

**Perceived Service Quality and Patients' Satisfaction in  
Selected Public Hospitals in Benin City**

**Sunny Ewan AIGBOMIAN  
PG/MGS 0716977**

**Department of Business Administration  
Faculty of Management Sciences  
University of Benin  
Benin City**

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**Sunny Ewan AIGBOMIAN  
PG/MGS 0716977**

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Benin City, Nigeria.**

**August, 2014**

## **DECLARATION**

I, Sunny Ewan AIGBOMIAN do hereby declare that this thesis titled “Perceived Service Quality and Patients’ Satisfaction in Selected public Hospitals in Benin City” is entirely my own work and composition. The work embodied in this thesis has not been submitted in candidature for the award of any degree or diploma and is not currently being submitted for any other degree. All references made to works of other persons have been duly acknowledged.

**Signature:** \_\_\_\_\_

**Date**-----

## CERTIFICATION

We certify that this work titled “Perceived Service Quality and Patients Satisfaction in Selected Public Hospitals in Benin City” was carried out by Mr. Sunny Ewan AIGBOMIAN in the Department of Business Administration, Faculty of Management Sciences and meets the regulations governing the award of the Master of Science, School of Postgraduate Studies, University of Benin, and is hereby accepted and approved for its contribution to knowledge and literary perception.

\_\_\_\_\_  
**MR PREST, Edward. E.**  
*(Research Supervisor)*

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**DR. A. TAFAMEL**  
*(Head of Department)*

\_\_\_\_\_  
**DATE**

**ATTESTATION OF CORRECTED THESIS**

We the undersigned attest that -----  
has successfully carried out all the required corrections as recommended by the external  
and internal examiners in his/her thesis titled  
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Thank you.

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**Dr. A.E. Tafamel**  
*(Ag. Head of Department)*

-----  
Sign and Date

-----  
**Mr. E. E. Prest**  
*(Chief Supervisor)*

-----  
Sign and Date

-----  
**Dr. I. Shaibu**  
**(Internal Examiner)**

-----  
Sign and Date

-----  
**Associate Prof. O.J. Ilaboya**  
*(PG Faculty Representative)*

-----  
Sign and Date

## **DEDICATION**

This work is dedicated to God Almighty, the creator of heaven and earth through His only begotten Son Jesus Christ who gave me the opportunity to complete this programme.

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## **ABSTRACT**

The study empirically examined Perceived Service Quality and Patients' Satisfaction in Selected Public Hospitals in Benin City. The survey method was adopted. Questionnaire was used to elicit the primary data with sample size of 241 respondents drawn from 2350 patients (population) of both hospitals. The study adopted a descriptive (frequency table, percentage, mean, standard deviation and standard error of the mean). While the inferential statistics include the Student t-test and Pearson Correlation analysis. The outcome of the study revealed that patients were satisfied with the time spent at the service points at the selected public hospitals in Benin City, patients of both hospitals are satisfied alike and that the quality of service at University of Benin Teaching Hospital is not better than that of General Hospital, Usen. It is recommended that policy makers should set standards and benchmarks on service times, especially time spent at service points, conscious efforts should be made by policy makers and indeed all stakeholders to improve service time at the healthcare delivery centers with a view to optimizing patients' time. Finally, future studies should seek to ascertain the average time spent by patients before being attended to at various service points in Public Hospitals as well as the level of Patients' Satisfaction with Service Quality.

# **CHAPTER ONE**

## **INTRODUCTION**

### **1.1 Background to the Study**

The neglect of the health sector by the Federal, States, and Local governments in Nigeria has caused a lot of problems: untimely death of patients as a result of incessant strikes, poor service quality, corruption, complaints by patients and a host of others. Amidst these challenges, the Federal, States and Local governments are busy spending colossal amount of money on irrelevant projects that will not benefit the country. These governments had failed to realise that good living is a product of good health. People that do not have free access to good living cannot be healthy and if people are not healthy, service quality and productivity could be compromise (Newswatch, May 2009).

In major of our public hospitals today, there is no regular supply of power, water and availability of modern equipment. The situation is better imagined than experienced. The issue of service quality is a function of many variables that span from human factors to physical facilities that are available. Delivery of quality service is of major concern to the citizens of Nigeria, but the extent to which the government takes it, ranging from staff strength to other facilities that are required in delivering quality service is another issue.

“Health is Wealth” is a popular axiom, which means that wealthy nations are products of a healthy people. In service industry such as the health sector, has not received adequate attention that is considered desirable. Government has paid a lot of attention to less important things while neglecting the health sector (Newswatch, May 2009). At the moment, “there are quite a number of complaints filed by patients of public

hospitals due to delays in providing quality services to them. This has resulted to incessant complaints and dissatisfaction in the services provided by public hospitals” (Public Complaint Bureau, 2006).

This research study focuses on quality service and patients’ satisfaction in selected public hospitals in Benin City with the motive of offering quality recommendations that can enhance quality services in public hospitals.

## **1.2 Statement of the Research Problem**

Majority of public hospitals in Nigeria are supposed to be centres of medical excellence but the present condition of no adequate regular water and power supply, incessant strikes, poor service delivery and patients’ complaints of dissatisfaction in these hospitals are reflection of governments’ attitude towards public hospitals in terms of neglect. Apart from the decay of facilities, the brain drain of medical personnel has also contributed to the present condition of the public health system. Many Nigerian doctors, nurses and other health personnel who were frustrated by the decay in the health sector have migrated to other countries where their services are more cherished and desired and where they have access to modern operational equipment. Patients’ complaints over epileptic power supply and infrastructural decay in public hospitals are the sources of patients’ dissatisfaction. The challenges of decay of facilities, brain drain of medical personnel, patients’ complaints, poor power supply and poor service delivery are the bases on which this study is predicated.

## **1.3 Research Questions**

In light of the issues raised above, the following research questions are of importance:

- a. is quality of service at University Benin Teaching Hospital better than the quality of service at the General Hospital, Usen?
- b. are patients of General Hospital, Usen more satisfied with services they received than patients of University Benin Teaching Hospital?
- c. what is the relationship between time spent at the service points and Patients' Satisfaction with Quality of Service in Selected Public Hospitals?

#### **1.4 Objectives of the Study**

The general objective of this study is to examine the Perceived Service Quality and Patients' Satisfaction in Selected Public Hospitals in Benin City. The sub objectives are to:

- a. determine whether Quality of Service at the University of Benin Teaching Hospital is better than the Quality of Service at the General Hospital, Usen;
- b. examine whether the patients of General Hospital, Usen are more satisfied with the service they received than the patients of University of Benin Teaching Hospital; and
- c. determine the relationship between time spent at service points and Patients' Satisfaction with Quality of Service in Selected Public Hospitals.

#### **1.5 Research Hypotheses**

The hypotheses stated below are in null form:

***Hypothesis 1:*** The Quality of Service at University of Benin Teaching Hospital is not better than the Quality of Service at the General Hospitals, Usen.

***Hypothesis2:*** The patients of General Hospital, Usen are not more satisfied with the services they received than patients of University of Benin Teaching Hospital.

***Hypothesis 3:*** There is no relationship between time spent at service points and Patients' Satisfaction with Quality Service in Selected Public Hospitals.

## **1.6 Scope of the Study**

This study is primarily focused on perceived service quality and patients' satisfaction in selected public hospitals in Benin City, covering patients of University of Benin Teaching Hospital and General Hospital, Usen. These hospitals are located in Edo state, Nigeria. The sizes and the number of patients in these hospitals adequately satisfy the salient requirements needed in a good sample frame. These two hospitals were chosen because they are strategically located, the sizes and nature of equipment present, University of Benin Teaching Hospital is a federal research institution with Service Quality (SERVICOM) Unit, while General hospital, Usen is a State Government hospital with state present. The study was confined to (2002-2012).



## **1.7 Significance of the Study**

The study would be of great benefit to hospital patients, hospitals management board, government, future researchers as well as the general public. However, the significance can be in specific terms as the study would help in these areas:

- a. It will help to improve the quality services of public hospitals as well as the general health system;
- b. It will help to boost the image of public hospitals and restore the lost glory of public hospitals. This is as a result of the series of complaints by the public hospitals users. Arising from this, the internally generated revenue of public hospitals would increase as patronage of patients will now be favourable;
- c. It will bring out the specific areas (registration, examination, consultation and treatment) where complaints are being recorded about service quality with the aim of providing succour to dissatisfied patients;
- d. It will also help management in effective and efficient time management in areas of registration, examination, consultation and treatment in the affairs of public hospitals services;
- e. Finally, the findings of this study will also serve as reference materials for scholars carrying out studies in this area.

## **1.8 Limitations of the Study**

This study focused on perceived service quality and patients satisfaction in selected public hospitals in Benin City. There was the limitation of what should be an ideal population in order to obtain a complete random sample. Time taken in getting the

utmost attention of patients especially those under acute ailment condition was not an easy task. However, these problems did not pose any significant setback with regards to the valid generalization that has been made on the Perceived Service Quality and Patients' Satisfaction in Selected Public Hospital in Benin City.

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

#### **2.1 INTRODUCTION**

This chapter reviewed related literature on the subject matter. In the process of the review, opinions, views and current development on Service Quality and Patients' Satisfaction were captured. Efforts were made to examine the concept of service quality, measuring service quality and other necessary related issues. The theoretical framework, criticisms of the study were also considered.

#### **2.2 Concept of Service Quality**

##### **2.2.1 Meaning of Service Quality**

Service quality is not a new concept. It has vast meaning and is dynamic in nature. Service quality is defined based on technology, facilities, human capital and most importantly, is consumers' assessment. Service quality is an essential part of the organizations' achievements. This is a result of increased customers' expectations and customization of services in many markets. It is documented "as one of the key driving forces for business sustainability and is crucial for accomplishment" (Rust & Oliver, 1994).

In management, quality refers to "the features of a product or service that bears on its ability to satisfy stated or implied needs" (Van Fleet, 1991). In the same vein, Johns (1996), has it that quality means "reliability of performance, ease of use, value for

money, speedy delivery and so on”. Quality itself has been defined as fundamentally relational, and is the ongoing process of building and sustaining relationships by assessing, anticipating as well as fulfilling stated and implied needs, Coulther (2003). Quality service is the customers’ perception of the value of the suppliers output, this is only achieved when one has produced a service that brings smiles to the customer. It is believed that when quality is ingrained into a product, it generates emotions and feelings even within those who have taken part in its creation or process of creation.

The word “Quality” represents the properties of a product and/ or services that are valued by the customer (Answers.com 2006). It also went further to explain that quality is a momentary perception that happens when something in the immediate environment interacts with us, in the pre-intellectual awareness that comes before rational thought takes over and begins establishing order. Personal report of the resulting order is then interpreted as good or bad quality value.

The Navy Medicine stated in the Quality Digest (2007) views quality as “delivery product and service to our customers which are faster, better, cheaper and newer”. It went further to explain the two types of quality: quality of design and quality of the process.

The business environment we operate in be it manufacturing, process manufacturing or service related industry, requires the consideration of issues of usability, comfort, as well as tolerance of durability beyond prescribed use and identity of ‘status’ of design quality. Implicitly, the ability to live up to the “quality of design” is maintained by the “quality of the process” (Answers.com 2006).

Quality as it were, is aimed at the translation, transformation, as well as the realization of the customer expectations, converting these to desired requirements. These requirements are expressed qualitatively and quantitatively, and measuring the process performance during and after the realization is a significant part of the requirements. Service quality is in the customer's mind, that is what he wants, and it can be seen as the expectations of the customer towards a service or product. To the service provider, it is the extent to which the organization achieves the following: reliability, how trustworthy and helpful they are in providing service when needed by customers; this determines the organization's ability to hang onto their customers. It is also an established fact that quality is accepted "as being an important factor that determines the demand of goods and services as well as the main indicator that affects the competitive advantage of the firms" (Fitzsimmons & Fitzsimmons, 1994).

On the same strength, Kotler and Armstrong (2008) opines that "a service firm's ability to hang onto its customers depends on how consistent it delivers value to them". According to Parasuraman, Zeithaml, and Berry, (1988) "service quality is an overall judgement similar to attitude towards the service", and "generally accepted as an antecedent of overall customer satisfaction". Parasuraman et al, (1988), also define service quality "as the ability of the organization to meet or exceed customer expectations".

While Parasuraman, Zeithaml and Berry (1994) also define service quality as "a measure of how well the service level delivered matches with expectations; delivery quality service means to conform to customers' expectations on a consistent basis".

Similarly, Zeithaml (1988) defines service quality as “the customers’ judgement about a product’s overall excellent or superiority”

Zeithmal, Parasuraman, and Berry (1990) opined that there are differences between customer expectations and perceived service, he explains further that perceived service results from comparisons by customers’ expectations with their perceptions of service delivered by the suppliers. From the foregoing, if expectation is higher than actual performance, then perceived quality is lower than the satisfaction which ends up as dissatisfaction.

Services have unique features that differentiate them from tangible products. The essential and notable thing that distinguishes service from tangible product is that services are produced and consumed at the same time in the presence of the customer and in some instances in the presences of service producer. In the process of production and consumption, the presence of human element in service delivery is very significant.

In the idea of Havva (2006) the term quality in the service industry, looks distinct from what the term stands for in the goods markets. He opines that “the production in the service sector is generally an abstract. Evaluating service quality becomes more difficult than evaluating quality of goods. Therefore, service quality measurements are in general, made by means of using consumers’ (patients as in the case of hospitals) perception about the quality of service”.

Moreover, “consumer’s perception is one of the sure indicators of quality in the Health care service” (Havva 2006). Although true level of service quality may either be

low or high, the main indicator is how the customer perceives the service quality as well as the efficiency of the health care system (Parasuraman, et al. 1988; Zeithaml, et al. 1990 and Kotler, et al. 2008).

Service providers in consideration “take the satisfaction of customers into account as a main goal of the strategies of their firms” (Zeithaml&Bitner 2000). There are studies on measuring service quality in the public health that use the satisfaction of customers. Corroborating the above opinion, Parasuraman, et al (1988), Babakus and Mangold (1992) maintain that “service quality is mainly based on the satisfaction of patients or their judgement about service quality”.

From the above, service quality can be distinguished in two ways: objectively and subjectively. Objective service quality means a concrete measurable conformed result with previously defined benefit. Measurability is remarkable and is dependent on the accuracy of the definition. But measurable quality criterion can easily turn out as a subjective one. Subjective service quality is perceived conformity of the working result with the expected benefit. This understanding is a function of customer’s original imagination of service and the service provider’s knowledge to present his performance as a good one.

### **2.2.2 Importance of Service Quality**

Service quality is an aspect that aids in making a successful business enterprise. The continued functioning of any business organization rests on service quality, customer relationship management (CRM) and the development of new products. If these business

concepts, especially service quality as in the case of this study, is not given the desired attention, the organization would be failing in acquiring more market share, and even sustaining the existing market share would be a game of chance.

The basic issue, currently confronting service business organizations in their efforts to improve market share “involves customer devotion and the company must satisfy the needs of the customers in ways that contribute to long-term loyalty” (Gomez, Balkin, David & Cardy 2005). Customers of today, have great expectations for numerous products and with the current issue of the state-of the art facilities in the minds of the customers, organizations must have a way of satisfying these demands of customers with up to date services.

Service quality is very significant when a business wants to prosper. Organizations’ main agenda is to create a customer because it is basically the customer that determines what the business actually is. It is important for the organization to provide time and efforts on how they should improve their products and services to the customers for the future success of the entire business.

Service quality is a key factor in achieving any business success. It can either make or break the business. This is the reason, the entire business plan, marketing strategies, sales and profits should depend on service quality impact on the customers. Essentially, business exists to generate a stream of revenue through sales of products and services to consumers who are in need of their services. These products should be able to make lives easier for the customer and not the other way round (World Health Organization Report 2000).



For the organization to be able to gain income adequately from the business continually, its products must be carefully designed as well as meet the desired need of the customers. This is the bedrock for an emerging and profitable business, every decision made should take into consideration the position of the customers as well as the service circumstance affecting the customers.

The belief is that people actually want to do business with service business organization because of the previous interesting experiences. It should be pointed out that strategies in marketing and sales have been of great significance in attracting new clients to business. It is also interesting to know that service quality makes people to come back for more or make a repeat purchase. To a dynamic entrepreneur, one has to ensure repeat purchase by offering good quality service.

Often time, dissatisfied customers will just simply walk away and never come back, thus decreasing potential revenue without the knowledge of the organization. It is therefore, a fact that service business organization cannot succeed for a long time without giving appropriate attention to service quality.

Every service business organization must recognize the fact that service quality is imperative in the success of business. This would ensure customers' loyalty and commitment to the business. The ability of the organization to focus on consumers' need and servicing them to the best of their ability would ensure that the business would be far more cost-effective than you have ever imagined.

Service quality is a crucial factor that helps in differentiating small and big business organizations. This provides a platform for each business to offer customers quality service in which they can be known for (Singhai&Singhai 2000).

It should be noted that there is a continued change in the pattern of customers demand in recent times, with this, it is important that business organizations offer satisfaction to their customers through quality service. This would help in retaining the existing customers for a long period as well as gaining additional customers.

### **2.2.3 Service Quality in the Public Service**

Good health is a condition that everybody wants and if possible desire and have it. The state of public hospitals in EdoState is not quite different from other public hospitals in other states in Nigeria. In other words, the situation in the health institutions even within the same state is similar to what obtains in their counterparts, the actual condition is not only serious but terrible.

There are four major and big hospitals in Edo State, these are: University of Benin Teaching Hospital (University of Benin Teaching Hospital), Benin City, Irrua Specialist Teaching Hospital, Irrua, Central Hospital, Benin City, and Stella Obasanjo Hospital, Benin City. Apart from these hospitals, there are other Government or General Hospitals in each of the eighteen (18) Local Government Areas of Edo State where health care services are provided. Newswatch (May 2009) reveals that all the Hospitals which are designed to be centres of medical excellence are grappling with the common problems of inadequate and obsolete equipment, underfunding, epileptic power supply, irregular water supply, inadequate medical personnel and brain drain. These problems hamper quality service delivery in these hospitals.

There is the problem of insufficient fund to retain staff of the hospitals especially in the teaching hospitals in the state. While in the non-teaching public hospitals the situation is worse off. The essential staffs in the non-teaching public hospitals in Edo State are not regularly trained to update their knowledge in their various fields. This training is important because the medical world is dynamic. So, training is indispensable for our public hospitals to keep pace with current issues on development. The condition of most of our public hospitals in our local governments in Edo State has created a lot of pressure on our few “major” teaching hospitals which is not good for the health sector.

The supposed objective of hospital is to ensure high quality service delivery in its numerous specialities in a safe environment. The hospital is not only met to serve the immediate environment as in the case of University of Benin Teaching Hospital, Benin City, which is located in the heart of Benin, but also should provide secondary and tertiary referral services in its regional and national specialities. In addition, it is required to consolidate and improve its teaching and research activities as a major academic teaching hospital with a superb national profile.

The non-availability of modern facilities in most public hospitals in Edo State is the perceived failure of successive governments to pay adequate attention to the health sector. Government, over the years, had misplaced their priorities because those in government can afford to go abroad for medical care. They have the option of going overseas, so they do not quite consider the poor people who do not have the means to travel abroad. But if successive government have been paying attention commensurate with what they give or spent in other irrelevant things, then we would have kept pace with what is obtainable in the developed world. As it is now, the gap is still very wide.

Public service is taking place around the world and the sector's revolutionary approach of citizen-centric service shifting from model of programmatic service to a citizen-focused approach where service quality is on people not programmes. Public institutions are realizing that efficient service quality can sincerely improve public sector value. Citizens and businesses have come to expect same from government institutions like what they experience in commercial sector. But how does the public sector wake-up to this enormous challenge? Obviously, the present general perception is not too well. Public institution is often characterized as being slow, bureaucratic and rarely innovative.

However, in our experience, this is not always the case. Public hospitals, worldwide, have moved to embrace service quality to make their services admirable as well as being able to compete favourably in the market place, but such service transformation in the private sector has moved even beyond that level.

Some public institutions are recognizing that service quality, and particularly citizen-centred service mechanism is necessary to meet desired public service outcomes. The citizen should be at the centre of service quality. Services and programme can be organized around the needs of clients and in turn aligned closely with expectations. Theories impacting on public hospitals derive from the field of public administration positions "public institutions as non-profit institutions that are focused on a mission that does not include maximization or stockholder interest" (Drucker 1992).

Drucker (1992) went further to explain that some institutions "experience difficulties in attracting and retaining skilled managerial, administrative and professional staff due to the probability that such workers will garner limited financial rewards for their work when compared to peers in profit institutional work settings". This requires the development of a system of rewards, benefits and motivational items that will foster job

satisfaction and reduce staff turnover. For many workers in such institutions, Drucker (1992) also suggests that the overarching service mission and charitable focus of the public hospital may serve as a source of inspiration and motivation. In addition, many public hospitals find it increasingly difficult to manage care. As SERVICOM, (2006e) noted that public hospitals are often more dependent upon public health insurance funding and payment than private hospitals and, consequently, face special skill and knowledge requirements for their administrators and staff members.

People desire service that work, easy to find, simple to use and respond to needs. They want requirements dealt with preferably at a go. If not instant want to know why and when it will be. Not to be passed between staff with limited knowledge.

Effective service delivery is not easy. It involves creating the right approaches and establishing clear ways of engaging the right people in place to respond to needs of customers. This is applicable to this study as the main focus is to ensure high service quality to public hospitals' patients.

The House of Commons Report (2006) outlined steps to a successful and high quality service in public service, these steps are stated accordingly:

The relevance of the above steps to this study is that it would assist the public hospitals to understand the needs of its patients, design a reform that will suit the patients, help to monitor service performance of the various service points and a host of others.

The following are some government measures to ensure better service delivery in public hospitals

1. Publicize standards what people should expect from public services;
2. Make performance information available for people to know how public services are being performed;
3. Create avenue for innovation, change should be open and services provided in different ways;
4. Organisations should be established to deal specifically with groups;
5. Staff should be trained to specifically think of clients and their needs;
6. There should be collaboration with voluntary or private sectors; and
7. Mechanisms should be put in place to handle complains about poor services.

In advanced countries like the U.S.A, Britain, France, and Germany, various governments are making significant advancements in service quality, technological transformation and process innovations implemented to deliver public services in a more citizen-focused and integrated way. There are issues of whole-of-government transformational visions to drive service quality home. In the above countries, expectation is changes will evolve better citizen engagement, efficient service, lower costs, and eventually qualitative public sector value.

But most developing countries, like Nigeria have not yet achieved these outcomes. Expectation in this regard is still high. Service transformation advances have been put in place to front-end delivery quality service but as countries' agenda on service quality evolve steps should be taken to develop back-end infrastructure. This is to ensure the supporting policy frameworks for desired cultural change to deliver on government visions. This will evolve a realistic transformational change environment where quality service delivery supports government priorities and policy outcomes.

#### **2.2.4 Improving Service Quality in Public Hospitals**

Service quality improvement is a forward looking process that should allow health care providers to use a collaborative method to achieve comprehensive excellence. Service quality improvement is based on the idea that problems in service quality essentially arise not from negligence or recklessness on the part of individual workers but from the systems in which the individuals operate.

According to Wisniewski and Donnelly (1996) patients are not getting what they need but it is not a matter of skill or will. Doctors and nurses cannot give the care they

want to give. It is time for new systems. It is not about blame. It is all about change. Traditionally, public hospitals have relied on quality assurance, which involves retrospectively measuring quality in relation to a predetermined threshold. The problem with this approach is the perception that quality assurance is focused on finding violations of standards and punishing those who violate them, rather than proactively ensuring high-quality care.

The service quality improvement in public hospitals programme should strive to raise the quality of health care by generating information that can guide improvement in service quality, accountability, choices and incentives devices. This is to stimulate quality service improvement to build the needed capacity of health care system to achieve and sustain quality service delivery. Information is a key to ensuring quality health care system. It can help the health care system and its component institutions to identify challenges and possibly take necessary steps to remedy them.

With fund support, (SERVICOM, 2006f) has been exploring what consumers want to know about their own physicians and how that information can be integrated into current performance measurement activities. This was done as a nation-wide coalition of providers, health planners, purchasers and government in collaboration to improve the quality of service. As a pilot test a survey of experiences of patients' care were received from public hospitals. The test helped to resolve important methodological issues pertaining to the measuring of performance of individual public hospitals.

Ibadin and Ebohon (2009) also view "Servicom" as "seeking to enhance the quality of governance and public confidence in government itself", "we the government and the people of Nigeria dedicate ourselves to providing the basic services to which each



citizen is entitled to in a timely, fair, honest, effective and transparent manner....”  
(Servicom, 2007).

Erstwhile President OlusegunObasanjo, (2003) in a retreat with Permanent Secretaries and Senior government officials, intimated them of the followings:

1. “Our public offices have for too long been showcases for the combined evils of inefficiency and corruption, whilst being impediments to effective implementation of government policies. Nigerians deserve better quality service. And we will ensure they get it”.
2. “Public officers are the shopping floor for government businesses. Regrettably, Nigerians have for long been short-charged by the quality of public service delivery by which decisions are not made without undue outside influence and files do not move except pushed with inducements....”
3. “Government recognized that: (i) No reform exercise will be credible and sustainable without workable quality service. (ii) Service quality is the object and subject of all reform efforts. According to Abdullah (2007) “Servicom is convinced that customers will be satisfied if government establishment pay attention” to
4. “Service delivery- that is the willingness to help customers/clients and to provide promised services”.
5. “Timeliness- delivery prompt services”
6. Professionalism-It is widely acknowledged that people prefer to be served by knowledgeable, courteous and confidence-inspiring staff”.

7. “Information- customers like to be told where, when and how it will take for services to be delivered”.
8. “Staff attitude-customers like to be valued and want caring, individualized attention. They also noticed the physical (non-verbal communication that indicates the staffs are happy to give services”.

It should be noted that rapid advance in service quality will not be possible without investing in significant resources-human and technology in the ability of the system to handle information, develop new models of care, and disseminate effective innovations..

The following could be used as overall blueprint of high-level strategic goals and objectives of hospitals. These objectives should ensure the health service reformis taking into cognisance (World Health Organization 2000).

- Introduce a conjoint working relationship or effective collaboration with other Teaching Hospitals/agencies
- Ensure the hospital provides best "value for money"
- High level of specialities should be developed especially on tertiary referral services
- Rapid development of infrastructural facilities in the hospital
- Day care facilities should be significantly developed
- Staff recruitment and retention is pivotal

- In economic crisis situation hospitals should ensure core services to be delivered
- Hospital's mission should ensure educational, training and research components should be foster and of high standard
- Processes to evolve management of risk, improvement of quality, clinical audit and accreditation should be in place
- Ensure modern practices, principles, incorporating both corporate and clinical governance
- Funding for minor capital projects/items should be addressed
- Ensure the best use of subvention to reduce the number of delayed discharge patients

## **2.3 Measuring Service Quality**

### **2.3.1 Measurement of Service Quality in Public Hospitals**

Large number of institutions / organizations claim to be offering quality service, service quality or service excellence, but very few of them actually succeed in doing what they claim to be. Many organizations look at service quality as something that an organization can provide for its customers as long as it is profitable to do and can be safely removed when and where the expected profit does not materialize. Some organizations look at it as something that is special and reserved for its profitable customers.

Basically, there are two broad approaches for measuring service quality as explained by Couter (2005) are internal and external service measurement techniques. Each of these approaches would be addressed respectively.

***Internal Service Measurement Techniques-*** by “internal” measurement techniques, it means that customers are not directly involved in the measurement process. Employees or contractors can be made to take place of customers. This techniques can be used in two ways.

Call monitoring- this technique is used in call centres. Someone monitoring service interactions/transaction and judges the quality of service along a determined score line. It can be more than listening it may be “shadow” watching the agent computer screens at a distance.

The advantages of the technique are in several folds. First, the customers are not burdened, and the service agents do not know when they are being monitored. Secondly, the assessment can be in real time. Challenges identified in the process can be appraised and quickly remedied before more clients are affected. Thirdly, service agent should be evaluated based on determined criteria.

This approach has its demerits. First, the monitors use their subjective and qualitative assessments of the agents' words and deeds. More monitors are required to ensure fairness. Secondly, monitors should be trained, ensured they are all evaluating the same way and the set criteria on the score sheet should reflect what is truly of interest to

the customer. Some may contain arbitrary demands that may have no direct bearing to customers. These are products of managerial judgment and not statistical means.

Mystery shopping-This is used heavily in consumer industries that is “get paid while you shop or eat.” However, the concept is applicable in most service environment. It is where a person is hired and assumes the position of a customer and tries to “exercise” the various paths possible in a service interaction. The “shopper” has a similar measurement almost like the call monitoring score sheet.

The focus of this approach is to evaluate the service how the agents and the system as a whole interact. In other approaches one can take what you get. While a shopper does waste a service agent's time, no real customer is directly affected. But the demerit is the cost. Clearly, this process is labour intensive. It would be prohibitively expensive to generate several “shopping” experiences with each service agent. Thus, this technique is not suitable for quality control monitoring. And just as with the call monitors above, the shoppers need to be trained and calibrated, the score sheet needs rigorous development, and summaries must be legitimate.

### ***External Service Measurement Techniques***

In this technique one assumes the position of a customer. The external measurement process feedback is directly captured from consumers of service.

Unsolicited comments- an external measurement technique for complaints or compliments. In this case, the customers take the initiative to tell the organization about their feelings but feedback only come from few customers. The key advantage here is cost. The book, “A Complaint is a Gift”, has made us to understand that complaint is free

market research. But it is not free when the system creates opportunity that encourages comments. However, it is still very cheap among other methods for the value received. At times when customers complain there is the possibility of truth in it. Such complaint is pointing to where the system has not done well. At still it is not without shortcomings. The challenges are not typical in nature and as such needs to be interpreted. Some survey forms of firms hold the view that these outcomes can be applied to every customers but it is so. The purpose of this technique isto honestly request feedback from customers.

Focus groups - known as “small group interviews,” it observed similar strengths and weaknesses of personal interviews. Here group interview is the order and not individual bases within an hour or two. It provides opportunity for group interaction among participants creating room for richer and detailed feedback than individual interview. It answers the ‘why behind the what’ of customer issues and displays good level of efficiency. Problems with group are logistical in nature. Planning and execution are very pivotal. Customers are in diverse geographical location. Hence, ability of the moderator to deliver good facilitation is absolutely critical.

User group feedback- it is a chance to evolve wealth of information collection. It is met for a group of customers who have a strong and committed zeal to the service/products. They are likely and willing to tell what their actual feelings are and what they would expect to see. The strength of the above is also the weakness of the approach. The customers used here are current users with a passion to drive product ideas toward improving the product for their own use. The sought feedback or ideas are not met to

appeal to market expansion. With this customers develop feelings of ownership for product and maybe affectedly dissatisfied when they do not see what they have proposed.

### **2.3.2 Determinants of Service Quality**

Competition, technological innovations, improvements, processes in delivery quality service have resulted in a gradual shift in strategic focus from price to service quality in the health care industry. Continuous flow of improvement in service quality is considered paramount in public hospitals at a time when it is undergoing an extraordinary rate of change in organization, products, as well as delivery methods.

In a related vein, Parasuraman, Zeithaml, and Berry (1985) posits that “Expectations are rarely concerned with a single aspect of the service package but rather with many aspects”. With reference to Parasuraman, et al (1985), they provided a list of criteria or determinants of Service Quality as a result of their focus group studies on service providers and customers. These are explained below;

**Reliability** - this is consistency of performance and dependability. Many of the factors promoting reliability are common to overall success. Efforts are made to ensure that personnel are in adequate supply to complete the required task.

**Responsiveness** – this is the willingness and readiness to perform services by the service providers. Personnel are encouraged to work and display the “spirit of service”. It should be noted that customers have problems, hence, the need for our service, and should be responded to accordingly.

**Competence** – Personnel should possess the required skills and up to date knowledge to perform effectively and efficiently.

**Understanding** – service providers should know and understand the customer's needs and expectations.

**Access** – approachability and ease of access to management should be cordial and flexible.

**Communication** – this is providing the customer (patient as in the case of hospitals) with effective information as and when due and at the service points.

**Courtesy** - this demands that service providers (personnel) should be friendly to customers at all time and should be able to handle customers complaints in the right and appropriate manner.

**Credibility** - trust and personal characteristics of personnel is very significant in the process of service delivery.

**Security** - safety, financial security, and confidentiality should be a cardinal focus.

**Tangibles** – these are parts of communication system, physical evidence of service, reports as well as inspections feedback either evening or morning hours or mid-day.

These determinants were later reduced to 5 (five) by Parasuraman, et al (1988) the reason for the reduction is that the investigation of Parasuraman, et al (1988) explain the fusion of competence, understanding, access, communication, courtesy, creditability as well as security into assurance.

**Tangibles** – physical facilities is the proof of the service: tools, equipment, personnel and communication materials to be used to provide the service.



**Reliability**- it is the service provider's ability to deliver on promised service in accurate, dependable and consistent manner. The firm delivers its promises when service is performed accurately at the right time and designated location.

**Responsiveness** – this is the willingness and readiness of employees to assist customers (patients as in the case of hospitals) and to ensure prompt service delivery in every respect.

**Assurance** – This is the ability to convey trust and confidence, competence (possession of the required skills and knowledge)to perform promised service. This is of utmost necessity.

**Empathy** - customers receive care and personal attention.This sends a message of understanding the specific needs to the customers.

The relevance of these five determinants to this study are: They enhance and show the evidence and appearance of the service, the ability to perform or deliver the promised service, the willingness of employees to help patients, the possession of the needed skills to perform expected service as well as the care required to attend to patients.

## **2.4 Factors affecting Service Quality**

### **2.4.1 Challenges in Service Quality**

According to the American College of Healthcare Executives (2012) financial challenges has been ranked as the top issues confronting hospitals for the past nine years and patients safety quality ranked as the second. For any organization to succeed in this uncertain environment, the issue of finance has to be settled for other things to take the necessary shape in the organization.

The quality of public sector institutions plays a crucial role in access and cost of the public service provided by the government to the citizens. Poor governance has affected greatly public service quality, both directly through higher price, and indirectly through lower quality or quantity available. Service quality is weakened by bad governance and this is a reflection of the kind of policymakers.

The quality of the service provided is not the only dimension through which bad governance may affect users. Bad governance, by promoting misallocation of resources and poor accountability may raise the cost of services both official and unofficial and this limits access of users to public service.

The difficulty of measuring official and unofficial costs and access to a particular public service is one of the major culprits of the lack of empirical studies issues. However, data collection efforts have been supported in several developing countries by the World Bank (2000) to gather country specific surveys of thousands of households, enterprises and public official.

Bribery can affect service quality indirectly by limiting the quantity of service available or reducing the quality, when the funds that could have been used to provide the needed equipment and other facilities in the hospitals are diverted to personal effects the result is what we are seeing today.

#### ***2.4.2 Procurement in the Process of Service Quality***

Information is critical to an effective and efficient service delivery in public hospitals especially in procurement process and financing is the engine that drives it in

the case of Nigeria. Making available sufficient funds for procurement of pharmaceuticals materials remains inevitable and pivotal in medicines procurement. Public hospitals Pharmacists whether directly or indirectly needs sound knowledge of procurement issues and the ability to effectively interact with stakeholders who potentially will be able to affect the process or have legal responsibility.

Procurement in public sector for a long time has been characterized with inefficiency, unabated corruption and high level disregard for value for money. There is no epitome of transparency management in this regard. This has adversely affected the rate and quality of progress in realizing the desired service of public hospitals in EdoState and Nigeria in general.

The idea behind transparency is that by actively disclosing information on how decisions are made as well as measures of performance we can improve public deliberation, reinforce accountability and inform citizen choice. In addition, transparency helps to document and disseminate information on the scope and consequences of corruption as well as help build support for anti-corruption programmes and target enforcement efforts.

## **2.5 Theoretical Framework**

### **2.5.1 Model/Theories for Service Quality**

Conceptual and empirical studies have evolved from past researchers on service quality. Examples are “customers’ experiences with tangibles, reliability, responsiveness, assurance, and empathy aspects of service quality by ” (Parasuraman, *et al.* 1988),

“technical and functional quality” by (Gronroos, 1984), “service product, service environment, and service delivery” by (Rust and Oliver 1994), “interaction quality, physical environment quality and outcome quality” by (Brady and Cronin, 2001). These previous studies are geared towards investigating the meaning of service quality in the various service organizations. In the same process, these models have been channelled to be adopted by the service organizations/institutions as a tool to assist in quality improvement programmes.

In a study carried out by Seith and Deshmukh (2005) they present a list of key service quality models including, Service-Profit Chain Model, (Heskett, Jones, Loveman, Sasser and Schlersiger (1994), Gap Theory or the Service quality gap Model (Parasuraman, et al, 1985,1988), Technical-Functional Quality Model (Gronroos, 1984), and Satisfaction-Service Quality Model (Spreng&Mackoy, 1996). These conceptual Models and others have contributed to the development of the different Schools of thought of service quality.

However, in this study, the Gap Theory also known as Service quality gap Model was adopted. The Model was proposed by Parasuraman, et al (1985, 1988) as  $SQ = \sum(P_i - E_i)$ . The meaning of these alphabets: SQ means quality service or service quality,  $P_i$  means perception and  $E_i$  means expectation.

Service quality is obtained by subtracting expectation score from the perception score for each item  $SQ=P-E$ ). Therefore, if perception exceeds expectation ( $P>E$ ), service quality is very satisfactory. If perception equals expectation ( $P=E$ ), service quality is

satisfactory. However, if expectation exceeds perception ( $E > P$ ) or ( $P < E$ ), service quality is poor.

This model identifies gaps or differences between what customer wants to receive from service provider and perception of service actually received. The model identifies 5(five) gaps. First four gaps are company gaps while the fifth gap is customer gap - as perceived by customer. Customer gap is outcome of the four company gaps. The five quality gaps suggested by Parasuraman, et al. (1985, 1988) are briefly highlighted before the elaborate explanation.

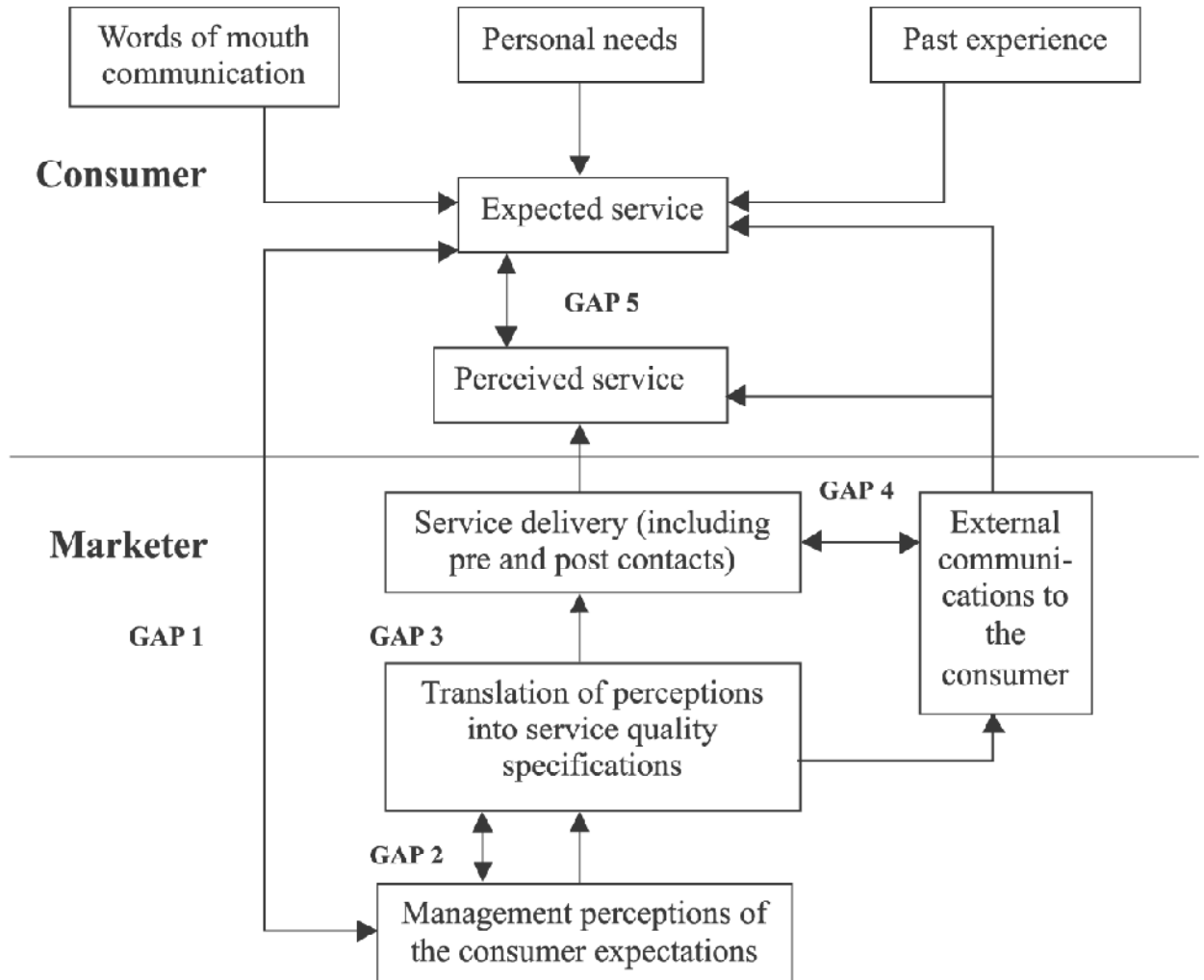
**Gap 1:** This is the difference between what customer actually expects and company's perception of what customer desires

**Gap 2:** The difference between company's perception of desired service to customer, and the designed service to be delivered by company and the performance standards set for the same

**Gap 3:** Gap between the service design and actual service delivered

**Gap 4:** Gap between actual service delivered and the service as perceived by customer

**Gap 5:** The difference between service as perceived by customer and service expected by company



**The diagram above is the adopted Gap Model**

Source: Parasuraman, A., Zeothamel, V. & Berry, L. L (1985)

The Model apart from being a measurement instrument it is also a management Model. The identified 5 Gaps cause customers or patients to experience poor service quality. The ‘gaps’ cause unsuccessful delivery.

**GAP 1: Consumer expectation and management perception gap:** This is when management seems not to understand correctly what customers expectation is. For instance – health- care managers may think patients desire good meals but patients may be interested with the nurses’ responsiveness. Possible factors leading to this gap could be:

- a) Insufficient marketing research
- b) Poorly interpreted information about the needs of the audience's
- c) When research is not channelled on quality
- d) When there are too many channels between the front line personnel and the top level of management

**GAP 2: Management perception and service quality specification gap:** management may perceive correctly what the customer desires but the right performance standard might not be there. An example would be that hospital management may inform nurses to respond to a request ‘fast’, but may not specify “how fast”. This could occur due to the following reasons:

- a) Insufficient planning procedures
- b) When management is not commitment
- c) When service design is too ambiguous
- d) New service process not systematic

**GAP 3: Service quality specification and service delivery gap:** This is from service personnel: poor training, incapability and unwillingness to meet the standard set for service. Reasons for this gap are:

- a) Deficiencies in human resource policies such as ineffective recruitment, role ambiguity, role conflict, improper evaluation and compensation system
- b) Internal marketing not coherently effective
- c) Demand and supply imbalance
- d) No customer education and training

**GAP 4: Service delivery and external communication gap:** what consumers' desires are determined by what the message of representatives and advertisements portray. Gap arises when perceived expectations are not met accordingly at the point of service delivery. For example, the hospital may have on its diary clean and well furnished rooms but in reality it is poorly maintained. In this case the patient's hope is dashed. Discrepancy on what the actual service is and the promised may exist due to:

- a) Over-promising in external communication campaign
- b) Inability to manage customer expectations
- c) Failure to deliver promised specifications

**GAP 5: Expected service and experienced service gap:** This exists when the consumer has a wrong understanding of service quality. For instance, hospital Doctor might be visiting patient to show care but patient may misunderstand this as an indication that something serious is going wrong.

The reasons for adopting this model in spite of some criticisms is that the researcher is of strong opinion that the Model is relevant and useable, hence the application in this research study.



The Model is flexible and has been designed to be applicable in a wide spectrum of services. The format could be adapted to fit to specific needs. The Model helps to bring out management shortfalls as well as the gaps. It would assist managers to re-deploy resources to specific areas of need.

### ***2.5.2 Criticism***

The service quality (SERVQUAL) Model has been extensively adopted by a number of researchers to measure service quality. In spite of its wide use, SERVQUAL five-factor instrument for ascertaining the level of service quality has been subjected to criticisms, theoretically, operationally, conceptually as well as empirically, Buttle (1996), Van Dyke, Kappelman, & Prybutok (1997). Some studies do not succumb to the five-factor structure advanced by Parasuraman, et al (1988).

Buttle (1996) opines that theoretically SERVQUAL model rest on the basis of an expectation-disconfirmation model when it is supposed to be an attitudinal model. He goes further to explain that the model 'is not based on well-known established economic, statistical, psychological theory or background', that SERVQUAL model stressed on the process of service delivery while it is supposed to look at the endings and outcomes of customers experience.

Van Dyke et al. (1997) criticised SERVQUAL model for using two different instruments for measuring two different concepts-“perceptions and expectations”; that to measure a third concept, “perceived service quality”, direct measurement is better. He further says that the model has empirical problems of low reliability and dimensionality. Ladhari (2008) argues that the use of gaps score is not the right method “because of the

lack of the support in literature to consumers evaluating service quality in terms of perceptions-minus-expectation". He also stresses that it has been recommended that service quality is more precisely and correctly evaluated by measuring only perception of quality, and lastly, that the concept expectation is not well defined and could be interpreted in different ways.

The achievement of quality in products/services has become of pivotal interest since 1980s. Quality in tangible goods has been described and measured by marketer. Quality in services is largely undefined and un-researched. Previous studies have made attempt to rectify by reporting the insights observed in exploratory investigation of quality in four service businesses. By this models of service quality were developed. Propositions and recommendations to enhance and foster furtherresearch on service quality were offered.

Service quality is the result of comparison customers make between expectations of a service and perception of the way the service was delivered (Lehtinen&Lehtinen 1982), while (Cardozo 1965, Churchill and Suprenant 1982) identified the foundation of service quality theory as having connection with product quality and customers satisfaction literature base on disconfirmation paradigm this was cited by (Brady & Cronin 2001). This understanding shows the size and direction of a person's initial perception position with respect to experience received.

Arising from the above, the disconfirmation is the size of the gap between prior expectation and actual performance received. This was cited by (Parasuraman, et al, 1985). According to these theories directions are in three classes: positive, negative and zero disconfirmations. Thisimplies that when a service is delivered better than

expectation a positive disconfirmation occurs resulting in satisfaction. When a service is performed below expectation a negative disconfirmation occurs resulting in dissatisfaction. But when a service is performed as expected zero disconfirmation occurs.

The contributions of (Parasuraman, et al 1988), is very spectacular in service quality because it developed a generic instrument called SERVQUAL that measures service quality based on input from focus groups. SERVQUAL was developed within the marketing sector but to a great extent, it is now being applied in other organizational settings. Service quality as a dynamic concept is still growing and will continue to advance as researches posit. Contributions of various authors also show that as long as the world is not static, there would be changes as well as improvement in service delivery by organizations.

Francis Buttle (1996) criticizes the Model in this article "SERVQUAL; review, critique, research agenda" and comes up with two clusters of criticisms based on theoretical and operational criteria. Nyeck, Morales, Ladhari, & Pons (2002) also review 40 articles that made use of SERVQUAL and discovered "that few researchers concern themselves with the validation of the measuring tool".

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter examines the methods that the study adopted in achieving the objectives of the study. Thus, the chapter presents the procedures, modalities, and sequential steps which the researcher adopted to ensure that the results of this research are dependable and valid. The chapter focuses on the research design, sampling techniques, operationalization of variables and method of data analysis.

#### **3.2 Research Design**

The study adopted the survey method. It is a systematic process of gathering relevant information from respondents for the purpose of understanding as well as predicting some aspects of the behaviour of the population of interest so as to obtain answers to research questions.

#### **3.3 Population and Sampling**

The population of this study consists of patients of the University of Benin Teaching Hospital, Benin, and General Hospital, Usen. Population size of 2350 was used. This was gotten from the records of registered patients for 21 working days in the month of May, 2013

### ***Sample Size***

The sample size for this study was 241 (two hundred and forty one) respondents which was drawn from the patients of University of Benin Teaching Hospital, Benin City and General Hospital, Usen.

Using the Yaro Yamani formula to determine the sample size

$$n = \frac{N}{1+N(e)^2}$$

Where: n = sample size

N = population

e = level of significance at 5 % (0.05)

$$\text{Thus } n = \frac{2350}{1 + (2350) (0.05)^2}$$

$$n = 241.02$$

Approximately 241

### ***Sampling Techniques***

The sampling method used in this study was the convenient sampling technique for the patients of both hospitals. This is because the patients were conveniently selected.

### **3.4 Operationalization and Measurement of Variables**

The five-point scale Likert-type question response format was adopted, the following values were assigned to the responses: Strongly Agree (SA) = 5 points; Agree (A) = 4 point; Not sure (NS) = 3point, Disagree (D) = 2; and Strongly Disagree (SD) = 1

### **3.5 Research Instrument**

The primary data for this study consists of information elicited from the sampled respondents. The questionnaire was used to elicit the primary data. The questionnaire consists of two parts – part one, the bio-data, which focuses on the demographic and personal data of the respondents; while part two addressed issues on the core subject matter of the study – ‘Patients’ Perception of Service Quality and Patients’ Satisfaction in selected Public Hospitals’ in Benin City. The question-response format consists of Likert-type questions, with options on the five-point scale ranging from a level of strong agreement (Strongly Agree), through a neutral zone (Not sure) to a level of strong disagreement (Strongly Disagree). Permission was obtained from the hospitals management to administer and retrieved the questionnaire and it was done personally with the assistance of few persons.

### **3.6 Sources of data**

The study utilized primary data. The responses elicited from the sampled respondents from the patients of University of Benin Teaching Hospital and the General Hospital, Usen, using the research instrument (the questionnaire) constituted the primary data.

### **3.7 Method of Data analyses plan**

The research data were analyzed using descriptive and inferential statistics. Descriptive statistics used include frequency tables, percentages, mean, standard deviation, and standard error of the mean. On the other hand, Student t-Test and Pearson Correlation analysis served as the inferential statistics. The choice of the Student t-test

was informed by the need to test for difference between two population means in two of the hypotheses; by splitting the responses elicited from the respondents into two groups, while Pearson Correlation analysis was used to test the influence of time spent at service points on patients' satisfaction with service quality in selected public hospitals Benin City.

## CHAPTER FOUR

### DATA PRESENTATION AND ANALYSES

#### 4.1 INTRODUCTION

In the first part of this chapter, the research data are presented and analyzed using descriptive statistics like frequency tables as well as inferential statistics such as the Pearson Correlation and the t-test for difference between two population means. Out of a total of 241 questionnaires that were administered, 210 representing 87.1% were retrieved. Out of the 210 questionnaire only 159 were found useable. 83 respondents were patients of General Hospital, Usen, while the remaining 76 were patients of University of Benin Teaching Hospital. Data analysis was done, using the Statistical Package for the Social Sciences (SPSS 16.0).

#### 4.2 Characteristics of the Sample

**Table 4.1 Demographic Profile of Respondents**

Table 4.1 shows demographic and personal characteristics of the respondents.

S/N	Categories	Response	
		Freq.	Percentage
<b>1.</b>	<b>Gender</b>		
	Male	64	40.25
	Female	95	59.75
<b>2.</b>	<b>Marital Status</b>		
	Single	20	12.6
	Married	120	75.5
	Widowed	15	9.4
	Divorced	4	2.5
<b>3.</b>	<b>Highest Educational Qualification</b>		
	SSCE	95	59.75
	OND/NCE	37	23.28
	HND/First Degree	15	9.43
	Higher Degree	12	7.54
<b>4</b>	<b>Health Institution</b>		
	University of Benin Teaching Hospital Patients		



	Outpatients	49	64.47
	Inpatients(Admitted)	27	35.53
	General Hospital, Usen, patients		
	Outpatients	51	61.45
	Inpatients(Admitted)	32	38.55

Source: Field work 2013, computation SPSS 16.0

The result in table 4.1 above shows that 64(40.25%) of the respondents were males while 95 (59.75%) were females. The marital distribution shows that majority of these respondents were married 120(75.5%), followed by single 20 (12.6%), widowed 15(9.4%) and divorced 4(2.5%). Furthermore, SSCE 95 (59.75), followed by OND/NCE 37 (23.28%), HND/First Degree 15 (9.43%). and Higher Degree 12 (7.54%). Respondents institution revealed that outpatients 49 (64.47%) and inpatients 27 (35.53%) were patients from University of Benin Teaching Hospital while 51 (61.45%) and inpatients 32 (38.55%) were patients from General Hospital, Usen.

#### 4.2.3 Indices of Patients Satisfaction with service in selected Public Hospitals

Table 4.2 *Indices of Patients Satisfaction with Service in selected Public Hospitals*

S/N	Patients Satisfaction indicator	Response				
		SA	A	Not Sure	D	SD
1.	Reliability	68 (42.8)	38(23 .9)	35 (22.0)	10 (6.3)	8 (5.0)
2.	Responsiveness	42 (26.4)	40 (25.2)	38 (23.9)	21 (13.2)	18 (11.3)
3.	Competence	76 (47.8)	38 (23.9)	25 (15.7)	10 (6.3)	10 (6.3)
4.	Accessibility	50 (31.4)	50 (31.4)	25 (15.7)	18 (11.3)	16 (10.1)
5.	Courtesy	60 (37.7)	40 (25.2)	30 (18.9)	16 (10.1)	13 (8.1)
6.	Credibility	51 (32.1)	56 (35.2)	36 (22.6)	10 (6.3)	6 (3.8)

Source: Field work 2013, computation SPSS 16.0.

From the results in table 4.3 above, 68(42.8%) and 38 (23.9%) respondents asserted that they strongly Agree and Agree respectively that reliability is an index of patients satisfaction with service rendered in public hospitals. On the other hand, the figure for undecided, Disagree and Strongly Disagree are 35 (22%), 10 (6.3%) and 8 (5%) respectively. The figure for respondents who posit that Responsiveness is an index of patients satisfaction with service quality in public hospital are 42 (26.4%) and 40 (25.2%). The equivalent figure for Undecided, Disagree and Strongly Disagree are 38 (23.9%), 21 (13.2%) and 18 (11.3%) respectively. With regard to Competence as index of patients satisfaction with service quality in selected public hospital, 76 (47.8%) and 38 (23.9%) respondents claimed Strongly Agree and Agree. The figure for Undecided, Disagree and Strongly Disagree are 25 (15.7%), 10 (6.3%) and 10 (6.3%) respectively. The responses of respondents to Accessibility as an index of patients satisfaction with service quality in selected public hospital, 50 (31.4%) and 50 (31.4%) responded Strongly Agree and Agree. The equivalent figures for Undecided, Disagree and Strongly Disagree are 25 (15.7%), 18 (11.3%) and 16 (10.1%) respectively. While responding to the question of courtesy as an index of patients' satisfaction with service quality in selected public hospital, 60 (37.7%) and 40 (25.2%) Strongly Agree and Agree. That notwithstanding, 30 (18.9%) were Undecided while 16 (10.1%) representing Disagree and Strongly Disagree 13 (8.1%). Looking at credibility as an index of patients' satisfaction with service quality in selected public hospital, 51 (32.1%) Strongly Agree, Agree 56 (35.2%), 36 (22.6%) Undecided while 10 (6.3%) and 6 (3.8%) Disagree and strongly disagree respectively.

**Table 4.3: Indices of Quality Service in selected Public Hospitals**

S/N	Service Quality Indicator	Response				
		SA	A	Not Sure	D	SD
1.	Reliability	47 (29.6)	47 (29.6)	26 (16.4)	18 (11.3)	21 (13.2)
2.	Responsiveness	50 (31.4)	55 (34.6)	31 (19.5)	10(6.3)	13 (8.2)
3.	Competence	49 (30.8)	69 (43.4)	19 (11.9)	14 (8.8)	8 (5.0)
4.	Accessibility	46 (28.9)	69 (43.4)	23 (14.5)	13 (8.2)	8 (5.0)
5.	Courtesy	44 (27.7)	68 (42.8)	24 (15.1)	15 (9.4)	8 (5.0)
6.	Credibility	43 (27)	75 (47.2)	16 (10.1)	16 (10.1)	9 (5.7)

Source: Field work 2013, computation SPSS 16.0.

Results in table 4.4 indicate that majority of the respondents either agreed or strongly agreed that the indices of quality service influence their satisfaction with the services rendered by the service providers. Responses to Reliability revealed that 47 (29.6%) Strongly Agree and 47 (29.6%) Agree. 26 (16.4%) Undecided, 18 (11.3%) Disagree and 21 (13.2%) Strongly Disagree. As In respect of Responsiveness, 50 (31.4%) strongly Agree, 55 (34.6%) Agree, 31(19.5%) Undecided, 10 (6.3%) and 13 (8.2%) Strongly Disagree. As for Competence, 49 (30.8%) Strongly Agree, 69 (43.4%) Agree, 19 (11.9%) Undecided, 14 (8.8%) Disagree and 8 (5.%) Strongly Disagree. Responding to item on Accessibility, 46 (28.9%) Strongly Agree, 69 (43.4%) Agree, 23 (14.5%) Undecided, 13 (8.2%) Disagree and 8 (5 %) Strongly Disagree. The responses to

Courtesy showed that 44 (27.7%) Strongly Agree, 68 (42.8%) Agree, 24 (15.1%) Undecided, 15 (9.4%) Disagree and 8 (5.%) Strongly Disagree. Finally, while responding to Credibility, 43 (27%) Strongly Agree, 75 (47.2%) Agree, 16 (10.1%) Undecided, 16 (10.1%) Disagree and 9 (5.7%) Strongly Disagree.

#### 4.2.4 Time spent by Patients at the various Service Points in Selected Public Hospitals

Table 4.4: Time spent by patients at the various service points in selected Public Hospitals in Benin City

S/N	Statement	Response				
		SA	A	Not Sure	D	SD
1.	Time spent on registration (Card Collection)	52 (32.7)	72 (45.3)	13 (8.2)	16 (10.1)	6 (3.8)
2.	Time spent on Examination (Check-up)	57 (35.8)	69 (43.4)	19 (11.9)	10 (6.3)	4 (2.5)
3.	Time spent on Consultation (Seeing the Doctor)	51 (32.1)	57 (35.8)	25 (15.7)	16 (10.1)	10 (6.3)
4.	Time spent on Treatment	59 (37.1)	68 (42.7)	16 (10.1)	14 (8.8)	2 (1.3)

Source: Field work 2013, computation SPSS 16.0.

The results in table 4.4 above show the responses of patients to question of satisfaction with the time spent on registration 52 (32.7%) Strongly Agree, 72 (45.3%) Agree, 13 (8.2%) Undecided, 16 (10.1%) Disagree and 6 (3.8%) Strongly Disagree .On satisfaction of time spent at the stage of Examination (check-up), 57 (35.8%) Strongly Agree, 69 (43.4%) Agree, 19 (11.9%) Undecided, 10 (6.3%) Disagree and 4 (2.5%) Strongly Disagree. .When asked of time at the consultation stage, 51 (32.1%) Strongly Agree, 57 (35.8%) Agree, 25 (15.7%) Undecided, 16 (10.1%) Disagree and 10 (6.3%) Strongly Disagree. 59 (37.1%) Strongly Agree that they were satisfied with the time

spent at the treatment stage while 68 (42.7%) Agree. 16 (10.1%) did not decide, while 14 (8.8%) and 2 (1.3%) Disagree and strongly disagree respectively.

### 4.3 Data presentation and analyses for hypothesized relationship of variables

Three hypotheses were tested and the outcome of the test is as follows:

**Table 4.5:** Differences in Quality Service between University Benin Teaching Hospital and General Hospitals, Usen.

		N	Mean	Std. Deviation	Std. Error			P
						Df	T	
reliability.q	UBTH	76	3.6447	1.35355	.15526	157	1.428	.234
	Usen	83	3.3855	1.37780	.15123			
	Total	159		1.36812				
responsiveness.q	UBTH	76	3.7368	1.14738	.13161	157	.013	.908
	Usen	83	3.7590	1.25514	.13777			
	Total	159		1.20110				
competency.q	UBTH	76	3.9079	1.13346	.13002	157	.254	.615
	Usen	83	3.8193	1.08363	.11894			
	Total	159		1.10510				
accessibility.q	UBTH	76	3.8816	1.05789	.12135	157	.321	.572
	Usen	83	3.7831	1.12671	.12367			
	Total	159		1.09202				
courtesy.q	UBTH	76	4.0000	.89443	.10260	157	5.617	.019
	Usen	83	3.5904	1.23995	.13610			
	Total	159		1.10445				
credibility.q	UBTH	76	3.8553	1.04184	.11951	157	.370	.544
	Usen	83	3.7470	1.18778	.13038			

Source: Field work 2013, computation SPSS 16.0

Hypothesis 1 predicted that the quality of service at University of Benin Teaching Hospital is not better than the quality of service at General Hospitals, Usen.

From the results, it was evidenced that the hypothesis was supported in all the indices of quality service except for courtesy at a level of 0.05 (2-tailed), ( $t=5.617$ ,  $df=157$ ,  $p>0.019$ ).

**Table 4.6:** Differences in perception between patients of General Hospital, Usen and University of Benin Teaching Hospital on satisfaction with services received.

		N	Mean	Std. Deviation	Std. Error	Df	T	P
Reliability	UBTH	76	3.8947	1.13817	.13056	157	.139	.710
	Usen	83	3.9639	1.19395	.13105			
	Total	159						
Responsiveness	UBTH	76	3.4474	1.27953	.14677	157	.057	.812
	Usen	83	3.3976	1.35196	.14840			
	Total	159			.			
Competency	UBTH	76	4.0526	1.27431	.14617	157	.213	.645
	Usen	83	3.9639	1.15237	.12649			
	Total	159			.			
Accessibility	UBTH	76	3.6053	1.26574	.14519	157	.201	.655
	Usen	83	3.6988	1.35912	.14918			
	Total	159						
Courtesy	UBTH	76	3.8816	1.22166	.14013	157	1.725	.191
	Usen	83	3.6145	1.33281	.14629			
	Total	159						
Credibility	UBTH	76	3.9211	1.06787	.12249	157	.447	.505
	Usen	83	3.8072					

Source: Field work 2013, computation SPSS 16.0

Hypothesis 2 stated that: The patients of General Hospital, Usen are not more satisfied with the service received than University of Benin Teaching Hospital. The data analyzed using T-test statistic gave a calculated value for Reliability of  $t=.139$  at a significant level of 0.05 (2-tailed), Responsiveness  $t=.057$  at a significant level of 0.05 (2-tailed), Competency  $t=.213$  at a significant level of 0.05 (2-tailed). As for Accessibility  $t=.201$  at a significant level of 0.05 (2-tailed), Courtesy  $t=1.725$  at a significant level of 0.05 (2-tailed). The calculated statistic  $t=.447$  at a significant level of 0.05 (2-tailed). Thus, the hypothesis was confirmed. The results statistically showed that there is no significant difference between satisfaction of patients of University of Benin Teaching Hospital and General Hospital, Usen. See table 4.7.

**Table 4.7** Relationship between time spent at service points and patients' satisfaction with quality service in public hospitals

<b>Variable</b>	<b>N</b>	<b>Mean</b>	<b>SD</b>	<b>DF</b>	<b>R</b>	<b>P</b>
Patients satisfaction with quality service	<b>159</b>	<b>3.7694</b>	<b>.8182</b>	<b>157</b>	<b>.161</b>	<b>.043</b>
time spent at service points	<b>159</b>	<b>3.9497</b>	<b>.4878</b>			

Source: Field work 2013 and computation SPSS 16.0.

Hypothesis 3 stated that there is no relationship between time spent at service points and patients' satisfaction with quality service in public hospitals. The data which was analyzed using Pearson Correlation analysis gave a calculated value of  $r=.161$  at a significant level of 0.05 (2-tailed). The calculated statistic  $r=.161$  was found to be greater than the critical value of  $r=.043$ . This statistically showed that there is relationship

between time spent at service points and patients' satisfaction with quality service in public hospitals.

#### **4.4 Discussion of findings**

Here, we discuss our findings in relation to similar researches. Results of the inferential analyses for hypothesis one stated that indices of quality of service at University of Benin Teaching Hospital is not better than that of General Hospital, Usen was not supported except for courtesy. This finding is consistent with Parasuraman et al (1985) study on the determinants of quality service. From the analysis, it is safe to conclude that quality of service at University of Benin Teaching Hospital, Benin City and General Hospital, Usen are the same. This means that the personnel, facilities as well as the working condition is the same.

Hypothesis two which stated that patients of General Hospital, Usen are not more satisfied with the services they received than patients of University of Benin Teaching Hospital was accepted or supported. Specifically, it was observed that the patients of both Hospitals were satisfied alike. This revealed that the indices used by the patients' in appraising the hospital in the study: reliability, responsiveness, competency, accessibility, courtesy as well as creditability are the same. Hence, the patients' satisfaction is the same in both hospitals.

Lastly, hypothesis three which states that there is no relationship between time spent at service points and patients' satisfaction with quality service in public hospitals was not accepted. The implication is that there is significant improvement on the part of hospitals management in response to patients' in terms of time spent at service points (registration, examination, consultation and treatment) in public hospitals in Nigeria. This



result agrees with the findings of World Health Organization (2000), Servicom (2007), Abdullah (2007) and Ibadin&Ebohon (2009).

## **CHAPTER FIVE**

### **SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

The study was carried out primarily to examine perceived service quality and patients satisfaction in selected public hospitals in Benin City. In an attempt to achieve this, a number of research questions were raised which led to the generation of objectives and formulation of three hypotheses. In the concluding chapter therefore, presents a summary of findings from the analyses in chapter four, a discussion of these findings and the conclusions that were drawn from them. Thereafter, we shall briefly state the recommendations from this study and areas of further research. .

#### **5.2 Summary of Findings**

The research findings are as follows

1. The quality of service at University of Benin Teaching Hospital is not better than that of the General Hospital, Usen. The services of both hospitals are okay.
2. The patients of General Hospital, Usen are not more satisfied with the services they received than patients of University of Benin Teaching Hospital and that they are both satisfied alike.
3. There is a positive relationship between time spent at service points and patients' satisfaction with quality service in public hospitals.
4. Reliability, Responsiveness, Courtesy, and Credibility significantly enhance patients' satisfaction with service delivery in Nigeria.

### **5.3 Contributions to knowledge**

The study has contributed to knowledge in the following ways:

- (1) The study provided insight that there is a significant improvement in quality service in public hospitals in Benin City in terms of time patients at service points.
- (2) The study identified indices of service quality as a predictor of patients' satisfaction.
- (3) The study also identified that patients of both hospitals are satisfied alike.

### **5.4 Conclusion**

The research conclusions are as follows:

1. Some of the indices used by patients of University of Benin Teaching Hospital and General Hospital, Usen, in measuring service quality include - Reliability, Responsiveness, Courtesy and Credibility, Competence, and Accessibility;
2. Employees in University of Benin Teaching Hospital and General Hospital, Usen, are Reliable, Responsive, Courteous, and Credible;
3. Patients are significantly satisfied with service time, especially time spent on registration (card collection), examination (check up), consultation (seeing the doctor) and treatment.

## **5.5 Recommendations**

### **5.5.1 Policy Recommendations**

Healthcare delivery is of vital importance to any economy because good health is a sine-qua-non for optimum productivity. This underscores the need for policy makers in government to ensure that the quality of service delivery in health institutions, whether public or private, is not compromised for any reason. In view of the problem definition and research findings, the following recommendations are suggested:

1. Federal, States and Local Government should set up adequate machinery to monitor service delivery at healthcare institutions to ensure that such service delivery conforms to set standards. They can even conduct surveys on “Patients’ Satisfaction with Service Delivery at Health Institutions” with a view to ascertaining patients’ perception of the quality of services provided by Healthcare Institutions;
2. Since it is evident that patients are significantly satisfied with service time, especially time spent on registration (card collection), examination (check up), consultation (seeing the doctor) and treatment, conscious efforts should be made by policy makers and indeed all stakeholders to improve service time at the healthcare delivery centers with a view to optimizing patients’ time at the healthcare centers;
3. Policy makers should find set standards and benchmarks on service times, especially time spent on registration (card collection), examination (check up), consultation (seeing the doctor) and treatment with a view to ensuring adequate comparison with actual times at the healthcare delivery centers. This will help to

ensure adequate control of deviations as well as significantly reduce unnecessary agitations by patients; and

4. Future studies should seek to ascertain the average time spent by patients before being attended to at various service points in public hospitals as well as the level of patients' satisfaction with service quality and the challenges confronting patients of public hospitals.

### **5.5.2 Recommendations for Further Studies**

First, further research study should be broadened to include comparison of service quality between public hospitals. Second, it would be valuable to conduct further research on service quality among the different sectors or industries, for instance, health and education, banking and aviation, telecommunication firms and a host of others. Further research studies in these areas would contribute to the overall improvement of service quality in Benin City in particular and Nigeria in general.

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## **APPENDIX I: QUESTIONNAIRE**

Department of Business  
Administration  
Faculty of Management Sciences  
University of Benin  
Benin City

Dear Sir/Madam,

### **REQUEST FOR ASSISTANCE IN COMPLETING A QUESTIONNAIRE**

I am a post-Graduate student of the above-named Department and institution. I am currently conducting a study on “Perceived Service Quality and Patients Satisfaction in Selected Public Hospitals in Benin City, Nigeria”. Please find attached a list of questions on the above captioned.

It will be highly appreciated if you will be kind enough to answer the questions as frankly as possible.

Be assured that your response will be treated in strict confidence and used solely for the stated academic purpose.

Yours Faithfully

-----  
Aigbomian, S. E.

## QUESTIONNAIRE

**INSTRUCTION:** Kindly tick the appropriate options and fill the blank spaces

Note: S.A: Strongly Agree; A: Agree; NS: Not Sure; D: Disagree; SD; Strongly Disagree.

### SECTION A

#### Bio-Data

1. Sex: Male [    ] Female [    ]
2. Marital status single [    ] Married [    ] Divorced [    ] Widowed [    ]
3. Highest Academic Qualification: SSCE [    ] HND/First Degree [    ] Higher Degree [    ]
4. Patients' Hospital: UBTH [    ] General Hospital Usen [    ]

### SECTION B

#### Indices of Service quality in selected Public Hospitals

**Instruction:** Please indicate the extent to which you agree that the following are indices of quality in public hospitals

S/N	Statement	SA	A	NS	D	SD
5	Reliability					
6	Responsiveness					
7	Competence					
8	Accessibility					
9	Courtesy					
10	Credibility					

## SECTION C

### Patients' Satisfaction with Service

**Instruction:** Please indicate the extent to which you are satisfied with the services of employees in this hospital with respect to:

S/N		SA	A	NS	D	SD
11	Reliability					
12	Responsibility					
13	Competence					
14	Accessibility					
15	Courtesy					
16	Credibility					

## SECTION D

### Time spent at Service Points in selected Public Hospital

**Instruction:** Please indicate the extent to which you are satisfied with the time spent at each of the following service points in this Hospital:

S/N	Statement	SA	A	NS	D	SD
17	Registration (Card Collection)					
18	Examination (Check-Up)					
19	Consultation (Seeing the Doctor)					
20	Treatment					

**THANK YOU.**

EQUENCIES VARIABLES=sex marital\_status patient\_reliability responsiveness  
 competency accessibility courtesy credibility  
 reliability.qresponsiveness.qcompetency.qaccessibility.qcourtesy.qcredibility.q  
 registration examination consultation treatment /STATISTICS=MEAN  
 /ORDER=ANALYSIS.

**Frequencies\_Patients**

**Notes**

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Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics are based on all cases with valid data.

	Syntax	<pre> FREQUENCIES VARIABLES=sex marital_status patient reliability responsiveness competency accessibility courtesy credibility reliability.qresponsiveness.qcompetency .qaccessibility.qcourtesy.qcredibility.q registration examination consultation treatment  /STATISTICS=MEAN  /ORDER=ANALYSIS. </pre>
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[DataSet0]

**Statistics**

		Sex	marital_status	Patient	reliability	responsiveness	Competency
N	Valid	159	159	159	159	159	159
	Missing	0	0	0	0	0	0
	Mean	1.4494	1.4717	1.5220	3.9308	3.4214	4.0063

**Statistics**

		accessibility	Courtesy	credibility	reliability.q	responsiveness.q	competency.q
N	Valid	159	159	159	159	159	159
	Missing	0	0	0	0	0	0
	Mean	3.6541	3.7421	3.8616	3.5094	3.7484	3.8616

**Statistics**

		accessibility.q	courtesy.q	credibility.q	Registration	Examination
N	Valid	159	159	159	159	159
	Missing	0	0	0	0	0
	Mean	3.8302	3.7862	3.7987	3.9308	4.0377

**Statistics**

		consultation	Treatment
N	Valid	159	159
	Missing	0	0
	Mean	3.7736	4.0566

## Frequency Table

### Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	64	40.25	44.9	55.1
	Female	95	59.75	55.1	100.0
	Total	159	100	100.0	

### marital\_status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	20	12.6		
	Married	120	75.5		
	Widowed	15	9.4		
	Divorced	4	2.5		
	Total	159	100.0		



**Patient**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	UBTH	76	47.8	47.8	47.8
	usen	83	52.2	52.2	100.0
	Total	159	100.0	100.0	

**Reliability**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	8	5.0	5.0	5.0
	Disagree	10	6.3	6.3	11.3
	undecided	35	22.0	22.0	33.3
	Agree	38	23.9	23.9	57.2
	strongly agree	68	42.8	42.8	100.0
	Total	159	100.0	100.0	

### Responsiveness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	18	11.3	11.3	11.3
	Disagree	21	13.2	13.2	24.5
	undecided	38	23.9	23.9	48.4
	Agree	40	25.2	25.2	73.6
	strongly agree	42	26.4	26.4	100.0
	Total	159	100.0	100.0	

### Competency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	10	6.3	6.3	6.3
	Disagree	10	6.3	6.3	12.6
	undecided	25	15.7	15.7	28.3
	Agree	38	23.9	23.9	52.2
	strongly agree	76	47.8	47.8	100.0
	Total	159	100.0	100.0	

**Accessibility**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	16	10.1	10.1	10.1
Disagree	17	10.7	10.7	20.8
undecided	25	15.7	15.7	36.5
Agree	50	31.4	31.4	67.9
strongly agree	50	31.4	31.4	99.4
6.00	1	.6	.6	100.0
Total	159	100.0	100.0	

**Courtesy**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	13	8.2	8.2	8.2
Disagree	16	10.1	10.1	18.2
undecided	30	18.9	18.9	37.1
Agree	40	25.2	25.2	62.3
strongly agree	60	37.7	37.7	100.0
Total	159	100.0	100.0	

**Credibility**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	6	3.8	3.8	3.8
	Disagree	10	6.3	6.3	10.1
	undecided	36	22.6	22.6	32.7
	Agree	56	35.2	35.2	67.9
	strongly agree	50	31.4	31.4	99.4
	6.00	1	.6	.6	100.0
	Total	159	100.0	100.0	

**reliability.q**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	21	13.2	13.2	13.2
	Disagree	18	11.3	11.3	24.5
	undecided	26	16.4	16.4	40.9
	Agree	47	29.6	29.6	70.4
	strongly agree	47	29.6	29.6	100.0
	Total	159	100.0	100.0	

**responsiveness.q**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	13	8.2	8.2	8.2
Disagree	10	6.3	6.3	14.5
undecided	31	19.5	19.5	34.0
Agree	55	34.6	34.6	68.6
strongly agree	50	31.4	31.4	100.0
Total	159	100.0	100.0	

**competency.q**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	8	5.0	5.0	5.0
Disagree	14	8.8	8.8	13.8
undecided	19	11.9	11.9	25.8
Agree	69	43.4	43.4	69.2
strongly agree	49	30.8	30.8	100.0
Total	159	100.0	100.0	

**accessibility.q**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	8	5.0	5.0	5.0
Disagree	13	8.2	8.2	13.2
undecided	23	14.5	14.5	27.7
Agree	69	43.4	43.4	71.1
strongly agree	46	28.9	28.9	100.0
Total	159	100.0	100.0	

**courtesy.q**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	8	5.0	5.0	5.0
disagree	15	9.4	9.4	14.5
undecided	24	15.1	15.1	29.6
agree	68	42.8	42.8	72.3
strongly agree	44	27.7	27.7	100.0
Total	159	100.0	100.0	

**credibility.q**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	9	5.7	5.7	5.7
disagree	16	10.1	10.1	15.7
undecided	16	10.1	10.1	25.8
agree	75	47.2	47.2	73.0
strongly agree	43	27.0	27.0	100.0
Total	159	100.0	100.0	

**Registration**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	6	3.8	3.8	3.8
disagree	16	10.1	10.1	13.8
undecided	13	8.2	8.2	22.0
agree	72	45.3	45.3	67.3
strongly agree	52	32.7	32.7	100.0
Total	159	100.0	100.0	

**Examination**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	4	2.5	2.5	2.5
	disagree	10	6.3	6.3	8.8
	undecided	19	11.9	11.9	20.8
	agree	69	43.4	43.4	64.2
	strongly agree	57	35.8	35.8	100.0
	Total	159	100.0	100.0	

**Consultation**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	10	6.3	6.3	6.3
	disagree	16	10.1	10.1	16.4
	undecided	25	15.7	15.7	32.1
	agree	57	35.8	35.8	67.9
	strongly agree	51	32.1	32.1	100.0
	Total	159	100.0	100.0	



**Treatment**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly disagree	2	1.3	1.3	1.3
disagree	14	8.8	8.8	10.1
undecided	16	10.1	10.1	20.1
agree	68	42.8	42.8	62.9
strongly agree	59	37.1	37.1	100.0
Total	159	100.0	100.0	

**Descriptives**

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Reliability	UBTH	76	3.8947	1.13817	.13056	3.6347	4.1548	1.00	5.00
	usen	83	3.9639	1.19395	.13105	3.7032	4.2246	1.00	5.00
	Total	159	3.9308	1.16445	.09235	3.7484	4.1132	1.00	5.00
Responsiveness	UBTH	76	3.4474	1.27953	.14677	3.1550	3.7398	1.00	5.00
	usen	83	3.3976	1.35196	.14840	3.1024	3.6928	1.00	5.00
	Total	159	3.4214	1.31392	.10420	3.2156	3.6272	1.00	5.00
Competency	UBTH	76	4.0526	1.27431	.14617	3.7614	4.3438	1.00	5.00
	usen	83	3.9639	1.15237	.12649	3.7122	4.2155	1.00	5.00
	Total	159	4.0063	1.20913	.09589	3.8169	4.1957	1.00	5.00
Accessibility	UBTH	76	3.6053	1.26574	.14519	3.3160	3.8945	1.00	5.00
	usen	83	3.6988	1.35912	.14918	3.4020	3.9956	1.00	6.00
	Total	159	3.6541	1.31201	.10405	3.4486	3.8596	1.00	6.00
Courtesy	UBTH	76	3.8816	1.22166	.14013	3.6024	4.1607	1.00	5.00
	usen	83	3.6145	1.33281	.14629	3.3234	3.9055	1.00	5.00
	Total	159	3.7421	1.28385	.10182	3.5410	3.9432	1.00	5.00
Credibility	UBTH	76	3.9211	1.06787	.12249	3.6770	4.1651	1.00	6.00
	usen	83	3.8072	1.07588	.11809	3.5723	4.0422	1.00	5.00
	Total	159	3.8616	1.07018	.08487	3.6940	4.0293	1.00	6.00

## ANOVA

		Sum of Squares	Df	Mean Square	F	Sig.
Reliability	Between Groups	.190	1	.190	.139	.710
	Within Groups	214.049	157	1.363		
	Total	214.239	158			
Responsiveness	Between Groups	.098	1	.098	.057	.812
	Within Groups	272.669	157	1.737		
	Total	272.767	158			
Competency	Between Groups	.313	1	.313	.213	.645
	Within Groups	230.681	157	1.469		
	Total	230.994	158			
Accessibility	Between Groups	.347	1	.347	.201	.655
	Within Groups	271.628	157	1.730		
	Total	271.975	158			
Courtesy	Between Groups	2.831	1	2.831	1.725	.191
	Within Groups	257.597	157	1.641		
	Total	260.428	158			
Credibility	Between Groups	.514	1	.514	.447	.505
	Within Groups	180.442	157	1.149		
	Total	180.956	158			

**Descriptives**

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Reliability.Q	UBTH	76	3.6447	1.35355	.15526	3.3354	3.9540	1.00	5.00
	usen	83	3.3855	1.37780	.15123	3.0847	3.6864	1.00	5.00
	Total	159	3.5094	1.36812	.10850	3.2951	3.7237	1.00	5.00
Responsiveness. q	UBTH	76	3.7368	1.14738	.13161	3.4747	3.9990	1.00	5.00
	usen	83	3.7590	1.25514	.13777	3.4850	4.0331	1.00	5.00
	Total	159	3.7484	1.20110	.09525	3.5603	3.9366	1.00	5.00
Competency.Q	UBTH	76	3.9079	1.13346	.13002	3.6489	4.1669	1.00	5.00
	usen	83	3.8193	1.08363	.11894	3.5827	4.0559	1.00	5.00
	Total	159	3.8616	1.10510	.08764	3.6885	4.0347	1.00	5.00
Accessibility.Q	UBTH	76	3.8816	1.05789	.12135	3.6398	4.1233	1.00	5.00
	usen	83	3.7831	1.12671	.12367	3.5371	4.0292	1.00	5.00
	Total	159	3.8302	1.09202	.08660	3.6591	4.0012	1.00	5.00
Courtesy.Q	UBTH	76	4.0000	.89443	.10260	3.7956	4.2044	1.00	5.00
	usen	83	3.5904	1.23995	.13610	3.3196	3.8611	1.00	5.00
	Total	159	3.7862	1.10445	.08759	3.6132	3.9592	1.00	5.00
Credibility.Q	UBTH	76	3.8553	1.04184	.11951	3.6172	4.0933	1.00	5.00
	usen	83	3.7470	1.18778	.13038	3.4876	4.0063	1.00	5.00
	Total	159	3.7987	1.11820	.08868	3.6236	3.9739	1.00	5.00

**Descriptives**

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Reliability.Q	UBTH	76	3.6447	1.35355	.15526	3.3354	3.9540	1.00	5.00
	usen	83	3.3855	1.37780	.15123	3.0847	3.6864	1.00	5.00
	Total	159	3.5094	1.36812	.10850	3.2951	3.7237	1.00	5.00
Responsiveness. q	UBTH	76	3.7368	1.14738	.13161	3.4747	3.9990	1.00	5.00
	usen	83	3.7590	1.25514	.13777	3.4850	4.0331	1.00	5.00
	Total	159	3.7484	1.20110	.09525	3.5603	3.9366	1.00	5.00
Competency.Q	UBTH	76	3.9079	1.13346	.13002	3.6489	4.1669	1.00	5.00
	usen	83	3.8193	1.08363	.11894	3.5827	4.0559	1.00	5.00
	Total	159	3.8616	1.10510	.08764	3.6885	4.0347	1.00	5.00
Accessibility.Q	UBTH	76	3.8816	1.05789	.12135	3.6398	4.1233	1.00	5.00
	usen	83	3.7831	1.12671	.12367	3.5371	4.0292	1.00	5.00
	Total	159	3.8302	1.09202	.08660	3.6591	4.0012	1.00	5.00
Courtesy.Q	UBTH	76	4.0000	.89443	.10260	3.7956	4.2044	1.00	5.00
	usen	83	3.5904	1.23995	.13610	3.3196	3.8611	1.00	5.00
	Total	159	3.7862	1.10445	.08759	3.6132	3.9592	1.00	5.00
Credibility.Q	UBTH	76	3.8553	1.04184	.11951	3.6172	4.0933	1.00	5.00
	usen	83	3.7470	1.18778	.13038	3.4876	4.0063	1.00	5.00
	Total	159	3.7987	1.11820	.08868	3.6236	3.9739	1.00	5.00

**ANOVA**

		Sum of Squares	df	Mean Square	F	Sig.
Reliability.q	Between Groups	2.665	1	2.665	1.428	.234
	Within Groups	293.071	157	1.867		
	Total	295.736	158			
Responsiveness.q	Between Groups	.020	1	.020	.013	.908
	Within Groups	227.918	157	1.452		
	Total	227.937	158			
Competency.q	Between Groups	.312	1	.312	.254	.615
	Within Groups	192.644	157	1.227		
	Total	192.956	158			
Accessibility.q	Between Groups	.384	1	.384	.321	.572
	Within Groups	188.031	157	1.198		
	Total	188.415	158			
Courtesy.q	Between Groups	6.657	1	6.657	5.617	.019
	Within Groups	186.072	157	1.185		
	Total	192.730	158			
Credibility.q	Between Groups	.465	1	.465	.370	.544
	Within Groups	197.095	157	1.255		
	Total	197.560	158			

**Descriptive Statistics**

	Mean	Std. Deviation	N
satisfaction	3.7694	.81817	159
Time	3.9497	.48781	159

**Correlations**

		satisfaction	Time
satisfaction	Pearson Correlation	1	.161
	Sig. (2-tailed)		.043
	N	159	159
Time	Pearson Correlation	.161	1
	Sig. (2-tailed)	.043	
	N	159	159

\*. Correlation is significant at the 0.05 level (2-tailed).

**Descriptives**

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Registration UBTH	76	3.9868	1.03915	.11920	3.7494	4.2243	1.00	5.00
Usen	83	3.8795	1.10870	.12170	3.6374	4.1216	1.00	5.00
Total	159	3.9308	1.07397	.08517	3.7626	4.0990	1.00	5.00
Examination UBTH	76	4.0526	1.00525	.11531	3.8229	4.2823	1.00	5.00
Usen	83	4.0241	.96241	.10564	3.8139	4.2342	1.00	5.00
Total	159	4.0377	.98010	.07773	3.8842	4.1913	1.00	5.00
Consultation UBTH	76	3.8421	1.18943	.13644	3.5703	4.1139	1.00	5.00
Usen	83	3.7108	1.18456	.13002	3.4522	3.9695	1.00	5.00
Total	159	3.7736	1.18495	.09397	3.5880	3.9592	1.00	5.00
Treatment UBTH	76	4.1316	.88457	.10147	3.9294	4.3337	1.00	5.00
Usen	83	3.9880	1.04174	.11435	3.7605	4.2154	1.00	5.00
Total	159	4.0566	.96944	.07688	3.9048	4.2085	1.00	5.00



**ANOVA**

		Sum of Squares	Df	Mean Square	F	Sig.
Registration	Between Groups	.457	1	.457	.395	.531
	Within Groups	181.782	157	1.158		
	Total	182.239	158			
Examination	Between Groups	.032	1	.032	.033	.855
	Within Groups	151.741	157	.967		
	Total	151.774	158			
Consultation	Between Groups	.684	1	.684	.485	.487
	Within Groups	221.166	157	1.409		
	Total	221.849	158			
Treatment	Between Groups	.818	1	.818	.870	.352
	Within Groups	147.672	157	.941		
	Total	148.491	158			