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PATIENTS' PREFERENCE OF PUBLIC AND PRIVATE HOSPITALS: EVIDENCE FROM KUMASI AND BIBIANI IN THE ASHANTI & WESTERN REGIONS OF GHANA

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DECLARATION

I hereby declare that this submission is my own work towards the Master of Business Administration (Strategic Management Option) 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.

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DEDICATION

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ABSTRACT

Ghana's health sector has seen some transformation resulting from government and development partners" interventions. By and large, the public health care delivery is generally seen as giving more impartial and evidence-based consideration. However, both public and private hospitals have clients patronizing them. The question therefore is, "at what point is a patient likely to opt for private or public healthcare. The study sought to assess clients" preference for private and public hospitals. The research design adopted for this study was descriptive design. The population comprised the inhabitants of Kumasi Metropolis (Ashanti Region) and Sefwi-Bibiani (Western Region), who are 18 years and above. Purposive and convenience sampling techniques were used to select 600 inhabitants from the selected regions (300 from each region). Data was collected from primary source by administering questionnaires to the inhabitants. After the study, it was concluded that, the choice of public hospital over private hospital was positively influenced by service quality, word-of-mouth, and the type of ailment (sickness). Satisfaction on the other hand, decreased the odds (likelihood) of public hospital being selected over private hospital. Private hospitals performed better on medical services, nursing services, support services, administrative services, patient safety, and hospital infrastructure. However, public hospitals performed better on the dimension of patient communication than private ones. The study also found that respondents who patronized private hospitals were slightly more satisfied with service than that of public hospital. The study recommends an improvement in waiting time within public hospitals in Ghana. This may be through the creation of additional consulting units and the use of appointments for those who prefer special services. Private hospitals are also encouraged to furnish patients and guardians with appropriate counseling to help them make informed decisions before and during service usage.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

For the past years an interesting and polarized open deliberation in global wellbeing (health) concerns the suitable role and equalization of people in public and private sector in giving social health services to the populace in both low and middle income nations (Berendes et al., 2011), like Ghana. As of late, debate between the advocates of private and public frameworks have turned out to be especially heated, as the worldwide economic subsidence that started in 2007 has put significant limitations on government spending plans particularly subsidizing for health care infrastructure in most developing nations (Stuckler et al., 2011). As part of measures towards addressing this gap, the IMF has proposed that nations enhance the scope of private sector provision in health services being a section of their conditions on loans granting. (Stucker & Basu, 2009)

Censuring such endeavors, the global not-for-profit organization, Oxfam, in its report; “Blind

Optimism,” concealed that “to achieve universal and equitable access to health care, the public sector must be made to work as the majority provider” (Oxfam, 2009). The World Bank continues to work at “more pragmatic approaches that build on what is available” by drawing in with the private sectors in countries where public sector services perform ineffectively (World Bank, 2009); the Center for Global Development likewise contended that the Oxfam report "disregarded the informal sector," and that needy individuals "need to go" to private providers and will "endure in doing as such" (Harding, 2009).

By and large, this level headed discussion has been isolated between those looking for all inclusive state-based health services accessibility and those upholding for the private division to give care in zones where the general population part has regularly fizzled. Private area advocates have indicated proof that the "private sector is the main provider," the same number of needy patients want to look for consideration at private centers (Berendes et al, 2011). The authors concealed that the private health facilities can be more efficient and better respond to patient needs due to intense rivalry in market as this will definitely outweigh public inefficiencies. Rosenthal and Newbrander (1996), interestingly contrasted that the public sector health promoters have highlighted disparities in

access to health services due to the failure of the poor to pay the cost of services rendered at the for private sector. They authors noticed that private markets frequently neglect to convey public health products including preventive services ("market failure"), and did not have the capabilities to coordinate health care activities to control disease outbreaks.

Essentially, expected to educate this civil argument is an orderly survey of existing proof.

Hanson et al. (2009: p.23) indicated that, “a strengthened evidence based on the performance of the public and private health sectors is essential to guide decision-makers towards policy choices that are appropriate for their contexts”. In line with the above, this study sought to examine patients‟ preference for public and private hospitals in Ghana using communities from the Western and Ashanti Regions.

1.2 Problem Statement

Human health care can be given through public and private providers. Public health service is normally given by the government of a country. Private health services can be given through "revenue driven" health centers and independently employed medical professionals, and "not for profit" non-government providers, including religious associations. There is then again, an amazing ideological argument around whether low-and middle income countries should sustain public versus private health services, however, most low-and middle income countries in reality use both categories of health delivery system, as in Ghana.

The provision of health care at the private sector is as a less than dependable rule battled to be more viable, capable, and conservative than the services delivered in the public sector. By and large, the public health care delivery is generally seen as giving more impartial and evidencebased consideration. However, both public and private hospitals have clients patronizing them.

The question therefore is, “at what point is a patient likely to opt for private or public healthcare?” This study therefore attempts to answer the above question by investigating patients‟ preference of public or private hospitals in Ghana.

1.3 Objectives of the Study

The fundamental point of this study was to assess clients‟ preference for private and public hospitals. Below are the specific objectives to be addressed.

i. To assess clients‟ perception of the health care quality of both public and private hospitals.

ii. To assess clients‟ level of satisfaction with service delivery at public and private hospitals.

iii. To examine factors that influence patients‟ choice of public or private hospitals in Ghana

1.4 Research Questions

The following research questions were formulated:

i. How do patients‟ perceive the quality of service of public and private hospitals? ii. What is the level of patients‟ satisfaction with service delivery at public and private hospitals?

iii. What accounts for clients‟ choice of one category (either public or private) of hospital over the other?

1.5 Significance of the Study

The study is first and foremost beneficial to the decision makers in the area of health. The study would unearth what either party is doing that is lacking in the other health facilities, thereby making them the preferred choice for certain categories of patients. The study also provides an accurate feedback to management of hospitals in the country. When all these are done, it is the client who

benefits. The study when implemented would lead to a higher service delivery in the area of health. And it is the clients of these hospitals who get to benefit the most from the development. In terms of contribution to academia, the researcher is optimistic that findings would further promote academic discourse as it adds to empirical work available. There is no doubt the economy stands to gain from increased productivity and quality health care culminating into a healthy nation.

1.6 Scope of the Study

The study looks at patients‟ preference for public or private hospitals in Ghana. In terms of geographical scope, the study covers communities within Bibiani and Kumasi Metropolis. Health facilities located within these two areas were considered for the study. Again, emphasis was on private and public hospitals. In terms of theoretical scope, the work covers customer satisfaction levels and service quality dimensions.

1.7 Overview of Methodology

This research involves a survey of a group of respondents selected from the Ashanti and Western regions of Ghana. The purpose of the study was to compare the populace viewpoints of the clients who patronize public hospitals and those who patronize private hospitals. The research design adopted was exploratory and descriptive. The population comprised inhabitants who often form part of the decision making unit within households. The study adopted both purposive sampling and convenience sampling techniques. A total of 800 respondents were sampled. The data was collected using a structured questionnaire. This was administered with the help of trained field assistants. Analysis of results were obtained and interpreted. Following the reliability tests, Cronbach Alpha (Internal Reliability) coefficient of the scale was calculated. The analyses involved frequencies, mean, standard deviation, and correlation, analysis of variance and factor analysis.

1.8 Limitation of the Study

As characteristic of other studies, this work was not without some challenges. First, data collection was a daunting task since the study had to do with patients, some of whom were on admission. For out-patients, the researcher had to devise innovative ways of getting them to participate in the research. Another constraint had to do with the geographical scope of the study which more likely limits the generalization of findings. Time and financial constraints equally hindered the effective completion of the work.

In spite of these limitations, the researcher ensured that a tall list of ailments and health services were provided to help respondents decide between private and public hospitals. Again, the researcher took time to explain the essence to the research as many thought government had plans of giving out some financial support to patients.

In addressing problem of language barrier, field research assistants were included to help explain questions in local dialects. The researcher therefore is optimistic that the study reflects the broader picture of patients in the country since patients in the Ashanti and Western Regions of

Ghana are not different from those located in the North, Greater Accra, Central, Eastern, BrongAhafo and Volta regions of the country.

1.9 Organization of the Study

The study was in five (5) chapters. Chapter one comprises the background to the study, the problem statement, the objectives, the research questions, justification, the scope, brief methodology and the organization of the study. The chapter two reviews existing literatures on the subject matter. It also comprises both conceptual and regulatory frameworks to the study.

Chapter three focuses on the research methodology, research design, source of data, unit of analysis, population and sampling frame, sample size, sampling technique, data collection

instrument, pilot study and data analysis. The fourth chapter comprises compilation, analysis of data and discussions. The fifth chapter presents the summary and concise highlight of the findings and conclusion of the study. Appropriate recommendations were also made.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section looks at previous works on clients‟ choice of hospitals. Reviews in other jurisdictions were harnessed to provide rich discourse on the subject matter. The literature map includes background of the health sector, public and private health care from other developed economies and perception of patients about the services of health providers in Ghana.

2.2 Overview of the Health Sector in Ghana

Since Ghana picked up its freedom from the colonial masters, numerous approaches have rose through the presentation of essential activities to underpin development, formerly, business activities that have antagonistic effect to the general public including the individuals in relation their health concerns are regarded as a ultimate key. According to the Ministry of Health report (2012), communities establish vital relationship with government playing a significant role in delivering health facilities at the urban areas, local levels and sub-neighborhood levels. Opening of private clinics has been on the ascendency to help strengthening health care delivery. From that point forward, a lot of assistance has been given by the Government and Non-Governmental Institutions. However, private health facilities don't corporate well with state health facilities. The Health Ministry plays a major role in the policy formulation whereas the Ghana Health Services as its agency responsible for executing these policies.

In addition, there is the need to deal with the different ailments combat overcrowding as a result of the geological location of sub-health facilities. The nation lacks health professionals thus

Doctor to Patient ratio is drastically low as indicated by health report in 2006.

2.3 Public and Private Healthcare Provision: Global Picture

The health service in the public sector now employs more than 1 million people and has a financial plan of over £98 billion (www.hm-treasury.gov.uk). It is a monster stone monument with shapeless capacities obscuring into public and private health services, and a vast provider of both public and private health delivery. The public service provider in the UK (NHS) is charged of the errand of

reducing social disparity and making basic health service accessible to each citizen “from the cradle to the grave” a complete health service free at the stage of delivery. Progressive administrations of different ideological orientation by the government have stayed focused on the public health sector establishing “principles of collectivism, comprehensiveness, equality and universality” (Bradshaw & Bradshaw, 2004).

Regardless of the complexities in overseeing such a change, the institutional models have been utilized to explain the NHS administration frameworks are; patient-focused market model, specialist-focused professional model, and government-controlled bureaucratic model (Alsop,

1995). Alford (1975) depicted the changed administration ethos as inserted in:

- professional monopolizers of doctors controlling arrangement and service provision;
- corporate rationalizers of government officials;
- administrators concerned for the most part with service proficiency and viability; and
- community enthusiasm of health lobbyists whose concerns are with affecting strategy through the force of influence and protest.

The general health amendments, portrayed as an "insurgency" by Hansen (2008), are supported by a major rule that the patient (client) is the purpose behind health service delivery.

Consequently, basic reorganization of the service to make it more responsive and responsible to the needs of individuals has prompted decentralizing the Primary Care Trusts (PCTs) and the formation of Foundation Trusts. Incomprehensibly, the changes have not given patients more prominent decision on the grounds that, as individual consumers, they don't take an interest in the activities of the quasi-market that happens between health authorities, general professionals

(GP), trust holding buyers, and health care providers (Bradshaw & Bradshaw, 2004). Government liberalization strategy in the 1980s prompted a quick extension of private health delivery by steadily auctioning off parts of the services fit for contending in an open market. US private hospitals multiplied and took the biggest share of the health sector. According to Allsop (1995), the health care reforms took a different dimension by engaging private venture capitalist and the

state to form a Public-Private Partnership (PPP) which helped to finance, build and run hospitals in the mid 1990‟s. The PPP initiative enhanced the client decision through the opposition of pluralism of providers (Allsop, 1995). In a far-reaching way, it is assumed that the mere sight of private health providers in the market sector would affect a more patientresponsive and highly efficient health delivery. This is likely in view of customary way of thinking which holds that private health providers are preferable set over their public health partners to convey client – focused bundle of worth due to their built up market-detecting capacities in connection to the nature of relationship in the middle of patients and doctors

2.4 Perceptions on Performance of Public versus Private

Differences and similarities between state-owned and private institutions form a vital topic in public administration and organizational theory. The three criteria most regularly utilized for characterizing public and private institutions are ownership, source of funding, and level of social control (private institutions are controlled by market forces, while public institutions are governed political control) (Perry and Rainey, 1988). Researchers have used these criteria as a premise for study by comparing at public and private institutions on a range of Perceptions of Public and Private Performance organizational features, for example, objective clarity, financial motivations, self-rule, red tape, and administrative qualities (Rainey, 2009; Rainey et al., 1976). Furthermore, to study the link between sector and performance, researchers have compared the effectiveness of state-owned and private institution in similar industry. Performance is one of the concepts that have attracted most scholarly attention in public management research in recent years (Moynihan, 2008). Performance is a multi-dimensional concept (Boyne, 2003). As

Andrews et al., (2011, pp.307) noted, “comprehensive analyses of the effects of public and private health service would need to cover different dimensions of performance, not least because a gain on one dimension (e.g., efficiency) may be obtained by sacrificing another (e.g., equity).” Thus in this paper the researcher distinguish between four dimensions of perceived performance, viz. perceived effectiveness, perceived benevolence, perceived cost-containment and perceived red tape.

Perceived effectiveness refers to the achievement of the formal objectives of services of the organization (Boyne, 2003). It is also referred to as the extent to which citizens perceive an organization to be capable and effective accomplishing its core mission. Property right theory emphasizes ownership as the main reason why private organizations (as opposed to public organizations) have an inherent incentive to improve the quality and productivity of services (Alchian & Demsetz, 1972; Clarkson, 1972). In addition, public organizations‟ funding depends on political decisions, whereas private organizations funding depends on how the organization is performing in the market. As a result, public organizations often do not experience a direct link between performance and funding. According to public choice theory, this means that private organizations—as opposed to public organizations—have an incentive to accommodate the interests of consumers and the quality of service (Boyne, 1998; Chubb & Moe, 1988, 1068). Perceived red tape refers to the degree to which people perceive an organization to have a high level of burdensome administrative rules and procedures that has a negative effect on performance (Bozeman, 1993). It also refers to citizens‟ perception of Perceptions of Public and Private Performance the extent of burdensome procedures. Red tape is typically associated with public organizations (Rainey & Bozeman, 2000). In addition, the media framing of bureaucracy often emphasizes high levels of red tape.

Perceived cost-competence refers to the extent to which citizens perceive an organization to be capable containing its costs (Hvidman & Andersen, 2013). The cost of a service is another important performance dimension. Organizations should—all else being equal—seek to

minimize the cost of its production. This is closely related to technical efficiency, which refer to the cost per unit of output. In private organizations, it is the private owner who bears the marginal profit or loss. Ultimately private organizations may go bankrupt if they are not sufficiently efficient. In public organizations, there is not the same automatic link between inefficiency and „going out of businesses. Rather than efficiency, public organizations' survival depends on their status and legitimacy among citizens and politicians. As a consequence, we would expect citizens to perceive private organizations to be more efficient.

Perceived benevolence is the degree to which people think that organizations genuinely care about citizens‟ interests (Hvidman & Andersen, 2013). Apart from objective performance criteria such as effectiveness and efficiency, scholars have emphasized more ethical dimensions of performance focusing particularly on the intentions of the organization‟s action (Grimmelikhuijsen & Meijer 2012). This is related to the Public Service Motivation literature that emphasizes how bureaucrats may be driven by motives such as doing good for others or society (Perry & Wise 1990; Andersen et al., 2011).

2.4.1 Performance of Hospitals

The spread of private management processes and techniques in the public health facilities has been advanced by the new public management (NPM) thought that drawing lessons from private segment administration will increase public sector effectiveness and efficiency. Performance control in public sector institutions is one kind of management practice that is inspired by private sector management. Performance control is a cyclical management technique amid which goals are detailed, execution data is created, and this data is used to change the goals (Andersen, 2008; Moynihan, 2008). If public organizations introduce formal management systems, citizens might get a more positive view of government and of the bureaucracy. As such, if public organizations aggressively adopt performance management systems it might mitigate the impact of sector on citizens‟ perceptions of organizational effectiveness and efficiency. In contrast, extensive use of performance measurement systems might be perceived as burdensome administrative procedures leading to a higher level of red tape.

2.5 Measuring Service Quality of Hospitals

In the last two decades, research on service quality has been substantively broadened. The service quality model picked up a considerable measure of consideration after the questionable discoveries of Parasuraman et al. (PZB) in 1985. The model took a gander at service quality as a correlation separation between the client perception and expectation of the service and the real performance of the service received by the client as given by the organization at certain time duration (Parasuraman et al., 1985). Furthermore, the authors explained that service quality takes into

account five dimensions (tangible, dependability, responsiveness, assurance, and compassion). The SERVQUAL model has given a comprehensive conceptualization of service quality with an instrument to gauge service quality, and give a greater number of diagnostics and down to earth implications than were beforehand suspected to be possible (Parasuraman et al., 1991, 1994; Angur et al., 1999).

Until today, many researchers have created services quality ideas across businesses and nations

(Aagja & Garg, 2010; Arasli et al., 2005, 2008; Angur et al., 1999; Bhat & Malik, 2007;

Dabholkar et al., 1996; Jabnoun & Chacker, 2003; Karatape et al., 2005; Lim & Tang, 2000; Newman, 2001). In a developing nation, Duggirala et al. (2008) found that health service quality consists of seven divisions (staff quality, infrastructure, managerial procedure, medical care procedure, security, general experience on clinical care, and social obligation). Meanwhile, Aagja and Garg (2010) came up with five dimensions in public health service quality as: admission, clinical care, general service, discharge procedure, and social obligation. In a deloped nation, Otani and Kurz (2004) revealed that admission process, physician and nursing care, empathy to family and companions, loveliness of surroundings, and discharge procedure were primarily used to gauge health service quality in the USA. Generally, health care quality recognition takes into account client‟s judgment of the services given by the health facility, for instance, between the patients and nurses, doctors and staff relationships (Martinez, 1999). Arasli et al. (2008) proposed six service quality dimensions in the public and private health facilities, namely: sympathy; offering priority to the inpatient needs; relationship in the middle of staff and patients; professional methodology; diet and the natural environment.

Moreover, Brady and Cronin (2001) characterized interpersonal relationship quality, natural environment quality, and result quality as key basis to gauge service quality in the health service division. The authors further clarified that those three dimensions play a key role in service quality recognition by the client. In this connection, interpersonal communication between clients and services has the highest effect on service quality perception. Trumble et al. (2006) clarified that

patients have the capacity to assess the doctors and nurses aptitudes when they are managing the clients. The patients' capacity to comprehend and their view of the health facility delivery outcome greatly impact the general clients assessment of service quality (Cronin &

Taylor, 1994; Lytle & Mokwa, 1992; Marley et al., 2004; Trumble et al., 2006; Zineldin, 2006).These outcomes affirm that the patient and doctors relationship is incredibly affected by the collaboration conduct of service providers (doctors) and boost the trust patients have in their doctors (Gaur et al., 2011). Correspondingly, Gill and White (2009) highlighted that agreeability with clinical care and management is essentially identified with the apparent quality and wellbeing result (Sandoval et al., 2006). Although service quality level fundamentally impacts on the selection of hospital, it is extremely difficult for a patient to comprehend the level of service quality given because of a health facility being a complex area with many attributes which includes numerous dimensions in the evaluation of service quality (Arasli et al., 2008; Hariharan et al., 2004; Hoel & Saether, 2003). Eleuch (2011) highlighted that patients do not have the information and ability to legitimately judge therapeutic administration quality for the specialized parts of service, for example, specialist's skills or professional's diagnostics.

Patients are more sufficiently qualified to gauge functional quality measurements, for example, lab cleanliness, than specialized quality angles (Bakar et al., 2008). In this sense, patients' assessment of the nature of clinic services alludes to the communication in the middle of patients and doctors, and this cooperation will add to the confident of the patients in the nature of the health facility given by a health facility (Suki et al., 2011). Besides, in receiving service quality adequately in the clinic business, administration is obliged to plainly comprehend the way of administration quality and how to actualize and change it in the setting of health facility culture. In spite of the fact that the SERVQUAL measurements have been accepted in a western setting, it is likely that the cultural differences of clients will impact its pertinence. Karatape et al. (2005) proposed that service quality measures created in one culture may catch service quality sentiments in another culture. In spite of the fact that, there is variation between public health centers, private health facilities, and international health facilities, they are in any case contending in the same business sector as far as offering reciprocal items and services for patients. (Taner & Antony, 2006).

2.6 Relationship between Service Quality and Customer Satisfaction in Healthcare

The services of health provider can be separated into two quality dimensions: technical quality and functional quality (Donabedian, 1980). Technical quality in the medical field is characterized fundamentally on the premise of the specialized accuracy of the clinical diagnosis and methodology, or the conformance to expert standards. Functional quality alludes to the way in which the health care is conveniently delivered to the patients. Andaleeb (1998) expressed: "Hospitals that fail to understand the importance of delivering customer satisfaction may be inviting possible extinction". The Consumer Marketing Research has underscored the significance of patient (consumer) in health facilities as consumer is included underway and utilization of services at the same time. Additionally, clients and organizations co-create value to individual clients, as there is a paradigm shift from item and services to experience situations.

Hence, comprehensive clients' understanding of medical services has become paramount. Reidenbach and Smallwood (1990) led variable survey and operationalised service quality as far as patient certainty, business capabilities, treatment quality, supplementary services, physical appearance, holding up time and sympathy. A number of researchers also designed their own particular structures and instruments to conceptualize service quality in hospital administrations. Vandamme and Leunis (1993) added to a scale to gauge service quality which is rendered by health facilities from patients' perspective. They discovered tangibles, clinical responsiveness, and assurance, nursing staff quality and individual norms and values to be the key factors in health service quality.

Lam (1997) applied SERVQUAL in health service. It was found that patients treated physical structures to be the minimum consideration in selecting a health facility. Nursing care, result and physician care constituted technical consideration whilst, diet, noise, room temperature, security, cleanliness and parking space were considered as interpersonal consideration by the client. As indicated by Hasin et al. (2001) in Thailand, correspondence, responsiveness, courtesy, service costs and neatness of the environment were the key factors considered in health service quality. They found that despite the fact overall services are quiet encouraging by the health facilities, the attitude and conduct of workers about the non-core services had to be improved. Baldwin and Sohal (2003) in assessing the relationship between service quality practices and service quality outcome

in dental care revealed that patient‟s anxiety, client‟s recognition of easily service and service, inclusion of patients in treatment were found to positively impact the understanding's perception of dental care. Boshoff and Gray (2004) mulled over the relationship between medical service quality and patients' purchasing expectations. They operationalized health service quality utilizing the measurements, correspondence, tangibles, and compassion of nursing staff, assurance, and responsiveness of regulatory staff, security and doctor responsiveness.

The SERQUAL literature in the setting of hospital centers has highly centered on patients and management's point of view so far. A percentage of the studies examined the gaps between the service delivery' recognitions and patients' perception. Health services, being high in credence qualities, subjective judgment won't win in the client‟s assessment of service conveyance. Duggirala et al (2008) revealed that patients are usually not in the right frame of mind to interact with the service providers and usually need the help of orderlies who are in a better mental and physiological state to judge the service quality

Service quality and client satisfaction have been seen as two sides of the same coin. While customer service may be related to values and prizes, service quality broadly does not depend on prizes(Anderson et al 1994). As service quality judgments are quiet specific to the service rendered, service satisfaction can be determined by a wider set factors including those outside the immediate service delivery experience (e.g. the mood of the service provider).

There are two fundamental models which are utilized to gauge the satisfaction of clients, to be specific, transaction specific model and cumulative satisfaction model. In transaction specific model, consumer satisfaction has been discovered as a component of mental builds, for example, state of mind, expectation and disconfirmation (Boulding et al., 1993; Oliver, 1993), whereas, in cumulative satisfaction model, the advantages derived from product or service attributes shape the essential forerunners to satisfaction (Gustaffson and Johnson, 2004). Actually, research work on service quality to a great extent has largely gained recognition in view of the idea that high service quality results in clients' satisfaction and their behavioral aims including positive or negative word of mouth to others, return to the provider, ability to pay higher prices for value, expectation to change to different providers, complaining about flawed services, and so on. Despite the fact that

there are different predecessors to customer satisfaction specifically; price, circumstances, identity of the purchaser (Natalisa and Subroto, 1998), service quality gets unique consideration from the service advertisers on the grounds that it is with the control of the service provider, and by enhancing service quality, its consequence on customer satisfaction could be enhanced, which might thus impact the purchaser's expectation to buy the service.

Generally, in all the sectors including the health service; service quality has been set up as an antecedent of customer satisfaction. Pakdil and Harwood (2005) concentrated on patient satisfaction in a pre-operative evaluation center. The authors demonstrated that patients were most disappointed with the holding up time and positive doctor-patient collaboration enhanced patient satisfaction more than any other factor considered. Rao et al. (2006) presumed that medication accessibility, medical data, staff conduct and doctor conduct had positive impact on patient satisfaction while holding up time had negative effect on patient fulfillment. Baalbaki et al. (2008) found that nursing was the most powerful factor in both emergency room and inpatient experiences regarding patient satisfaction in Lebanon health facilities. Duggirala et al.

(2008), in their study on Indian health facilities, uncovered that all the seven divisions of health care service quality to be specific, physical infrastructure, work force quality, clinical care procedures, managerial procedures, safety markers, general experience of clinical care and social obligation were al found to be indicators of patient satisfaction. Ramsaran-Fowdar (2008), in a study on private health providers, found that "reliability, and fair and equitable treatment" was the most essential service quality measurement impacting patient satisfaction in Mauritius health service providers. They had utilized changed SERVQUAL scale for this reason. Williams et al. (1998) established that the patient satisfaction did not improve after redesign of the emergency division of a health facility under study. They further speculated that satisfaction scores may enhance if the objectives of redesign, efficiency, and confidentiality were met.

2.7 Consumer Decision Making Process

This section looks at consumer decision making process. There are two main approaches to understand customer decision making (5 stage model and 3 stage model). The five-stage model for consumer decision involves the following steps: Need recognition, Information search, Evaluation of alternatives, Purchase and Post purchase decision/outcomes. According to the three stage model of service consumption, consumers go through three major stages when they consume services: the

pre-purchase stage, the service encounter stage and the post encounter stage (Lovelock and Wirtz, 2011).

2.7.1 The Pre-Purchase Stage

The pre-purchase stage of the decision-making process for services is more complex in comparison with that for goods as it involves a composite set of factors and activities (Fisk

1981). Because consumers participate in the service production process, the decision-making process takes more time and is more complicated than in the case of goods. Consumer expertise, knowledge (Byrne, 2005) and perceived risk (Diacon and Ennew, 2001) play important roles in this pre-purchase phase. In the pre-purchase stage, a need arousal triggers consumers to start searching for information and evaluate alternatives before they make a purchase decision. There are various sources that could trigger needs: the unconscious mind (e.g., impulse buying), internal conditions (e.g., hunger) or external sources (e.g., marketing mix) to name a few. According to the notion of planned purchase behaviour, once consumers recognize a need or problem they are motivated to search for solutions to satisfy that need or resolve that problem.

The information obtained in the pre-purchase stage has a significant impact on consumer‟s purchase decision (Alba and Hutchinson, 2000).

2.7.2 Information Search

Consumer information search in services is more extensive than in goods (Alba and Hutchinson 2000; Mattila and Wirtz, 2002) due to the uncertainty and perceived risk associated with a purchase decision. Both uncertainty and perceived risk are considered to be higher in services due to their intangible nature and variability (Murray and Schlacter 1990; Bansal and Voyer, 2000) and because of the high degree of price uncertainty due to service firms‟ revenue management strategies (Kimes and Wirtz, 2003; Wirtz and Kimes 2007). Because of the above, service consumers typically do not limit themselves to a single source of information, but employ multiple sources of information depending on their orientation (multichannel orientation), their tendency to innovate and the perceived pleasure of the shopping experience. They search for information from multiple sources to explore and evaluate alternative service offering, develop performance expectations of offers in the consideration set, save money, and to reduce risk (Konus, 2008). In addition, service

consumers acquire information not only from multiple sources but from different types of sources. Thus, they seek information from trusted and respected personal sources such as family, friends and peers; they use the Internet to compare service offerings and search for independent reviews and ratings; they rely on firms with a good reputation; they look for guarantees and warranties; they visit service facilities or try aspects of the service before purchasing; they examine tangible cues and other physical evidence and ask knowledgeable employees about competing services (Boshoff 2002; Lovelock and Wirtz 2011; Zeithaml and Bitner, 2003).

2.7.3 Evaluation of Alternative Service Offers

During the search process, consumers form their consideration set, learn about the service attributes they should consider and form expectations of how firms in the consideration set perform on those attributes (Lovelock and Wirtz, 2011). Multi-attribute models have been widely used to simulate consumer decision making. According to these models, consumers use service attributes (e.g., quality, price and convenience) that are important to them to evaluate and compare alternative offerings of firms in their consideration set. Each attribute is weighted according to its importance. After consumers have evaluated the possible alternatives, they are ready to make a decision and move on to the service encounter stage. This next step may take place immediately, or may involve an advance reservation or membership subscription.

2.7.4 The Service Encounter Stage

The service encounter stage involves consumer interactions with the service firm. In this stage, consumers co-create experiences and value, and co-produce a service while evaluating the service experience. Nowadays, customers are empowered and engaged in the service delivery process. Consumer engagement has recently attracted research attention in the branding and services literature (Brodie et al. 2011). Consumer engagement has been considered the emotional tie that binds the consumer to the service provider (Goldsmith 2011) and can be used as a proxy for the strength of a firm‟s consumer relationships based on both emotional and rational bonds consumers have developed with a brand (McEwen 2004). Bowden (2009) supports that engagement is a construct particularly applicable to services because they usually involve a certain degree of

interactivity such as that seen between consumers and frontline personnel, and therefore imply a reciprocal relationship. Engagement might include feelings of confidence, integrity, pride and passion in a firm/brand (McEwen, 2004). In addition to these affective elements, consumer engagement with service brands has been considered a behavioural manifestation toward a brand or firm that goes beyond a purchase and includes positive word of mouth, recommendations, helping other consumers, blogging, writing reviews and even engaging in legal action (van Doorn et al. 2010).

2.8 Causes of Poor Quality Healthcare Delivery

2.8.1 Poor Customer Service

Inadequate provision of care in hospitals leads to lack of funds, interest, respect, belief etc. In Ghana, health service leading unproductively main aim is to enhance the best care services given to Ghanaians. It envisaged clients receive good customer care by health facilities given much focus so far as patient‟s expectation is concerned. In the healthcare facility, for every 100 clients that experienced poor services, about 70 patients would be unlikely to patronize the same health facility again. Moreover, for the same 100 patients who have experienced deficient services, about 75 of them will tell average 9 relatives members and colleagues about their experiences. 75 dissatisfied patients will finally be about 465 people who might have been potential patients will probably not patronize the health facility (Comm, 2001).

2.8.2 Inadequate Health Professionals

According to a study conducted in 2006 by an organization responsible for health issues, propounded that African accounts for 24% of the world sickness. Meanwhile, only 3% of the whole health employees are available to take care of them. This is partly due to the movement of health professionals from developing countries to developed areas. This showed worldwide worry which is called “brain drain”. An organization concerned with health outlined Tuberculosis, Fever and Human Immune Virus as being the main concern to be addressed. The result arising from these sicknesses is amazing. Statistically, 350,000 persons live having human immune virus and Acquired Immune Deficiency Syndrome living here in the country (WHO 2006). Diseases that

affect the lungs also recorded 79,000 whilst 3.5million was recorded for yearly (WHO 2006). With a population size of 25million citizen, such challenges affect the countries. According to a study conducted by Turkson (2009) the researcher‟s focus on a community sectors above their understanding on prevention and treatment of diseases in Ghana. The research found out that inadequate health professionals, lack of ambulance at the hospital and payment policy were some of the factors that affect poor quality health care in Ghana.

2.8.3 Inadequate Resources/Materials

Inadequate Resource like human resources, equipment, consumable supplies and some essential medicine undermines facility functioning, damages reputation, increased out-of-pocket costs to patients and brings a spiral of mistrust and alienation. Ghanaians seem to have the tendency to move from rural to urban cities. According to the study health professionals move to seek for better remuneration and, arrangement is even made before they are awarded the certificate.

2.8.4 Untrained Staff

There is not enough staff training available in Ghana in order to take care of the available diseases hence the need for continuous in-service training to build up the capacities of health personnel‟s. This can go a long way to bridge up the gap in the various hospitals

2.8.5 Inadequate Funds

Ghana is one of the few African countries that started the National Health Insurance (NHI) law (Act 650). This was possible due to the small population size. Inadequate fund is a major challenge faced by most health facilities. This is as a result of the implementation of National health Insurance Scheme. About 98% patients are insured living about 2% non-insured (Annual Report of Bechem Government Hospital, 2012) The delay in the reimbursement of the NHIS consequently affect quality of healthcare delivery due to lack of enough fund to purchase medical equipment and supplies. Some of the challenges faced by the NHIS in Ghana include the institutional framework as provided for in the NHIS Act. The application of the framework has led to governance, operational administrative and financial challenges (Government of Ghana, 2009).

2.8.6 Refusal of Postings

Padarah et al (2003) are of the view that movement factors by employees of hospital facilities are as a result of priorities given to material items. Vujick et al., (2004) in the research study indicated that health care professionals are ready to migrate from developing country to developed nation as a result of differential salaries between the two countries. The researchers caution adequate treatment will be given to clients of the developed nation due to higher salary.

2.9 Customer Satisfaction

The increasing importance of quality in both service and manufacturing industries has also created a proliferation of research, with more than 15,000 academic and trade articles having been published on the topic of customer satisfaction in the past two decades (Peterson and Wilson, 1992). Several conferences have been devoted to the subject and extensive literature reviews have been published (Barsky, 1992; Oh and Parks, 1997). The result of all this research has been the development of nine distinct theories of customer satisfaction.

Customer satisfaction is a psychological concept that involves the feeling of well-being and pleasure that results from obtaining what one hopes for and expects from an appealing product and/or service (WTO, 1985). While there are a variety of approaches to the explanation of customer satisfaction/dissatisfaction, the most widely used is the one proposed by Richard Oliver who has developed the expectancy disconfirmation theory (Oliver, 1980). According to this theory, which has been tested and confirmed in several studies (Oliver and De Sarbo, 1988; Tse and Wilton, 1988), customers purchase goods and services with pre-purchase expectations about anticipated performance. Once the product or service has been purchased and used, outcomes are compared against expectations. When outcome matches expectations, confirmation occurs. Disconfirmation occurs when there are differences between expectations and outcomes. Negative disconfirmation occurs when product/service performance is less than expected. Positive disconfirmation occurs when product/service performance is better than expected. Satisfaction is caused by confirmation

or positive disconfirmation of consumer expectations, and dissatisfaction is caused by negative disconfirmation of consumer expectations.

Customer satisfaction can also be defined as satisfaction based on an outcome or a process.

Vavra‟s (1997, p. 4) outcome definition of customer satisfaction characterizes satisfaction as the end-state resulting from the experience of consumption. This end state may be a cognitive state of reward, an emotional response to an experience or a comparison of rewards and costs to the anticipated consequences. Vavra also puts forth a definition of customer satisfaction based as a process, emphasizing the perceptual, evaluative and psychological processes contributing to customer satisfaction (1997, p. 4). In this definition, assessment of satisfaction is made during the service delivery process.

A minority of researchers perceive the satisfaction process to be subjective in expectations but objective in the perceptions of the product attributes, or outcome. Thus, Klaus (1985, p. 21) defines satisfaction as “the customer's subjective evaluation of a consumption experience, based on some relationship between the customer's perceptions and objective attributes of the product”. Others point out that both what is perceived (outcome) and what is expected are subjective and therefore psychological phenomena -not reality (Maister, 1985). The importance of the subjective nature of the process cannot be overstated. Since both expectations and perceptions are psychological phenomena, they are both susceptible to external influences and manipulation.

Satisfaction is not a universal phenomenon and not everyone gets the same satisfaction out of the same service experience. The reason is that customers have different needs, objectives and past experiences that influence their expectations. This necessitates the segmentation of the market, because no service or product can offer everyone the same degree of satisfaction (WTO, 1985).

2.10 Conceptual Framework

From the literature reviewed, it was realized that the preference for either public or private is as a result of service quality and customer satisfaction. The service quality could either be functional or technical. The researcher added a two more dimension, i.e. is recommendation (Word-ofMouth)

and type of ailment or sickness. This researcher believes also influence the choice of private or public hospitals.

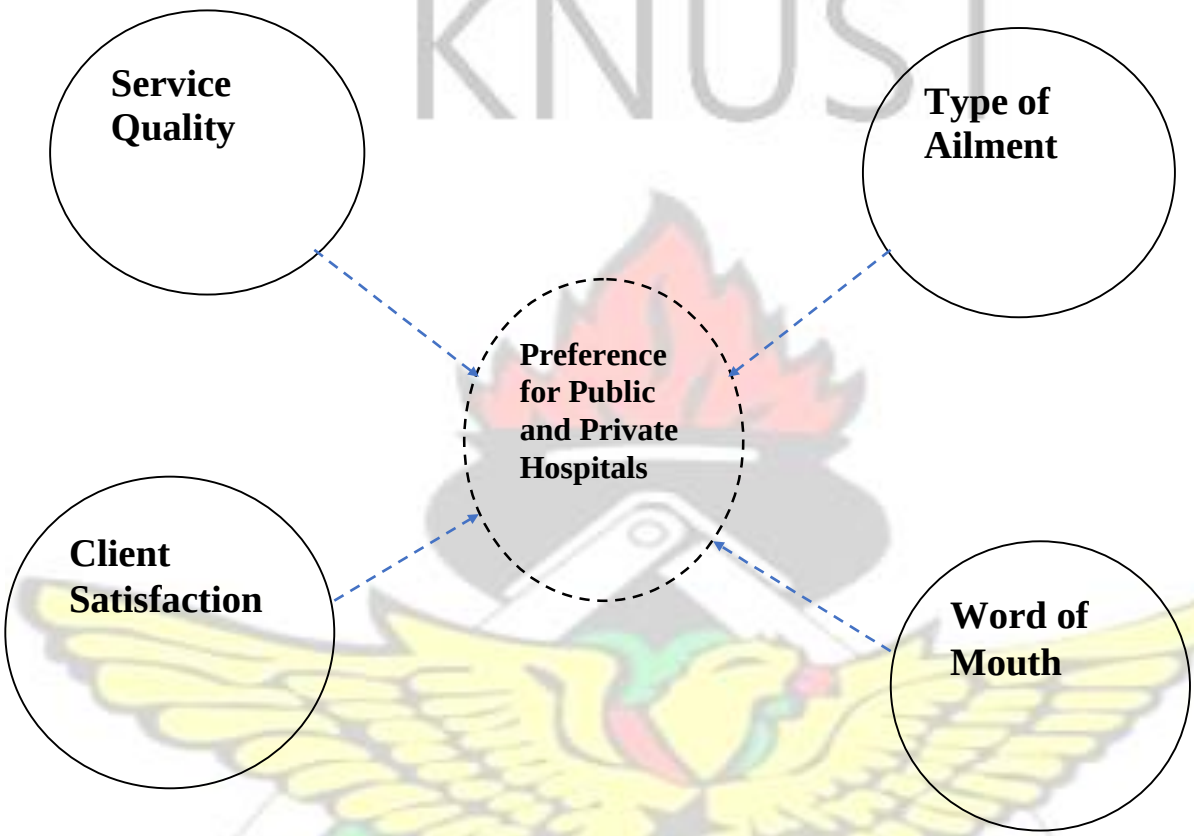

Figure 2.1 Conceptual framework

Source: Researcher's Construction, 2015.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter addresses issues about research methodology. It covers areas such as research design used, sample size and population, sampling techniques, data analyses and unit of analysis, sources of data and ethical considerations.

3.2 Research Design

According to Saunders et al. (2009), research design has three common methods, namely, the exploratory, descriptive and the explanatory. The research design adopted for this study was exploratory and descriptive design. An exploratory study is a valuable means of finding out

„what is happening; to seek new insights; to ask questions and to assess phenomena in a new light" (Robson, 2002, p.59). It is particularly useful if you wish to clarify your understanding of a problem, such as if you are unsure of the precise nature of the problem (Saunders et al., 2009). The study was also descriptive in nature because it sought to portray an accurate profile of respondents (university students) (Robson, 2002). Descriptive design may be an extension of, or a forerunner to, a piece of exploratory research or a piece of explanatory research. It is necessary to have a clear picture of the phenomena on which you wish to collect data

3.3 Sources of Data

The data were basically drawn from primary source by administering questionnaires to the people in Kumasi (Ashanti Region) and Bibiani in the Western Region of Ghana. The nature of the research required that data be gathered from a primary source. In Jankuwics (2002), primary data is defined as consisting of materials that you have gathered yourself through systematic observation, information from archives, the results of questionnaires and interviews and case study which you have compiled. Primary data has not been published yet and is more reliable, authentic and objective. Primary data has not been changed or altered by human beings and therefore its validity is greater than secondary data.

3.4 Unit of Analysis

The units of analyses for this research were respondents drawn from Kumasi and Bibiani who patronize the services of hospitals. The research generally reflects the clients" preference for private or public hospitals; however for the purposes of data collection, it was limited to the above communities.

3.5 Population and Sample Frame

The population of any research is made up of the individual units or an aggregate, that is the unit or the individuals that form the population whereas a sample is a section of the population selected randomly or otherwise to represent the population **(**Punch, 2000**).**The sampling frame on the other hand, is the list of all the elements in the population. The adequacy of sampling frame is vital in shaping the quality of sample drawn from it. The population for the research comprised of population above 18 years with access to hospital services. The Adult population for the two communities (Bibiani and Kumasi Metropolis) was estimated at 2.1 million.

3.6 Sampling Size

A sample consists of one or more elements selected from the population. In all, Six Hundred (600) respondents were selected from these two communities. Below is a breakdown of how the sample size was derived. Below is a breakdown of how the sample size was derived.

To arrive at the sample size, the following formula was used;

$$SS = \frac{Z^2 * (P) * (1-P)}{C_2}$$

Z = Z – value

P = Percentage of population picking a choice, expressed as decimal

C = Confidence interval, expressed as decimal

Z – Values (cumulative normal probability Table) represent the probability that a sample will fall within a certain distribution.

The Z – values for confidence levels are:

1.645 = 90% confidence level

1.96 = 95% confidence level

2.576 = 99% confidence level

Source: Godden (2004)

In line with the current study, the following values were used:

Z = 1.96 for 95 percent confidence level

P = 0.5

C = 0.05 (5 percent margin of error)

Note: these estimates are for the infinite population. After which the sample size derived from the calculation would be used to calculate a new sample size for the finite population.

Calculation for the infinite population

$$SS = \frac{Z^2 * (P) * (1-P)}{C^2}$$

$$SS = \frac{1.96^2 * 0.5 * (1 - 0.5)}{0.05^2}$$

$$SS = \frac{3.8416 * 0.5 * 0.5}{0.0025}$$

SS = 384

We now calculate for new sample size using the finite population.

Finite population = 21,000,000

$$\text{New SS} = \frac{SS}{\{1+(\frac{SS-1}{Pop.})\}}$$

$$\frac{384}{\{1+(\frac{384-1}{21,000,000})\}}$$

$$\frac{384}{1.00002}$$

New sample size = 384

The implication is that the researcher is not allowed to use a sample less than 384. As shown above, the sample size used was 600 (**Source: Godden, 2004)**

The distribution for the two areas (Kumasi and Bibiani) as follows:

Table 3.1: Sample size

Community / Area	**Population**	**Sample**
Kumasi Metropolis	1,300,000	350
Bibiani District	800,000	250
Total	**2,100,000**	**600**

Source: Researcher‟s Construction, 2015.

3.7 Sampling Technique

Sampling is very important as far as collecting data from primary sources are concerned. The study adopted purposive and convenience sampling technique. According to Saunders et al. (2009), convenience sampling (haphazard sampling) involves selecting haphazardly those cases that are easiest to obtain for your sample. However, each of them was also selected for two purposes, namely, 1) they were 18 years and over, and 2) they access hospital facility either in the public or private.

3.8 Data Collection Instrument

The study made use of primary data gathered with questionnaire as a research instrument. Questionnaire was appropriate for the study because Saunders et al. (2009) indicated that both experiment and case study research strategies can make use of this research instrument. It was also used because data collected using questions can be stable, constant and has uniform measure without variation. It also reduces bias caused by the researcher‟s presentation of issues. The questionnaire used was structured.

3.9 Pilot Testing

A pilot study was conducted in the Kumasi metropolis to pre-test the questionnaire. This helped in determining whether questions were properly framed, correctly ordered, and complete. Besides, it

allowed closure of some open-ended questions and identified pre-coded responses that were not useful. It also allowed testing of the reliability of the questions. The pilot study also offered the researcher opportunity for further practice. The researcher was able to identify probable challenges and prepared for them. Twenty (20) clients were used for the pre-test.

3.10 Data Analysis

The data gathered for the study was quantitative in nature. According to Bernard (1998), data analysis consists of systematically looking for patterns in recorded observations and formulating ideas that account for those patterns. The quantitative data was analyzed with the Statistical Package for Social Science (SPSS) 17.0. The types of analyses conducted include T-test, regression, mean, standard deviation, and simple frequencies.

CHAPTER FOUR

DATA ANALYSIS, FINDINGS AND DISCUSSIONS

4.1 Introduction

This study sought to assess patients‟ preference for Public and Private Hospitals in the Kumasi metropolis and Sefwi-Bibiani district in Ashanti and Western region respectively. Data was gathered from 600 people in the selected areas. The respondents were selected from households, and not hospitals. Percentages, one sample t-test, mean, and binomial logistic regression was utilized as a part of the examination. This examination was finished with the guide of SPSS (v.17).

4.2 Demographics

Table 4.1 ***Demographics***

Demographics	**Reponses**	**Percentages (%)**
Gender	Male	40.0
	Female	60.0
Age	18-30 years	53.0
	31-40 years	28.0
	50-60 years	15.5
	60 years & Above	3.5
Occupation	Public servant	23.5
	Private servant	7.5
	Self-employed	33.0
	Student	27.5
	Retired	2.5
	Unemployed	6.0
Education	No formal education	17.0
	Basic school	24.0
	Secondary	17.5
	Tertiary	41.5
Type of Hospital	Public	58.5
	Private	41.5
Frequency of visit	Once every month	30.0

	Once every three months	26.0
	Once every 6 months	28.0
	Once a year	12.0
	Not regular	4.0

Source: Field work, 2015.

Demographic variables in study are important because they could affect the choice of responses. Because they represent an independent variable the influences respondents choice. The distribution on gender indicates that, 40% of the respondents were males whiles 60% were female. Clearly, the females dominated the study. The age distribution also indicates that, 53% of the respondents were aged 18-30 years, 28% were aged 31-40 years, 15.5% were aged 50-60 years, and 3.5% aged above 60 years. The youth therefore dominated the study. Among the respondents, the self-employed represented 33%, students were 27.5%, public servants were

23.5%, private servants were 7.5%, the unemployed being 6%, and the retired being 2.5%. The hospitals attended were grouped into public or private. From table 4.1, 58.5% of the respondents mostly attended public hospitals, and the remaining 41.5% also mostly attended private hospitals. This is not an indication that respondents only attended one of the categories, but the one mostly attended was selected. The distribution indicates that 30% of the respondents attended the hospital once every month, 26% attended once in every three months, 28% attended once every 6 months, 12% attended once a year, and 4% did not visit the hospital on a regular basis, perhaps once in every three years.

4.3 Clients' Perception of the Service Quality of Public and Private Hospitals

In ascertaining the perceived service quality of public and private hospitals, the data was divided into, and analysis conducted separately. Analysis was done using one sample t-test, after which the results were compared. For a solitary specimen test, the theory was situated as: Ho: U = or > Uo and Ha: U < Uo. With Ho speaking to the invalid speculation, Ha speaking to the option theory and Uo speaking to the estimated mean. The Uo is the discriminating rating beneath which the variable is viewed as vital. The Likert scale was, 1=Strongly concur, 2=Agree, 3=Neutral, 4=Disagree, and 5=Strongly oppose this idea. Under this segment, the lower evaluations of 1 and

2 were decided for the rating scale as unequivocally concur and concur separately while the Uo was situated at 2.5, with 95% as the significance level in accordance with the antecedent. Three things must occur at the same time for an item to be accepted as measuring a particular dimension. 1) It must have a mean score of less than 2.5; 2) it must have a t-value of equal or greater +-1.65; and 3) it must be statistically significant at 0.05 (p-value = or

< 0.05). The absence of any would mean the rejection of that variable.

Table 4.2 ***Perceived service quality***

Health Service Quality	***Test Value = 2.5***					
	Public			**Private**		
	Mean	***T***	***Sig. (2-tailed)***	**Mean**	***T***	***Sig. (2tailed)***
Medical Service (MS)						
MS1	2.1368	-3.286	.001	1.5783	-7.595	.000
MS2	1.7949	-9.884	.000	1.4940	-14.503	.000
MS3	1.9487	-6.781	.000	1.8193	-6.347	.000
MS4	2.1282	-3.904	.000	2.0241	-3.744	.000
Nursing Services (NS)						
NS1	2.1282	-4.308	.000	2.0482	-3.808	.000
NS2	1.8632	-7.352	.000	1.8675	-6.546	.000
NS3	2.2051	-3.289	.001	2.1325	-3.169	.002
NS4	2.1453	-3.861	.000	1.9639	-5.111	.000
Supportive Servic es (SS)						
SS1	2.9316	4.563	.000	2.2289	-2.003	.048
SS2	2.9060	4.248	.000	2.0723	-4.497	.000
SS3	4.1111	13.422	.000	3.1807	4.675	.000
SS4	2.2308	-2.954	.004	1.8072	-4.115	.000
Administrative Se rvices (AS)						
AS1	2.1624	-3.562	.001	2.0241	-4.694	.000
AS2	2.1880	-4.348	.000	1.9277	-6.575	.000
AS3	2.4701	-.350	.727	1.9398	-5.932	.000
AS4	2.2308	-2.722	.007	1.7590	-9.094	.000

Patient Safety (PS)						
PS1	1.6410	-13.263	.000	1.5663	-8.932	.000
PS2	2.1624	-3.718	.000	1.6506	-8.099	.000
PS3	1.6068	-10.410	.000	1.6506	-7.518	.000
Patient Communic ation (PC)						
PC1	2.0769	-5.500	.000	2.2771	-2.188	.032
PC2	2.0000	-7.219	.000	2.0843	-4.566	.000
PC3	2.3932	-1.156	.250	2.6024	.382	.703
Hospital Infrastru cture (HI)						
HI1	2.0598	-5.113	.000	1.6386	-11.659	.000
HI2	2.5214	.236	.814	1.8675	-7.568	.000
HI3	1.5641	-13.986	.000	1.4578	-13.493	.000

*See appendix for full meaning of variables

Source: Field work, 2015.

There were four items measuring the dimension of medical service quality. The respondents who attended public hospital agreed that doctor were prompt in attending to their needs (MS1), doctors listen carefully to their problems (MS2), they were satisfied with the time spent by doctors with them during consultation (MS3), and adequate information was provided by doctors about treatment procedures and outcomes (MS4). The t-scores for all the four items were above 1.65 (accepted), and were all statistically significant (p-value <.05). The respondents of the private hospitals also agreed to all items, however, the mean scores were all below that of the public hospitals. This indicates that, on the dimension of „medical service" private hospitals performed better. On the dimension of nursing service quality, four items were used in the measurement. The output indicates that, public hospital attendants agreed that nurses were prompt in attending to their needs (NS1), nurses administered prescribed medication on time (NS2), nurses were courteous (NS3), and nurses were helpful and empathetic (NS4). The t-scores were all above 1.65 (accepted), and also statistically significant at 0.05 (p-value < 0.05). The private hospital attendants also agreed on all the four dimensions. And with the exception of NS2, the mean score of private hospital attendants were smaller than the public hospitals. This means that, on the dimension of „nursing service", private hospitals were ranked higher.

For supportive services, public hospital attendants agreed to only one out of the four items of measurement. Respondents agreed housekeeping staff maintains cleanliness in the ward/room

(SS4). They disagreed on that the public hospitals provided good food (nutritious, hygiene and timelines) (SS3), and were indifferent with the fact that public hospitals provided diagnostics services with less waiting time (SS1), and the availability of required medicines at the pharmacy

(SS2). All these items were statistically significant with t-values greater than 1.65

On the contrary, respondents from the private hospitals agreed that the hospital provides diagnostics services with less waiting time; required medicines were available in the pharmacy; and housekeeping staff maintains cleanliness in the ward/room. Just like public hospitals, private hospitals also did not provide good food (nutritious, hygiene and timelines). These were also statistically significant at 0.05.

For administrative services, both public and private hospitals attendants agreed hospital admission processes were simple (AS1), proper facilities were provided in the hospital (AS2), hospital administration responded immediately to solving problems (AS3), and the discharge process was completed without delay (AS4). Once again, the respondents from the private hospitals ranked the „administrative service" higher than those from the public hospitals. With the exception of AS3 under the public hospital, all the other items were statistically significant at

0.05. Three observed items measured patient safety. These items were all statistically significant (p-values < 0.05) for both public and private medical centers. Customers from the two gatherings concurred that sufficiency of hygienic consideration and methods (e.g. hand wash, wearing gloves) were trailed by the doctor's facility staff (PS1), the clinics gave fitting measures (e.g. bed with side handrails in paths, slopes intended for wheelchairs) to reduce the risk of patient harm resulting from falls (PS2), and patients have never suffered from hospital infection after 24 hours of admission (PS3). With the exception of PS3, patients from the private hospitals ranked

„patient safety" dimensions higher than public hospitals.

Under patient communication, three observed items were used in measurement. Respondents from the public hospital agreed that adequate information was provided by the staff (PC1), there was a clarity in staff communication (PC2), and the during admission patients and family members were given proper counseling to make informed decisions (PC3). However, PC3 was not statistically significant at 0.05. Private hospital respondents also agreed on PC1 and PC2. There were

indifferent with PC3, and it was even not statistically significant at 0.05. Contrary to previous service quality dimensions, public hospital respondents ranked „patient communication" higher than respondents from the private hospitals.

The last dimension on service quality was hospital infrastructure. Three observed items were used in measurement. The respondents from the public hospital agreed the physical facilities of hospital are visually appealing (HI1), and the hospital staff are well dressed and appear neat (HI3). They were however indifferent with the fact that the public hospitals have necessary upto-date equipment (HI2) and this item was also not statistically significant at 0.05. The respondents from the private hospitals also agreed the physical facilities of hospital are visually appealing; the hospital have necessary up-to-date equipment; the hospital staffs are well dressed and appear neat. These items were all statistically significant at 0.05.

4.4 Clients' Level of Satisfaction with Service Delivery at Public and Private Hospitals

Table 4.3 ***Clients' level of satisfaction***

Satisfaction	**Responses**	**Public (%)**	**Private (%)**
Receiving anticipated service	Yes, definitely	29.1	36.1
	Yes, generally	63.2	55.4
	No, not really	7.7	8.4
Service meeting needs	Almost all of my needs have been met	38.5	33.7
	Most of my needs have been met	53.0	54.2
	Only a few of my needs have been met	8.5	10.8
	None of my needs have been met	-	1.2
Service effectively dealing with problems	Yes, they helped a great deal	34.2	33.7
	Yes, they helped	62.4	62.7
	No, they didn't help	3.4	3.6
Satisfaction with help	Very satisfied	23.1	33.7
	Mostly satisfied	70.1	61.4
	Indifferent or mildly dissatisfied	6.8	2.4
	Quite dissatisfied	-	2.4
Overall Satisfaction	Very satisfied	23.1	41.0
	Mostly satisfied	67.5	53.0

	Indifferent	7.7	4.8
	Quite dissatisfied	1.7	1.2
Recommending hospital	Yes, definitely	42.7	56.6
	Yes, I think so	55.6	42.2
	No, I don't think so	1.7	1.2
Visiting same service provider in future	No, definitely not	3.4	1.2
	No, I don't think so	6.0	8.4
	Yes, I think so	57.3	47.0
	Yes, definitely	33.3	43.4

Source: Field work, 2015.

Series of questions were asked to ascertain the level of satisfaction with service provided at the respective hospitals (public and private). The analysis which was presented in table 4.3 indicates that, patients from both set received the kind of service they had anticipated before joining patronizing the service. Client satisfaction arises when the actual service consumed equals the anticipated services. They get delighted when they receive more. From the table 4.3, respondents from both public and private hospitals received the kind of service they anticipated for. Only

1.2% of the private hospital respondents did not receive the kind of services wanted.

The analysis also showed that service received the service received effectively dealt with the problems of patients. And they were satisfied with the kind of help received. Overall, both set of respondents were satisfied with service received. However, 41% of the private hospital respondents were very satisfied, as opposed to 23.1% from the public hospital respondents. As has been the case, satisfied clients are more likely to recommend service provider to family and friends. And because the respondents from both public and private hospitals were willing to recommend service providers to family and friends. They were also more likely to continue patronizing services of the hospitals they usually attend.

4.5 Word-of-Mouth as a Factor of Hospital Choice

From the table 4.4 below, it was realized that the choice of a public hospital was not influenced by workplace policy. Respondents disagreed on that item (mean =3.9, approximately 4). They were indifferent on the other items. All the items were statistically significant. On the part of the private

hospital respondents, they were indifferent on all the five items measuring word-ofmouth, i.e. influence from parents, siblings, other family members, friends and workplace policy.

With the exception of parents, all the items were statistically significant.

Table 4.4: ***Word-of-Mouth***

Word-of-Mouth	***Test Value = 2.5***					
	Public			**Private**		
	Mean	***T***	***Sig. (2-tailed)***	**Mean**	***T***	***Sig. (2tailed)***
Parents	3.1880	4.676	.000	2.6145	.686	.495
Siblings	3.2735	5.900	.000	2.8795	2.550	.013
Other family members	3.1197	4.820	.000	2.8313	2.401	.019
Friends	3.2222	5.569	.000	2.8795	2.469	.016
Workplace policy	3.9060	10.754	.000	3.3373	4.927	.000

Source: Field work, 2015.

4.6 Type of Ailment

Table 4.5 indicates that, the choice of either private or public hospital also depended on the type of ailment or sickness. For antenatal, pregnancy (childbirth), and malaria or typhoid fever, respondents preferred private hospitals to public. For acute headache (migraine), minor injuries, stress related conditions, snake bites, STDS (i.e. gonorrhea, chlamydia, syphilis etc.), fertility related issues, eyes, nasal, tooth and ear conditions, ulcers (digestive disorder), skin infection, pneumonia or respiratory illness, scans (x-ray, CT scans, MRI), spinal disorders, heart attack,

HIV Aids, cancer and mental disorder, respondents preferred to visit the public hospitals.

Table 4.5 ***Type of ailment***

Ailment	**Private (%)**	**Public (%)**
Antenatal	55.7	44.3
Pregnancy / Childbirth	54.8	45.2
Malaria/typhoid Fever	52.5	47.5

Postnatal	50.0	50.0
Acute headache / Migraine	48.0	52.0
Minor injuries	48.0	52.0
Stress related conditions	47.5	52.5
Snake bites	40.5	59.5
STDs (i.e Gonorrhea, chlamydia, syphilis etc)	40.5	59.5
Fertility related issues	40.0	60.0
Eyes, nasal, tooth and ear conditions	39.5	60.5
Ulcers / digestive disorder	39.5	60.5
Skin infection	35.5	64.5
Pneumonia / respiratory illness	35.5	64.5
Scans (X-ray, CT scans, MRI)	33.0	67.0
Spinal disorders	28.5	71.5
Heart attack	27.5	72.5
HIV AIDS	26.0	74.0
Cancer	25.5	74.5
Mental disorder	23.5	76.5

Source: Field work, 2015.

4.7 Binary Logistics Regression to Establish Factors Influencing the Choice of Hospital The crucial limitation of linear regression (being run in Ordinary Least Square-OLS) is that it cannot deal with dependent variables that are dichotomous and categorical. A range of regression techniques have been developed for analyzing data with categorical dependent variables, including logistic regression and discriminant analysis. However, Binary Logistical regression was used in this analysis because there are only two categories of the dependent variable (Public hospital or Private hospital). The researcher used service quality, word-of-mouth, type of ailment, and client satisfaction as the independent variables and the choice of hospitals as the dependent variable. The choice of hospital was coded 0=Private hospital and 1=Public hospital.

Table 4.6 ***Factors influencing choice of hospital***

Variables	**Cox & Snell R ^{2}**	**Nagelkerke R_2**	**B**	**Wald**	**Sig.**	**Exp(B)**
Constant	.294	.396	-7.397	33.370	.000	.001
Service Quality			1.200	9.680	.002	3.319
Word-of-Mouth			.337	4.113	.043	1.401
Ailment			3.643	34.266	.000	38.204
Satisfaction			-.595	4.275	.039	.552

Source: Field work, 2015.

Note:

B - These are the values for the logistic regression equation for foreseeing the dependent variable from the autonomous variable (the incline values). They are in log-chances units. Wald and Sig. - This is the Wald chi-square test that tests the null hypothesis that the constant equivalents 0. This theory is rejected when the p-value (recorded in the section called "Sig.") is smaller than the critical p-estimation of .05.

Exp (B) - These are the chances proportions for the indicators. They are the exponentiation of the coefficients.

Most factual bundles give further insights that may be utilized to gauge the handiness of the model and that are like the coefficient of determination (R2) in straight relapse. The Cox & Snell and the Nagelkerke R2 are two such measurements. There is a noteworthy issue with Cox and Snell's Pseudo R2, then again, which is that, its greatest can be (and more often than not is) under 1.0,

making it hard to decipher. The Nagelkerke R2 is a balanced variant of the Cox & Snell R2 and covers the full range from 0 to 1, and hence it is frequently favored. The R2 insights don't gauge the integrity of attack of the model (the rate of difference in the needy variable clarified by the free variables) yet demonstrate how helpful the illustrative variables are in anticipating the reaction variable and can be alluded to as measures of impact size. The estimation of 0.396 shows that the model is valuable in anticipating decision of clinic. Because the coefficients (B) in Logistics regression output are in log-odds units, the researcher only used them to determine the direction (+, -), but did not assign meaning as coefficient would be explained in OLS regression. The effects were explained instead using the odds ratio, which is the Exp (B). From the table 4.6, service quality, word-of-mouth, and type of ailment had a positive relation the choice of hospital. This means higher service quality influenced the choice of Public hospitals, the presence of (influence) of word-of-mouth increases the chance of Public hospital selection, and the presence of a particular type of ailment also influenced the choice of Public hospitals. Satisfaction however had a negative relationship with choice of Public hospital. This means that based on satisfaction, clients would rather prefer to go to Private hospitals instead of public.

The Wald test works by testing the null hypothesis that a set of parameters is equal to some value. In the model being tested here, the null hypothesis is that the four coefficients (independent variables) of interest are simultaneously equal to zero. If the test fails to reject the null hypothesis, this suggests that removing the variables from the model will not substantially harm the fit of that model. From the regression output presented, all the four independent variables were statistically significant in predicting the choice or otherwise of a Public hospital.

And the removal of any of the variables would significantly affect the prediction of the model.

The binary logistic regression equation when computed would be;

Logit (**Choice of hospital**) = -7.397 + 1.20(*Quality*) + .337(*W-o-M*) + 3.643(*Ailment*) - .595(*Satisfaction*).

The Exp(B) of service quality was 3.319. Meaning that, the service quality increases the odds that a patient would choose Public hospital by 3.319 times, and the vice versa. Word-of-mouth increases the odds of patients choosing a public hospital by 1.401 times. The type of ailment or sickness also

increases the odds of choosing a public hospital by 38.284. This indicates that, the type of sickness was the most significant factor influencing the choice of public hospital. Satisfaction on the other hand, had a negative relationship with choice of hospital. This means that considering satisfaction as a choice factor, patients are less likely to choose public hospitals at odds of .552.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of findings of the study and focus on the findings, conclusions drawn from the findings and recommendations.

5.2 Summary of Findings

5.2.1 Clients' Perception of the Service Quality of Public and Private Hospitals

The study used seven latent variables in measuring hospital service quality. Private hospitals performed better on six dimensions. Private hospitals performed better on medical services, nursing services, support services, administrative services, patient safety, and hospital infrastructure. Only on the dimension of patient communication did the public hospitals performed better than the private ones. The overall impression was that, private hospitals provided a more quality service than public hospitals.

5.2.2 Clients' Level of Satisfaction with Service Delivery at Public and Private Hospitals The study showed that, both public and private hospital respondents were satisfied with service received. However, the respondents from the private hospitals were slightly more satisfied with service than the public hospital. Respondents received anticipated service, services received effectively dealt with problems, satisfied with help received from the hospitals, were willing to recommend service providers to friends and families, and also to re-patronize service.

5.2.3 Word-of-Mouth as a Factor of Hospital Choice

It was realized that, word-of-mouth (recommendations) from parents, siblings, other family members, friends, and workplace policy, indifferently affected both the choice of public and private hospitals.

5.2.4 Type of Ailment as a factor of hospital choice

For antenatal, pregnancy (childbirth), and malaria or typhoid fever, respondents preferred private hospitals to public. For acute headache (migraine), minor injuries, stress related conditions, snake bites, STDS (i.e. gonorrhea, chlamydia, syphilis etc.), fertility related issues, eyes, nasal, tooth and ear conditions, ulcers (digestive disorder), skin infection, pneumonia or respiratory illness, scans

(x-ray, CT scans, MRI), spinal disorders, heart attack, HIV Aids, cancer and mental disorder, respondents preferred to visit the public hospitals.

5.2.5 Binary Logistics Regression to Establish Factors Influencing the Choice of Hospital The binary logistic regression equation derived from the analysis was *logit*(**Choice of hospital**) = -7.397 + 1.20(*Quality*) + .337(*W-o-M*) + 3.643(*Ailment*) - .595(*Satisfaction*).

From the analysis, the choice of public hospital over private hospital was positively influenced by service quality, word-of-mouth, and the type of ailment (sickness). Satisfaction on the other hand, decreased the odds (likelihood) of public hospital being selected over private hospital.

5.3 Conclusions

The study sought to ascertain the factors influencing the choice of public and private hospitals. A thorough review of literature was conducted, to have a better appreciation of concepts understudy. After the study, it was concluded that, the choice of public hospital over private hospital was positively influenced by service quality, word-of-mouth, and the type of ailment (sickness). Satisfaction on the other hand, decreased the odds (likelihood) of public hospital being selected over private hospital.

The study used seven latent variables in measuring hospital service quality. Private hospitals performed better on medical services, nursing services, support services, administrative services, patient safety, and hospital infrastructure. Only on the dimension of patient communication did the public hospitals performed better than the private ones. Both public and private hospital respondents were satisfied with service received. However, the respondents from the private hospitals were slightly more satisfied with service than the public hospital. Word-of-mouth (recommendations) from parents, siblings, other family members, friends, and workplace policy, indifferently affected both the choice of public and private hospitals.

5.4 Recommendations

After undertaking the study, the following recommendations were made;

Waiting time is very crucial in service delivery, as it add up to the interpretation or meaning assigned to the service quality clients receive. The study showed that, public hospitals are unable to provide diagnostics services with less waiting time. The researcher recommends a critical attention be paid to that.

The unavailable of medicine from the dispensaries of public hospitals is also another issue wealth addressing. This is very frustrating to patients, especially if they are on the NHIS, and due to the unavailability, they had to pay and buy from pharmacies outside the hospital.

Disclosure of information is very crucial in service patronage, especially medical service. They study found out that during admission patients and their family members were not furnished with the appropriate counseling to make informed decisions at the private hospitals. This should be an area of concern to private hospitals, as it affects the overall perceived service quality.

The study showed that, although respondents were selected randomly, most of them attended public hospitals. The most significant factor of selection identified using a logistic regression was the type of ailments. The private hospitals in order to catch up, must expand their facility to be more effective and efficient in addressing sickness such as mental disorders, cancers, HIV, heart diseases, spinal disorders, etc.

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APPENDIX

QUESTIONNAIRE

This questionnaire seeks to assess patients‟ preference of Public and Private Hospitals. The research is in fulfillment of the requirement for the award of an MBA in Strategic management.

Respondents are assured that information given would be treated with maximum confidentiality. I will be grateful if you could spare few minutes of your time in answering the following questions.

Section A: Demographics

Q1. Location/ town …….

Q2. Gender Male [ ] Female [ ]

Q3. Age 18-30 years [ ] 31-40 years [ ] 50-60 years [ ] 60 years and above [ ]

Q5. Occupation Public servant [ ] Private servant [ ] Self-employed [ ] Student [ ] Retired [ ] Unemployed [ ]

Q6. Educational level No formal education [ ] Basic school [ ] Secondary [ ]

Tertiary [ ]

Q7. Which hospital do you usually attend in case of ailment? Public [ ] Private [ ]

Q8. What is/are the name(s) of hospital usually attended? ……

……..

Q9. Number of hospital visits in a year.

[Once every month, [ ] once every three months, [ ], once every 6months, [ ] once a year

[ ] Other, please specify ……..

Q10. Which of the following accounted for your visits to the hospital?
Medical Check-up [ ] Pregnancy / Childbirth [ ] Emergency [ ]

Heart attack / stroke [ ] Pneumonia / respiratory illness [ ] Ulcers / digestive disorder [ ] Chronic condition [ ] Cancer [ ] Planned surgical procedure [ ] Malaria/Fever [ ]

Others [ ] ……

Section B: Health Service Quality

Q11. Kindly indicate the extent to which you agree with the following statements. Please tick (√) either 1=Strongly agree, 2=Agree, 3=Neutral, 4=Disagree or 5=Strongly disagree.

Health Service Quality Dimensions	1	2	3	4	5
Medical Service (MS)					
Doctor was prompt in attending my needs					
Doctors listen carefully to my problem					
I am satisfied with the time spent by doctors with me during consultation					
Adequate information was provided by the doctor about treatment procedures and outcomes					
Nursing Services (NS)					
Nurses were prompt in attending to my needs					
Nurses administered prescribed medication on time					
Nurses were courteous					
Nurse were helpful and empathetic					
Supportive Services (SS)					
The hospital provides Diagnostics services with less waiting time					
Required Medicines are available in the pharmacy					
Hospital provided good food (nutritious, hygiene and timelines)					
Housekeeping staff maintains cleanliness in the ward/room					
Administrative Services (AS)					
Hospital admission processes were simple					
Proper facilities were provided in the hospital by attendants					
Hospital administration responded immediately to solve your problems					
Discharge process was completed without delay					
Patient Safety (PS)					
Adequacy of hygienic care and procedures (e.g. hand wash, wearing gloves) followed by the hospital staff					
The hospital provides proper measures (e.g. bed with side handrails in aisles, ramps designed for wheelchairs) to reduce the risk of patient harm resulting from falls					
I have not suffered from hospital acquired infection after 24 hours of admission					
Patient Communication (PC)					
Adequate information was provided by the staff					
There is a clarity in staff communication					
During admission you and /or your family members were given proper counseling to make informed decisions					
Hospital Infrastructure (HI)					
The physical facilities of hospital are visually appealing					
The hospital have necessary up-to-date equipment					
The hospital staff are well dressed and appear neat					

Section C: Patients' Satisfaction

Q12. How would you rate the quality of service you receive from your hospital?

Excellent [ ] Good [ ] Fair [ ] Poor [ ]

Q13. Do you get the kind of service you want?

Yes, definitely [ ] Yes, generally [ ] No, not really [ ] No, definitely [ ]

Q14. To what extent has the service meet your health needs?

Almost all of my needs have been met [ ] Most of my needs have been met [ ]

Only a few of my needs have been met [ ] None of my needs have been met [ ]

Q15. If a friend were in need of similar health services, would you recommend the hospital to him or her?

Yes, definitely [ ] Yes, I think so [ ] No, I don"t think so [ ] No, definitely not [ ]

Q16. How satisfied are you with the amount of help you have received?

Very satisfied [ ] Mostly satisfied [ ]

Indifferent or mildly dissatisfied [ ] Quite dissatisfied [ ]

Q17. Have the services you received helped you to deal more effectively with your problems?

Yes, they helped a great deal [ ] Yes, they helped [ ]

No, they really didn"t help [ ] No, they seemed to make things worse [ ]

Q18. In an overall, general sense, how satisfied are you with the service you have received?

Very satisfied [ ] Mostly satisfied [ ]

Indifferent or mildly dissatisfied [ ] Quite dissatisfied [ ]

Q19. If you were to seek help again, would you come back to our program?

No, definitely not [ ] No, I don‟t think so [ ] Yes, I think so [ ] Yes, definitely [ ]

Section D: PATIENTS' CHOICE OF HOSPITALS

20. Kindly indicate the extent to which you agree with the following statements. Please tick (√) either 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree or 5=Strongly agree.

PATIENTS CHOICE OF HOSPITAL	**1**	**2**	**3**	**4**	**5**
SELECTING A HOSPITAL					
My choice of hospital was based on recommendation from *parents/ guardian*					
My choice of hospital was influence by older *siblings*					
My choice of hospital was based on recommendation from *other family members*					
My choice of hospital was based on recommendation from close *friends*					
I visit a particular hospital because of my employers‟ *workplace* policy					

21. In this part, respondents are required to state their preference of hospital (private or public) using the following ailments. ***Please note that these conditions are assumptions and that you need not suffer from them.***

CHOICE OF HOSPITAL FOR AILMENTS / CONDITIONS	**Private Hospital**	**Public Hospital**
Antenatal (if applicable)		
Pregnancy / Childbirth (if applicable)		
Postnatal (if applicable)		
Malaria/typhoid Fever		

Acute headache / Migraine		
Stress related conditions		
Skin infection		
Mental disorder		
Heart attack		
Pneumonia / respiratory illness		
Ulcers / digestive disorder		
Cancer		
Minor injuries		
Snake bites		
STDs (i.e. Gonorrhea, chlamydia, syphilis etc.)		
HIV AIDS		
Scans (X-ray, CT scans, MRI)		
Fertility related issues		
Eyes, nasal, tooth and ear conditions		
Spinal disorders		
Stroke		
Others specify……..		

22. What explanations will you assign to selecting either private or public hospital using the above conditions (for instance, why will you go to a private hospital with Malaria)?

……

……

……

……

Thank You