015

DECLARATIONS

I hereby declare that this is my own work towards the award of MBA and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the university, except where due acknowledgement has been made in the text.

Christopher KwakyeBrenyah / PG 2109514	.....	.....…..……
(Name and ID number)	**Signature**	**Date**

Certified by

Dr. Ahmed Agyapong	……	...……
Supervisor	**Signature**	**Date**

Certified by

Dr. Ahmed Agyapong	……...	……...
Head of Department	**Signature**	**Date**

DEDICATION

I dedicate this work to my parents Mr and Mrs Brenyah for their invaluable support.

ACKNOWLEDGEMENT

All appreciation goes to God Almighty for the strength and all that was required for the entire research. I am appreciative to my supervisor, Mr. Ahmed Agyapong for the support and tutelage at each step of the way.I am also grateful to all staff at the various health facilities visited in course of data collection for their input.

ABSTRACT

This study sought to contribute to the body of knowledge on marketing and organisational behaviour by empirically investigating into the role of employee motivation and commitment in improving service quality. The study was contextualized in a healthcare delivery environment in the Greater Accra Region (GAR) of Ghana and focused on doctors as the informants. Data were collected using questionnaires from 127 doctors in Public, Private and Missions hospitals. Both descriptive and inferential statistical tools and techniques were employed to analyse data collected. Hierarchical moderated regression analysis was employed in estimating the study's proposed model. The descriptive statistical results obtained indicated that doctors who participated in the study have moderate level of commitment in their job and are more motivated intrinsically. An average participant also perceives service quality in healthcare delivery within the research context as more satisfactory. The study further finds that both intrinsic motivation and commitment among doctors significantly have positive effects on service quality. The study's results also indicated that extrinsic motivation does not have significant positive effect on service quality than commitment. In all, it was found that both motivation and commitment significantly explain 23.7% variations in service quality. The findings thus suggest that government's and management's efforts to improving quality healthcare services in the country would be more likely to manifest should they focus on improving the level of motivation and commitment among healthcare workers at the workplace. In this line, it suggested that appropriate authorities and relevant stakeholders collaborate in designing work and benefits in light of health workers' contribution to quality healthcare delivery in the country.

TABLE OF CONTENTS DECLARATIONS

I

2.0 CHAPTER TWO – LITERATURE REVIEW

3.0 CHAPTER THREE – METHODOLGY

LIST OF FIGURES

APPENDIX

CHAPTER ONE

1.1 BACKGROUND OF THE STUDY

Motivation is a topic that is extensively researched. Halfway the twentieth century the first significant motivational theories arose, namely Maslow's hierarchy of needs, Herzberg's two-factor theory and Vroom's expectancy theory. Those researches focused on motivation in general and employee motivation more specifically. In the past years various definitions of motivation were defined, e.g. Herzberg defined employee motivation once as carrying out a work related action because you deem it fit.

The health service sector is one of the fastest growing industries. The rapid growth in this sector is categorized by increased number of people to attend hospitals as against substitute sources of health care, sensitive expectation of service quality by patients and their families, rise of competitive private health care facilities. Service quality in health is therefore gaining prominence with the main stay remaining, high service quality for enhanced patient satisfaction and retention. The paradigm of service quality has spurred scholarly debate with extant literature enlightening absence of compromise on the measurement of service quality, owing to service untouchability, heterogeneity and multidimensionality (Navarro et al., 2005). What is motivation? Why do people act in the way they do? Why do people behave differently? Is it possible for an organisation to influence the people they employ in a foreseeable and methodical way to act in a way they want them to? These are all questions managers tussle with every day and it is perhaps for this reason that motivation and the factors or elements of motivation are one of the most widely researched topics and why a lot of research has been undertaken to understand the concept of motivation in an organisational setting.

Hodgetts and Hegar (2008) confirm this statement by saying that one of the most important questions in human relations today is: How do you get people to do things? The answer rests

on the understanding of what motivation is all about, for it is motivated workers who finally get things done and without such people no organisation can hope to be effective.

According to Mills, Mills, Bratton and Forshaw (2006:207), work motivation is one of the most researched yet misconstrued perceptions. It is a subject many would say has been studied to the penultimate , yet still has far more enquiries than solutions.

Obligation to an organiz ation is positively related to such desirable outcomes as motivation (Mowday, Steers and Porter 1979) and pres ence (Mathieu &Z ajac, 1990: Steers & Rhodes,1978) and is negatively related to outcome as absenteeism and turnover(Clegg 1983: cotton & Tuttle1986). Horton too stated that organization commitment could result in less turnover absenteeism, thus increasing organization output (Schuler & Jackson, 1996). Employ ees with great level of organizational commitment provide a safe and stable workforce (Steers 1977) and thus providing competitive benefit to the organization.

The committed employee has been found to be more imaginative; they are less likely to leave anorganization than those who are uncommitted (Porter et.al. 1974).

According to Arturo L. Tolentino (2004) Sustained efficiency improvement depends on the enterprise's human capital (the skills, knowledge, competencies and attitudes that reside in the individual employe e of the enterprise) and its social capital (trust and confidence, communication, cooperative working dynamics and interaction, partnership, shared values, teamwork, etc. among these individuals.

A committed employee is perceived to be one who stays with the organization even in difficult times, is punctual, protects company's assets and shares company's goal (Meyer and Allen, 1997).Therefore it is evident that for quality service, employee commitment is an significant factor.

Some study examines the interaction of commitment with various factors. Mathieu &Zajac, (1990), shown that obligation has been positively related to personal characteristicssuch as age ,how long one has been in a particular organization (Luthans, McCaul, & Dodd, 1985), and marital status (John & Taylor, 1999) and have inverse relation to the employee's level of education (Glisson &Durick, 1988). In addition, commitment has been found to be related to such job characteristicsas task independence (Dunham, Grube, & Castaneda, 1994), feedback (Hutichison&Garstka, 1996) and job challenge (Meyer, Irving, & Allen, 1998) and certain work experiencessuch as job security (Yousef, 1998), promotion opportunities (Gaertner&Nollen, 1989), training and mentoring opportunities (Scandura, 1997), and supportive and considerate leadership (DeCottis& Summers, 1987).

Moreover, the concept of organizational commitment is defined as the mental attachment of the workers to the organization (Guntur, Haerani& Hasan 2012). Increasingly, firms of all types find that an effective way to differentiate themselves from their competitors is to provide a higher level of service quality, and that their employees dictate that necessity (Johlke&Duhan 2000). Since people are the most important resource in a company service (Schnidt, Adler &Weering 2003), a regular meetings with all service personnel is crucial in order to monitor how satisfied they are with their position, because satisfied employees are more likely to satisfy customers, thus helping the organization to move onward (Lee & Chen 2013) . The effectiveness of any service company is mostly a result of output of its employees

The concept of employees' commitment to the organization got an increased admiration due to the impact it has on the firm (Armstrong 2000). Even when an improvement of the job performance of an employee can lead to success of the organization, it can be assumed that employee expectation is not always clear (Morris et al. 1990). Moreover, the lack of necessary

skills to perform the job may represent an issue for both the employee and the employer (McConnell 2003). Therefore, this study investigates which are benefits and challenges that companies may face while improving the concepts mentioned above.

The personal features of employ ees (T aormina 1999) in addition to organizational characteristics, such as job or role related features and the design of the organization (Steers & Porter 1997) may have direct influences on job performance outcomes, such as turnover, absences, quality and quantity of work and other financial presentation aspects.

1.2 PROBLEM STATEMENT

Motivation, according to Nel, van Dyk, Haasbroek& Schultz (2004:310), is a very compound issue due to the exclusivity of people and the wide range of internal and external factors that impact on it. Nel et al (2004:326) further state that organisations exploit various resources In order to compete successfully, few people realise that in comparison to other resources, human resources is the only resource that increases in quality and capacity the more it is utilised. Organisations cannot meet the expense of ignoring this valuable resource. Motivation is a planned technique that managers can use to explore human potential and talents.

Employ ee commitment is important because high levels of commitment lead to several favorable organizational outcomes. It reflects the extent to which employee's identify with and organization and is committed to its goals. BiljanaDordevic (2004) stated that the commitment of employees is an vital issue because it may be used to predict employee's performance, nonattendance and other behaviors. An impressive amount of research efforts have been conducted to understanding the concepts and to identify implication of organizational commitment over the performance of the employees on the workplace. Meyer, Paunonen, Gellatly, Goffin, and Jackson (1989) examined facts of a positive

association between organizational commitment and job performance, Low commitment has

also been associated with low levels of morale (DeCottis& Summers, 1987), non-committed employees may depict the organization in negative terms to outsiders thereby preventing the organization's ability to recruit high-quality employees (Mowday, Porter, & Steers, 1982) and decreased measures of unselfishness and compliance (Schappe, 1998).

This industry under study has faced a lot of workforce challenges in the form of strikes relating to salaries, conditions of service, etc. So, our study becomes much more important in the attempt to extract how employee output can be improved as result of motivation.

1.3 RESEARCH OBJECTIVES

The study examines the effects of motivation and commitment on service quality in healthcare delivery in Greater Accra Region (GAR). The research is thus guided by four objectives:

1. To examine the level of motivation among doctors in the Greater Accra Region.
2. To examine doctors' perceptions of service quality of healthcare services in Greater Accra Region.
3. To measure doctors' commitment in the healthcare delivery in Greater Accra Region.
4. To examine the moderation role of commitment on the relationship between motivation and service quality.

1.4 RESEARCH QUESTIONS

The study seeks to address the following questions:

1. What is the level of motivation among doctors in Greater Accra Region?
2. What is the perception of doctors on service quality in healthcare series in Greater Accra Region?

3. What commitment do doctors in Greater Accra Region have in their job?

4. Does commitment moderate the relationship between motivation and service quality?

1.5 SCOPE OF THE STUDY

This research prioritizes hospitals and health care facilities in the Greater Accra Region with regard to gathering data.

1.6 SIGNIFICANCE OF THE STUDY

The concept of employees' commitment to the organization got an increased admiration due to the impact it has on the firm (Armstrong 2000). Employee commitment can benefit organization in a number of ways such as it can improve output; reduced absenteeism, and turnover thereby resulting in sustained efficiency, thus improved service quality overall.

Therefore, this research intends to break new grounds on the link between motivation and service quality in healthcare by examining level of motivation, employee commitment, as well as assessing the relationship between motivation and service quality.In trying to find an answer(s) to the research questions and on the basis of the abovebackground discussion and research question, this work will equally assist in enabling further studies by other researchers who are interested to know much on the link between motivation and service quality. Furthermore, it will also assist management of health facilities obtain a broader knowledge on motivation of their employees.

1.7 BRIEF METHODOLOGY

This research adopts a non probability sampling method, specifically, specifically convenience sampling. Convenience sampling involves selecting haphazardly those cases that are easiest to obtain for your sample (Saunders 2005). Data collection instrument is primarily administration of questionnaires. Secondary data however will not be used in this study.

1.8 LIMITATIONS OF THE STUDY

The research was constrained by a few factors. One of such is time constraint. Due the scattered location of hospitals, as well as traffic in the Greater Accra Region, there was a strain on the time designated for the research.

There was also the problem of convincing doctors to participate, most especially because the time of the data collection coincided with their strike action. Most of them felt uncomfortable for fear that their responses may be used against them.

1.9 ORGANISATION OF THE STUDY

The paper is categorised under five (5) main sections or chapters, although there are other minor sections. The first chapter introduces the entire research, it gives readers an idea of what the researcher intends to achieve. Chapter two (2) is a literature review. The researcher brings forth literature concerning the topic under study, done by other researchers or writers. Chapter three (3) defines the researcher's methodology and method. Other material (s) for data collection is also added. The fourth chapter is an analysis and discussion of data. The fifth and last chapter is the conclusive part of the research in the form of a summary, conclusion and suggested recommendations given the findings of the research. Followed are references and an appendix of questionnaire and tables.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter review the studies and research done by other writers with respect to the topic under study. A critical review of the literature is necessary to help develop a thorough understanding of and insight into preceding research that relates to research question(s) and objectives. The review will set this research in context by critically deliberating and referencing work that has already been undertaken, drawing out key points and presenting them in a logically argued way, and stress those areas where they will provide fresh understandings.

2.2 MOTIVATION

The term motivation ascended in the early 1880's; before that time the term "will" was used by philosophers as well as social philosophers when discussing effortful, directed and motivated human behaviour (Forgas, Williams and Laham, 2005). According to them motivation used to be considered as: an entity that compelled one to action. Lately, various researchers proposed different definitions of motivation. Motivation has been defined as: the psychological procedurethat gives performance meaning and course (Kreitner, 1995); a tendency to behave in apurposive manner to achieve specific, unmet needs (Buford, Bedeian, & Lindner, 1995); and B. Keijzers; Employee motivation connected to employee performance in the organisation and internal determination to satisfy an discontented need(Higgins, 1994); and the will to achieve(Bedeian, 1993). Mitchell (1982) stresses that although there is some disagreement about the importance of different aspects in the definition of motivation, there is consensus about some fundamental belongings. Namely, that motivation is an individual

entity, it is described as being deliberate, it is multifaceted and that the purpose of motivational theories is to forecast behaviour. Mitchell (1982) also argues that motivation is concerned with action and the internal and external forces that influence one's choice of action. And that motivation is not the behaviour itself, and it certainly is not performance. In relation to this, Mitchell (1982) proposes his own definition of motivation: "motivation becomes the notch to which an individual wants and chooses to engagein certain specified behaviours". It is evident that mangers need to motivate workers to obtain the necessary results for the organisation. .

Kreitner (1995), Buford, Bedeian&Linder (1995), Higgins (1994) all cited in Linder (1998) defined motivation as "the psychosomatic process that gives behaviour purpose and direction, a susceptibility to behave in a purposive manner to achieve precise unmet needs, an unsatisfied need, and the will to attain, respectively. Young (2000, p1) suggest that motivation can be defined in a variety of ways depending on who you ask . Therefore motivation is the force within an individual that excuse for the level, direction, and persistence of effort expended at work."

Halepota (2005) defines motivation as "a persons vigorous contribution and obligation to achieve the prescribed results. "Halepota further presents that the concept of motivation is intangible because different strategies produce different results at different times and there is no single strategy that can produce definite favourable results all the times. According to Antomioni (1999), "the expanse of effort people are willing to put in their work depends on the amount to which they feel their motivational needs will be satisfied. On the other hand, individuals become de-motivated if they feel something in the organization thwarts them from attaining good outcomes.

According to Greenberg and Baron (2000) this definition could be divided into three main parts. The first part looks at stimulation that deals with the drive, or energy behind individual (s) action. People turn to be directed by their interest in making a good imprint on others, doing

interesting work and being efficacious in what they do. The second part referring to the choice people make and the direction their behaviour takes. The last part deals with upholding behaviour clearly defining how long people have to persevere at attempting to meet their objectives.

It can be witnessed from the above definitions that, motivation in general, is more or less basically concern with influences or events that moves, leads, and drives certain human action or inaction over a given period of time given the prevalent conditions. Further more the definitions propose that there need to be an" imperceptible force" to push people to do something in return. It could also be deduced from the definition that having an inspired work force or generating an environment in which high levels of motivation are maintained remains a contest for today's management. . This challenge may originate from the simple fact that motivation is not a fixed trait –as it could change with fluctuations in personal, psychological, financial or social factors.

For this thesis, the explanation of motivation by Greenberg & Baron (2003) is adopted, as it is more representative and simple as it considers the individual and his enactment. Greenberg &Baron defines motivation as:

"The set of procedures that arouse, direct, and preserve human b ehaviour towards accomplishing some goal". (Greenberg &Baron, 2003)Bassett-Jones &Lloyd (2005), presents that two views of human nature inspired earlyresearch into employee motivation. The first view emphasis on Taylorism, which regardedpeople as basically lazy and work – shy", and thus held that these set of employees can only beenthused by external stimulation. The second view was grounded on Hawthorn findings, whichheld the view that employees

are motivated to work well for "its own sake" as well as for thesocial and monetary benefits this type of motivation according to this school was internallymotivated.

2.3 THE CONCEPT OF MOTIVATION

The first query that arises is: "why managers need to motivate employees?" (Herzberg, 1959). According to Smith (1994) it is because of the endurance of the company. Amabile (1993) adds to this statement by disagreeing that it is important that managers and organisational leaders learn to comprehend and deal effectively with their employee's motivation; since motivated employees are essential to let the organisation being successful in the next century. She also debates that unmotivated employees are likely to consume little effort in their jobs, avoid the workplace as much as possible, exit the organisation and produce low class of work. In the case that employees are motivated; they help organisations survive in speedily changing workplaces (Lindner, 1998). Lindner also argues that the most intricate purpose of managers is to motivate employees; because what stimulates employees changes persistently (Bowen and Radhakrishna, 1991).

2.4 MOTIVATIONAL THEORIES

Motivation has been a matter of anxiety in the past and has established itself as an vital part in current organizational settings. Motivation is quite complex to grasp thus placing alertness to the fact that several factors influence employees routine in a particular organization. Reason being that, what motivates one worker will not motivate the other employee within the same company. McShane et al defines motivation as "...a factor that occur in an individual which has the prospective to affect the way, power and keenness of behaving towards work". (McShane & Von Glinow 2003) The above definition of motivation has been buttressed by

Petri & Govern, "motivation is the thought that explains the driving force in an individual that explains variances in intensity of behavior". (Petri & Govern 2004).

Even though research been conducted on the field of financial motivation and many researchers and writers have projected theories on the concept of financial motivation, and its role in augmenting employee's performance in every organisation some of these models have been widely used and accepted by today's organisation leaders. Motivated employees are willing to bestow time to certain level of commitment for a specific objective in an organization. The theories of motivation seek to substantiate why certain employees act or do things in a certain way rather than others. The following theories will be discussed: the Maslow's hierarchy of needs, Herzberg's Motivation–hygiene theory,Fifty-Fifty theory and Vroom's Expectancy theory.

2.4.1 Maslow's Hierachy of Needs Theory of Motivation

Mukherjee (2009) states that one of the best-known philosophies of motivation is the need hierarchy theory suggested by Abraham Maslow. According to Maslow, human beings always want more and what they want always hinge on what they already have. He suggests that human needs can be branded in five broad areas (needs), arranged in a certain order according to their prominence for the person, or what is called a hierarchy. These needs are:

- **Physiological needs** – The lowest or most basic level of Maslow's hierarchy of needs is physiological needs. In the organisation these needs include pay, company cafeteria and basic working conditions. According to Maslow's theory, a behaviour will be directed towards satisfying these needs. As soon as these needs are satisfied, they will no longer impact employee behaviour.

- **Safety needs** - After the employees' basic physiological needs have been satisfied, the needs on the subsequent level of the hierarchy becomes important. Safety or security needs in the organisation includes insurance needs such as, medical aid, pension or provident fund, safe working settings as well as the steadiness of the organisation. The presence of these types of employer benefits and guarantee will satisfy the employee's safety needs.
- **Social needs** – Social needs includes the need for love, recognition, friendship, understanding by other fellow employees or groups within the organisation. Through teams and work groups, managers can embolden sufficient interaction among employ ees to ensure that employee social needs are enthused and met.
- **Esteem needs** - The need for self-respect and acknowledgement by others. Examples of esteem needs include need for success, recognition and appreciation of achievement.
- **Self-actualisation needs** - The utmost level of Maslow's hierarchy of needs is the need for self-actualisation. Self-actualisation is the full expansion of an individual's potential. This is the most difficult need to mollify in an organisational setting.

Maslow detached his hierarchy of needs into higher and lower order needs. Physiological and safety needs were described as lower-order needs and social, esteem and selfactualisation needs, as higher-order needs. Robbins, Judge, Odendaal and Roodt (2009) clarify that the distinction between the two orders was made on the foundation that higher order needs are satisfied internally (within the person), whereas lower order needs are principally satisfied externally (by such things as pay, union contracts, and tenure). As a lower-level need(s) becomes extensively fulfilled the next higher-order need(s) increases in strength and thus becomes an influential motivator.

Hellriegel& Slocum (2007) state that research has exposed that top managers are better able to satisfy their reverence and self-actualisation needs than lower level managers; part of the reason is that top managers have more perplexing jobs and opportunities for self-actualisation.

2.4.2 Herzberg's Two Factor Theory

Herzberg had the notion that those aspects which cause job gratification are the contrary to those that causes job dissatisfaction. Herzberg survey was conceded from a group of accountants and engineers. Herzberg in his studies came up with the inference that employees are influenced by two factors that are; the motivators and hygiene factors. Motivatorscreate job satisfactions which include achievement, recognition, autonomy and other intrinsic aspects when there are content. On the other hand he came up the hygiene factorswhich will augment dissatisfaction when they are not pleased. Motivatorsare those factors which provide feeling of job contentment at work. These factors impact the ways of work in a company; for example giving obligation to carry a widen task within an organization and providing the person with the required settings will lead to growth and progression to higher level tasks. Motivators are those dynamics which come from within an individual that is intrinsic. These dynamics could be achievements, interest in the task, responsibility of enlarge task, growth and progression to higher level. Herzberg hygiene factorscreate a appropriate work environment though not increase in satisfaction. For instance low pay can cause job discontent which will affect employees' performance. Hygiene factors are essential to make sure that the work environment does not develop into a frustrating situation. Typical hygiene elements are salary, working condition, status, company policies and administration. (Saiyadain 2009).

2.4.3 Fifty-Fifty Theory

The fifty-fifty theory was established by John Adair as a motivational factor that could influence company performance. From his observation fifty percent of motivation comes from within a person and the outstanding fifty percent comes from the environment, mainly from people around us. This rule is not used to affirm the exact proportions, but it tries to explain that, fifty per cent of our motivation comes from inside us and fifty per cent from an external influence, that is, from our environment, predominantly from the people around us. These observations are symbolic rather than mathematical and they may differ from person to person. Within these imperativeexternal factors the nature and quality of the leadership present is principally important. Hence the tough link between leadership and motivation becomes vital to decide employee's motivation. The Fifty-Fifty rule does have the benefit of repeating leaders that they have a key role to play for the success or failure in the motivation of employ ees at work. Fortunately or unfortunately not all the cards are in their hands, for they are dealing with people who are self motivating in innumerable degree. These are the encounters that confront the HRM to incite employee motivation with the work environment.
(John 2007).

2.4.4 Vroom's Expectancy Theory

The concept of expectancy theory was first developed by Victor Vroom and was published in 1964.Victor Vroom offered an expectancy approach to the appreciativeness of motivation. As a result, motivation is a product of the projected value to a person in an action. He perceived likelihood that the person's goals would be accomplished as a product of the anticipated value in an action. Thus the Vroom' model is built around the notions of value, expectancy and force. The perception of force is on the whole equivalent to motivation and may be presented to be the algebraic sum of the products of valences and expectations Thus, *Motivation (force) = V*

alence x Expectancy. Valence is the strength of an individual's inclination for an outcome or goal. The strength may be undesirable (fear demotion or transfer to less important job) or affirmative (prospect for promotion). Expectancy is the prospect that a particular action will lead to a required outcome. If the employee has a precise goal, some behavior has to be formed to accomplish that goal. The employee has to weigh the likelihood of various behaviors that will achieve the desired goals and select the most successful behavior. Thus the employee's motivation according to Vroom may be amplified by changing the acuity or by boosting the expectancy level through better communication and augmenting the actual reward that will result. Vroom's theory explains the relationship between the employee and the organizational goals and identifies the differences between employ ees in creating work motivation. Furthermore, this theory is consistent with the idea that a manager's job is to scheme an environment for performance, necessarily taking into account the variances in various situations. Thus Vroom's theory is quite consistent with management by objectives. However, this theory is difficult to research and is opposed with practical difficulties in its use. (Bose 2004).

Vroom tackles three beliefs and brings out with some lucidity and applicability. Each of the beliefs deals with what employees think will happen if they put out effort to perform. The first (B1) encompasses the relationship between effort and performance, that is, (B1) is the employ ee's belief about the prospect that effort will lead to performance. Another definition is that, B1 is the expectancy that effort will lead to success. (B1) can be seen as the employee's belief about whether or not what is expected can be done. The second (B2) encompasses with the relationship between performance and outcomes, that is, the employee's belief about the probability that performance will lead to conclusions. B2 can be stated in diverse ways, that is the employee's belief about the relationship between "what you do" and "what you get." It is the belief about outcomes subsequent to performance and the third (B3)

looks at the relationship between outcomes and satisfaction. The third belief (B3) is the employ ee's belief about how satisfying the outcomes will be. It is the belief about how fulfilling or meaningful they will be. It is the belief about how much value the outcomes will have in the future when they are established, rather than what their value is now. (Green 1992)

2.4.5 Erg Theory of Motivation

The ERG theory is another central need theory of motivation that was developed by Clayton Alderfer, a Yale psychologist, and is viewed as an extension and refinement of Maslow's hierarchy of needs theory with numerous important differences between the two (Griffin and Moorhead, 2009:88). The E, R, and G stands for three basic need categories: existence, relatedness, and growth. These needs can be summarised as:

- **Existence needs** – is concerned with providing the human's basic material survival requirements; the items Maslow measured as physiological and safety needs.
- **Relatedness needs** – is concerned with the human's craving to maintain important interpersonal relationships. These social and status desires require communication with others if they are to be satisfied; they bring into line with Maslow's social needs and the external mechanisms of Maslow's esteem needs.
- **Growth needs** – is concerned with the human's intrinsic need for personal development which aligns with the external constituents of Maslow's esteem needs and self-actualisation needs.

the ERG theory has not enthused much research and is therefore difficult to assess whether it has been buttressed by empirical evidence or not. However, the basic idea of ERG theory, that individuals outline their actions to satisfy unfulfilled needs, is consistent with other motivational principles.

2.5 COMMITMENT

The modern concept of commitment was developed by Fayol (1949), bearing in mind that the organization's interests must always triumph over the interests of individuals or groups of employment.

As mentioned by Vance (2006), some experts define commitment both as a preparedness to persevere in a course of action and reluctance to change plans, often owing to a sense of duty to stay the course. Also, if human resources are said to be an organization's supreme assets, then committed human resources should be considered as an organization's competitive advantage (Ramshida&Manikandan, 2013).

Nowadays, the stream policies in the commitment stem are evolving and their eventual form is more difficult to anticipate (Walton & Lawrence 1985). According to Morgan and Hunt (1994), commitment is followed by trust, and it is defined as an exchange partner believing that an ongoing relationship with another is so significant as to warrant maximum effort at maintaining it. Another approach (Hoccut 1998) points out that commitment may be regarded as a function of satisfaction with the service provider, quality of substitute providers and investment in the relationship. The notion of commitment is also linked to the psychological contract (Rothwell 1995), which is cultivated through individualistic involvement practices and is based on shared values, which integrate the internationalization of organizational objectives (Corbridge&Pilbeam 1998).

A number of researchers, such as Cyert and March (1963) point out that an institute is really a coalition of interest groups where political processes are an unavoidable part of everyday life, recognizing the dissimilar interests and values. Moreover, Argyris (1964) sees commitment as an facet of self-stem and associates it with the nature of goal seeking behavior, which individuals manifest towards their work. Commitment is improved when the employee defines his/her goals, can relate his/her goals to their fundamental needs and values, he/she is able to

define the paths to these goals, and those goals characterize a realistic level of aspiration including challenges and an element of risk (Lewin 1952). Summing up it can be said that devoted employees have a strong belief in and acceptance of the organization's goals, show a disposition to put an effort on behalf of the organization and have a strong desire to uphold a membership with the latter (Marthis& Jackson 2000; Sopiah 2008; Baptiste 2008).

Commitment is thus a potency that binds an individual to a course of action of relevance to one or more objectives (Meyer/Herscovitch 2001:302). 'Binding' refers to the maintenance of the relationship with the commitment purpose and is seen as the most important outcome of commitment (e.g. Meyer et al. 2002). Thus, devoted individuals stick to the object(s) of their commitment.

2.6 EMPLOYEE COMMITMENT

Employee commitment is imperative because high levels of commitment lead to several constructive organizational outcomes. It reflects the degree to which employee's identify with and organization and is committed to its aims. BiljanaDordevic (2004) stated that the commitment of employees is an essential issue because it may be used to foretell employee's performance, absenteeism and other behaviors. RajendranMuthurveloo and RaduanChe Rose (2005) pronounced that the organizational commitment is the subset of employee commitment, which encompassed to work commitment, career commitment and organizational commitment and also added greater structural commitment can aid higher productivity. An extraordinary amount of research efforts have been conducted to understanding the concepts and to identify repercussion of organizational commitment over the performance of the employees on the workplace.

Aamir Ali Chughtai&Sohail Zafar (2006) studied the influence of organizational commitment on turnover intents and on job performance. RajendranMuthuveloo and RaduanChe Rose (2005) explores that organizational commitment, leads to progressive organizational consequences. Komal Khalid Bhatti, SaminaNawab (2011) said job satisfaction has the high est effect on high employees' commitment and productivity. Meyer, Paunonen, Gellatly, Goffin, and Jackson (1989) examined particulars of a positive relationship between organizational commitment and job performance, Low commitment has been associated with low levels of morale (DeCottis& Summers, 1987). Non-committed employees may portraythe organization in negative terms to outsiders thereby inhibiting the organization's capability to recruit high-quality employees (Mowday, Porter, & Steers, 1982) and decrease measures of selflessness and submission (Schappe, 1998). Some study examines the relationship of commitment with several factors. Mathieu &Zajac, (1990), shown that commitment has been positively related to personal featuressuch as age ,length of service in a particular organization (Luthans, McCaul, & Dodd, 1985), and marital status (John & Taylor, 1999) and have contrary relation to the employee's level of education (Glisson &Durick, 1988).

In addition, commitment has been found to be related to such job featuresas task autonomy (Dunham, Grube, & Castaneda, 1994), response (Hutichison&Garstka, 1996) and job contest (Meyer, Irving, & Allen, 1998) and certain work experiencessuch as job security (Yousef, 1998), promotion openings (Gaertner&Nollen, 1989), training and mentoring opportunities (Scandura, 1997), and supportive and thoughtful leadership (DeCottis& Summers, 1987).

2.7 DIMENSIONS OF ORGANIZATIONAL COMMITMENT

Meyer and Allen (1984,1990, 1991) labelled three dimensional model of commitment:

Affective, Continuance and Normative (as discussed earlier). He supposed Affective Commitmentis based on how much an individual 'want' to remain in the organization. Continuance Commitmentrefers to an alertness of the costs associated with leaving the organization. Continuance commitment is based on individual having to remain with the organization.

2.7.1 Normative Commitment:

This imitates a feeling of obligation to continue employment. Employees with a high level of normative commitment feel that they ought to stay with the org anization.Normative commitment develops on the basis of earlier familiarities influenced by, for example familybased experiences or cultural experiences (authorisations against "job-hopping") (Allen & Meyer, 1996). Normative commitment can upsurge through beliefs that the employees have that employers provide more than they can give. The normative aspect progresses as individuals' observation of their moral obligation to remain with a specific organization, irrespective of how much status enhancement or fulfilment the organization gives the individual over the years (March &Mannari 1977). Normative commitment/obligation is seen as a result of the receipt of benefits (which encourages a feeling that one should reply), and/or recognition of terms of a psychological contract.

2.7.2 Affective commitment:

Numerous studies, describe the term commitment as an affective alignment of the employees toward the organization. Employ ees with aff ective commitment endure service with organization because they wantto do so. Kanter (1968) describe interrelation commitment as the supplement of an individual's found of affectivity and emotion to the group. Affective commitment to the goal and values and to the organization for its own sake, apart from its purely instrumental value.Buchanan (1974). Porter and Mowday et al. (1979) define affective

approach as “the relative asset of an individual’s identification with and contribution in a particular organization. Therefore, an individual who is affectively committed or passionately committed to the organization, (i) believe in the goal and values of the organization ,(ii) works hard for the organization and (iii) plan to stay with the organization (Mowday et al.,1982). Meyer & Allen (1996) links affective commitment with work experiences where employees practice psychologically comfortable feelings (such as approachable managers), increasing their intellect of competence (such as feedback). The improvement of affective commitment involves recognizing the organization’s worth and internalising its ideologies and morals (Beck & Wilson 2000).

2.7.3 Continuance Commitment:

When employees enter into an organization, they are bound to preserve a link with the organization or dedicated to remain with the organization because l ack of alternative opportunity or consciousness of the costs associated with leaving the organization. The cost allied with leaving includes attractive benefits, the threat of wasting the time, effort spends acquiring, , disrupt personal relationship. This was more suitably defined by Allen & Meyer (1990) he projected that continuance commitment develops on the basis of two factors: (1) number of investment individuals make in their existing organization and (2) perceived lack of substitutions. These investment can be anything that the individual considers treasured such as pension plans, organization benefits, status etc that would be lost by leaving the organization, which makes them stay with their existing employers (Meyer & Allen, 1984) Likewise, lack of employment alternatives also upsurges the perceived costs associated with leaving the organization and therefore escalate the continuance commitment of employees to the organization (Allen & Meyer, 1990). Kanter (1968) defined continuance commitment as “ cognitive – continuance commitment as that which occurs when there is a profit linked with

continued participation and a cost associated with leaving". Somers (1993) suggests that continuance commitment can be sectioned into high sacrifice commitment ("personal sacrifice" associated with leaving) and low alternative commitment ("limited opportunities" for other employment). The method of continuance commitment develops when an individual recognizes that he or she loses investments (the money they earn as a result of the time spent in the organization), and/or recognizes that there are no alternatives or other course of action. When an individual have awareness about expenses and threats connected to leaving the organization, this form of commitment is reflected to be calculative (Meyer & Allen 1997).

2.8 EFFECTS OF EMPLOYEE COMMITMENTS ON ORGANISATIONAL PERFORMANCE

According to Konovsky and Cropanzano (1991) and Meyer (1998), they exposed a positive affiliation between commitment and job performance. Employees who are committed to their corresponding organization are more likely not only to remain with the organization but are also likely to exercise more efforts on behalf of the organization and work towards its success and therefore are also likely to unveil better performance that the uncommitted employees. Employee commitment can benefit organization in a number of ways such as it can mend performance; reduced absenteeism, and turnover thereby resulting in sustained productivity. Commitment to organization is positively related to such required outcomes as motivation (Mowday, Steers and Porter 1979) and attendance (Mathieu &Zajac, 1990: Steers & Rhodes,1978) and is negatively associated to outcome as absenteeism and turnover(Clegg 1983: cotton & Tuttle 1986).

Horton stated that organization commitment could result in less income, absenteeism, thus increasing organization productivity (Schuler & Jackson, 1996). Employees with great level

of organizational commitment offer a secure and stable workforce (Steers 1977) and thus providing competitive advantage to the organization.

The committed employee has been found to be more innovative; they are less likely to leave an organization than those who are uncommitted (Porter et.al. 1974). According to Arturo L. Tolentino (2004) Continuous productivity improvement depends on the enterprise's human capital (the skills, knowledge, competencies and attitudes that exist in the individual employ ee of the enterprise) and its social capital (trust and confidence, communication, cooperative working dynamics and interaction, partnership, shared values and teamwork among these individuals.

A committed employee is perceived to be one who stays with the organization even in stormy times, attends work frequently, protects company's assets and shares company's goal (Meyer and Allen, 1997).Therefore it is obvious that for sustained productivity, employee commitment is an significant factor.

As assumed by Akintayo (2010) and Tumwesigye (2010), one of the reasons why commitment has attracted research attention is that organizations hinge on committed employ ees to construct and maintain competitive advantage and achieve a superior performance. According to Payne et al(2003), performance linked reward systems have consequences such as substantial employee's commitment and dramatic improvements in performance; where an equivalent reward seems to be fair. This point of view is supported by Farrel and Rusbult, (1981), Williams and Hazer (1986), Porter et al. (1974) and Chen, Silverthrone and Hung (2006) where the notion of commitment appears to affect the job performance and turnover. Furthermore, when level of commitment increases, positive outcomes are quite evident, and this high level of commitment is intensely linked to high level of organizational performance (Khan, Ziauddin, &Ramay 2010).

However, some authors (Cooper & Hartley 1991) recommend that the level of commitment could indeed cut organizational performance, where commitment might decrease flexibility and obstruct creative problem solving, and, also, this implies the possibility of reducing staff turnover. In the same way McBain's studies (2001/2003) have revealed a high degree of correlation between job satisfaction and organizational commitment, impacting right on achieving high staff performance level. Moreover, managers can be surer to exploit employee commitment as one of the important factors to increase job performance in workplaces, and previous conclusions that stated commitment is largely unrelated to performance are dropped by new findings (Sutanto 1999). Rothmann and Coetzer (2003) recommend that research seems to indicate that employees who have some sort of emotional affection with the organization perform better as equaled with others. Leaders will influence organizational commitment and job performance because they can lead employees towards the accomplishments of job objectives (Yeh& Hong 2012). Studies performed by Yukl (2002) and Lee (2010) identified that transformational leadership has a positive impact on organizational commitment and subsequently an impact on performance (Chi, Yeh& Yu 2008; Pradeep &Prabhu 2011).

Chen, Silverthrone and Hung (2006), argue that reinforcement of communication channels and processes in the company lifts employees' commitment and improves performance. Other researchers (Epitropaki& Martin 2005) have shown a positive correlation between the job-related well-being and affective commitment. As an example, Khan, Ziauddin, &Ramay (2010) investigated the impact of employee commitment among a sample of 153 workers in Pakistan where results show a positive relationship between employee commitment and their performance. Hence, the commitment of the employees is an important matter as it may be used to foretell employee's performance, absenteeism and other behaviors (Dordevic 2004).

Contrariwise, a study conducted by Steers and Porter (1997) has shown a weak relationship between commitment and performance. Even when there are some studies that show that "affective commitment" is positively associated to job performance, that relationship is varying across the samples and measures of performance. Further, Suliman(2012) also suggests very weak rel ationship between employee commitment and job performance. Nonetheless, more recent empirical evidence indicates that "affective commitment" is in a significant relationship with job performance (Siders, George &Dharwadkar 2001; Clarke 2006).

Additionally, in respect to other forms of commitment, some research shows that the relationship between "continuance commitment" and job performance is adverse (Clarke 2006). Concerning "normative commitment", the research has been vague, showing positive and negative relationship or no relationship at all between the variables (Allen & Meyer 1996; Clarke 2006). Studies supported by Jaramilloa, Mulki and Marshal (2005) and Al Ahmadi (2009) point out that employee performance may be contingent on the nature of the commitment, some organizations tend to increase commitment through those aspects that influence each element, such as career promotions, skills training and compensation plans (Sam Gnanakkan 2010).

2.9 SERVICE QUALITY

A practical approach to the problems of definition by Gilbert and Joshi (1992) attempted to classify quality into two major groups: the product-attributed method and the consumeroriented approach. The latter group is subdivided further into a consumer necessity approach to quality and a consumer expectation orientation. The authors' view emphasises that

service quality should be measured in the second sub-group, since it acknowledges the importance of consumer behaviour in the evaluation of services. This concept brings quality closer to service design and marketing where the devotion is on understanding and manipulating the service production process by considering consumer discernments, and by inference, the psychological, sociological and situational factors which occur during the service encounter. The product attribute approach raises the issue of whether attributes of a product or service have distinguishing qualities and therefore, has direct relations to evaluation and expectations.

Quality of service has been described to be one of the major causative factors needed in enhancing customer satisfaction. But in order to augment the research this concept was parted into two different words (i.e.) quality and service. Quality itself has been well-defined as basically relational and an uncompleted procedure of building, including the sustenance of relationships through assessing, anticipating and satisfying stated and indirect needs. Additionally, quality is the careful observation of the supplier's work output by customers (Verma 2008).

Service has also been well-defined as a task assumed by an employee or group of employees that benefits another such as customers. Furthermore, this term (service) in economics has been labeled to be a type of business activity that is intangible, cannot be reserved for future usage and does not result in a straight ownership by either the supplier or recipient. From this, it is realized that it is difficult for customers to assess and evaluate the quality of service delivered by an organization.

Service quality observation results from a divergence of what the customer expected before the service and the seeming level of service received (Krutz&Clow 1998).

Furthermore, customers can use this process in the evaluation of the services rendered by the organization and differentiate from other contending services in order to make proper choices to enhance their satisfaction. Expectation of customers then plays a dynamic role in the valuation of service quality therefore it is essential that service providers develop a scheme through which their target customers can adopt in the assessment of their service submissions. (Zeithmal et al, 2000).

Service quality has been defined in terms of meeting or surpassing a consumer's expectation (Parasuraman, Zeithaml and Berry, 1985; Gronroos, 1984; Lewis and Boom, 1983). "Service quality is a ration of how well the service level delivered matches customer expectations. Delivering quality service means in compliance to customer expectations on a consistent basis (Lewis and Boom, 1983). This evaluative decision process may be operationalised in two ways; either by comparison of anticipations to service providers' behavioural performance (gap theory) or simply by direct evaluation of performance paralleled (disconfirmation theory) to customers' expectations (Gronroos, 1982; Parasuraman, Zeithaml and Berry, 1985; 1988). In the first case, customers' expectations are measured and then a measure is taken of the evaluation of the real performance of the service. This "gap" is the difference.

2.10 FACTORS AFFECTING SERVICE QUALITY

2.10.1 Policy

The policy within the organization is one of critical factors that can affect working performance or quality service. Sometimes, the customer expected too high for the products or services but the employee could not offer as much as customer want due to the employee forced to follow the company policy. Robert Horowitz (2011) discusses there are five guiding principles are adopted by public as well as private agencies delivering excellent customer service. The

guiding policies. (1) Embrace change and persistently strive to improve (be a learning organization). (2) Continually ask the target customers what they want and then give it to them. (3) Empower, support, and reward frontline personnel. (4) Harness the power of information, and (5) establish an enabling infrastructure.

2.10.2 Quality Control

Quality is one of the key objectives of operation, while quality management is crossfunctional in nature and involves the entire organization. Operation has a special responsibility to produce a quality product or service for the customer (Roger G. Schroeder et al., 2010). ISO 9000 is quality standard approach, which is worldwide exercised. Rao et al. (1997) In their study, they empirically explore, in the international context, the relationship between ISO 9000 and the level of quality management practices and quality results. The findings indicate that ISO 9000 registered companies exhibit higher levels of quality leadership, information and analysis, strategic quality planning, human resource development, quality assurance, supplier relationships, customer orientation and quality results. Without a support and careful attention from the management and control of quality, it is difficult for operation to deliver a quality product or service.

2.10.3 Workload

Morrison (1996) suggested that a company's Human Resource Management (HRM) practices could create an environment that elicits more customer-oriented behavior from employees. In turn, the behavior that these employees perform will positively impact service quality. A long-term heavy workload can affect an employee's physical or mental health, performance, or productivity including service quality. Consequently, heavy workloads have been shown to have a negative impact on turnover (Chen et al, 2010), certainly contribute to astate of stress

and give rise to strain, accidents or illness. High employee turnover carries with it the problems of both a high labor cost and quality issues that hurt the performance and growth of a company (Davidson *et al*., 2006).

2.10.4 Health

Physical health is very critical in today's work place. In today's high-end technology world it is necessary to work smart and possess great skills. There are many important jobs that require good skills and significant amount of strength to be able to perform at the high level and long hour work. Physical health and work performance works hand in hand. Mental and physical health plays a very important role for an employee's growth and productivity. It helps to improve the efficiency of the employee, leading to greater performance, which means good service quality(Ryan, 2010). Ryan also added the productivity and job performance can be increased by good physical health of the employees. Healthy work environment will help in improving employee's productivity and performance.

2.10.5 Income & Benefits

Income includes monthly salary, over-time payment, and per diem, while the benefits come with something that aids or promotes well being of employees. This factor is a need of person in maintaining their lives according to their social status. It can respond to personal basic needs and make persons satisfied with their job (Spector, 1997). Appropriate income makes employees satisfied in their work and make them work productively and effectively (Locke, 1976). Arik and Kato, 2010 said that inappropriate income causes staff dissatisfaction and lack of motivation.

2.10.6 Attitude

Attitude is very vital factor that reflect people thought and perception towards something. Swarts, 2008 stated that psychologists have found it difficult to formulate an acceptable

definition of an attitude, as it is not clear whether an attitude should be considered to be a sample or multiple phenomenons. The simple definition describes an attitude as a favorable or unfavorable feeling towards something. An example of the simple definition can be referred to Robbins and Judge (2007) who state that attitudes are evaluative statements or judgments- either favorable or unfavorable – concerning objects, people or events. Stock and Hoyer, 2005 views attitudes as a multiple phenomenon, consisting their components: cognition, affect and behavior. An example of a multiple definition can be found in Gibson et al. (2006) who indicates an attitude as "a positive or negative feeling or mental state of readiness, learned and organized through experience, that exerts specific influence on a person's response to people, objects and situations". The definition has the following (1) attitudes are learned; (2) attitudes define our predispositions towards given aspects of the world; (3) attitudes provide the emotional basis of our interpersonal relations and identification with others; and (4) attitudes are organized and are close to the core of personality (Gibson et al. 2006)

2.10.7 Personality

Personality can be defined as enduring emotional, interpersonal, experiential, attitudinal and motivational style that explains individual's behavior in different situations (McCrae & Costa, 1989). There are many studies discussed about personality and job performance such as Dalton & Wilson (2000), Caligiuri (2000a), Mol et al. (2005), and Shaffer et al. (2006).

However, these results show a mixed finding on the relationship between dimensions of the Big Five personality and job performanc e. For instance, while Shubramaniam, Raduan, Naresh, Jegak (2010) examine how personality influences job performance both directly and indirectly. From their study, both the interaction and work adjustment found to partially mediates the relationship between personality and job performance.

A review of the Industrial/Organizational psychology literature suggests that all personality characteristics can be categorized in five basic trait dimensions- extroversion, conscientiousness, agreeableness, openness to experience and neuroticism. These five trait dimensions subsequently labeled as the Big Five Personality (Hough, 1992; Digman, 1997).

The first dimension, extroversion, has been related with heightened level of sociability. Individuals high in extraversion tend to like groups and gatherings, to be talkative and energetic and generally to be more active and assertive (Costa & McCrae, 1992). An extrovert person considered sociable and outgoing with others (Huang et al., 2005).

Conscientiousness dimension (2nd) described as a form of conformity to rules and standards,

and linked to traits like responsibility, organization, hard work, impulse control and prudence (Barrick & Mount, 1991; Hogan & Ones, 1997). Individuals high on conscientiousness are also dependable and trustworthy (Costa & McCrae, 1992).

The third dimension, agreeableness has been associated with conformity with others and friendliness in the interpersonal setting (Digman, 1990). Individuals high on agreeableness tend to be more helpful and sympathetic towards others, as well as more trusting of the intentions of other people (Costa & McCrae, 1992).

The fourth dimension, openness to experience appears to be a personality trait that reflects individuals' habitual willingness to try new ideas, tolerate ambiguity and dissonance and generally be curious and eager to learn (Barrick & Mount, 1991). Individuals high on openness to experience tend to be open minded, original in thought, intelligent, imaginative, and non-judgmental.

Finally, neuroticism personality is associated with lessened emotional control and stability

(Mount & Barrick, 1995). Neurotic individuals tend to have relatively negative core selfevaluations, leading to emotional distress and associated behaviors (Rusting & Larsen, 1998). Neuroticism also related to a person's general tendency to experience negative effects such as fear, sadness, embarrassment, anger, guilt, and disgust (Dalton & Wilson, 2000).

2.11 SERVICE QUALITY DIMENSIONS

According to Nargundkar (2006, 58) service quality exists in six distinct dimensions. These include experience, tangibles, reliability, responsiveness, relationships and empathy, finally value sharing and assurance. Value sharing and assurance though may be the foundation of the assimilation of all the other dimensions does not exist on its own. The sustenance of customer delight, employee knowledge, trust and confidence c annot exist without the assistance of the other dimensions of service quality. It can therefore be seen that these dimensions are so connected that they each tend to depend on each other in order to enhance customer satisfaction.

2.11.1 Experiential dimension

Experiential dimension refers to the dimension that reveals the vision of the organization through which defines how employees' are recruited, trained and motivated with stated objectives. But unless this dimension is merged with other dimensions it becomes a single sequence of incident. The opposite tends to occur when it is combined with other dimensions (Hayes 2008). The retention, motivation and training of employees over a period of time then become an investment for the organization which will enable them render quality service.

The supremacy of experiential dimension is that unless employees are made aware of their obligation including responsibilities whilst being offered the required facilities the vision of the organization becomes ineffective and of no consequential effect though they (i.e.

employees) may be having the requisite experience (Hayes et al 2008).

2.11.2 Tangible dimension

Tangible dimension simply refers to the physical appearance of service providers such as equipment, facilities, and written materials which customers, especially new customers use to evaluate the quality of service provided by business organizations. These tangibles are further used to augment the image of the organization and signal quality to customers. Since this dimension cannot be assessed without the assistance of the other dimensions service organizations are obliged to combine it with other dimensions in order to create a service strategy. (Schneider et al 2004)

2.11.3 Reliability dimension

According to Berry et al (1991) reliability dimension measures the employee's ability and willingness to undertake the expected service consistently and precisely. Organizations whose employees' render quality service consistently and precisely through problem resolution and favourable pricing tend to be the preferred organizations normally chosen by customers for business transactions. Despite this it is important for business organizations to be aware of the expectations of their target customers concerning r eliability since this (i.e. reliability) dimension is normally regarded as the most important determinant of service quality (Srinivasan 2009).

2.11.4 Responsive dimension

According to Berry et al (1991) employees' can further adopt responsive dimension this to inform their customers concerning the period of time needed to wait for their complaints and feedback to be attended to either promptly or in a later time. Responsive dimension stresses

the significance of flexibility and ability within the organization in the field of customer service delivery for customer needs. In this regard organizations that intend to excel with this dimension are required to view service delivery from the perspective of their customers instead of their organization. It therefore becomes a pre-requisite for the setting up of standards according to the customer's requirement due to the fact that the customer's view of promptness might differ from the perspective of the organization. (Nargundkar et al 2006)

2.11.5 Relationships & empathy dimension

There seems to be a common cordiality between the dimensions of relationship and empathy which can be seen from their implications. Relationship dimension allows both employees and customers to carefully observe the link between activities including final results obtained from these activities. Furthermore, it (i.e. relationship) assists them (i.e. customers) to understand the interrelationship among employees, equipment, processes, business environment, policies and procedures. Empathy dimension implies the caring and special attention accorded to customers by employees (Berry et al 1991).

Additionally, this dimension also makes use of the interpersonal relationship existing between customers and employees in establishing a long-term relationship of loyalty including trust with suppliers. Finally, it enables management to internally remove departmental barriers existing in their organization so as to make the entire organization function as an incorporated system instead of subsystems (Berry et al 1991).

2.11.6 Value-sharing & assurance dimension

The value-sharing dimension earlier elaborated tends to have its base in relational economics through which it provides the most competent economic system. Value-sharing enables

business organizations to establish customer loyalty by focusing on fulfilling the needs of customers on a constant basis due to the frequent changes in customer needs. (Srinivasan et al 2009. 125) In order for these changes to be fulfilled managers ought to on a constant basis assure customers of attempts being made to fulfil those needs. This is due to the fact that the assurance dimension is normally experienced from the employees' knowledge, courtesy and ability to inspire trust including confidence in customers. This dimension (i.e. assurance) as a dimension of quality service is of very significant value to customers especially if the service rendered entails a very high degree of risk. In this regard service employees who render these services have the sole responsibility to instill trust and loyalty for the customers by enhancing

the quality of interactions. To improve the quality of interactions it is advisable for organizations to recruit employees with a positive attitude toward quality of service since the degree of friendliness, credibility, trustworthiness and competence is likely to reflect in customer perception of service quality. (Berry et al. 1991).

Thus, for the Customer Satisfaction medical and healthcare industry, assurance is an important dimension that customers look at in assessing a hospital or a surgeon for an operation. The trust and confidence may be represented in the personnel who links the customer to the organization (Zeithaml et al., 2006).

2.12 RELATIONSHIP BETWEEN MOTIVATION AND PERFORMANCE

It has already been argued that managers need to motivate employees to perform well in the firm, since the organisation's success is reliant upon them (Ramlall, 2008). The perspective that motivation causes performance comes from the human relations theory (Filley et al., 1976). The liaison between employee motivation and job performance has been studied for a long period. However, earlier research could not succeed in instituting a direct relationship

between the two (Vroom, 1964). Yet, it seems that that the causes do influence each other. Petty et al. (1984) reviewed the 15 studies Vroom (1964) used in his research and added another 20 more recent studies; they concluded that employee motivation and performance are undeniably related. The results of their research point out that the relationship between individual, general job satisfaction and individual job performance is more consistent than reported in previous researches (e.g. Vroom, 1964). Hackman and Oldham (1976) argue that when employee fulfillment is added, a circular relationship is formed with performance, satisfaction and motivation. The term satisfaction is also used by Herzberg (1959); who says that when intrinsic factors (motivators) are present at the job, gratification is likely to occur as well as an increase in employee motivation. Amabile (1993) states that work performances are reliant upon the individual's level of motivation; the individual's level of motivation can be intrinsically and/or extrinsically based. It is also argued that certain job features are necessary in establishing the relationship between employee motivation and performance (Hackman & Oldham, 1976; etc.).

Brass (1981) argues that when certain job features are present in an organisation, employees are better motivated and an increase in performance is noticeable. Job characteristics refer to precise attributes or magnitudes that can be used to describe different tasks (Griffin et al., 1981). Hackman and Oldham (1976), defined five job characteristics, which are based on the Two-Factor Theory from Herzberg (1959). The results of their study indicated that employees who work on jobs recording high on the five characteristics, show high work motivation, satisfaction and performance (Brass, 1981). Hackman and Oldham (1976) settle that employe es can be motivated through the design of their work; they also said that by providing certain intrinsic and extrinsic factors, an employee can be motivated to perform well.

2.12.1 Intrinsic and Extrinsic Motivation

Motivation can be divided in intrinsic and extrinsic motivation. Amabile (1993) explains this as follows:

- People are intrinsically motivated when they seek enjoyment, interest, satisfaction of curiosity, self-expression, or personal challenge in the work.
- People are extrinsically motivated when they engage in the work in order to obtain some goal that is apart from the work itself.

Deci (1972) describes extrinsic motivation as, money and verbal fortification, mediated outside of the person, whereas intrinsic motivation is facilitated within the person. And a person is intrinsically motivated to perform an activity if there is no obvious reward except the activity itself or the feelings which result from it.

Amabile (1993) maintains that employees can be either intrinsically or extrinsically motivated or even both. It seems that intrinsic and extrinsic motivators apply contrarily to persons. Vroom (1964) debates that some employees center on intrinsic outcomes whereas others are focused on extrinsic outcomes. According to Story et al. (2009), persons high in intrinsic motivation seem to desire challenging cognitive tasks and can self-regulate their behaviours, so offering rewards, setting external goals, or targets, will do little for them, unless they are also high in extrinsic motivation. For employees high in intrinsic motivation, emphasis could be placed on the latter. Hackman and Oldham (1976) argue that people have individual dissimilarities in response to the same work; they differentiate employees high and low in growth need strength. People high in growth and strength are most likely to be motivated by jobs with high skill diversity, task identity, t ask significance, independence and feedback. And people low in strength are relatively indifferent for these factors according to them. This statement is supported by Furnham et al. (1998); who argue that, introverts are more extrinsically motivated

and extraverts more intrinsically motivated. However, it not only seems that persons are inversely motivated, but intrinsic and extrinsic motivations also have effect on each other.

2.13 OVERVIEW OF THE HEALTH SECTOR IN GHANA

Ghana's healthcare industry is characterized by a government sector that serves the majority of the population and a growing private sector that serves 40% of healthcare needs. The Ghana Health Service (GHS) is a Ghanaian government organization established in 1996 as part of the Health Sector Reform of Ghana. The Health Service is under the Ministry of Health. The Health service primarily manages the health services provided by the government and in implementing government strategies on healthcare. The Ghana Health Service (GHS) is a Public Service body established under Act 525 of 1996 as required by the 1992 constitution. It is a self-governing Executive Agency responsible for implementation of national policies under the regulate of the Ghana Minister for Health through its governing Council - the Ghana Health Service Council. The GHS remain to receive public funds and thus remain within the public sector.

The establishment of Ghana Health Service was an indispensable part of the key strategies identified in the Ghana Health Sector Reform process, as outlined in the Medium Term Health Strategy (MTHS), which were necessary steps in forming a fairer, competent, reachable and approachable health care system. Themes that were central to the reorganization of 1993 remain significant today for the Ghana Health Service: careful stewardship of resources, clear lines of responsibility and control, decentralization, and answerability for performance rather than inputs. GHS performs the following functions amongst others: Provide all-inclusive health services at all levels in Ghana directly and by contracting out to other Ghana agencies.

As part of its function, the GHS develops appropriate strategies and set technical rules to achieve Ghana national policy goals/objectives, undertake management and administration of

the overall Ghana health resources within the service, promote healthy mode of living and good health habits by people in Ghana, establish operative instrument for disease surveillance, prevention and control in Ghana, determine charges for Ghana health services with the approval of the Ghana Minister of Health, provide in-service training and continuing education in Ghana and perform any other functions appropriate to the promotion, protection and refurbishment of health in Ghana

2.14 CONCEPTUAL MODEL /FRAMEWORK

EMPLOYEE COMMITMENT

SERVICE QUALITY

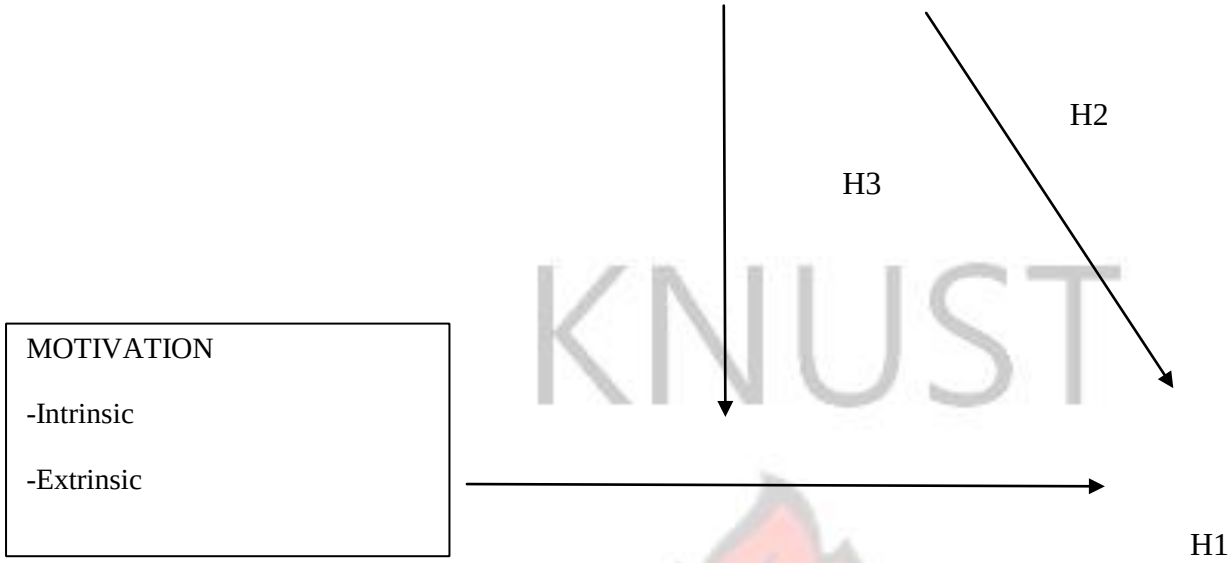


Figure 2.1

Ghana is one of the sub-Saharan African countries making significant progress towards universal access to quality healthcare. However, it remains a challenge to attain the 2015 targets for the health related Millennium Development Goals (MDGs) partly due to health sector human resource encounters including low staff motivation. Service quality within the health sector in Ghana has been of great distress to many. For years, the quality of health services in hospitals has come under deep scrutiny and this has become more worrying in recent times. Quality of care in public/private sector facilities in Ghana is a venerable and continuing concern of users of the health services and civil society as well as health sector policy makers, providers, administrators and managers. User grievances and media reports of rude and inpatient providers, inconvenient hours of operation, long waiting times, lack of drugs and other essential inputs are common.

2.14.1 H1: The Relationship Between Motivation And Service Quality

A nation's growth does not only hinge on its income or natural resources but also on social services such as development in healthcare delivery. Workers cannot work as deserve of them in the absence of effective healthcare (Baidoo, 2009). In other words the health sector, like the

economic and educational sectors play a key part in the development of a nation. Without good healthcare, people cannot work. Thus “health is a fundamental human right crucial for the exercise of other human right” (UN, 2000).

Health workers occupy a principal position in any health care facility. They heal and care for people, relieve them of their pain and suffering and prevent diseases (WHO, 2006). “They are the definitive resource in health because they bring about and synchronise all other health resources, including financing, technology, information and infrastructure”. Therefore, for them to work effectively, they must be motivated and sustained (Joint Learning Initiative, 2004).

On the contrary, when there is nonexistence of motivation and satisfaction, workers tend to shirk their duties, absent themselves from work, are impolite, etc. Additionally, lack of motivation partly expounds why health workers in most third world countries like Ghana, migrate to developed countries. Low salaries, poor working settings, absence of opportunities for professional development and promotion (Bach, 2003) leave workers dissatisfied, usually pushing them away from their home countries to search for greener pastures elsewhere. Peters, Chakraborty, Mah apatra and Steinhardt (2010) noted that motivation and employe e satisfaction are imperative if health workers are to be retained and effectively deliver health services, whether they work in public or private sector.

2.14.2 H2: The Relationship Between Commitment And Service

The prominence of commitment was highlighted by Walton (1985), where he pointed out that performance can be improved if the organization takes a commitment strategy rather than a control oriented approach. Employees come to work to make a contribution (Johnson 2004)

and those employees who are committed to deliver customer satisfaction constitute a value asset in any organization (Payne et al. 2003). In addition to this, the opportunity of having committed employees will give the organization support in order to achieve the corporate goals, and so they can become a significant source of competitive advantage (Rashid, Sambasivan& Johari 2003) due to their greater capacity of innovation and flexibility (Walton 1999).

Other studies have also shown that commitment affects behaviors at work in relation to the workers' "in role" effort and performance (DeCotiis& Summers 1987; Kim & Mauborgne 1998).

Low level commitment, in its turn, makes organizations less productive leading to a decline of product and service quality (Johns 2005). It is expected that committed workers will be highly motivated and will go "beyond the contract" (Mabey, Salaman& Storey 1998). Affective commitment, also referred to as attitudinal commitment (Swailes 2002;

Torrington, Hall & Taylor 2005) considers the employee's emotional attachment (Sahoo, Behera&Tripathy 2010) as a person to the organization (Lumley et al. 2011), and is concerned with the extent, to which the employees enjoy their membership and identify themselves with the organization (Culpepper, Gamble &Blubaugh 2004). Affective commitment, according to Meyer and Allen (1991), is influenced by the individual's needs and expectations about the organization and whether those match or not, according to their

actual experience, establishing evident links to the psychological contract. In the same way, it has been shown to be associated with higher productivity and with positive work attitudes (Meyer et al. 1989).

The severe resource constraints under which the health sector in Ghana functions underlies the problem of commitment. For example, promotions are important because of the status of

having a higher rank, as well as the accompanying increase in salary. Years of delayed promotion can be very demotivating, especially if staff observe others with fewer years of service being promoted. Accommodation, can also be an issue for commitment, the free housing provided by the Ghana Health service is very limited, and staff who are not fortunate enough to get such a unit do not receive any allowance to cover rental elsewhere. In the Accra metropolis, most staff live in rented accommodation all over the city. Coupled with this, there is no truly public transport system per se. 'Public' transport is actually private transport through a wide network of minibuses and taxicabs organized by the Ghana Private Road Transport Union of the Trades Union Congress. Though the networks are good, the overall quality is poor. Long waiting times and crowded buses especially at peak periods when most staff move to and from work are the norm. Traffic in the city is also a problem. Depending on where staff live in the city, they may have to make several changes of minibus and spend hours in traffic before getting to work already tired and stressed. Inadequate staffing at the workplace is also an obstacle.

An already existing chronic brain drain of professional staff from the health service has accelerated in recent years with the active recruitment of nurses from developing countries by some developed countries. Director of Health Service for Greater Accra Region has decried the doctor-patient ratio in the country, which is approximately one doctor to 15259 patients a year. (GHS-Greater Accra Region, 2004). Additional duty hours allowance (ADHA) payments scheme was introduced by the government of Ghana in 1998 to recognize

and remunerate health workers for any additional hours worked over following strikes by junior doctors in the teaching hospitals protesting the long hours they worked and their low salaries, they were introduced by the Ministry of Health. It was hoped this would help to motivate health workers for higher performance towards providing improved quality care (MOH, 2000).

2.14.3 H3: Commitment,Motivation And Service Quality

The relationship between employee motivation and job performance has been studied in the past (Vroom, 1964). But high correlations between the two were not established. However, later research concluded that employee motivation and job performance are indeed positively correlated (Petty et al., 1984). Petty et al. (1984) argue that the relationship between motivation, commitment and performance (service quality) is circular and starts by a high performance causing satisfaction. According to them, when the employee performs well on a particular task, satisfaction will occur. Because of the internal satisfaction of the employee, the employee is motivated to try to perform well in the future (Brass, 1981). Low quality of health service delivery in the public/private health sector usually occur as a result of labour force or internal customers who daily face a barrage of workplace obstacles that frustrate and de-motivate them. In addition, some of the workplace obstacles such as lack of essential tools and equipment to work with and poorly targeted in-service training in and of themselves directly help to lower the technical quality of care.

Al Hussein et al. (1993) in a study in the central region of Ghana into factors leading to poor quality of nursing care made similar observations about the lack of basic equipment and supplies, effective supervision and inadequate basic training as well as delayed promotions and inadequate allowances negatively influencing work performance.

Bennett and Franco (2000) define motivation in the work context as an individual's degree of willingness to exert and maintain an effort towards organizational goals. The daily unresolved frustrations of workers in the health service reduce their willingness to exert and maintain efforts towards attaining the stated org anizational goal of providing high quality care. Moreover, they pent up frustrations are sometimes turned outwards onto clients in the form of rudeness, anger, unfriendly behavior and resentment. The problems interconnect with each other and are not always simple linear relationships. Improving staff motivation in the Ghana

health service requires an understanding of the inter-related nature of the problems and the need to devise solutions that simultaneously address multiple interrelated problems. It is unlikely that the Ghana Health Service can provide high quality of care to its end users (external customers) if workplace obstacles that de-motivate staff (internal customers) and negatively influence their performance are not properly acknowledged and addressed as a complex of inter-related problems producing a common result—dissatisfied poorly motivated staff and resulting poor quality services.

Health workers should be treated as internal customers of the health system to enable them to deliver good quality care to patients (external customers). An enhanced level of staff satisfaction with the work environment is most likely to spill over, onto clients and increase satisfaction with service quality.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter presents the research methodology which includes the research design, methods and procedures used in conducting the study. It also includes the subject respondents, research instrument, research environment or locus of the study and method of analysis of the data gathered. The chapter has the following sections: research design, population of the study, sample and sampling technique, method of data collection and method of data analysis.

3.2 RESEARCH DESIGN

According to Saunders 2005, the research design is the general plan of how to go about answering the research questions. He further describes it as the overall plan of the project. The research design encompasses the methodology and procedure employed to conduct the research. It serves as the blue print for collection, measurement and analysis of data. The design of a study defines the study type

There are two types of research Quantitative research and Qualitative research. The former is a more logical and data-led approach which provides a measure of what people think from a statistical and numerical point of view. Quantitative research can gather a large amount of data that can be easily organised and manipulated into reports for analysis.

Quantitative research largely uses methods such as questionnaires and surveys with set questions and answers that respondents tick from a predefined selection. Answers can be measured in strengths of feeling such as ‘strongly agree’ ‘disagree’ or numbers such as scales out of 10.Qualitative research on the other hand is more focused on how people feel, what they

think and why they make certain choices. For the purpose of this study the quantitative approach was utilized due to the amount of data to be gathered and statistical results required

This research uses exploratory as well as explanatory research approaches. Exploratory approach, which by Robson 2002, is a valuable means of finding out what is happening, seeking new insights, asking questions and assessing phenomena in a new light. The research design also encompasses the methods and methodology adopted. Research methods are the techniques and procedures used to obtain and analyse data (Saunders 2005). In this research, only questionnaire was the method of obtaining data to address the research objectives. Research methodology on the other hand refers to the theory of how the research should be undertaken (Saunders 2005), basically the research process.

3.3 POPULATION OF THE STUDY

Population is the full set of cases from which a sample is taken (Saunders, 2005). A group of people who are the subject to a piece of research is known as the population (Cohen, L et al 2000). The population of this study was hospital, clinics and health centres in the Greater Accra Region, both the public and private sector. However, data was sought only from medical doctors.

3.4 SAMPLE AND SAMPLING TECHNIQUE

Cohen, L et al (2000) says that it is often not feasible to investigate the entire "population" - for reasons of cost, time, accessibility, etc. - researchers are often obliged to obtain data from a smaller group, known as a "subset" of the population. Therefore, researchers (usually) seek

to define the subset in such a way that the data obtained will be representative of the total population. Saunders 2005 identifies two main types of sampling technique, probability or representative sampling technique and the non probability or judgemental sampling technique. Saunders 2005 defines probability sampling as a sampling technique in which every member of the population will have a known non - zero probability of selection, while a non - probability sampling is a sampling technique in which units of a sample are selected on the basis of personal judgement or convenience.

The study was conducted on a sample size of one hundred and fifty (150) medical doctors across various hospitals and health centres within the Accra Metropolis. This sample was obtained using the non - probability sampling technique, specifically convenience sampling. Convenience sampling involves selecting haphazardly those cases that are easiest to obtain for your sample (Saunders 2005). The population of this study has little variation, thus the problem of making flawed generalisations using this method is minimized. This process of selection was continued until the required sample size was attained.

Table 3:1

Hospital	**Est. Dr Pop.**	**Sample size**	**Sample Process**
Afariwaa Medical Center	20 <	2	Convenience Sampling
Romans Medical Center	10 <	1	Convenience Sampling
Holy Cross Clinic	15 <	3	Convenience Sampling
Kaneshi Polyclinic	10 <	7	Convenience Sampling
Korle - bu Teaching Hospital	500 <	15	Convenience Sampling

Bennette Memorial Clinic	10 <	1	Convenience Sampling
Cantoment Hospital	10 <	5	Convenience Sampling
St Patrick Hospital	10 <	1	Convenience Sampling
SDA Clinic	20 <	1	Convenience Sampling
Adabraka Clinic	10 <	2	Convenience Sampling
Yentumi Boayitey Clinic	10 <	1	Convenience Sampling
Catholic Clinic	20 <	2	Convenience Sampling
Ga South District Hospital	5 <	3	Convenience Sampling
Nyaho Medical Center	30 <	10	Convenience Sampling
Ridge Hospital	100<	1	Convenience Sampling
Lister Hospital	10 <	2	Convenience Sampling
Martins De Porres Hospital	5 <	1	Convenience Sampling
Ascension Hospital	15 <	1	Convenience Sampling
Methodist Hospital	10 <	2	Convenience Sampling
Gloryve Medical Center	5 <	5	Convenience Sampling

Christ For us hospital	10 <	1	Convenience Sampling
Faith Hospital	20 <	2	Convenience Sampling
Fecty Hospital	15 <	7	Convenience Sampling
37 Military Clinic	100 <	16	Convenience Sampling
Police Hospital	30<	4	Convenience Sampling
Legon Hospital	20 <	2	Convenience Sampling
Family Health Hospital	10 <	1	Convenience Sampling
Katherine Clinic	30 <	20	Convenience Sampling
Elikem Herbal Center	10 <	1	Convenience Sampling
Total	1000<	120	

3.5 METHOD OF DATA COLLECTION

Data can be collected from two main sources, the primary source and secondary source. Primary data is data collected specifically for the research under study. It usually takes the form of observations, interviews and questionnaires. For this research, collecting data by observation, or interviews was ignored; questionnaire was the primary source of data. Questionnaires were administered to medical doctors in hospitals visited. Responses to the questionnaires were therefore the source of data for the study. Secondary data according to

Saunders 2005, is data collected already for some other purpose, this study however does not make use of this type of data.

3.6 METHOD OF DATA ANALYSIS

Data that is not interpreted and analysed conveys little or no meaning to end users. There is the need to analyse data after collection to make conclusions and meaningful recommendations. There are various data analysis techniques such as various types of graphs and charts, building models and relationships between variables to establish a trend, writer's judgement and other statistical analysis tools. The type of analysis technique will however depend on the type of data, quantitative or qualitative data. The Statistical Package for the Social Sciences (SPSS) was used in analysing the quantitative data. Among its features are modules for statistical data analysis, including descriptive statistics such as plots, frequencies, charts, and lists, as well as sophisticated inferential and multivariate statistical procedures like analysis of variance (ANOVA), factor analysis, cluster analysis, and categorical data analysis.

3.7 ACCRA METROPOLIS

Accra is the capital and largest city of Ghana, with an estimated urban population of 2.27 million as of 2012. It is also the capital of the Greater Accra Region and of the Accra Metropolitan District, with which it is coterminous. Accra is furthermore the anchor of a larger metropolitan area, the Greater Accra Metropolitan Area (GAMA), which is inhabited by about 4 million people, making it the second largest metropolitan conglomeration in Ghana by population, and the eleventh-largest metropolitan area in Africa. Accra stretches along the

Ghanaian Atlantic coast and extends north into Ghana's interior. Accra serves as the Greater Accra region's economic and administrative hub. It is furthermore a centre of a wide range of nightclubs, restaurants and hotels. The central business district of Accra contains the city's main banks and department stores, and an area known as the Ministries, where Ghana's governm ent administration is concentrated. Economic activities in Accra include the financial and agricultural sectors, Atlantic fishing, and the manufacture of processed food, lumber, plywood, textiles, clothing and chemicals.

3.7.1 Population and Population Trend

With a population of about 1,695,136 million people (2000 National Population Census), Accra, Ghana's capital since 1877, is today one of the most populated and fast growing Metropolis of Africa with an annual growth rate of 3.36%. It is estimate that the city accommodates between 2.5 million to 3 million people in terms of socio-economic activities aside the residential dimension captured by the 2000 National Population Census. The primacy of the Accra Metropolitan Area as an administrative, educational, industrial and commercial centre in attracting people from all over Ghana, continues to be the major force for rapid population growth, with migration contributing to over 35% of the population increase.

The period between 1960 and 1970 saw rapid industrialisation and expansion in Accra's manufacturing and commercial sectors. This contributed to high rural-urban migration to the city, and consequently a high population growth rate. The stagnation of the Ghanaian economy during the 1970s slowed the growth of Accra's population, as shown by the falling growth rate of the 1970-1984 intercensal y ears. Later, however, the decline in agriculture in rural communities in Ghana and rising industrialisation in urban regions, coupled with the late-1980s boom in the service sector, once again propelled immigration to Accra. The primacy of

the Accra Metropolitan Area as the Greater Accra region's administrative, educational, industrial and commercial centre continues to be the major force for its population growth, with immigration contributing to over 35% of the Accra's population growth.

3.7.2 Distribution and density

The gross density of population for the Accra Metropolitan Area in 2000 was 10.03 persons per hectare, compared to 6.23 per hectare in 1970. The highest densities were recorded in the Accra Metropolitan Assembly, with an overall average of 69.3 persons per hectare. At the community level, densities exceeding 250 persons per hectare occurred mostly in the immigrant and depressed areas in the oldest parts of Accra, such as Accra New Town, Nima, James Town and Ussher Town. In higher-income areas, densities ranged between 17.5 and 40 persons per hectare.

3.7.3 Population distribution by age and gender

Accra's population is a very youthful one, with 56% of the population being under 24 years of age. This predominance of young people is not expected to decline in the foreseeable future. Fifty-one percent (51%) of the population are females, and the remaining 49% males. This gives a males-to-females ratio of 1:1.04. The greater number of females is a reflection of the nationwide trend, where the estimated ratio of males to females is 1:1.03.

CHAPTER FOUR

DATA ANALYSIS, FINDINGS, AND DISCUSSIONS

4.1 Introduction

The results and the findings of the study are presented in this chapter. Relevant discussions of the findings are presented in light of the study's objectives and pertinent literature.

The presentations in the chapter start with an overview of data collected and demographic profile of the respondents, and then descriptive summary of the key issues (motivation, commitment, and service quality) being investigated into within the research context.

The subsequent sections focus on presenting the statistical techniques and procedures employ ed in estimating the study's proposed framework, the results, and discussions of the findings thereof.

4.2 Overview of study and data collected

This study was c arried to primarily examine the effects of employe e motivation and commitment on service quality in healthcare delivery in Ghana. Specifically, the target informants considered in the study were doctors. Questionnaires were used to capture the relevant data.

In all, 150 questionnaires were administered. 130 were received. Inspections through them revealed a lot of missing data values on 2 of them and hence rejected. 128 were thus used for analysis purposes, which represented an effective response rate of 85.33%. The demographic profile of the respondents are presented as follows:

4.3 Demographic profile of respondents

To get representative responses for the study, the researcher collected data from three key types of health facilities in the country. The results as shown in table 4.1 show that data for the

study were collected from 43.3%, 45.7%, and 11.0% doctors in Public, Private, and Missions hospitals. Similarly, fair responses were collected from male (61.4%) and female (38.6%) doctors.

Table 4.1: Demographic breakdown of informants

		Frequency	Percent
Facility type	Public	55	43.3%
	Private	58	45.7%
	Missions	14	11.0%
	Valid N	**127**	
Gender	Male	78	61.4%
	Female	49	38.6%
	Valid N	**127**	
Years of service	Under 5 years 6	33	27.0%
	to 10	36	29.5%
	11 to 15 years	32	26.2%
	16 to 20 years	13	10.7%
	More than 20 years	8	6.6%
	Valid N	**122**	

Source: Field study (2015)

Lastly, adequate knowledge and experience of the informants in their profession on the issues being investigated into in the study were key to the researcher. Data on the years of service of the informants in their facilities were thus collected. The results as shown in table 4.1 indicate that 27.0%, 29.5%, 26.2%, and 6.6% respectively have been in their respective health

facilities for less than 5 years, 6 to 10 years, 11 to 15 years, 16 to 20 years, and more than 20 years.

Given that most of the respondents have spent at least 5 years in the profession gave the researcher the hope that they possess good experience in the job and could provide responses that adequately reflect the issues being understudied.

Generally, it can be seen that at least adequate number of responses were collected from each category of the staffing structure of doctors in the country. Notwithstanding this, any potential effects of these demographic factors on the main concepts of the study were examined and controlled prior to estimating the proposed model for the study. The subsequent sections examine their perceptions on service quality in the health facilities, their motivation and commitment level.

4.4 Level of motivation among doctors

The first specific objective of the study was to examine the level of motivation among doctors. Motivation was conceived in the study as a bi-dimensional construct, comprising of intrinsic and extrinsic factors. A five point scale, measuring from 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, to 5=strongly agree was used to measure them. In all, 13 items each were used to assess intrinsic and extrinsic motivation. The summary of the results obtained are presented as follows:

4.4.1 Level of intrinsic motivation among doctors

At the workplace, Amabile (1993) points out that intrinsic motivation is present when individuals seek enjoyment, interest, satisfaction of curiosity, self-expression, or personal challenge in the work.

Table 4.2: Level of intrinsic motivation among doctors

ITEMS	N	Min	Max	Mean	SD
1. I enjoy working on new health cases	127	1	5	3.64	1.029
2. I feel an inner satisfaction when I'm part of an outreach team	128	2	5	3.98	.827
3. I enjoy contributing to healthcare research	121	1	5	3.86	.986
4. I enjoy helping patients recover	127	1	5	3.87	.891
5. The major satisfaction in my life comes from my job	127	1	5	3.87	.951
6. Pursuing my career is important to my self-image	126	1	5	3.84	.958
7. I'm motivated when I get recognized by peers	127	1	5	3.98	.873
8. I am noticed when I do a good job	122	1	5	3.94	.939
9. I feel valued when recognized by senior management	128	1	5	3.84	.986
10. I'm excited when I get full credit for the work I do	126	1	5	3.91	.886
11. I feel a personal obligation to give out my best	127	1	5	3.88	.956
12. I don't need to be told what I already know I have to do	127	1	5	3.98	.864
13. I work hard because I want to be the best	126	1	5	4.06	.874
Overall mean score	**109**	**2.62**	**4.85**	**4.01**	**.569**

Source: Field study (2015)

Among the doctors considered in the study, the results as shown in table 4.2 generally indicate that they have an adequate level of this inner drive necessary to carry out this work, given that the overall mean score (M=4.01; SD=.569; n=109) obtained on the 5 point scale employed was far above the mid-point (i.e. 3.00) of the scale which represents a level of indifference in the respondent's scores.

In order of higher mean scores, an average respondent indicates that he/she works hard because he/she want to be the best, feels an inner satisfaction in working, does not need to be told what he/she know has to be done, and feels motivated when recognised by others.

4.4.2 Level of extrinsic motivation among doctors

Amabile (1993) also indicates that individuals are extrinsically motivated when they engage in the work in order to obtain some goal that is apart from the work itself. The results shown in table 4.3 provide that the doctors considered in the study are also partly motivated extrinsically in their job and thus work to obtain some benefits other than the work itself, given that an overall mean score obtained on the 13 items was 3.94 (SD=.551; n=120) and was above 3.00 and could be approximated to 4.00.

Table 4.3: Level of extrinsic motivation among doctors

ITEMS	N	Min	Max	Mean	SD
1. I feel motivated when my pay /salary increases	128	1	5	3.66	1.053
2. I chose this job because of the respect given to the profession	128	1	5	3.73	.984
3. I'm more likely to give out my best if other work benefits (i.e allowances) are paid on time)	128	1	5	3.82	1.007
4. I believe in equal pay for equal work	128	1	5	3.82	.817
5. Work environment has a great impact on my productivity	126	1	5	3.80	.867

6. I do well when I know the standards of work expected of me.	127	1	5	3.98	.854
7. I will do better if I have a clear understanding of my job responsibilities and what is expected of me.	126	1	5	3.86	.986
8. I do far better if my immediate supervisor gives me feedback on my job	125	1	5	3.94	.836
9. Having a clear career path would motivate me to give out my best	127	1	5	3.85	.926
10. I love working with minimal supervision	128	1	5	3.87	.908
11. Leadership style of my supervisor can affect my output	127	1	5	3.97	.806
12. I believe health workers should be accorded much respect if they need to give out their best	128	1	5	3.93	.941
13. Different reward systems should be developed for different category of health workers if they need to give out their best	128	2	5	4.11	.806
Overall mean score	**120**	**2.46**	**4.85**	**3.94**	**.551**

Source: Field study (2015)

Specifically, among the 13 items, it found that reward systems that reflect work performance is what is seen as more motivating to an average doctor who participated in the study. Further, a comparison between the overall mean scores obtained on each dimension of motivation show that these doctors are more motivated intrinsically, given Intrinsic motivation = (M=4.01; SD=.569; n=109) and Extrinsic motivation =3.94, SD=.551; n=120)

4.5 Level of commitment among doctors

The study also sought to examine the level of commitment among doctors. Relevant literature suggest that commitment is both the willingness to persist in a course of action and reluctance to change plans, often owing to a sense of obligation to stay the course (Vance, 2006). In assessing this among the doctors, 14 items were adapted from literature which basically measure both job commitment and organisational commitment. The assessment was done using a 5 point scale, which measured from 1=strongly disagree to 5=strongly agree. The results of the assessment are shown in table 4.4.

Concerning commitment, the overall mean score (M=3.74; SD=.674; n=123) on the 14 items as shown in table 4.4 reveals that an average respondent in the study is somehow committed to his/her job and the organisation. The scores on the specific items also show that the doctors who participated in the study somehow have little commitment, given that none of the items was scored by an average respondent to be 4.0 or more, and with some scores even closure to the mid-point of the scale representing level of indifference. Comparing these scores to that of motivation, it can be said that the respondent's commitment level is lower than their level of motivation at the workplace.

Table 4.4: Level of commitment among doctors

ITEMS	N	Min	Max	Mean	SD
1. It would be very hard for me to leave my organization right now.	127	1	5	3.42	1.003
2. I see myself as part of this organization.	127	2	5	3.68	.815
3. I feel emotionally attached to this organization.	126	1	5	3.92	.873
4. I feel bonded to this organization.	127	1	5	3.80	.960
5. This is the best organization to work for.	127	1	5	3.87	.858
6. I am not thinking of changing to another organization.	125	1	5	3.78	.932
7. I will like to spend greater part of my working life in this organization.	126	1	5	3.81	.936

8. I am proud to tell others about my work in this organization.	127	1	5	3.83	.924
9. I believe that this organization has my interests at heart.	127	1	5	3.72	.906
10. My organisation generally has employee interest at heart.	127	1	5	3.80	.903
11. My supervisor's visibly demonstrates a commitment to quality.	127	1	5	3.44	.905
12. Top management ensures that tools neede work for are available.	127	1	5	3.60	1.049
13. Top management visibly demonstrates their commitment to employee wellbeing.	127	1	5	3.58	1.123
14. Top management visibly demonstrates their commitment to customer satisfaction.	127	1	5	3.69	1.082
Overall mean score	**123**	**2.21**	**4.71**	**3.74**	**.674**

Source: Field study (2015)

4.6 Nature of service quality in health facilities as perceived by doctors

The study further explored into the doctors' perceptions on the nature of service quality in health facilities. In carrying out this assessment, the researcher relied on Parasuraman et al.'s (1988) conceptualization of service quality and accordingly operationalized it as a 5 dimensional constructs, that is, reliability, assurance, tangibles, empathy, and responsiveness. Respectively, 4, 4, 6, 5, and 4 items were used to measure these subcomponents of service quality. The respondents were asked to use a 5 point scale, measuring from 1=not satisfactory to 5 extremely to indicate what they think patients perceive facility's services to be. The summary of this examination is presented as follows:

Table 4.5: Doctors perceptions on service quality

Dimensions	N	Min	Max	Mean	SD
1. Reliability	127	1.25	5.00	3.91	.776
2. Assurance	125	1.75	5.00	3.80	.859
3. Tangibles	112	1.83	5.00	3.86	.752

4. Empathy	124	1.80	5.00	3.76	.761
5. Responsiveness	123	1.75	5.00	4.10	.777
Intrinsic motivation	109	2.62	4.85	4.01	.569
Extrinsic motivation	120	2.46	4.85	3.94	.551
Commitment	123	2.21	4.71	3.74	.674

Source: Field study (2015)

The reliability dimension of service quality refers to as the employees' ability and willingness to undertake the expected service consistently and precisely (Berry et al., 1991). From the table 4.5, it can be observed that respondents tend to be satisfied with all the statements under reliability; this is shown by mean scores above 3.0 (the midpoint of the scale). This reflected in the overall average of [Mean=3.91; and SD=0.776], implying that the average participant health worker in this study perceive to a large extent that hospitals in Ghana provides reliable services.

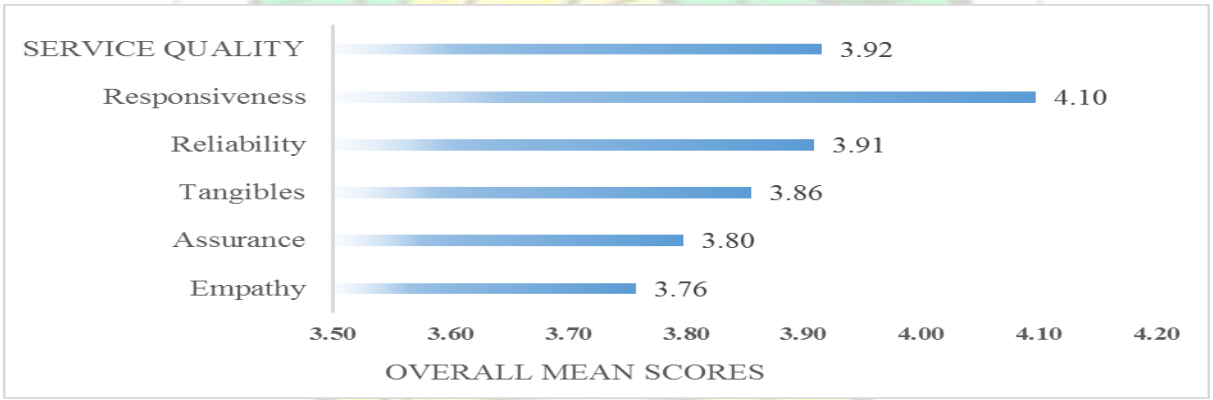
The assurance quality dimension of a service explains the degree of friendliness, credibility, trustworthiness and competence of staff to inspire customers to have confidence in them, the service provided (Parasuraman et al., 1988; and Berry et al., 1991). As shown in table 4.5, an average score of 3.798 (SD=0.859], suggests that, overall, medical staff who participated in the study on average perceive a high assurance quality in the Ghanaian health services.

The tangibles aspect of quality of a service measures the appearance of service facilities, equipment, providers/staff and service ambience, which augments the service provided and hence critical in service quality evaluation of customers (Schneider et al 2004). It can be observed from table 4.5 that the average mean score of 3.855 (SD=0.752) implies a general perception of high tangible quality in Ghanaian hospitals.

The empathy aspect of quality encompasses the caring and special attention accorded to customers by employees (Berry et al 1991), which assist customers to understand the relationships, processes and procedures in service provision. Responses as shown in table 4.5, the overall mean score obtained on empathy was 3.76 (SD= .761), which indicate that averag e doctor contacted for the study perceive a high empathy quality in the Ghana health sector.

Responsive quality is said to stress the significance of flexibility and ability within the organization in the field of customer service delivery for customer needs, and is said to increasingly become a pre-requisite in setting standards of service delivery for competitiveness (Nargundkar et al., 2006). From table 4.5, the overall mean score obtained (Mean=4.098; and SD=0.777) suggests that respondents on the whole perceive a higher responsive quality of health care services in the Ghanaian health service.

In all, overall mean score on the five dimension of service quality generally show that the respondents perceive service quality in health facilities as more satisfactory, given that all the dimensions had score above 3.00.



Note

Scale: 1=not satisfactory 3=satisfactory, 5=extremely satisfactory

Figure 4.1

Figure 4.1: Nature of service quality in health facilities as perceived by doctors Source: Field study (2015)

The results also show that, among the dimensions of service quality, the respondents think patients most perceive that their health facilities are responsive in attending to their (i.e. patients) needs. This is followed by service reliability, and then tangibles. Compared to the other scores, the doctors believe that patients perceive the doctors to be less empathetic, that is, understanding patients, given them individual attention, listing to them, etc.

The next sections of the chapter focus on estimating the proposed theoretical framework and evaluating the hypothesized relationships between the concepts discussed above.

4.7 Measurement model evaluation and results

Before estimating the study's proposed model, various steps were taken to purify the items adapted to measure the respective constructs. The proposed model had three main constructs: motivation, commitment, and service quality. As already discussed above, motivation was operationalized as a two dimensional constructs (i.e. intrinsic and extrinsic motivation), and 13 items were used to measure each sub-construct. In the case of service quality, it was operationalized as a five dimensional constructs: reliability, assurance, tangibles, empathy, and responsiveness; and 4, 4, 6, 5, and 4 items were respectively used to measure each subcomponent. Commitment was however operationalized as a unidimensional construct, with 14 items adapted to measure it.

Two main statistical techniques were used to assess these constructs and their respective measures, in terms of reliability and validity. These techniques were reliability test and exploratory factor analysis. Also, given the statistical technique (i.e. ordinary least square regression analysis) employed to estimate the structural model, it became necessary to perform

multi-collinearity tests to help improve the quality of the study. The results and the discussions are as follows:

4.7.1 Reliability Test

Cronbach alpha values were used to assess the reliability of the scales and the items employ ed in the study. The results of this analysis are shown in table 4.6. The test reveals the least alpha value of .782 on the Reliability construct, which is above the recommended minimum cut-off point of .700 (Bogazzi and Yi, 2012), and thus indicates that the scales and the measures employed to measure the respective constructs have good internal consistency (Field, 2009).

e 4.6: Reliability test results

Construct	Number of items	Alpha
1. Reliability	4	.782
2. Assurance	4	.848
3. Tangibles	6	.834
4. Empathy	5	.809
5. Responsiveness	4	.851
6. Intrinsic motivation	13	.907
7. Extrinsic motivation	13	.891
8. Commitment	14	.932

Source: Field study (2015)

dimensional constructs (i.e. intrinsic and extrinsic motivation), and 13 items were used to measure each sub-construct. In the case of service quality, it was operationalized as a five dimensional constructs: reliability, assurance, tangibles, empathy, and responsiveness; and 4, 4, 6, 5, and 4 items were respectively used to measure each sub-component. Commitment was however operationalized as a unidimensional construct, with 14 items adapted to measure it.

4.7.2 Exploratory factor analysis

Further, exploratory factory analysis (EFA) was used to assess the dimensionality of the measures and their underlying concepts. Given the numerous items employed and the many sub-components of the constructs, it became necessary to perform separate EFAs in order not to unnecessarily delete items. In all, three EFAs were performed, according to their theoretical basis. That is, the items on the five sub-components of service quality were run together, while the items measuring intrinsic and extrinsic motivation were run together, and the items on commitment were run together.

Tabl

The factor analytic technique employed for all the EFAs was Principal Component Analysis (PCA) with Kaiser Normalization and Direct Oblimin for rotation. In each case also, the system was set to suppress loadings below .50. The results are as follows:

4.7.2.1 EFA_ Motivation

Initial EFAs were run for each sub-component of motivation. Components extracted with highest total variance explained and had items which did not cross load on other components were retained. The retained items from each analysis were run together. The system extracted two components, which together explained a variance of 62.482%. 5 out of the 13 items on each constructs were retained after the analysis. These items and their respective communa8lities, variance explained, and KMO and Bartlett's test of Sphericity results are shown in table 4.7.

e 4.7: EFA _ Motivation

Construct/measures *[KMO=.896; X^2(df)= 518.559 (45), p < . 001]*	**Extraction**	**Variance explained**
Intrinsic motivation		
IM4: I enjoy helping patients recover	.692	12.128%
IM6: Pursuing my career is important to my self-image	.520	
IM8: I am noticed when I do a good job	.585	
IM11: I feel a personal obligation to give out my best	.673	
IM12: I don't need to be told what I already know I have to do	.554	
Extrinsic		
EM5: Work environment has a great impact on my productivity	.568	50.354%
EM7: I will do better if I have a clear understanding of my job	.694	
EM8: I do far better if my immediate supervisor gives me feedback on my job	.642	
EM10: I love working with minimal supervision	.695	
EM12: I believe health workers should be accorded much respect if they need to give out their best	.625	

Note:

1. Extraction method: Principal Component Analysis (PCA)
2. Rotation method: Oblimin with Kaiser Normalization
3. Extraction based on Eigenvalues greater than 1
4. Coefficients display suppressed below | 0.500 |
5. Rotation converged in 7 iterations **Source: Field study (2015)**

4.7.2.2 EFA_ Commitment

The EFA on commitment was performed on 14 items. Two components were extracted. The first component explained a variance of 53.096% while the other explained 10.291%. Only items on the first component were retained in the study. Refer to table 4.8 for the retained items and their respective communalities, and KMO and Bartlett's test of Sphericity results.

Tabl

Tabl
e 4.8: EFA _ Commitment

Construct/measures *[KMO=.896; X^2(df)= 518.559 (45), p < . 001]*	**Extraction**	**Variance explained**
COM1: It would be very hard for me to leave my organization right now.	.626	
COM 2: I see myself as part of this organization.	.523	
COM 6: I am not thinking of changing to another organization.	.596	
COM 8: I am proud to tell others about my work in this organization.	.680	
COM 11: My supervisor's visibly demonstrates a commitment to quality.	.598	53.069%
COM 12: Top management ensures that tools needed for work are available.	.705	
COM 13: Top management visibly demonstrates their commitment to employee wellbeing.	.731	
COM 14: Top management visibly demonstrates their commitment to customer satisfaction.	.648	

Note: Extraction method: Principal Component Analysis (PCA)

1. Rotation method: Oblimin with Kaiser Normalization
2. Extraction based on Eigenvalues greater than 1
3. Coefficients display suppressed below | 0.500 |
4. Rotation converged in 5 iterations **Source: Field study (2015)**

4.7.2.3 EFA_ Service quality

For service quality, all the 23 items were subjected to EFA. Given the many subcomponents, the system was set to extract 5 components. The 5 components extracted together explained a variance of 64.584%. All items were retained on their respective components, except for one item on empathy which could not load on its component, and was accordingly eliminated. The retained items and their respective communalities, variance explained, and KMO and Bartlett's test of Sphericity results are shown in table 4.9.

Tabl

e 4.9: EFA _ Service quality

Construct/measures ***[KMO=.857; X (df)= 1276.144 (253), p < .001]***	**Extraction**	**Variance explained**
Reliability		
REL1:The provision of accurate diagnosis of patient's problems	.746	
REL2: Being effective at handling patients' problems	.629	9.545%
REL3: Prescribing efficient and reliable medicines	.516	
REL4: Taking time to advice patients about healthy lifestyles	.615	
Assurance		
ASS1: Being courteous and friendly to patients	.751	
ASS2: Inspiring trust and confidence in patients	.657	
ASS3: Taking time to explain patients' medical condition and treatment	.744	5.080%
ASS4: Creating an atmosphere for patients to feel safe and relaxed	.694	
Tangibles		
TAN1: Looking professional at all times	.489	
TAN2: Availability of modern medical equipment	.616	
TAN3: The use of visually attractive and comfortable physical facility	.775	35.834%
TAN4: The use of appealing materials to engage patients as they wait.	.678	
TAN5: Using directional signs to help patients with easy navigation	.622	
TAN6: Having hospital structures that are disability friendly	.460	
Empathy		
EMP1: Reassuring patients about their medical treatment	.599	
EMP2: Making time to listen to patients	.648	7.928%
EMP3: Responding to patients' questions and worries	.599	
EMP5: Making follow-ups to check on patients (i.e phone calls)	.724	
Responsiveness		
RES1: Keeping to time given for appointment	.734	
RES2: Waiting time to meet doctors	.587	6.197%
RES3: Accessibility of Doctors by phone	.716	

RES4: Accessibility during emergency cases	.774

2

Note:

1. Extraction method: Principal Component Analysis (PCA)
2. Rotation method: Oblimin with Kaiser Normalization
3. Extraction based on fixed factors: set at 5
4. Coefficients display suppressed below | 0.500 |
5. Rotation converged in 17 iterations

Tabl
Source: Field study (2015)

For further analysis, only the retained items after the EFA were used. The items retained under each component were average to obtain a single indicant variables. In the case of the multidimensional constructs, the items on the sub-constructs were first of all averaged, after which composite variables were cre ated for th em. The interaction terms (i.e. intrinsic motivation*commitment; and extrinsic motivation*commitment) was created by following the residual centring approach in order to attenuate for multicollinearity (Tabachnick and Fidell, 2013). This required the creation of a product term, which was predicted by both constructs. The unstandardized residual values (ε) were saved as the 'pure' interaction terms, which was subsequently used to predict service quality.

4.7.3 Correlational analysis and multicollinearity tests

This section of the chapter examines and presents results on the bivariate relationships between the variables used to predict service quality and also their relationships and service. The correlational results were also used to verify the presence of multicollinearity among the variables.

Authors such as Pallant (2007) and Hair et al. (2014) indicate that the quality of ordinary least square regression analysis estimates depends on the quality of data on the variables used, and as such preliminary checks should be made to make sure that certain assumptions are not violated. One of such assumptions assessed in the study is multicollinearity. This assumption was assed using correlational analysis.

Pallant (2007) suggests that correlation coefficients above .70 for relationships between independent variables indicate the presence of multicollinearity. The test results as shown in

table 4.10 reveal coefficients below the cut-off limit of .70 and thus suggesting that the assumption of multicollinearity was not violated in the study.

Table 4.10: Correlational analysis results and descriptive statistics

	1	2	3	4	5	6	7	8	9
1. Gender[d]									
2. Facility type[d]	.048								
3. Years of service	-.110	-.063							
4. Intrinsic motivation	-.037	.403**	.011						
5. Extrinsic motivation	-.006	.329**	.011	.631**					
6. Commitment	-.035	.339**	.004	.505**	.423**				
7. Intrinsic motivation*commitment	.098	.024	.099	.000	.078	.000			
8. Extrinsic motivation*commitment	.017	.026	.015	.006	.000	.000	.402**		
9. Service quality	-.060	.293**	.257**	.432**	.522**	.498**	.128	-.021	-

Note:

1. [d] represents dummy variable; facility type coded as 1= "public facility" and 0= "others", and gender coded as 1= "male" and 0= "female"
2. **. Correlation is significant at the 0.01 level (1-tailed). **Source:**

Field study (2015)

4.7.3.1 Relationship between the main effect variables and the criterion

The results of the correlational analysis also show that there exist statistically significant positive association between the main outcome variable, i.e. service quality and all the main effect variables, i.e. intrinsic motivation (r=.432, p < .01); extrinsic motivation (r= .522, p < .01); commitment (r= .498, p < .01). These bivariate results indicate that service quality improves when employees (i.e. doctors) are more intrinsically motivated, extrinsically motivated, and committed.

4.7.3.2 Relationship between the interaction terms and the criterion

Further, the results point out that, neither the interaction between commitment and intrinsic motivation (r= .128, p > .05) nor commitment and extrinsic motivation (r= -.021, p > .05) is significantly related to service quality. These imply that, the effect of neither intrinsic motivation nor extrinsic motivation on service quality is not statistically contingent upon the level of employee commitment.

4.7.3.3 Relationship between the control variables and the criterion

For the control variables, it is seen that there exist statistically significant positive relationship between service quality and facility type (r= .293, p < .01) and service quality and years of service (r= .257, p < .01). These results mean that doctors who are in public facilities are more likely to improve service quality than those in other facilities (i.e. private and missions). Further, the results indicate that the more time doctors spend on their job, the more likely they are to improve service quality.

Lastly, the results indicate that gender (r= -.060, p > .05) is not a significant determinant of employee's ability to improve service quality, i.e. male doctors do not significantly make efforts to improve service quality more than their female counterparts.

Notwithstanding the above correlational analysis results, the evaluation of the proposed paths were done using regression analysis estimates.

4.8 Structural model estimation, results and hypothesis evaluation

In estimating the proposed model, ordinary least square regression analysis was used. Four hierarchical models were developed. Model 1 was predicted by three control variables (facility type, gender, and years of service). This significantly predicted 15.3% variations in service quality; given $F(89) = 5.348$; $p < .01$.

In Model 2, intrinsic motivation and extrinsic motivation were added. This resulted in a significant change in R^2 by 19.0%; given $F(87) = 12.560$; $p < .01$. Model 3 had commitment added to Model 2. This led to a significant change in R^2 by 4.8%; $F(86) = 6.749$; $p < .01$.

In the last model (Model 4), the interaction terms (intrinsic motivation*commitment and extrinsic motivation*commitment) were added to the analysis. This did not result in a significant change in R^2, giv ^{2} =.18%; $F(84) = 1.243$, $p > .05$. The evaluation of the

en ΔR

hypotheses are presented and discussed as follows based on the standardized coefficient results shown in table 4.11.

Table 4.11: Ordinary least square regression analysis results

VARIABLES	**Service quality [**Standardized coefficients]															
	Model 1				Model 2				Model 3				Model 4			
	B	**t**	**Sig.**	**VIF**	**β**	**T**	**Sig.**	**VIF**	**β**	**t**	**Sig.**	**VIF**	**β**	**t**	**Sig.**	**VIF**
Control paths																
Gender[d]	.004	.036	.971	1.016	.038	-.435	.665	1.037	-.037	-.434	.665	1.037	-.053	-.620	.537	1.053
Facility type[d]	.252	2.579	.012	1.005	.085	.904	.368	1.169	.048	.517	.606	1.198	.044	.482	.631	1.199
Years of service	.291	2.967	.004	1.013	.246	2.796	.006	1.024	.241	2.828	.006	1.025	.221	2.565	.012	1.050
Hypothesized paths																
Main effects																
Intrinsic motivation					.206	1.928	.057	1.506	.115	1.054	.295	1.678	.117	1.075	.285	1.682
Extrinsic motivation					.328	3.125	.002	1.461	.313	3.069	.003	1.466	.322	3.151	.002	1.478
Commitment									.249	2.598	.011	1.298	.253	2.641	.010	1.301
Interaction effect														1.323		
Intrinsic motivation*Commitment													.121		.189	1.178
Extrinsic motivation*Commitment													-.115	-1.274	.206	1.162
FIT INDICES																
R^2	.153				.343				.390				.408			
ΔR^2					.190				.048				.018			
Adjusted R^2	.124				.305				.348				.352			

F statistics	5.348	12.560	6.749	1.243
DF	89	87	86	84
Sig.	.002	.000	.011	.294

Note:

1. [d] represents dummy variable; facility type coded as 1= "public facility" and 0= "others", and gender coded as 1= "male" and 0= "female"

2. Hypothesized paths evaluated at 5% (1-tailed test: t-value =1.645) **Source: Field study (2015)**

In relation to the study's proposed model, three hypotheses were advanced. Their evaluations based on the results in table 4.11 are as follows:

Hypothesis one (H_1) argued that motivation is positively related to the service quality in healthcare services in Ghana. This hypothesis was evaluated from two dimensions: that is, the relationships between service quality and intrinsic motivation and extrinsic motivation.

The study provided results that indicate that intrinsic motivation has a positive association with service quality, however, the relationship was not significant at 5%, given $\beta = .117$; $t = 1.075$. The results also show that there exist statistically significant positive association between extrinsic motivation and service quality, given $\beta = .322$; $t = 3.151$, $p < .01$. Based on these two results, it can be said that H_1 was partially supported. These findings generally indicate that, higher levels of motivation correlates with higher levels of service quality within healthcare, however, extrinsic motivational factors are more likely to cause employees to improve service quality than intrinsic motivational factors.

This finding of the study is in line with theory. For example as explained by the Herzberg's two factor theory, employee performance, in this case, as it would manifest in them giving out their best in improving the service delivery process, is dependent on both the level of motivators and hygiene factors. Intrinsic drives enable the employee to give out his/her best. Similarly, the nature of pay and other benefits, for example, influence employee performance at work, to the extent that, employees who perceive that their financial rewards commensurate their efforts are more likely to improve on his/her performance (Saiyadain, 2009).

Further, in a typical work environment, when there is lack of motivation, workers tend to shirk their duties, absent themselves from work, are impolite, etc. For example, it is noted that, lack of motivation partly explains why health workers in most third world countries like Ghana,

migrate to Western countries. Poor working environment, absence of opportunities for professional development and promotion leave workers dissatisfied, usually pushing them away from their home countries to search for greener pastures elsewhere (Bach, 2003) which affect the performance of organisations, in this case service quality. In this line, Peters et al. (2010) note that motivation is important if health workers are to be retained and effectively deliver health services.

Hypothesis two (H_2) stated that employee commitment is positively related to service quality in healthcare services in Ghana.The study provided results: $\beta = .253$; $t = 2.641$, $p < .01$; that statistically support this hypothesis. The study finds that when employees are more committed at the workplace, they are more likely to enhance service quality, which is line with theory and extant findings in literature.

For example Payne et al. (2003) note that employees who are committed constitute a value asset in organisations and will give the organisation the necessary support needed to achieve corporate goals (Rashid et al., 2003) such as improving service performance (e.g. service quality and customer satisfaction).

Also, authors such as Kim and Mauborgne (1998) report that commitment affect employee behaviour and attitude towards work and performance, to the extent that, low levels of commitment makes organisations less productive resulting in a decline in product and service quality (Johns, 2005).

The third hypothesis (H_3) advanced that the interaction effect of employee's commitment and motivation is positively related to service quality in healthcare services in Ghana. The results obtained in the study did not provide statistically significant support for this hypothesis, given the interaction between intrinsic motivation and commitment yielding these results: $\beta = .121$;

t= .1.323, p > .05; and that of extrinsic motivation and commitment yielding the following r esults: β= -.115; t= -.1.274, p > .05.

Although it was expected that the positive relationship between motivation and service quality would be enhanced when the level of commitment is higher, the results obtained, although positive, it was not significant at 5%.

Sharma et al. (1981) indicate that when moderator variables, in this case, commitment, is significantly related to the criterion (i.e. service quality) and or the predictor (i.e. motivation), but has no significant interaction effect on the criterion, it should be regarded as a predictor or an antecedent. It can be seen from the correlational analysis result shown in table 4.11, commitment per data collected is both statistically significant with both intrinsic motivation (r = .505, p < .01) and extrinsic motivation (r = .423, p < .01) and service quality (r = .498, p < .01). Given this, it can be said commitment does not significant moderate the relationship between motivation and service quality.

4.9 Chapter summary

This chapter focused on presenting the results of the study. The chapter started with presenting an overview of data collected and the demographic profile of the respondents. Descriptive statistical results and discussions on key concepts: motivation, commitment, and service quality in healthcare services were presented afterwards. The subsequent sections focused on how the measures employed in measuring the constructs were examined and purified to improve validity and reliability. The structural model analysis, results and evaluation of the proposed relationships between variables were presented and discussed.

The summary of the findings as well as the conclusion of the study and the recommendations are presented in the next chapter.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION, AND RECOMMENDATIONS

5.1 Introduction

The summary of the study's findings are presented in this chapter. In addition, the chapter presents the conclusion of the study and the relevant recommendations.

5.2 Summary of findings

This study primarily focused on examining the effects of motivation and commitment on service in healthcare delivery in Greater Accra Region (GAR). 127 responses were collected using questionnaires from doctors working in health facilities in GAR. The findings of the study are presented in line with the objectives of the study and the hypotheses formulated.

5.2.1 The level of motivation among doctors in the GAR

The study finds that the level of motivation among doctors within the research context is adequate. However, a comparison between the overall mean scores obtained on each dimension of motivation show that these doctors are more motivated intrinsically, given intrinsic motivation = (M=4.01; SD=.569 and extrinsic motivation (3.94, SD=.551)

5.2.2 Doctors' perceptions of service quality in the healthcare services in the GAR

It was also found that doctors perceive service quality in health facilities as more satisfactory. The results also show that, among the dimensions of service quality, the respondents think patients most perceive that their health facilities are responsive in attending to their needs. This is followed by service reliability, and then tangibles.

5.2.3 The level of commitment among doctors in the GAR

The study finds that doctors who participated in the study somehow have little commitment, given that none of the items was scored by an average respondent to be 4.0 or more, and with some scores even closure to the mid-point of the scale representing level of indifference

5.2.4 The moderation role of doctors' commitment in the link between motivation andservice quality

Also, the study's results indicate that commitment does not significantly moderate the relationship between motivation and service quality. It was however found that commitment is and should be treated as an antecedent to service quality.

5.2.5 Hypothesis results and findings

The findings of the study indicated that extrinsic motivation and commitment among doctors significantly have positive effects on service quality. It was also found that although intrinsic motivation has positive effect on service quality, it was not significant at 5%. The findings generally indicated that doctors who are highly motivated and committed are more likely to work hard to improve the service delivery in health facilities.

The study's findings also indicate that extrinsic motivation ($\beta = .322$) has stronger association with service quality than commitment ($\beta = .253$). In all, it was found that intrinsic motivation, extrinsic motivation and commitment significantly explain 23.7% variation in service quality. The summary of the hypotheses results are shown in table 5.1 below:

Table 5.1: Summary of hypothesis findings Hypothesis		Results	Conclusion
H_{1ab}	Intrinsic motivation is positively related to the service quality in healthcare services in Ghana	β= .117; t= 1.075	Partially supported
	Extrinsic motivation is positively related to the service quality in healthcare services in Ghana	β= .322; t= 3.151	
H_2	Employee commitment is positively related to service quality in healthcare services in Ghana	β= .253; t= 2.641	Supported
H_{3ab}	Interaction effect of employee's commitment and intrinsic motivation is positively related to service quality in healthcare services in Ghana	β= .121; t= .1.323	Not supported
	Interaction effect of employee's commitment and intrinsic motivation is positively related to service quality in healthcare services in Ghana	β= -.115; t= -.1.274	

Source: Field study (2015)

5.3 Conclusion

Over the past decades, improving healthcare delivery has become a global concern. Workforce development in the health sector has partly been a focus of governments and policy makers to achieve improvements in quality healthcare delivery. Within the context of Ghana, many concerns have lately been raised on the level of motivation and commitment among healthcare personnel, particularly, doctors, which literature provides that ineffective management of these issues could negatively affect quality healthcare services. To get empirical evidence on these issues, this study was carried out within the Greater Accra Region (GAR) of Ghana.

The study's findings indicate that doctors who participated in the study have moderate level of commitment in their job and are more motivated intrinsically. They also perceive that

service quality in healthcare within GAR is more satisfactory. The study also finds, that intrinsic motivation and commitment have significant positive effects on service quality, and thus improving motivation and commitment among doctors is key to enhance their performance towards improving quality healthcare delivery within the research context.

5.4 Recommendations

In relation to the findings and the limitations of the study, the research makes two broad recommendations:

5.4.1 Managerial implications and suggestions

The results of the study, first of all, indicate that the level of motivation among doctors who participated in the study are less on the part of extrinsic factors. That is, the study finds that the doctors somehow perceive work benefits such as remuneration, recognition, etc. as less adequate. However, literature suggests that some employees are more likely to work harder when these benefits are adequately present within the organisation. Specifically, it was indicated that, effective reward system is a drive to getting the best out of the doctors. It is accordingly suggested that, the government, management of the facilities, and other stakeholders effectively design remuneration system that would be perceived by the doctors as equitable and commensurate their efforts to enable them to give out their best in the profession.

Relatedly, the study finds that, commitment among these doctors is not that much. Potential reason for this could be attributed to their perceive level of poor remuneration system in the professions. This assertion is supported by the study's results. It was found that there exist significant association between extrinsic motivation and commitment (i.e. $r=.423$; $p < .01$). Hence, it is hoped that improving reward system as discussed above could partly address this issue.

Lastly, the study finds that quality healthcare delivery is significantly dependent on both motivation and commitment, and therefore stakeholders' efforts to engaging in practices that would improve doctors' motivation and commitment would not be wasted.

5.4.2 Areas for further research

First of all, although the study focused on healthcare workers, data collected, analysis performed, and discussions made were done from the perspective of doctors, and not all healthcare workers. This approach was taken to help the researcher delve deep into and provide another angle to understanding the issues being investigated into, due to the critical role that doctors play in improving quality healthcare services.

The researcher acknowledges that the scores provided by the staff on service quality could differ from the perspective of the actual service recipients. To address this limitation, it is suggested that future researchers evaluate service quality from the perspective of patients while the staff provide responses on the other two concepts. However, taking this approach would require many health facilities with few respondents, say 3 to 4 health personnel and less than 10 patients. It is therefore recommended that future studies collect larger data (as suggested earlier, researchers can include responses from other health workers other than doctors) and re-examine this relationship.

APPENDIX –

DATA COLLECTION INSTRUMENT

As part of measures toward improving health care service delivery in Ghana, this study seeks to examine your perceptions about the quality of health care services provided by hospitals in Ghana. This questionnaire requires respondents to answer questions relating to staff motivation and commitment and their effect on service quality levels. Respondents are assured that all information given shall be treated as highly confidential.

Kindly select by ticking [√] the box or column that best describes your opinion; also fill in the spaces provided where applicable.

PART A: DEMOGRAPHICS

---

1. Which of the following hospitals do you work with? [ ]Public, [ ] Private, [ ]Missions
2. Gender [ ] Male, [ ]Female
3. How long have you worked with the hospital?
   [ ] under 5 years [ ] 5-10yrs [ ] 10-15yrs [ ] 15-20yrs [ ] more than 20yrs

PART B: PERCEPTION ABOUT SERVICE QUALITY

This section requires respondent to use a 5point Likert scale in indicating what they think patients' overall perception are about the hospital's services.

i. PERCEPTION: What do you think patients PERCEIVE the hospital's services to be?

PERCEPTION **1= Not satisfactory , 2= Somehow satisfactory, 3=satisfactory, 4= Very satisfactory , 5=Extremely satisfactory**		**PERCEPTION** *To what extent do you think patients are satisfied with these items*				
RELIABILITY		**1**	**2**	**3**	**4**	**5**
	The provision of accurate diagnosis of patient's problems					
	Being effective at handling patients' problems					
	Prescribing efficient and reliable medicines					
	Taking time to advice patients about healthy lifestyles					
ASSURANCE		**1**	**2**	**3**	**4**	**5**
	Being courteous and friendly to patients					
	Inspiring trust and confidence in patients					
	Taking time to explain patients' medical condition and treatment					
	Creating an atmosphere for patients to feel safe and relaxed					

TANGIBLES		**1**	**2**	**3**	**4**	**5**
	Looking professional at all times					
	Availability of modern medical equipment					
	The use of visually attractive and comfortable physical facility (i.e chairs, beds, table).					
	The use of appealing materials (i.e brochures, magazines, newspapers etc) to engage patients as they wait.					
	Using directional signs to help patients with easy navigation					

	Having hospital structures that are disability friendly					
Empathy		**1**	**2**	**3**	**4**	**5**
	Reassuring patients about their medical treatment					
	Making time to listen to patients					
	Responding to patients' questions and worries					
	The hospital should be willing to take feedback from patients					
	Making follow-ups to check on patients (i.e phone calls)					
Responsiveness		**1**	**2**	**3**	**4**	**5**
	Keeping to time given for appointment					
	Waiting time to meet doctors					
	Accessibility of Doctors by phone					
	Accessibility during emergency cases					

PART C: STAFF MOTIVATION AND COMMITMENT

This section requires respondents to use a 5 point Likert scale (***strongly disagree1, 2, 3, 4, 5, strongly agree***) in assessing their level of motivation and commitment ***To what extent do you agree with the following statements?***

INTRINSIC MOTIVATION	**1**	**2**	**3**	**4**	**5**
1. I enjoy working on new health cases					
2. I feel an inner satisfaction when I'm part of an outreach team					
3. I enjoy contributing to healthcare research					
4. I enjoy helping patients recover					
5. The major satisfaction in my life comes from my job					
6. Pursuing my career is important to my self-image					
7. I'm motivated when I get recognized by peers					
8. I am noticed when I do a good job					
9. I feel valued when recognized by senior management					
10. I'm excited when I get full credit for the work I do					
11. I feel a personal obligation to give out my best					
12. I don't need to be told what I already know I have to					
13. I work hard because I want to be the best					

EXTRINSIC MOTIVATION	**1**	**2**	**3**	**4**	**5**

1. I feel motivated when my pay /salary increases					
2. I chose this job because of the respect given to the profession					
3. I'm more likely to give out my best if other work benefits					
4. I believe in equal pay for equal work					
5. Work environment has a great impact on my productivity					
6. I do well when I know the standards of work expected of me.					
7. I will do better if I have a clear understanding of my job responsibilities and what is expected of me.					
8. I do far better if my immediate supervisor gives me feedback on my job					
9. Having a clear career path would motivate me to give out my best					
10. I love working with minimal supervision					
11. Leadership style of my supervisor can affect my output					
12. I believe health workers should be accorded much respect if they need to give out their best					
13. Different reward systems should be developed for different category of health workers if they need to give out their best					

COMMITMENT	**1**	**2**	**3**	**4**	**5**

It would be very hard for me to leave my organization right now.					
I see myself as part of this organization.					
I feel emotionally attached to this organization.					
I feel bonded to this organization.					
This is the best organization to work for.					
I am not thinking of changing to another organization.					
I will like to spend greater part of my working life in this organization.					
I am proud to tell others about my work in this organization.					
I believe that this organization has my interests at heart.					
My organisation generally has employee interest at heart.					
My supervisor's visibly demonstrates a commitment to quality.					
Top management ensures that tools needed for work are available.					
Top management visibly demonstrates their commitment to employee wellbeing.					
Top management visibly demonstrates their commitment to customer satisfaction.					

REFERENCES

Agyepong, I. A., Anafi, P., Asiamah, E., Ansah, K. E., Ashon, D. A. and Narh-Dometey,

C. (2004). "Health Worker (Internal Customer) Satisfaction and Motivation in the Public Sector in Ghana".*International Journal of Health Planning and Management* 19:319-336.

Al-hawary, S., Alghanim, S., & Mohammed, A. M. (2011). Quality level of health care service provided by King

Amabile, T. M. (1993). Motivational synergy: toward new conceptualizations of intrinsic and extrinsic motivation in the workplace. *Human Resource Management Review*, 3 (3), 185- 201.

Andersen, L. B. and Kjeldsen, A. M. (2010). "How Public Service Motivation affects Job Satisfaction: A Question of Employment Sector or Public Service Job". *Paper Presented at the 32nd EGPA Conference in Toulouse*, 8-10 September, 2010.

Ansar, J., Cantor, P. & Sparks, R. W. (1997).Efficiency wages and the regulated firm.*Journal of Regulatory Economics*, 11, 55-66.

Arshavin, P. (1992) "The concept of quality health care", 2nd edition, Churchill Livingstone Page 103,116-118

Bagozzi, P. R. and Yi, Y. (2012).Specification, evaluation, and interpretation of structural equation models.*Academy of Marketing Science*, vol. 40, pp. 8–34

Becker, T. E., Billings, R. S., Eveleth, D. M. & Gilbert, N. L. (1996). Foci and Bases of Employee Commitment: Implications for Job Performance. *The Academy of Management Journal*, 39 (2), 464-482.

Brass, D. J. (1981).Relationships, Job Characteristics, and Worker Satisfaction and Performance.*Administrative Science Quarterly*, 26 (3), 331-348.

Cohen, A. and Lowenbcrg, G. (1990) ARc-cxamination of the Side-bet Theory Applied to organizational Commitment: A Mcta-analysis. Human Relations No. 43. pp. 1015-1050.

Cooper, D. J. (1993) Health Care Management - Philosophical and Managerial Implications. Strategic Issues in Health Care Management: Setting Priorities in Health Care, Second International Conference, University of St Andrews.

Czepiel, J.A., Solomon, M.R., Surprenant, C.F., 1985. The Service Encounter, Managing Employee/Customer Interaction in Service Businesses.Lexington Books, Lexington, MA.

Dagger, T. S., Jillian, C. S. & Lester, W. J. (2007). A hierarchical model of health service quality: scale development and investigation of an integrated model. *Journal of Service Research, 10* (2), 123-142.

Davies, B., Baron, S., Gear, T. & Read, M. (1999). Measuring and managing service quality. *Marketing Intelligence & Planning, 17* (1), 33-40.

Field, A. (2009). *Discovering statistics using SPSS*.(3rd edition). SAGE Publications Inc. Thousand Oaks, California.

Furnham, A., Forde, L. & Ferrari, K. (1998). Personality and work motivation. *Personality and individual differences*, 26.1035-1043.

Galloway, L. (1998). Quality perceptions of internal and external customers: a case study in educational administration. *The TQM Magazine*, 10 (1), 20-26.

Ghana Health Service [GHS] (2010). *Ghana Health Service Annual Report for 2010.*Accra: Ghana Health Service

Griffin, R. W., Welsh, A. & Moorhead, G. (1981). Perceived Task Characteristics and Employee Performance: A Literature Review. *Academy of Management Review*, 6 (4), 655-664.

Hair Jr. F. J., Black, C. W., Babin, J. B. and Anderson, E. R. (2014).*Multivariate Data Analysis*.(7th Edition).Pearson Education Ltd. Edinburgh Gata, Harlow.

Herzberg, F., Mausner, B., & Snyderman, B. B. (1959).*The motivation to work*. New York: John Wiley & Sons.

Herzberg, F. (1966).*Work and the Nature of Man*. Cleveland, OH: World.

Higgins, J. M. (1994). *The management challenge* (2nd ed.). New York: Macmillan.

Kovach, K. A. (1987). What motivates employees? Workers and supervisors give different answers. *Business Horizons*, 30.58-65.

Kraimer, M. L., Wayne, S. J., Liden, R. C. &Sparrowe, R. T. (2005).The role of job security in understanding the relationship between employees' perceptions of temporary workers and employees' performance.*Journal ofApplied Psychology*, 90 (2), 389-398.

Leete, L. (2000). Wage equity and employee motivation in nonprofit and for-profit organisations. *Journal of Economic Behaviour & Organisation*, 43, 423-446.

Lindner, J. R. (1998). Understanding employee motivation.*Journal of Extension*, 36 (3).

Maslow, A. H. (1943). A theory of human motivation.*Psychological Review*, 50, 370-396.

McKinley R.K., Stevenson K., Adams S., Manku-Scott T. K. (2002) Meeting patient expectations of care: the major determinant of satisfaction with out-of hour's primary medical care.*Family Practice,* vol. 19 (4), p. 333 – 338

Michal K. Brady & J. Joseph Cronin, 2000.*Effects on Customer Service Perceptions and Outcomes Behaviours.*Journal of Service Research.

Mitchell, T. R. (1982). Motivation: New directions for theory, research and practice. *Academy of Management Review*, 7 (1), 80-88.

Orpen, C. O. (1979). The effects of job enrichment on employee satisfaction, motivation, involvement, and performance: a field experiment. *Human Relations*, 32 (3), 189-217.

Otley, D. (1999). Performance management: a framework for management control systems research. *Management Accounting Research*, 10, 363-382.

Pallant, J. (2007). *SPSS Survival Manual, A Step by Step Guide to Data Analysis using SPSS for Windows* (3rd edn). McGraw-Hill House, Berkshire England, p.204

Parasuraman, A., Zeithaml, V.A., Berry, L.L. (1985). "A Conceptual Model of Service Quality and its Implications forFuture Research'.J*ournal of Marketing*.49, p.41-50.

Perry, J. L. & Porter, L. W. (1982).Factors affecting the context for motivation in public organisations.*Academy of Management Review*, 7 (1), 89-98.

Ryan, R. M. &Deci, E. L. (2000).Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being.*American Psychologist*, 55, 68–78.

Rynes, S. L., Gerhart, B. & Minette, K. A. (2004). The importance of pay in employee motivation: discrepancies between what people say and what they do. *Human Resource Management*, 43 (4), 381-394.

Shaw C.D.(2002) Health care quality is a global issue. *Clinical Governance Bulletin*, vol. 3 (2), p. 2-5

Singh, R. (2010). Patients' perception towards government hospitals in Haryana, *VSRD Technical and Non-Technical Journal, 1* (4), 198- 206.

Smith, G. P. (1994). *Motivation*. In W. Tracey (ed.), Human resources management and development handbook (2nd ed.).

Sofaer, S., &Firminger, K. (2005).Patient perceptions of the quality of health services, *Annual Review of Public Health*, 26, 513-559.

Sower,V., Duffy, J., Kilbourne, W., Kohers, G., & Jones, P. (2001). The dimensions of service quality for hospitals: development and use of the KQCAH scale, *Health Care Management Review, 26* (2), 47–59.

Staw, B. M. (1976). *Intrinsic and Extrinsic Motivation*. Morristown, NJ: General Learning Press.

Story, P. A., Hart, J. W, Stasson, M. F. & Mahoney J. M. (2008).Using a two-factor theory of achievement motivation to examine performance-based outcomes and self-regulatory processes.*Personality and Individualdifferences*, 46, 391-395.

Suki, N. M., Lian, J. C., &Suki, N. M. (2009) . A comparison of human elements and nonhuman elements in private health care settings: customers' perceptions and expectations. *Journal of Hospital Marketing Public Relations*, *19* (2), 113-128.

Tabachnick, G. B., and Fidell, S. L. (2013).*Using multivariate statistics.*(6th Edition). Pearson Education Inc. New Jersey.

The Ghana health service expert guidelines towards an excellence in health care, 2005 edition, Pages 12,15,20,21-22

The World Health Report.(2000) Health systems: improving performance. *World Health Organization*.

Todd, Z., Nerlich, B., McKeown, S., & Clarke, D. D. (2004).*Mixing methods in psychology: The integration of qualitative and quantitative methods in theory and practice.*East Sussex, UK: Psychology Press.

Tucker, J. L. & Adams, S. R. (2001). Incorporating patients' assessment of satisfaction and quality: an integrative model of patients' evaluations of their care, *Managing Service Quality*, 11 (4), 272-286.

Turkson, P. K. (2009). Perceived quality of healthcare delivery in a rural district of Ghana, *Ghana Medical Journal*, 43 (3), 65-70.

Vroom, V.H. (1964).*Work and motivation.*New York: Wiley.

Vroom, V.H. &Deci, E.L. (1970).An overview of work motivation.*Management and motivation*, 9-19.

Wong, J. C. H. (2002). Service quality measurement in a medical imaging department.*International Journal of Health Care Quality Assurance*, *15* (5) 206-212.

World Health Organization [WHO] (2000).*World health report 2000: health systems: improving performance*, New York: Oxford University Press.