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Towards An Understanding of Antecedents of Service Quality Illusions/Gaps in Ghana's Private Healthcare Sector

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ABSTRACT

Service Quality Gap (SQG) is the difference between client's intrinsic expectations and perceived quality of services delivered which may be positive gap or negative gap due to weakened inner system processes. The thrust of our efforts in this discourse is to set the stage for a study that focuses on the negative gaps in Service Quality in the target Sector. We will engage a mixed methods approach and sequential explanatory strategy for our research design. We will employ for quantitative survey data collection, CAPI based on consecutive non-probability sampling. The intention is to collect data selected districts in Accra, Ghana. Patients on consecutive sampling will be selected from each private hospital under study to provide the sample size. Data collected will be coded and analyzed using the Statistical package for the Social Sciences (SPSS), version 22 program . The results of data collected and analyzed will inform the qualitative part of the study. Interviews will be conducted among the management of selected Health Care Service providers in Accra A descriptive analysis, hierarchical regression and multi linear regression analysis will then be conducted to establish causal factors of gap in service quality. Reccomendations will be made based on our findings at the end of the research

Keywords: Healthcare, Service Quality Gap, Interaction Quality, Physical Environment, Patients.

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1. BACKGROUND OF THE STUDY

Globally, service quality has been an area with a plethora of seasoned scholarly research covering almost every area of businesses. This is due to the fact that servicequality is seen as the bedrock of value creation and also as one of the bases of uniqueselling propositions (USP) of business differentiation, which provides a competitive edge across sectors (Chahal & Kumari, 2012; Lee, 2007; Parasuraman & Berry, 1985; Taner & Antony, 2006). Indeed, service quality is considered as fundamental to success of any enterprise across nations, and it is, therefore, a fundamental or critical success factor in the conception of an entrepreneurial initiative. Service quality is a critical business differentiator. The quest for it by organizations across the world as a key element of service processes can tilt the scale of business performance (Lagrosen et al., 2005).

Additionally, other researchers have also considered service quality as a pivotal and significant driver to every service provider business (Yusoff et al., 2010; Clemes et al., 2008). This becomes central as pilot directing the key performance indexes of every business such as customer satisfaction, trust, customer loyalty, and value perception (Bakti & Sumaedi, 2013; Lai & Chen, 2011; Moliner, 2009; Olorunnivo et al., 2006).Service quality itself is viewed as fluid or abstract, which defies any universally acceptable definition which can be benchmarked or considered as gold standard (Mosadeghrad, 2011). Healthcare service quality is even more complex and complicated to define or measure because of peculiar features of coproduction, simultaneity, numerous healthcare professionals involvement at different times (Nahev & Stern, 2005).

Thus the concept of service quality gap and its ambiguity has challenged scholars onwhat constitute gap since this is relative to each client of the hospital (Shaffer & Sherrell, 1997). Also unlike product quality which has measurable indexes and parameters, service quality gap is difficult to describe and evaluate in healthcare setting, as interrelationships between user expectations and the impact on certain service features such intangibility, inseparability, heterogeneity, and perishability (Parasuraman et al., 1985; Zeithaml et al., 2006; Parasuraman et al., 1985, 1988).

1.1 Key constructs definitions

In this section we explain some key constructs used in the body of this work.

a) **Healthcare**: In the context of this study, refers to specific use for private hospitals and in a generic context to the healthcare sector in general.
b) **SQG:** Service Quality Gap (SQG) is the difference between client's intrinsic expectations and perceived quality of services delivered, which may be a positive gap (Where services delivered exceeded expectations) or a negative gap (Where services delivered was below expectations) due to weakened inner system processes (Aghamolaei et al., 2008; Baru & Qadeer, 2012; Berry & Bendapudi, 2007; Carcamo, 2011).
c) **Physical environment quality or service organization:** The hub, the hospital that proclaims the brand, that is the physical structure, that catches the attention of the patient. It represents the 'sum-total of the healthcare centre. It is also a total infrastructural layout of a hospital which immediately impacts on patient perception and service expectations, the biomedical equipment, and all the physical facilities of a healthcare centre (Baker, 1986; Baker et al., 1994; Bitner, 1990, 1992; Spangenberg et al., 1996; Wakefield et al., 1996; Wener, 1985).
d) **Interaction quality or the service providers.** This refers to the most profound contruct during hospital visit by a patient. It determines the outcome of a patient's medical condition, the prognosis and the prescriptions. A critical part of service quality in Healthcare is covered by interaction quality.
e) **Outcome quality or consumer /patient quality**: This is the scorecard, the results, orthe aggregate of all the consumer has experienced in the form of services at the hospital. This can also be referred to as the finished product of the healthcare services.

Fig 1: Service Quality Gaps
Source: https://www.marketing91.com/servqual/

2. RELATED WORKS

According to Carcamo (2011), “Patients as human beings determined by their structure cannot, while having an experience, distinguish between a gap and reality, therefore they experience the different domains of existence and the different domains of reality” Service quality is regarded as totally abstract, indefinable and subject to different stakeholders -customers, doctors, nurses et al.’s perspectives (Owusu-Frimpong et al., 2010). Loughlin (1993, p.69) provided a clear perspective of healthcare service quality gap in proper context: "While there is widespread agreement that "quality matters' there is little agreement over what this thing is that matters so much".

From these researchers' viewpoints, service gap is a component of service quality which might be due in part to varied perceptions and several constructions of the reality of their experience of services at a distance by customers or gaps between the serviceprovider's perception of service quality and the patients' expectations (Carcamo, 2011; Owusu-Frimpong et al., 2010; Nahev & Stern, 2005). For example, in a research study which further attest to different perceptions of service and gaps that metamorphoses to service quality gap of service, 80 percent of senior medical professionals said that they gave patients quality service encounter while just 8% of their patients concurredthat they had a high-quality service encounter (Coffman & Stotz, 2007). These marked differences show that there is a wide gap between healthcare professionals perception of quality service and patients perceptions or expectations.

Furthermore, Shaffer and Sherrell (1998), within the healthcare sector, found how service quality gap is wrapped in the ambiguity of high credence of technical quality,which leaves the patient as an outsider in the co-production of the service. The researcher opines that most customers are generally unschooled in the esoteric knowledge of the healthcare technicalities, and therefore customers' expectations of services are often at variance to services received.

Fig 2: Typical Healthcare Delivery Settings in Africa
Source: https://www.un.org/africarenewal/magazine/september-2020/could-be-turning-point-africa%E2%80%99s-health-systems

Therefore at the root of the gap of the services in Healthcare are the patient's intrinsicexpectations which are completely at variance with services delivered (Lee & Khong, 2014; Baru & Qadeer, 2000; Loughlin, 1993). This phenomenon provides the platform for service quality gap (SQG). Contextualizing service quality gap in the private hospitals in Ghana, the researcher states that there are cases where nurses are impliedly presented as qualified registered nurses through a dress code where all nurses wear scrubs or white uniforms. Interestingly, in most cases, some of the nurses presented are ward maids trained by the physicians at the hospital, while others may be enrollednurses, and only a few are registered nurses. In a research study on nurses uniforms and perception of professionalism, posited that nurse uniforms affect patients and vistors perceptions of hospital image, trust and satisfaction during a visit to the hospital (Albert & Wocial, 2007). In support of service quality gap in Healthcare, Baru and Qadeer (2000) further stated that private hospitals should not be hailed on the basis ofun-scrutinized efficiency and profits reports driven through market forces but to be examined on the basis of questionable expertise, weakened inner processes and poor working conditions which impair patient's care outcome.

In support of the foregoing on service quality gap, a study on the healthcare sector has reported how patients' gaps for services delivered are not addressed because in Healthcare, services are not commoditized (healthcare service consumption not traded as commodities) in the developing countries. As patients have no choice of doctors inprivate hospitals, but the doctor- on- duty attend to every patient at a particular time (Bradshaw & Bradshaw, 2004; Coulter, 2002). Consequently, to put service quality gap in the context of patient's experience duringhospital visits as follows: the doctor you see is not the doctor you thought, the nursesyou see are not the nurses you thought. The frequency of changes to healthcare professionals that handle a single in-patient or out patient in a day could be daunting.All these can make a patient develop psycho-dissatisfaction of encounter with the hospital and service providers (Berry & Bendapudi, 2007; Loughlin, 1993). Similarly, Sotirios and Stavrinides (2000, p.117) in the banking sector reaffirmed theissue of service quality gap, stated that service quality is a vital bank branch performance assessment indicator. The branch may report a high volume of productsand services offered as well as profits but fail the sustainability test due to weakenedinner processes that have eroded its service quality.

To illustrate service quality gap further, in the study conducted by Rigby and Litt (2000, p.209), the researchers stated several preventable and avoidable adverse events which, if patients are aware, may create damaging effects to such facility but unfortunately, these adverse events, are often not disclosed when there is an occurrence of any during or after a hospital visit. These adverse events include - lower respiratory infections (pneumonia or bronchitis), strength, agility and cognition (patient falls, injuries and restraints) Blood product transfusion wound infections; pressure sores; urinary tract infections; inadequate manipulation of fractures; pulmonary embolism; unnecessary operations; bleeding due to non-steroidal anti-inflammatory drugs; deep vein thrombosis; postoperative nausea and vomiting; and pneumothorax, hospital- acquired infection and the surgical site acquired infection (SSI). The impact of the damaging effect to a healthcare facility when a patient becomes aware of the adverse event could be high. In some cases, they could result in medico-legal issue and with adverse public media about such events. There is no other servicesector that has hidden adverse events except the healthcare services, and this place responsibility on the service provider and service organization to be open and simple(Burke, 2003).

It is against the background of the research studies above that the research study hasbeen carried out in this grey area of service quality, and it is imperative to note that service quality evaluation by individual customers will have varied perceptions regarding the gaps of the service (Carcamo, 2011). Today, a customer might want to attend Healthcare with a popular name or well known-brand with the expectations ofgetting the best quality service. However, academic research on service quality gap, which is built on service quality, has been overlooked, and this has created aknowledge gap in service quality literature (Berry & Bendapudi, 2007).

A critical observation of all these earlier studies has shown that less is known when it comes toservice quality gap within the healthcare sector, especially in Ghana, which this studywill be examining to fill that knowledge gap.

2.1 Statement of the problem

Firstly, it is imperative that service quality gap experience is examined from a globalperspective to be able to bring out research studies that have been done in this area. The researcher observes that extant literature on service quality gap in healthcare is very scanty, as Berry and Bendapudi (2007, pp.111-122) affirmed that service qualitydifficulties or challenges that are notable and inescapable in healthcare sector delivery, however, are infrequently talked about in the non-clinical writing and literature. To buttress further, in a research conducted at Mayo Clinic by Berry and Bendapudi (2007), patients see physicians as having perfect knowledge, perfect expertise in their chosen specialities, placed on a high pedestal with incredible knowledge in handling patients and capable of applying professional judgment in meeting every patient concerns. (Berry & Bendapudi, 2007).

Impliedly patients deification of physicians and other healthcare professionals is service quality gap and status or position gap as there are no physicians that deliver perfect services unbiased, perfect in diagnoses, perfect in prescription, and perfect in professional judgment in all contact with patients (Berry & Bendapudi, 2007; McGlynn, 2003; Wennberg & Fisher, 2006). Moreover, the variability of service quality in style, communication, at times technical skill and careoutcomes from one hospital to another or even one doctor to another within the samefacility sends the warning shot in legal parlance caveat emptor of service quality gap(McGlynn et al., 2003).

To affirm further the shroud of service quality in the healthcare sector, a rand Corporation, USA (2003), discovered in an explorative study that by and large, American patients get suitable clinical therapies or appropriate consultation and diagnosis just 55% of the time. The analysts investigated the clinical records of 6,712patients in 12 urban communities to survey the therapy of 30 ailments and contrastedthe discoveries with acknowledged meanings of standard consideration of such ailments (Berry & Bendapudi, 2007; McGlynn et al., 2003). Fitting clinical medicinesin just 55% of the time; however, in 45% of the time, unseemly medicines intrinsically affirms service quality gap at a disturbing rate in medical services, even in the most developed country of the world-USA.

In another study in the US, In an effort to mitigate SSI, various hospital managementalong with the AOPRN, Association of perioperative Registered Nurses in the USA, published guidelines to minimize SSI by stipulating that surgeons and other practitioners should wear "bouffant cap" style headwear that covered the hair, ears, nape of the neck, and facial hair, rather than the traditional "skull" cap during surgery.Although there is no empirical data to back this directive up and it has direct benefitsto patient care or treatment outcome, yet a flawed policy, a pattern analogous to mosthealthcare policy processes that lack empirical data are norms in Healthcare, a quality improvement gap premised on solutionism (seen to be doing something). The study concluded that bouffant cap has no improvement on patient care outcome but an service quality gap to the patients (Naumann et al., 2019).

Furthermore, in a study conducted in Europe, the finding stated that only fifty-three (53%) of European Union (EU) citizens feel comfortable with visiting a hospital without fear of experiencing medical or professional negligence by a doctor or Healthcare professional (Eurobarometer, 2006). It means that forty-seven (47%) of EU citizens are afraid that they will experience severe medical errors during a hospital visit. Forty-seven (47%) percent is a considerable percentage of respondents to conclude that the service quality in hospitals is not service but service quality gap. Likewise, in another study in the UK on Healthcare, the conclusion asserted that service quality was veiled in only "a pseudo-intellectual 'management-speak, whose quasi-economic ugliness fails to disguise a shocking lack of precision on service quality".

Therefore, the study affirmed that standard of service quality in NHIS UK isgap of quality (Loughlin, 1993).

Interestingly, there are also some studies conducted within the Asian context, where the issue of service quality and customer gap of service experience discussed. To mention a notable study on this is the study titled - Medical industry, Gap of Quality (Baru & Qadeer, 2012), service quality was debunked as farce in a study in which assessment of conformance to rules and regulations especially on employment conditions, adherence to regulators' acceptable standard of procedures(SOP). In addition, procedures regarding pricing, billing, biomedical equipment maintenance, acceptable minimum level of medical informatics and records, financial reporting and medical audit, which are necessary barometers of transparency, equity and excellent facility structures, were also examined.

The study concluded that in all reports and assessments, private hospitals performed woefully, and they concluded that the empirical evidence does not support high service quality cum efficiency of private hospitals under close scrutiny. In another study in Asia, a submission was made that there exist an gapary perception of service quality in the private healthcare sector, the gap of high quality by management where quality evaluation reports based on less objectivity is accepted without any reevaluation to establish the accuracy or otherwise by the management on a false premise (Bhatt, 2001).

3. GAPS OVERVIEW

In defining Service quality gap, based on the foregoing extant literature above, 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 below expectations) due to weakened inner system processes (Aghamolaei et al., 2008; Baru & Qadeer, 2012; Berry & Bendapudi, 2007; Carcamo, 2011). Recognizing clients' views and expectations of service quality, as well as defining the quality gap,is the first step in closing the gap . The goal of this research was to find out the causalfactors or antecedents that crystallize into service quality gap (negative gap) in the private healthcare sector of Ghana.

To expand further, it translates to where organizational total service quality offerings decline, but the organizational brand image or performance seems unimpaired (Lee Khong et al., 2006). Therefore it means service quality gap effect presents a façade of normalcy in operations and processes of the hospital to patients, but when forensic service qualityis carried out, the management may be shocked with the level of deterioration in biomedical equipment apathy and pains among the medical professionals. In some cases, an almost non-existence quality service management system perhaps because the business seems to look good, topline untouched, and the bottom line looks robustenough to excite bankers (Baru & Qadeer, 2000; Lee, 2014; Nandraj, 1994). Perhaps service quality gap may be part of the major reasons why well known corporate brands of yesteryears suddenly collapsed, and the pandora box is opened!

In summary and taking a critical look at all the above research studies, the researcherobserved that all the studies were based on an either explorative qualitative or quantitative methodology. There was no study with mixed methods (Method Gap). None of all the extant literature examined employed any theoretical perspective in the studies (Theoretical Gap), and contextually, the researcher was unable to find any literature in healthcare Ghana that was based on service quality gap or even in any other sectors (Knowledge Gap). Conclusively, therefore, the researcher posits that service quality gap is a phenomenon in the healthcare sector Ghana that has only been researched in part by scholars from other parts of the world, but this knowledge gap needs to be filled in the private healthcare sector Ghana. This will be evaluated from the theoretical perspective of Balance Theory (Heider, 1958), interlaced with an integrative model –The hierarchical model (Brady & Cronin, 2001).

The researcher opined that there are antecedents that crystallized into service quality gap and the application of Balance theory triad relationship, in conjuction with the hierarchical model having its Triad dimensions and sub-dimensions situated in the triad of balance theory will be employed to test this study hypotheses as the dimensions relate to service quality gap.

4. RESEARCH THRUST

The thrust of this research is to investigate the - Antecedents of Service Quality gap, evidence from Ghana's Private healthcare sector. The drive to achieving the key objective above will be accelerated through the following secondary objectives:

i. To examine the effect of interaction quality on Service Quality gap in Ghana'sprivate healthcare sector.
ii. To examine the effect of Physical environment quality on Service Quality gapin Ghana's private healthcare sector
iii. To examine the effect of Outcome quality on Service Quality gap in Ghana'sprivate healthcare sector.
iv. To understand the relationships between the antecedents on service quality gapfrom empirical point of view.

4.1 Research questions

To be able to achieve the stated objectives of this research, these are the key researchquestions:

i. To what extent does interaction quality affect service quality gap?
ii. What is the effect of Physical environment quality on Service quality gap?
iii. What is the effect of Outcome quality on Service quality gap?
iv. What are the roles, from practical point of view of the antecedents on servicequality gap ?

4.2 Significance of the study

The private healthcare sector is a key player in the effective and efficient healthcare delivery system of Ghana. Therefore it is highly justifiable that concerted effort is made to research into the activities of this important player in our healthcare deliverysystem. A lot of research work abound on public hospitals and polyclinics across thecountry, but detailed researches on the private hospitals and clinics are not so common because of the non- obligatory publication of financial reports or any other statutory reports by private limited liability companies under which private hospitals and clinics fall, as a result of this, evidence-based data are almost non-existence cum any centre of private healthcare repository agency that can be consulted.

Therefore this research is focused on private healthcare sector to be able to create additional knowledge in the area of service quality gap in the sector. A common phenomenon in the private healthcare sector is the mini- micro one-room consulting clinics which can be found in almost every street corner of the cities and towns across the country. The service quality is generally unregulated despite the several publications and reports of Ghana health service and its focus on primary healthcare delivery. It is hoped that a research study like this will provided some of the needed insight for raising the bars of service quality.

As pointed earlier, the fathers of quality management systems have handed over to the world their time tested theories and postulations that excellent service quality is directly related to robust financial performance, increase in market shares etc. but thereis the research gap when there is deficiency or decline in service quality, yet organization performance seems unimpaired. It raises the curious questions that despite compromised quality standards, business seems to look good, and the medical practitioners and other allied health professionals appear to be unaffected- "business as usual", what creates this phenomenon is that

which the researcher called Process gap (Pi effect). Significantly, this study seeks to help the private healthcare sector inunveiling the façade service quality gap that prevents hospital managers from taking action as medical equipment deteriorate, human capital policies which are not frequently reviewed, non-disclosure of adverse events and medical errors, and other high credence challenges that impair patient care outcomes.

5. EXPECTED CONTRIBUTIONS OF KNOWLEDGE

This study will be very important not only in the private healthcare sector but to decision-makers as well in the public sector, ministry of health and in academia for the following reasons. Research work in the private healthcare sector on Quality service gap is not easy to come by in the private healthcare sector of Ghana. Research work that focuses on Service quality gap or deficiency or declination or process evaluation of quality servicein this chosen sector seems to be limited. The contributions of the study include thefollowing:

- Service quality gap emanates from imbalances of triadic of hospital dimensions.
- Interaction quality is the key dimension that creates imbalances and the managementmust factor this in right from recruitment of personnel to in house and continue education training
- Government could leverage on the outcome for similar studies in the public sector ofGhana in order to identify key drivers of service quality gap or process gaps in that sector to help healthcare policy makers.
- Balance and Imbalance theories as tools to mitigate service quality process gaps in healthcare.
- The antecedents are the dimensions or causal factors or traps that lead to process gap of service quality in the private healthcare sector and how private hospital managers and directors could turn these key pointers into management tools to enhance qualityservice in the sector. This research has also added a small bit to the body of knowledge by unearthing service quality gap or process gap as a façade that prevents managers from observing and taking concrete steps in remedying deteriorating service quality. It is expected that this study will stimulate further research work in the area of servicequality gap or process gap as possibly one of the causal factors of corporate brand orsudden brand failures.

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