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Dimensions of Healthcare Quality Services Gaps in the Ghanaian Private Health Sector– An Overview of Concepts, Antecedents and Associated Literature

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Dimensions of Healthcare Quality Services Gaps in the Ghanaian Private Health Sector– An Overview of Concepts, Antecedents and Associated Literature

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ABSTRACT

The concept of service quality gap (SQG) is the difference between client's intrinsic expectations and perceived quality of services delivered which may be positive gap (where services delivered exceeded expectations) or negative gap (where services delivered were expectations) due to weakened inner system processes This paper focuses on the review of concepts, antecedents and associated literature related to healthcare service quality gaps. Customer satisfaction antecedent is prima facie service quality. Therefore a measurement of service quality becomes the fulcrum of establishing customer satisfaction or the gap of it. Healthcare service quality dimensions of measurement have an omnibus classification into the functional quality and technical quality. While technical quality (Curing quality) in the health care sector refers primarily to the technical accuracy of the medical diagnoses and procedures or the conformance to standard operating medical procedures or professional specifications, functional quality engenders the ' How' or manner or caring quality of service delivery to patients (Lam, 1997). It outlines the research work of notable scholars and academic in the area of healthcare service quality and the generic concept of general service quality. A cross-sectoral overview and historical perspective and service quality gap were highlighted. We also examine contexts both core and tangential to the discourse and provide insights into health services in Ghana and private healthcare givers as well as SERVQUAL critiques and their justification

Keywords: Healthcare, Quality, Services, Gaps, Concepts, Antecedents, SERVQUAL, Critiques

1. INTRODUCTION

(Aghamolaei et al., 2008; Baru & Qadeer, 2000; Berry & Bendapudi, 2007; Carcamo, 2011). To further support the study carried out in India, Baru and Quadeer (2000) posited that it is a quality gap to assume that the private healthcare sector offers better service quality than public hospitals because investigations show that it is a façade. Although empirical evidence has shown over the years of a direct correlation between superior quality service/product offerings and superior business performance, high productivity, increase market shares and where service or product quality is deficient or poor services, and it results in supposedly poor business financial results, and overall corporate or organizational performance but in the private healthcare sector of Ghana, there are cases at variance to this age long-held views and conclusions (Kwanteng & Lumor, 2017). The works of one of the fathers of quality management support the former direct impact of quality and high organizational performance.

The service quality underpinning foundational work was supported by researchers in the manufacturing sector. They asserted finished products match or exceed customer's

expectations, their work laid down benchmark not only on finished products but on service quality and these new standards impacted Japanese industrialists to embrace new concepts about eighty (80) decades ago (Keinan & Karugu, 2018). These researchers went further to state that as the quality of finished products increases, down-time hours will reduce as the organization is better resourced due to improved revenue, customers bonding will improve and ultimately, adjustments in prices and size of the market will shift upward (Arauz & Suzuki, 2014; Klefsjo, Bergquist & Edgerman, 2006).

They stated that by improving quality, it is feasible to expand profitability, which brings about the improved seriousness of a business venture and therefore recommended that improvement of value moves misuse of worker hours and of machine time into the assembling of good items and better products (Evans & Lindsay, 2008). Managing for Quality and Performance Excellence. Mason, Ohio: Thomson Business and EconomicsBetter calibre can mean better fulfilled and satisfied clients and more steadfast in business relationships (Deming, 1986; Gaither & Frazier, 1999). Therefore a violation of the above foundational principles in the healthcare sector will portend negative consequences.

This study was therefore focused on unearthing any trait 'process gap syndrome' of service quality gap, which can affect the 'finished products' of the private healthcare sector in Ghana. Reports of a few studies on service gap or gap of quality are stated below: Private hospitals faired poorly on all the parameters of assessment of service quality for example, quality of water used was compromised due to no system in place for cleaning of storage water tanks periodically, unqualified personnel that were poorly remunerated, lack of regular maintenance of biomedical equipment etc., therefore the assumption that the private sector is more efficient and provides better quality care does not stand up to empirical scrutiny. It is a "Medical gap or process illusion". There must be stringent conditions of employment regulations and controls, these are very important and not cosmetic renewal of licenses (Baru & Quadeer, 2000).

In another study by Koksma and Kremer (2019), the gap of quality in healthcare must be constantly examined in order to recreate quality improvement that positively impacts all stakeholders. The study furthered conceptualized a new era of quality improvement in which patients and health care providers work together to overcome quality distortion obstacles and eventually eliminate imbalances. Furthermore, the quality gap was also considered as the problem, which starts when people see their models as true and turn their back on the complexity of the real world. That creates an gap." "A quality gap?" Health care providers and patients are all on the road together, and quality is not a final destination but a journey itself. Health care providers should not deny the dynamic, pluralistic, and moral nature of quality but, instead, see it as the starting point of a journey of discovery. The quest is to discover how individual patients define quality and to work with them to achieve it(Loughlin, 1993).

Customer satisfaction antecedent is prima facie service quality (Baharun & Feiz, 2012). Therefore a measurement of service quality becomes the fulcrum of establishing customer satisfaction or the gap of it. Healthcare service quality dimensions of measurement have an omnibus classification into the functional quality and technical quality (Gronroos, 1984). While technical quality (Curing quality) in the health care sector refers primarily to the technical accuracy of the medical diagnoses and procedures or the conformance to standard operating medical procedures or professional specifications, functional quality engenders the ' How' or manner or caring quality of service delivery to patients (Lam, 1997).
Finally, the study of Soteriou and Stavrinides (1997) puts service quality gap and bank profit gap in a proper perspective as they stated that "a bank branch may report a high volume of

products and services offered, as well as profits, but lose this advantage in the long run because of eroding service quality".

2. ANTECEDENTS OF SERVICE QUALITY GAP

Patently, the administrative and support quality, along with specialized technical skills quality, are considered as the two fundamentals that influence perceptions of a patient on service quality of private hospitals (Orava & Tuominen, 2002; Brady, Wasson, Stirling, McAllister & Damani, 2006). Moreover, Trumble, O'Brien and Hartwig (2006), for example, showed that patients could evaluate the abilities of specialists or physician and other medical personnel while interfacing with them (technical quality); however, where a patient is in serious pain or gotten under crisis condition, the advantage of service quality appraisal is practically non-presence. Anyway, Patient (Where the patient ailment permits) his impression of service quality level essentially impacts the decision of the emergency clinic. However, experience has shown that patients at times think that its hard to comprehend the degree of medical care skills and precision of treatment in light of its intricate, high credence nature, and many interrelated multi-point interactions (Hariharan, Day, Mosely, Kumar & Gora, 2004; Arasli, Ekiz & Katircioglu, 2008).

In any case, judging from high credence and specialized parts of medical care, like specialist's abilities or professional's diagnostics mastery, has consistently been a test for patients (Eleuch, 2011). Patients are anyway more ready to evaluate useful quality measurements, which includes strong support regularly than not, is simpler to survey by patients giving actual proof, when contrasted with a specialized quality area of healthcare (Bakar, Akgun & Al-Assaf, 2008). Anyway, in a set of three orders of HM of service quality by Brady and Cronin (2001), the team considered healthcare dimensionalities as containing :

1. Interaction quality-which incorporates relationship, behaviour interpersonal relations, level of skills: medical service, nursing services and support services.
2. Physical environment quality—Considered as 'the hospital', a representation of the brand, which includes tangibles- hospital infrastructure and ambient conditions, and social factors.
3. Outcome quality- which includes turnaround time, satisfaction, tangible evidence of quality service and loyalty or valance.

The triad captures how patients judge healthcare service quality based on their interactions with these dimensions. And in a notable work of "Service triangle" by Carson and Carson (1997), the impetus of the work accentuates Brady and Cronin Hierarchical model Triad service quality measurement as they introduced another Triad dominant to delivery processes of service quality and, in particular, healthcare service quality viz (Tenner & DeToro, 1992). These three dominant dimensions are the service organization, the service provider, and the consumer/patient.

Service organization represents the private hospital, management and its system set up in order to meet the needs of service providers (Healthcare professionals - Doctors, consultants, Nurses, etc.) and the consumers (Patients-In and Out) (Albrecht, 1988; Carson & Carson, 1997). Subjecting Brady and Cronin's dimensions under this triad relationships will bring to fore the impact and connections of the dimensions in a service triangular examination and the mirror from patients perspective (Albrecht, 1988; Albrecht & Zemke, 1985).

It is against this background of the above dimensions relationships that this study was expected to examine crystallizing factors that snowballed into service quality gap (SQG) in the private healthcare sector Ghana.

3. THE CONCEPT OF HEALTHCARE SERVICE QUALITY (HSQ)

Healthcare affects the economies of nations and every living person globally,it impacts the nature of daily living of man and universally considered as an uncommon service that individuals require yet feel they don't really need it (Carson et al., 2007). The nature of the high risks involved in healthcare distinguishes this phenomenon as unique,in fact, it is evidently the most individualized and significant service that buyers purchase, yet with different quality levels even within a locality that boasts of only a handful of healthcare facilities. Medical services are one of the typical examples of variations in service delivery from one healthcare facility to another, indeed healthcare delineates its quality levels (Wennberg & Fisher, 2006).

The sector is often seen across nations of the world as the most troubled yet very important and unique service that its costs could be prohibitive, accessibility could be discriminative, errors could be concealed and fatal, and wastages could be abysmally high. Therefore conceptualizing healthcare service quality (HSQ) and assessing patients perception and satisfaction becomes a very complex thing (Tanner & Anthony, 2006). Furthermore, the complexity of healthcare service quality is even more difficult to define and measure than in other service sectors.

The healthcare service sector has distinct characteristics which set it apart from other sectors, and these include its intangibility, heterogeneity and simultaneity. These peculiar features make it difficult to define and measure quality (Kwanteng et al., 2017). Additionally, healthcare service quality depends on the service process and customer and service provider interactions. Some healthcare quality attributes such as timeliness, consistency, and accuracy are hard to measure beyond a subjective assessment by the customer. It is often difficult to reproduce consistent healthcare services (Lewis, 1989; Dutta, 2009). Healthcare services can differ between producers, customers, places, and daily. This 'heterogeneity' can occur because different professionals (e.g. physicians, nurses, etc.) deliver the service to patients with varying needs. Quality standards are more difficult to establish in-service operations.

Healthcare professionals provide services differently because factors vary, such as experience, individual abilities, and personalities (Teicher, 2002). Quality healthcare is a subjective, complex, and multi-dimensional concept. Robinson (2003) defined healthcare quality as 'the application of medical science and technology in a manner that maximises its benefit to health without correspondingly increasing the risk'. He distinguishes three components of quality: technical quality, interpersonal quality, and amenities. Technical quality relates to the effectiveness of care in producing achievable health gain. Interpersonal quality refers to the extent of accommodation of patient needs and preferences. Amenities include features such as the comfort of physical surroundings and attributes of the organisation of service provision. Øvretveit (2015) defines quality care as the 'Provision of care that exceeds patient expectations and achieves the highest possible clinical outcomes with the resources available.'

Unlike other Service quality in other industries or of human activities with universal applicability of assessments and cross-sectoral dimensions of similar challenges, in healthcare-specific SQ challenges which are significant and pervasive are mostly not attractive areas of discussion and research in non-medical literature, such as lab errors, communication errors, wrong diagnosis, surgery errors or false alarm test in a mammogram or burn out –stressed healthcare personnel on a continuous twelve hourly shifts unabated.

All with resultant effects of impairing healthcare service quality (Trampuz & Widmer, 2004; Berry, 2004; Burke, 2003). The distinctiveness of this sector, removing at par measurement with other sectors service quality that focuses on customer perceptions and satisfaction, a significant part of research work normally centres around “want-services” for the most part, like entertainment, hotel and hospitality, fitness, transportation and telecommunication, media etc.; while less consideration is dedicated to the investigation of core services clients need yet do not want, like the medical care

It might likewise influence how much the patient acknowledges the "coproducer or visible " position important for a good result because healthcare service quality is conceived in a complex structure where a customer reluctance may affect service quality perceptions (Bendapudi & Leone, 2003). Obviously, healthcare service quality goes beyond the customer perception gap of what the researcher termed- “Parasuramanism or Taylorism” (SERVQUAL and SERVPERF fame); healthcare service quality could involve doctors or physicians responding on-demand to medical issues ranging from a very minor medical condition (common cold or headache or malaria) to the critical life-threatening medical emergency (a heart attack –myocardial infarction). Doctors should take care of their patients' both physical and feelings in an altruistic way paying less attention to not-so- ideal conditions dissimilar to healthcare services. Hospital patients are normally sick and under pressure and (in some cases) live in the detained at the hospital ward as In- Patient. In spite of the fact that they are consumers yet they are patients, accordingly serving a client who shows up with a blend of disease, agony, pain, vulnerability, and dread, dissimilar to service quality in other sectors, presents a remarkable test to specialists/consultants and other healthcare professionals (Raghunathan, Pham, & Corfman, 2006).

Although at times services at the hospital could be exceptional, the experience of hospitalization is probably going to intensify the intrinsic pressure that goes with sickness or excruciating pain. Nevertheless, hospitals are terrifying where patients go through operations and additionally get complicated clinical treatment (Cmiel et al., 2004). In addition, unlike other services, patients practically surrender their privacy and reveal intimate details about themselves, and this makes healthcare services inalienably totally personal yet not private. Other sectors services do not expect clients to surrender such an extensive amount of their privacy or to uncovered themselves actually and sincerely as is needed in the case when receiving healthcare services (Berry & Bendapudi, 2007).

These inherent peculiarities affect assessment and perceptions by a sick customer of service quality, and more so, he is no longer in control of his privacy vis-avis outcomes of care plans which could care to life or end of life. A dilemma or impasse of what is considered high service quality ensues. Based on this person and yet not private state, ill customer, risk exposed customer cognitive of service quality is affected in evaluating medical errors and mistakes or clinical negligence hidden in high credence of technical quality of healthcare. Handwritten prescriptions by physicians are also sources of mistakes in this sector, the consequences which at times could be fatal (Wachter & Shojania, 2004). No other services across business sectors carry sublime risks as in healthcare, its service quality measurement must patently, therefore, be different.

3.1 Conceptualisation of Healthcare Quality

Although healthcare is an essential service across nations of the world but the complexity of quality assessment remains an unresolved issue. Healthcare service quality is defined, according to the the Institute of Medicine (2001, p. 21), as ‘ how much the wellbeing or health status of people and the general populace the probability of wanted wellbeing results and are in consonance with the current experts" position and information. In another instance, a study by Palmer, Donabedian and Povar (1991) concurred that the quality in healthcare services was considered as ' the creation of improved wellbeing and fulfilment of a populace inside the imperatives of existing technological innovation, available resources, and patients’ conditions (Palmer, Donabedian & Povar, 1991). Once more, Hult and Lukas (1995, p. 40) clarified the significance of healthcare services by recognizing ‘clinical credence’ in ‘diagnosing and medicating to cure' and ‘support credence’, which is focused on creating ‘happy experience’ as a hallmark of hospital service'. They contend that while ' clinical credence' basically comprises of the specialized and clinical dimensions of wellbeing and healthcare, ' support credence ' encompasses a broader spectrum of activities from the gate marshal to hospital leadership which anchors overall corporate strategic management.

Lately, as a result of great strides of technological advancement in healthcare, there has been an exceptional change in accentuation from over-dependence on the ' medically sick ' as wellbeing or hospital patrons to the ' well individuals ' with expanding accentuation on preventive shift not to ‘more medication but more education’ inpatient care centred (PCC) healthcare and customer satisfaction services. The concept of healthcare has moved from the traditional or conventional practice in the developed world to smart healrhcare of internet of things (IoT), artificial intelligence, wearable devices, virtual consltations etc. (Tian et al., 2019). This becomes imperative given the upsurge of non-transferable infections like diabetes, hypertension, overweight, HIV etc. (Sajid & Baig, 2007; Thomas, 2011).

4. OVERVIEW OF GHANA HEALTH SERVICE AND PRIVATE HOSPITALS

In Ghana, formal health service delivery is delivered by four (4) teaching hospitals, nine (9) regional hospitals, three (3) psychiatric hospitals, three hundred and forty- three (343) district hospitals, over two hundred (2000) clinics, health centres and polyclinics. In terms of classification of ownership, there are one thousand, six hundred and seven 1607 government-owned facilities, ninety-one (91) quasi- government, two hundred and forty-five (245) mission and one thousand, two hundred and seventy-seven (1277) private-for-private facilities (Jehu-Appiah et al., 2014).

It is imperative that the level of customer satisfaction can be monitored and evaluated in order to raise the bar of quality of healthcare and evolve quality improvement mechanism and a kind of feedback to healthcare professionals and decision-makers in any healthcare facilities setting (Bara et al., 2002). At the heart of service quality is customer satisfaction, therefore the basic underlying construct of quality management for doing business regardless of the sector requires satisfaction of the customer and in healthcare patient and establishment of a system that promotes constant improvement of service delivery to fuel sustainable customer base expansion and growth (Kruger, 2001; Virmani, 2002; Scott, 2005). However, when imbalances set in, patient care outcome is impaired due to cognitive dissonance, which results in service quality gap.

It is important to note that customers of today are highly informed about the ubiquitous and pervasive internet (Evans, 2017). Customers are able to access first, detailed information about their medical condition prognosis before even a visit to a healthcare service provider. Therefore expectations and perceptions of service quality are high (Parasuraman et al., 1988). How then can the expectations and perceptions of customer satisfaction be met, because customers are really concerned about the competency and professional skill set of the providers to provide the desired health outcomes after the visit and at an affordable rate (Ramsaran-Fowdar, 2005)? Private healthcare providers can match or exceed expectations of the desired services by ensuring a valid model as a catalyst of excellent service quality barometer and measurement all the time. It is essentially important for Private healthcare providers to grasp and have a full understanding of what service quality is all about and not just some ambiguous conceptions. Crosby (1979) conceptualized quality as having zero defects, while Juran (1980) submitted that quality as conformance to requirement and Garvin (1983) concluded that quality could be measured by counting internal and external failures.

4.1 Related Research: Generic Service Quality (GSQ)

Service quality is a fundamental concept of patients perception and establishes the prevailing aspect of purchasers ' assessment regarding unadulterated services like medical care (Zeithaml, Bitner & Gremler, 2009). In medical services, particular attributes like immaterialness, in-distinguishability, heterogeneity and perishability complicate the measurement of service quality in the sector (Parasuraman et al.,1985). In addition, Parasuraman, Zeithaml and Berry (1988) defined service quality as an engaged assessment that reflects patient's impression of unwavering quality, affirmation, responsiveness, compassion and physical structures or tangibles. These measurements address how consumers appraise the essence of service quality to them.

The SERVQUAL scale used to gauge service quality was initially evolved by Parasuraman et al. (1985) utilizing the gap model, which evaluated service quality as a contrast between patient's expectations and perceptions of service quality. The resultant net difference in perception and expectation scores decide the degree of satisfaction receives by a patient. The SERVQUAL instrument was later modified to expand its psychometric strength and down to earth application (Parasuraman et al.,1988), finishing in a five-dimensional scale, in particular physical assets or facility structures(tangibles),dependability (reliability), responsiveness,

reassurance(assurance) and compassion-empathy (TERRA) (Parasuraman, 1988; Zeithaml et al., 2009). There has been a multiplicity of investigations and in-depth studies into service quality with fluctuated conceptualizations looking to build up an enduring estimation structure to survey service quality and its prescient legitimacy. While researchers keep on discussing the significance of service quality, the overall agreement is that service quality is a multidimensional construct (Brady & Cronin, 2001; Dagger & Sweeney, 2007). The SERVQUAL scale is the most broadly utilized service quality estimation instrument today on account of its apparent reasonableness (Ramsaran-Fowdar, 2008; Cengiz & Fidan, 2017).

According to Ladhari (2009), SERVQUAL has acquired unmistakable quality in service quality writing as it has been tried across a wide scope of service settings and discovered to be by and large dependable. Its central case to adaptability and all- inclusiveness obtained from the serious level of flexibility of its primary dimensionalities, taking into account the simplicity of customization of its variables to suit different service sectors and relevant circumstances. Buttle (1996) hailed the ideals of the SERVQUAL model for its overall agreeableness as a norm for surveying service quality, its legitimacy and unwavering dependability quality for an assortment of service circumstances, its miserliness because of the predetermined number of constructs

working with speedy reaction and finally its utility as far as the tested procedures to aid valid investigation and translation of reliable results.

Notwithstanding, pundits of the perceptions-expectations gap model of the first SERVQUAL scale contend that there are applied difficulties in defining what precisely is implied by expectation given the number of potential degrees of expectations and that, preferably, expectations ought to be estimated before services are consumed (Carman, 1990; Cronin & Taylor, 1992). They further contended that the utilization of expectations as a construct for measurement lessens the discriminant legitimacy and content validity as well. Consequently, they supported a perception as a construct of measurement only, and this is generally referred to as the SERVPERF model. With regards to this, we assessed patients ' perception was considered as it were.

4.2 SERVQUAL Critiques And Their Justification

The constructs may not flow seamlessly as Parasuraman has listed the variables in his work, but these dimensions can be grouped into two groups of core clinical services and support services (McDougall & Levesque, 1994). There are also arguments that the generic conceptualization of servqual dimensions makes it inappropriate to be fully integrated without modifications (Carman, 1990). There are others that see SERVQUAL dimensions as focusing on measuring Expectations (Servexp.) rather than assessing attitudes (Cronin & Taylor, 1992). The Critics continue to argue that a performance-based measure is better suited for analyzing service quality because it is premised on consumer's attitude (Sureshchandar et al., 2001). The perception of the intangibility of service has also emboldened many researchers to conclude that customer satisfaction is the resultant effects of efficient service performance (servperf) (Patterson et al., 1997; Sharma & Ojha, 2004).

However, despite the observed grey areas of Servqual, the general cross-sectorial appeal of servqual constructs has kept it as a preferred model of service quality. Asubonteng et al. (1996) posited that "SERVQUAL is popular with managers because it combines ease of application and flexibility with a clear and uninvolved theory". Other advantages (Mensah et al., 2014) of SERVQUAL as a standard model globally. Its pervasiveness in evaluating service quality across industries confirms the preeminent position of SERVQUAL. Such industries include hotels, travel agencies, higher education, real estates, accountancy, architecture, construction services, Public and private healthcare, dentistry, Service call centres of Telecoms (Foster, 2001). Other sectors include: universities (Galloway, 1998), police services (Donnelly et al., 2006), banking (Kangis & Passa, 1997), travel agencies (Luk, 1997) and public utilities (Babakus & Boller, 1992).

The simplicity of the dimensions is customer-friendly to quickly fill the questionnaire associated with it. SERVQUAL Can be used in assessing different service dimensions of service; It has a standard analysis to aid interpretation of results. Empirical evidence has also shown that Its validity is equivocal across several service situations and peer- reviewed researched papers attested to it. However, Mensah et al. (2014) and Taylor and Cronin (1994) gave the caveat that to generally apply SERVQUAL might be very challenging. Therefore private healthcare managers should modify SERVQUAL to reflect their peculiar environment. Therefore, some researchers, including the originator –Parasuraman, concluded that the SERVQUAL model should be tailored in adaptation to be sector or industry or culture-specific (Parasuraman et al., 1991a), and in this context, the private healthcare sector Ghana provides the boundary investigation in this study.

5. CONCLUDING REMARKS

In the globalized world of today, private healthcare is totally indispensable to the socio-economic development of any nation, Ghana not being an exemption. According to the Ghana Health Service (2017), private healthcare accounted for about half of the 2897 healthcare facilities in Ghana. This means the sector is evolving to highly competitive and major economic contributors in the value chain of the healthcare delivery system in Ghana. A general belief or perception is that private hospitals are providers of more efficient and quality healthcare services (Bhatta, 2001). The differences may be premised on the disparity between the level of incentives in employee compensations, better biomedical equipment, well-researched market penetration strategies and business-focused organizational structures (Zeppou & Sotirakou, 2003).

In this paper, we reviewed concepts, antecedents and associated literature related to healthcare service quality gaps with a focus on Ghana. Our research outlined efforts in the domain of of healthcare service quality and the generic concept of general service quality were highlighted. Future work will examine theoretical and conceptual frameworks that can be employed and engaged to provide an understanding of the challenges faced in the domain of discuss and provide solutions to same .

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