UNIVERSITY OF CAPE COAST

SPATIO-TEMPORAL ASSESSMENT OF CUSTOMER CARE PRACTICES AMONG PUBLIC UNIVERSITY HOSPITALS IN GHANA

MOSES MACLEAN ABNORY

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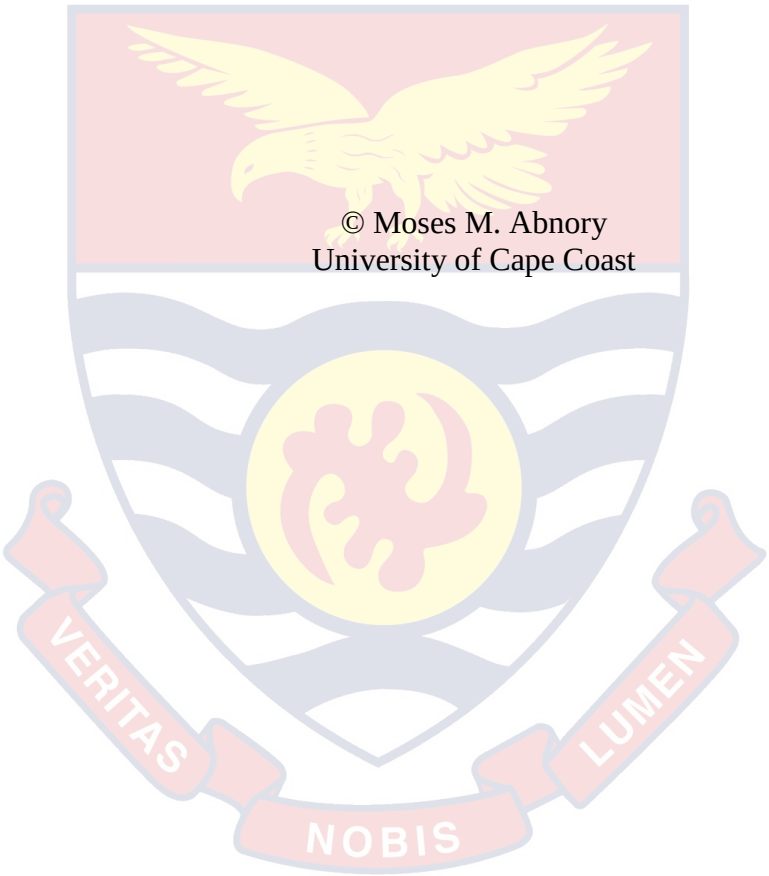

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SPATIO-TEMPORAL ASSESSMENT OF CUSTOMER CARE PRACTICES AMONG PUBLIC UNIVERSITY HOSPITALS IN GHANA

BY

MOSES MACLEAN ABNORY

Thesis submitted to the Department of Geography and Regional Planning of the Faculty of Social Sciences, College of Humanities and Legal Studies, University of Cape Coast in partial fulfillment of the requirements for the Award of Doctor of Philosophy Degree in Geography.

SEPTEMBER 2020

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is a result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature …… Date ……..

Name: Moses Maclean Abnory

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature……. Date ……

Name: Professor Akwasi Kumi-Kyereme

Co-Supervisor's Signature …… Date ……..

Name: Professor Kwabena Barima Antwi

ABSTRACT

This study sought to assess the existing customer care practices in two selected public university hospitals in Ghana. Specifically, it explored the customer care experiences of patients, assessed the satisfaction of patients with the care/services, assessed the spatial variations in the customer care practices, assessed how customer care practices in the two hospitals have evolved over the last decade and explored views of key staff and patients on innovative ways to improve on customer care. Employing an embedded concurrent mixed methods strategy, both questionnaires and interview guides were used for data collection. A sample of 1,010 from the 2 hospitals and 30 in-depth interviews were conducted to collect quantitative and qualitative data respectively. The study found that service providers were friendly and welcoming. They communicated adequately with respondents and talked politely with them. Service providers respected the difference in values, culture and belief of the clients. It was also found that there was good customer care among the two hospitals under study. Majority of the respondents were satisfied with the overall experience and the health facility. It was concluded that major changes in both hospitals included: introduction of "the enquiry desk", "a client satisfaction survey" and "respect and dignity" measures. The innovative ways to improve customer care are ICT applications "good communication" with patients, transparency with patients and timely service delivery. It was recommended that service providers need to improve upon communication and at all times display their name, title and their role in the department. Service providers are to deliver their services on time, be transparent and see patients as part of the health care system.

KEYWORDS

Customer Care

Healthcare

Patient Satisfaction

Service Delivery

Spatio-temporal

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Finally, the Management and Staff of Kwame Nkrumah University of Science and Technology and University of Ghana Hospital and the patients as respondents deserve this acknowledgement.

DEDICATION

To my spouse, Mrs. Sophia A. Abnory, and our children, Emmanuel,

Ammishadai and Abel Abnory

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LIST OF ABBREVIATIONS

CFA	Client-Flow Analysis
COPE	Client-Oriented, Provider-Efficient
FUSSAG	Federation of University Senior Staff Association of Ghana
IVR	Interactive Voice Responses
KNUST	Kwame Nkrumah University of Science and Technology
MDG	Millennium Development Goals
NHIS	National Health Insurance Scheme
SDGs	Sustainable Development Goals
TEWU	Tertiary Education Workers Union
TTD	The Touch-Tone-Dialling
UCC	University of Cape Coast
UG	University of Ghana
UH	Unit Heads
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USSR	Union of Soviet Socialist Republics
VCT	Voluntary Counselling and Testing
WCED	World Commission on Environment and Development
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Background to the Study

At the core of healthcare systems are people with varying and interdependent roles which are considered very critical to service delivery. In essence, healthcare systems are "human-systems" which are increasingly drifting towards client-centeredness (Agyepong, et al., 2017; Sheikh, Ranson, & Gilson, 2014). Due to the critical role that health systems play in regional and national development, international organizations and policymakers often demand efficiency and effectiveness from service providers. These demands include putting in place adequate and reliable facilities to taking good care of clients or patients who access those services.

Although the social, political and economic dynamics remain critical in healthcare delivery in the public sector, there is an important element that is often ignored. This important element is what is termed as *geography of care*. This geography of care has become an integral part of the health delivery process because of its critical role in accessibility to services.

The notion "care" is subject to differing social, political, ethical, and cultural interpretations. Much emphasis is also placed on ensuring care is defined in terms of the needs of the care - recipient. Increasingly, however, there has been emergence of debate around how the notion of care is perceived among those who are the recipients of caregiving. There can be significant variation not only in the duties and tasks that an informal career carries out for people experiencing different forms and levels of illness or disability, but also in how that care is conceived in each case. There are many different ways to

think about the geographies of care. Geography of care particularly is interested in the spaces, practices, and experiences that emerge through and within relations of care (Conradson, 2003). In examining care in a variety of settings—from the home and hospital through to rural communities, urban drop-in centres and voluntary counselling environments Conradson (2003) moved beyond the themes of accessibility and distribution that characterized the earlier engagement of medical geography with health care (see Curtis & Taket 1996). To echo Parr (2003), however, this was not to suggest that such issues had become unimportant. Rather it was reflective of the broader shift from medical to health geographies that Kearns and Moon (2002) described, itself in part linked to the turn towards culture in human geography. This led us to consider care as a form of relation more broadly implicated in the unfolding of human geographies.

Establishing a well-functioning health care system that is accessible, high quality, and affordable could be very challenging as it will mean balancing demand and supply for quantity, quality and wide range of specialized medical care (Koylu, Delil, Guo, & Celik, 2018). The use of geographical boundary in the analysis of accessibility to healthcare has been embraced by researchers and policy makers.

The introduction of spatio-temporal analysis in healthcare seeks to advance awareness on the contributions and potential caveats of using geographic boundary analysis to study health outcomes and determinants of quality of healthcare services. An increased understanding of the locations, extent, and strength of geographic boundaries can directly strengthen our understanding of the spatio-temporal dynamics of access to healthcare. Space

and time dynamics regarding access and quality of healthcare have been established in the scientific literature (Shah, Bell, & Wilson, 2016; Gayawan, Spatial analysis of choice of place of delivery in Nigeria, 2014; Koylu, Delil, Guo, & Celik, 2018) with distance to health facility a strong determinant of the choice of healthcare (Biswas & Kabir, 2017). Patients/clients who are in search of immediate, affordable, and specialized treatments travel long distances, and often go beyond the usual territorial boundaries (Glinos, Baeten, Helble, & Maarse, 2010; Kelly, Hulme, Farragher, & Clarke, 2016).

Globally, there have been policy shifts in healthcare to ensure that resources are harnessed and channeled in a way that will improve healthcare delivery. The international agreement in relation to policy shifts on health and development was established in 1978. This agreement came about as a result of a World Health Organization (WHO) and United Nations Children's Fund (UNICEF) joint conference on Primary Health Care (PHC) in Alma Ata (or Almaty), Union of Soviet Socialist Republics (USSR). It was at this forum that the allocation of health resources which were not well-balanced at the time was recognized. For example, there were situations where large hospitals which were accessible to less than 20 percent of the population were allocated 80 percent of national health budget (M'Jamtu-sie, 1996). As such, policy interventions have been initiated to ensure that healthcare delivery is effective, efficient and client-centered across all levels of healthcare within the broader healthcare system.

In recent times, customer care is increasingly gaining recognition as one of the most important issues in healthcare policy formulation and dialogue (Potter, Perry, Stockert, & Hall, 2016). Healthcare services are generally

provided either through public or private providers even though there are increasing calls for Public-Private Partnership (PPP) in healthcare delivery in recent times, especially in resource-limited settings. Public healthcare is usually delivered by governments through national healthcare systems (mainly in government health facilities) while private healthcare services are delivered through "for-profit" hospitals self-employed private practitioners, and "not-for-profit" non-governmental providers, including faith-based organizations (Basu, Andrews, Kishore, Panjabi, & Stuckler, 2012). As part of the broader mission statement of the Ministry of Health (MoH), public hospitals in Ghana are expected to deliver high-quality healthcare services that meet the health needs of patients (GHS, 2017).

Commonly, though, the healthcare system in Ghana has a generalized classification – government, private, institutional and mission hospitals (Saleh, 2013). University hospitals are often placed in the category of institutional hospitals and regardless of the reality that these university hospitals may be government-assisted in terms of funding; their main administrative care is left in the hands of the university authorities. Popular among such university hospitals in Ghana are the Kwame Nkrumah University of Science and Technology (KNUST) Hospital in Kumasi, the University of Ghana (UG) Hospital located in Accra, and the University of Cape Coast (UCC) Hospital in Cape Coast. As institutional healthcare facilities, university hospitals are regarded as quasi-government health institutions because invariably, the hospitals are opened to the public for general service. What this means is that one does not necessarily have to be a student or a staff of the university to

access health-care in any of the university hospitals (University of Cape Coast, 2017).

Evolution of Customer Care

Before the 19th Century (Pre-1870s), client or customer relations depended on indigenous means of interaction, including face-to-face conversation (Cornelissen, 2017). Customers had to ride a horse back to the store if they had a question, problem or concern with a product or service that they have purchased. In addition, customers had to wait for days or weeks for a repairer if they needed, for example, draglink on a tractor or a broken horseshoe. This was the plight of customers until the telephone was invented in 1876 by Graham Bell. With the invention of the telephone switchboard in 1894, the first manufactured telephones were sold in pairs and only worked between two persons (Lovelock & Wirtz, 2004). Later on, the use of telephone begun to expand and that led to the setting up of telephone switchboards across the country that consequently resulted in multiple phone calls. The implication is that if a patient was wealthy enough to own a phone in his/her home, he/she will be able to communicate directly with the hospital they receive treatment from and as much as possible try to communicate their condition of health and schedule appointment with the healthcare facility.

The emergence of call centres in the 1960s enhanced the efficiency of organizations. In an effort to increase efficiency, large companies, including healthcare organizations begun investing their funds in departments purposely dedicated to receiving and answering customers'/patients' inquiries. Customer support centres emerged within this period. These centres became particularly

prolific in the 1970s with the advent of the Interactive Voice Responses (IVRs). The Touch-Tone-Dialing (TTD) was introduced in 1962 which also saw the introduction of computers that could dial numbers with just tones rather than rotary dialing. The innovation of the TTD system was a breakthrough that led to the recognition and response of sounds/voices by a computer. In the late 1970s, Interactive Voice Response Technology (IVR) evolved which saw its integration with the customer support centres. However, it was not until the 1980s that elaborate, complex and difficult phone trees emerged. In 1990s phone trees grew in complexity and customer help desks also emerged in businesses, including hospitals within the same period (Leonardi, 2013).

By 1991, the World-Wide-Web (www) emerged and coincided with the era of the internet, enabling online marketing and customer service support. This period brought a radical transformation in businesses and healthcare delivery. In 1996, email service and live chat support were added to the internet. With the exponential growth of the internet, many customer support and service centres started introducing this new and effective form of customer service. With companies and hospitals building websites, subscribing to official email addresses enabled customers or patients to easily contact a customer support agent without the inconvenience of a telephone. Hospitals also for the first time in almost 40 years ventured into the world of live chatting where customer service returned to a one-to-one interaction with another person instead of a sequence of robotic responses (Leonardi, 2013).

By the turn of the new millennium, customer care and support software became much more available. By 2008, social media support such as

Facebook, Twitter, and WhatsApp became more prominent in customer care. With the proliferation of social media, the interaction between service providers and customer/patients has been closer as it used to be prior to the introduction of these technologies. Customers are now at liberty to comment on Facebook walls or have their concerns tweeted, and agents are able to give a rapid response to their questions and concerns (Leonardi, 2013; Zembik, 2014).

Customer Care and Contemporary Healthcare Delivery

There has been a growing debate in global health regarding the appropriate role and balance between public and the private sector in the provision of healthcare services to the general population in low- and middle-income countries (Berendes, Heywood, Oliver, & Garner, 2011). Given the financial pressure that the provision of healthcare service exerts on government budget, the International Monetary Fund (IMF) has recommended that countries (especially resource-limited countries) expand the scope of private sector's contribution to healthcare as a way of relieving governments of developing economies from the ever-increasing debt stock (Stuckler & Basu, 2009). Healthcare services are gradually becoming client-centred and irrespective of the system (public, private, mission, institutional), the customer or clients are the focuses of attention (Sheikh, Ranson, & Gilson, 2014).

A customer (patient) is the person who patronizes an organization's goods or services. A customer (patient) is the most critical input in an organization's systems of operation and survival. In other words, the customer (patient) is not dependent on the organization. The organization depends on

the customer. The major reason for the existence of every business is attributable to customers and without them, no business can survive (Vlachos, 2008). There is evidence to suggest that the ability of an organization to perform and be able to compete with others depends significantly on adequate and well-trained human resources in a well-organized manner. It is, however, important to note that the performance of organizations may be poor when human resources are poor (Pearn & Kanaka, as cited in Natuhwera, 2011; Vlachos, 2008).

There is an increasing recognition that healthcare is a business and as such, the economic cost of delivering healthcare will always have to be considered in efforts to provide solutions to healthcare challenges and improve the general health systems (Torpie, 2014). In order to deliver an excellent service to customers, the organization has to provide services which are beyond the expectations of customers. Santon (1999) argued that providing good customer services requires the organization to focus entirely on the customer. Indeed, a customer is an individual or organization that decides about a purchase. Drucker (1994) identified the creation of customer care as one of the key objectives of any business.

He further argued that other components of the organization will not be sustainable without a customer. Customer care programmes are therefore designed by organizations with the aim of acquiring new customers, provide superior customer satisfaction and build customer loyalty (Kotler & Armstrong, 2008). Good customer care or service is a process that involves the services provided to customers throughout the purchasing process (i.e. before, during and after purchase). According to Rainer, Turban and Potter (2009)

customer care comprises series of activities which are designed to improve customer satisfaction level. Thus, customer care is concerned with the feeling that the service or product has to meet the expectations of customers. This is influenced by a multiplicity of factors including geography of care which is very critical in the entire process of service delivery and utilization.

Geography of care among other things recognizes the spatial dimension of healthcare delivery and therefore focuses on the interrelationships between people (patients and service providers), places, and care. Care and care relationships are therefore viewed through the lens of their location in, and contribution to, the shaping of the various sites within which healthcare takes place (Milligan & Wiles, Landscapes of Care, 2010). Geography of care not only emphasizes the complexity and importance of the spatial dimension of care, but also its impacts on health and well-being of both patients/customers and service providers (Milligan, 2014). With the advancement in technology; from the advent and spread of the internet to mobile phone and wi-fi technologies, the role of geography of care has even gained more prominence in recent times.

The improvement in technology supports remote healthcare, such that customers and service providers living at a considerable distance between each other interact to deliver and receive appropriate care and information regarding health. As such, geography of care spans from a highly localized to global settings and can take place in both private and public facilities. It recognizes not only the importance of "where" care takes place, but also that any change in the place of care can alter the care outcome. Geography of care most importantly gives attention to the complex and multiple sites within

which healthcare occurs and the interactions between them. Therefore, it recognizes the issues regarding distance and proximity (place) in the delivery and receiving of care and the bridging of the distance through the use of technology (Atkinson, Macnaughton, Saunders, & Evans, 2010).

Statement of the Problem

The Sustainable Development Goals (SDGs), officially known as transforming our world: the 2030 Agenda for Sustainable Development are an intergovernmental set of aspiration goals with 169 targets. The SDG goal 3 (Ensure healthy lives and promote well-being for all at all ages), target 8 seeks to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (UN, 2015). Hence, sustainable healthcare delivery plays a critical role in the developmental agenda of countries worldwide (Marimuthu & Paulose, 2015).

Globally, communication problems exist between healthcare providers and patients who seek care and services from the various facilities. Consistently, studies have pointed to dissatisfaction among many patients with regard to the quality of the interaction with healthcare providers (Stewart, 1995; Mazor, Ockene, Rogers, Carlin, & Quirk, 2005; Epstein & Street, 2011). Many of the communication problems encountered in healthcare delivery often emanate from the fact that many providers dedicate more attention to diseases and their management, instead of the patients, their lives and their health issues.

One of the most basic, less complex, yet often ignored aspect of healthcare delivery is good customer care which has the potential to address many of the communication problems that exist in healthcare service delivery. In a systematic review conducted by Batbaatar and colleagues which covered the period 1980-2014, it was consistently evident that attitudes of healthcare workers (interpersonal care), mannerism, and quality of services rendered during patients' experiences at a health facility weigh with similar importance to the treatment processes (Batbaatar, Dorjdagva, Luvsannyam, Savino, & Amenta, 2017). In recent times, health administrators and researchers are unanimous in their recognition of healthcare from the perspective of the patients as consumer-focused service has taken a centre stage in healthcare delivery (Rathert, Mittler, Banerjee, & McDaniel, 2017).

Healthcare providers and hospital authorities are increasingly realizing how patient-centred good service delivery and not just good treatment outcomes contribute to the satisfaction of patients (Dwamena, et al., 2012; Rathert, Mittler, Banerjee, & McDaniel, 2017). Evidence suggests that optimizing the patient's positive experience with regards to service delivery is critical to health improvement and ensuring loyal patient population (Elrod & Fortenberry, 2018). As such, healthcare facilities (irrespective of whether public or private, levels of care) are increasingly incorporating customer care policies into their service delivery. With healthcare systems drifting towards client-centeredness, facilities are increasingly putting measures in place to ensure that clients (patients) enjoy higher status within the healthcare setting.

In the healthcare setting, patients are usually vulnerable, often in pain, frightened, exhausted and confused due to their illnesses and injuries. Despite

this, patients sometimes have to make critical, often complex decisions within a short time frame regarding their health. This makes patients a unique type of customers that require special attention. Consequently, customer care services have been introduced in many health facilities to assist patients in decision making regarding their health and ultimately improve service delivery. Customer care unit or what is often referred to as "complaint desk" has been established in many health facilities to ensure that both service providers and clients get closer as much as possible and at the same time address the grievances of patients.

In recent years, healthcare facilities are employing Information Technology (IT) to organize, automate, respond to the concerns of patients (customer care) and promote their brand. The main intention is to find, attract and win new customers while at the same time retaining the old customers (Haux, Ammenwerth, Herzog, & Knaup, 2002). Most patients have very fundamental needs – they want to be treated with respect and to feel as if their health is the priority of the service providers. Patients or customers want to be engaged in the treatment process and be shown compassion at all times. With the emergence and ever-growing popularity of social media (e.g.; Facebook, Twitter, andWhatsApp), blogs, and video sharing sites such as YouTube, the potential of ICT to enhance customer care in healthcare is enormous (Greenberg, 2009).

Despite the interventions put in place to promote customer care in hospitals, patients' satisfaction surveys have consistently shown dissatisfaction among large proportions of patients (Batbaatar et al., 2017). Within the context of Ghana, very little empirical literature exists on customer care in

healthcare (see Dwamena, et al. 2012). For example, Nketiah-Amponsah and Hiemenz (2009). Looked at the determinants of consumer satisfaction of health care in Ghana, Ampah and Ali (2019) looked at the role of service quality in patients (customer) satisfaction in public healthcare institutions in Ghana whereas Escribano-Ferrer, Cluzeau, Cutler, Akufo, and Chalkidou (2016) did a study on the quality of health care in Ghana. In addition, the spatio-temporal dynamics of customer care in healthcare has barely been investigated in the scientific literature in Ghana even though it is evident elsewhere (Bjørn Jensen, Lukic, & Gulis, 2018; Gayawan, 2014; Sahoo & Ghosh, 2016). There is, thus, a paucity of research evidence on customer care within the context of healthcare delivery in Ghana. Some pertinent questions still remain including: What are the customer care experiences of patients in public university hospitals in Ghana? Does customer care necessarily translate into patients' satisfaction? Are there spatio-temporal variations in the customer care practices among key staff in the two selected public universities in Ghana? How can customer care be improved upon in the two selected hospitals? It is against this background; the gaps in standards, literature, and empirical evidence for the provision of effective customer care that the study sought to explore customer care practices in two selected institutional hospitals in Ghana, towards achieving sustainable healthcare delivery and by extension, the achievement of SGD 3.

Objectives of the Study

The general objective of the study was to assess the existing customer care practices in two selected public university hospitals in Ghana.

Specifically, the study sought to:

1. Chronicle how customer care practices in the two hospitals have evolved over the last decade;
2. Explore the customer care experiences of patients in the two selected public university hospitals in Ghana;
3. Assess the level of satisfaction of patients with the customer care/services received at the two selected hospitals;
4. Analyse the spatial variations in the customer care practices in the two selected hospitals;
5. Seek the views of key staff and patients on innovative ways to improve on customer care.

Research Hypotheses

In order to help achieve the above objectives, the following hypotheses have been formulated:

Hypothesis 1 (H_0): There is no statistically significant relationship between customer care experience and satisfaction of patients.

Hypothesis 1 (H_1): There is a statistically significant relationship between customer care experience and satisfaction of patients.

Hypothesis 2 (H_0): There is no spatial variation in customer care practices between the two university hospitals.

Hypothesis 2 (H_1): There is a spatial variation in customer care practices between the two university hospitals.

Significance of the Study

The study sought to assess the existing customer care practices in two selected public university hospitals towards sustainable healthcare delivery in

Ghana. A study on sustainable healthcare delivery which is driven by customer care is indeed significant for a number of reasons. The outcome of this research would be significant in contributing to the realization of the SDG 3 – i.e. ensure healthy lives and promote well-being for all at all ages. Sustainable healthcare delivery features prominently in Ghana's developmental agenda. As such, studies that are aligned to providing empirical evidence to set the country on the move towards achieving this developmental agenda are worth pursuing.

This study will also contribute to the existing body of knowledge in the area of the importance of human relations and empowerment of clients in the delivery of healthcare. Even though issues of customer care have been extensively documented in the literature, most of the studies were conducted in mainstream business with very limited studies conducted in Ghana. In recent times however, researchers are gradually shifting attention to understanding customer care within the context of healthcare delivery. This study will therefore partially fill the gap in the literature by adding to the existing literature on customer care in healthcare delivery.

In addition, the outcome of this study would be useful to all the key stakeholders in the healthcare industry – policymakers, top management, programme managers, service providers and the local and international development partners seeking to create wealth through health. With healthcare delivery increasingly drifting towards client-centeredness, the outcome of this study could provide a meaningful insight into the customer care situations in healthcare facilities to inform reforms. The outcome of the study would equally serve as a useful source of reference for researchers, academics,

students and human relations practitioners who continually seek to improve future healthcare delivery with best practices and policy research.

Organization of the Study

This thesis is organised into six chapters. Chapter one puts the study into perspective by dealing with background to the study, statement of the problem, objectives of the study, research hypothesis, and the significance of the study. The second chapter is dedicated to reviewing of relevant and related literature in the field of customer care within the healthcare system. The review was largely guided by the objectives of the study. The review mainly made use of peer-reviewed published articles that are available in English. In addition, some grey literature such as reports and conference materials which were deemed relevant were also reviewed. Furthermore, the chapter also reviewed some theories to inform the study.

The third chapter was devoted to the research methods, including the philosophical foundations and study design that guided the study. It also included the study area, sources and types of data, sampling technique, sample size, instrument for data collection, pre-testing, data collection procedure, data processing and analysis, and ethical issues that were considered in the study. In chapter four, the study results are presented where both descriptive and inferential tables were presented. The Chapter Five of the thesis was devoted to the discussion of the study results. The results were discussed within the remit of the existing literature that informed the study. In the final chapter of the thesis (Chapter Six), a summary of the main findings was provided and

conclusions were drawn based on the major findings. In addition, some recommendations were made and areas for further studies were suggested.

CHAPTER TWO

THEORETICAL REVIEW OF CUSTOMER CARE

Introduction

A review of literature is a written summary of journal articles, books, book chapters, reports, and other relevant documents that described existing evidence (past and current state of information) on the topic of interest (Creswell, 2012). Literature review is critical as it provides a theoretical background to the study. It also helps to establish the link between the study phenomenon and what has already been studied. Therefore, this chapter reviewed some existing theories and concepts in public healthcare delivery in the context of customer care, which helped in the development of the conceptual framework for the study. Theories are very critical as they provide the basis for the undertaking of an empirical studies.

In an attempt to find relevant theories that explain meaning, challenges, concept and practices of customer care in public organizations, google search engine, google scholar, PubMed and Scopus were searched with combination of words such as “theories of customer care”, “challenges of customer care”, “customer care in public hospitals”, “theory and practice of customer care in hospitals” and “concept/theories of customer care”. In order to undertake effective literature review, chronological approach was adopted where first of all; the relevant theories in customer care have been reviewed and situated within the context of healthcare delivery. Secondly, the various concepts within the theories have been reviewed and discussed. In the next chapter, the empirical evidence on customer care in healthcare delivery have been reviewed and synthesized. Lessons learned (conceptual, methodological,

and analytical) have been provided. Finally, a conceptual framework of customer care in healthcare delivery has been developed to help towards the achievement of the study objectives.

Theories in Public Healthcare

The application of theories in public healthcare has been identified to be very crucial and an important aspect of health science. This is because concepts and theories determine the structural principles that must guide the perspective from which healthcare is perceived (Ogunrin, Ogunrin, & Akerele, 2007). Five major theories are discussed in this section – positivism, social construction, post modernism critical theory and Health Communication theory. Positivism is a theory of health science that perceives the delivery of health care to the masses as a service duty that the caregiver owes to the patient (Aluwihare, 2012). The caregiver is therefore expected to have a positive attitude towards health care delivery that is backed with optimism and believe that all health problems are solution oriented.

The social constructionist theory on the other hand argues that for healthcare to be effective and comprehensive, it must be offered in an atmosphere of social freedom, whereby healthcare is not seen as "a do or die" affair (Awadh, Al-rahwi & Lindequist, 2004). Imperatively, social constructionist believes that the patient must be seen as a partner in the healthcare cycle, whose involvement is required to bring about change (Buor, 2013). Finally, the post-modernist also opines that until such a time that healthcare is seen as a pragmatic business, results will be minimal. To this

end, advocates of this theory propose a strategy of thinking outside the box to ensure that boundaries of current practices are broken down (Buor, 2002).

Positivism and Social Medicine

The focus and attention of the positivism and social medicine theories have been to relate the cause of medical health situations to the effects of these thereof (Hodgkin, 2007). By implication, when health professionals are delivering their duties based on this theory, they would take account of social contexts of the problems that service users are faced with and translate these into a physical context (Armstrong, 1983). In effect, the theory seeks to apportion different levels of reactions to the same health conditions for different people based on their age, sex or race. By application to customer care practice, service providers are admonished by the theory to see each patient as an entirely different or separate entity. In some cases, health practitioners have been criticized for equating all their service users with the same measure and as such using the same strategy of health service delivery on them (Puig-Junoy & Ortun, 2003).

The inefficiency with such an approach where positivism is absent is that what may work well for one patient may not work for the other and so the same kind of high level result cannot be achieved if strategies are not varied. In the same manner, when issuing out customer care approaches, it is important for care givers to have a system of critically studying their customers to know the best methods of care that they would most appreciate. One way to know some of these different means by which customers may

want to be cared for is through the use of research and development among the different customer base of a given hospital (Pfeffer, 2004).

Social Construction Theory

Social construction theory has been explained with an emphasis on how people construct their own evidence of issues that face them. That is, when different people face the same experience, they are likely to construct and report this experience in different ways depending on key factors such as previous experience and social perception about life. The social construction theory has been said to be the opposite of the positivism theory because whereas in positivism theory, the same people would want different experiences, in social construction, even when different people receive the same experience, they tend to report it in different ways (Armstrong, 1983).

In the medical field, as far as customer care is concerned, the use of customized service has been said to be an effective way of using social construction theory to deliver excellent customer care. This is because Alderson (1998) reports that "there is no neutral, objective perspective; whatever the origins of the pain, the experience and the observers' responses are deeply personal." In effect, service providers must have as part of their programmes of care, health care delivery that comes within a scope of customer's specification even if this would cost the customer some extra amount of money (Hodgkin, 2007).

In the Ghanaian context, the practice of social construction theory exists through specialist care given to patients who pay for these services. At the Kwame Nkrumah University of Science and Technology Hospital for

instance, there are special wards that patients can request for in order to receive personal care once such patients are ready to pay some extra fee (Moynihan, 2003).

Post Modernism

When doctors and other health care service providers are made to think outside the box, it is argued they are applying the post modernism theory. This is because the post modernism theory is fundamentally concerned with breaking down boundaries and being innovative in one's practice and application (Gupta, Verhoeven & Tiongson, 2009). Most often than not, the fields of medicine and health science have been said to be one that is very rigid and robust with changes (Addae-Mensah, 2012). Even though on a daily basis new medicines are discovered and breakthroughs are made with the cure of diseases, such changes and new discoveries are not extended to the organizational culture that controls the working and activities within the health care system (Hodgkin, 2007). Regardless of this situation, Alderson (1998) sees the health sector as holding a special key to unlocking several doors of centenary breakthroughs. As such, the position with reference to doctors that three centuries of modern science are founded on "sharp dichotomies: the binary system used in computers, life/death, and mother/child".

In terms of customer care delivery, the most obvious explanation that can be given to this theory is that doctors and other health care service providers must be accustomed with a new era of thinking and practice where the kind of customer care they give to service users would be described as out of the box thinking and out of the ordinary. In a modern and computer

sophisticated world like ours, university hospitals in Ghana can achieve this practice by using a 24/7 customer care telephony system. There could also be the creation of a voice over internet protocol medical alert system.

Critical Theory

This theory may be said to be in a very sharp contrast to the positivism and social construction theories. This is because with this theory, the emphasis and focus are on the preference of the health service providers rather than the service users or beneficiaries. The basis of the theory is that society cannot be seen as single unit that can be satisfied from only one dimension of intervention (Addae-Mensah, 2012). Recognising that, each of the different people within the system of society would want its own preference when in reality there cannot be room for all of these demands. Alderson (1998) therefore states that critical theory does not see society as a well-functioning organism, rather as a collection of many factions competing for power and resources. For the health care provider to apply this critical theory therefore, one must be ready to stamp his/her authority down in making decisions for service users as and when one will be best catered for their health problems.

In terms of customer care delivery, the use of critical theory has been cautioned to be applied only sparingly and in rare situations (Oliver, 2000). It has been said that critical theory should be applied to customer care delivery only as a last resort and in cases where the health service provider is not in a position to meet all the different demands that come from service users. Even though Ghana is still a developing country, the researcher holds the opinion that the country could still challenge university hospitals to go beyond the

critical theory as it does not guarantee equality in the customer care delivery agenda (Bigman et al, 2000).

Health Communication Theory

Health Communication Theory (HCT) was put forward by Weick (1979) between 1969 and 1979 after extensive work on communication in healthcare delivery. Weick's theory (1979) emphasizes the essential role of communication and information pre-processing within social groups, institutions and organization. The focus of the theory is built on the premise that communication between healthcare providers as well as client – provider communication is critical in quality service delivery and customer care. Based on Ottawa declaration, which indicates that there is the need for identification of group influences on healthcare, Weick's work can be considered as an important health promotion theory. Improvement in communication promotes accuracy of information transfer, organizational adaptation and improvement (Kreps, 2009; Weick, 1979).

Weick's Health Communication Theory is made up of three tenets phases-enactment, selection, and retention. The enactment phase focuses on health-related challenges. In the enactment phase of the theory, customers or patients and healthcare providers need to develop the best communication strategy and intervention for addressing a particular healthcare delivery issue. The selection phase involves decisions regarding ways of increasing the understandability of communication as a product of customer care. In the retention phase, processes are used to preserve what was learned by creating a range of experience regarding work worked (successful) and what didn't

(unsuccessful) (Weick, 1979). An example of retention may involve a programme that was directed at improving customer care through the provision of a 24/7 help lines to address the concerns of patients. Clients who have experienced a health issue and got helped through the help line will now assist other clients with the use of the help lines.

Organizational rules and interactions are used to improve upon equivocality (understandability of message). At each level of organization services providers strive to transform equivocal messages into understandable and predictable messages. Since different individuals are able to manage different levels of equivocality, a range of communication strategies and cycles may be required to make sense of the information being conveyed (Kreps, 2009; Weick, 1979). For instance, an uneducated client who cannot speak English, but has been presented with detailed information about a crucial diagnosis may feel confused. Rules and cycles are intended to assist individuals to manage equivocal or confusing messages. Health pamphlets, posters and other printed instructions are examples of rule-governed strategies, whereas examples of communication cycles include establishing of protocol for referring a client to a specialist, having a nurse available to explain information to the client in the local language, referring a client to a support group that could help him/her to obtain the needed information or making available the ICT resources for the client to obtain information anytime (Kreps, 2009).

Even though the theoretical review showed that all the above theories offered some theoretical insight into customer care in healthcare delivery, the study adapted the Health Communication Theory as the theoretical framework

to guide the study. This is because of the relative advantage that it offers over the other theories as far as the focus of this study is concerned. The positivism and social medicine, social construction theory, post modernism theory, and critical theory assumed grand theory characteristics and as a result, it does not offer a contextual in-depth theoretical insight to the study. Therefore, Health Communication Theory was adapted since it considered issues at the middle and micro-levels and offers contextual in-depth understanding of customer care in healthcare delivery.

Conceptual Issues in Customer Care in Healthcare Delivery

The Concept of Customer Care

Customer care has to do with all the efforts that are made to maintain good relationship between an organization and its clients by satisfying the customers' needs and expectations. This can be accomplished by conducting research into customer wants, designing products or services to meet their needs and receiving feedback to measure customer satisfaction. Kotler (1998) described customer care as a service in any activity or benefit that one party can offer to another that is essentially intangible and does not result in the ownership of anything. According to Ngahu (2001) customer care can be defined as any good service rendered to a customer in the process of selling a product or service. Ngahu further explains customer care as the "activities" which are offered for sale or are provided in connection with the sale of goods.

According to Balunywa (1995) any service rendered to a customer is the one referred to as customer care. Indeed, so many scholars have attempted to describe customer care. However, the notion of the whole concept of

customer care is that any one in business must not only concentrate on the product or service being offered but should accompany it with sincere service to the targeted customers. Balunywa (1995) observed that the concept of customer care is still new and most managers are yet to embrace it. Mbonigaba (1995) posited that it is important to satisfy customers since they help businesses to grow. Customer care in most organizations starts with the front office staff. There is the need for secretaries at the front office to appreciate the essence of customer care because it presents any business with the best opportunity to create the first impression that they render good services to its customers.

Kotler (1998) observed that satisfaction of customers depends on the extent to which the expectations of customers about the services are fulfilled and these expectations are dynamic (i.e. not static). Kotler further noted that good customer service among other things involves fulfilling the promises made to customers, and also given the nature of the operating environment desist from guaranteeing things that cannot be possible. Customer care is thus, an important component in quality healthcare delivery.

Concept of Customer Satisfaction as Influenced by Customer Care

Customer satisfaction refers to the perception of the customer that his or her expectations have been met. The customer becomes satisfied if his or her expectations are met. Moreover, he or she becomes delighted if his/her expectations are surpassed but if the expectations are not met, then it results in the dissatisfaction of the customer (Kotler, 2001). Therefore Patient/Customer satisfaction is achieved when a patient's/customer's expectations are met and

this is to a large extent influenced by the value of customer care provided by the organization. According to Kotler (1995) in the service-profit chain, it is greater service delivery that results in satisfied and loyal customers who in turn make repeat purchases and refer other customers to the organization.

In a maiden study by Caruana, Legrand, and Omajor (as cited in Natuhwera, 2011) on the subject of customer satisfaction, the team grouped the various moments of truth into four interfaces; the management – customer interface, the staff – customer interface, the management – staff interface, the customer – system interface. With regard to the management - customer interface, it is important to note that top management does not often deal directly with most customers. However, there is contact when dealing with key clients. It is therefore very important that these contacts are well managed. The general rule states that the bulk of the company's business is attributed to few numbers of its customers. Thus, management needs to be cognitive of the general rule.

The staff - customer interface: The staff that comes into contact with customers on a continuous basis or by job occupation should consider and understand the customer needs on an individual basis. Furthermore, staff that does not come into direct contact with customers should be made to realize that they are supporting those who do come into direct contact with customers. In dealing with the management - staff interfaces, it is important to note that the calibre of people employed by any organization is only as good as the organization. It is therefore necessary to pay due attention to the recruitment, training and commitment to employees. In order to promote a customer satisfaction orientation, the welfare of employees is required.

The customer system interface refers to the process of delivering the services to the customers. It is the responsibility of management to design and establish a service delivery process that is deemed satisfactory by its actual and potential customers. Moreover, management needs to ensure that the environment of the organization or hospital will be pleasant to the customer as well as portrays the desired image. The customer satisfaction model laid emphasis between active information linkage (feedback) to top management and the market management needs to inform their decision on the desires of customers.

Components of Customer Satisfaction

Customer satisfaction has been shown to be the identification and management of moment of truth (Natuhwera, 2011). Zemice and Albrecht (2004) who advocate for the philosophy of satisfaction have identified the three components of customer care – service strategy, the system, and the people (employees). Service strategy refers to the decision about a service that will provide it with a unique identity in relation to competition. It further serves as a means of creating shared value for the organizational purpose of unifying management as well as service priorities for the staff members. To advance customer satisfaction, an adopted service strategy should be customer-centered in order to enable the business to meet the needs, expectations and motivation of the target market (in this case, the patients who access healthcare).

The system represents the mode of service delivery. The design of customer care system should be guided by the provision of a system with a

maximum level of ease and convenience to customers. This could be achieved by conducting a task analysis that will identify the service and enable staff to rehearse the performance required to satisfy the customer. The analysis will have revealed what will best work in a given healthcare delivery context.

Employees are very crucial component of the moment of truth. This is because the quality of the service to be delivered is determined by employees or health service providers. The quality of contact and service given, attitude and appearance of the employees are crucial. Service providers are very critical in bringing about reforms to the service delivery system, including customer care (see, Ahalt, Rothman, & Williams, 2017). Due to the critical roles that customers play, it is important to handle them in such a way that their loyalty is maintained. Levit (1990) thus put forward some persuasive ways to manage customers including; encourage customer complaints, refund, take disciplinary actions against staff, looking smart and efficient, apologize, equal treatment of complainers, and replace or make full or partial corrections of the products and services when source of error is attributed to the providers.

Encouraging complaints of customer is strategically important and should be handled with great attention and care. The healthcare institute should create opportunities for patients to complain. The avenues or opportunities usually created for patients include putting in place suggestion box and telephone help lines (Filip, 2013). The responses by customers to errors or unpleasant incidents do not follow a unique path (Maxham & Netemeyer, 2002). Some customers may initiate a public action, which may include sending a complaint to the organization, complaining to a third party such as customer association, or even trying to address the problem by

initiating legal actions (Filip, 2013). In extreme cases, customers may embark on private actions by sending negative messages to other potential customers or end the business relationship all together and follow that with migrations behaviour (Lovelock & Wirtz, 2004). Therefore, actively encouraging customers to express dissatisfaction is critical for the ultimate survival of the organization, especially when we consider the reluctance of customers to complain and the tendency to resort to negative actions (Maxham & Netemeyer, 2002).

Replacing or making full or partial corrections to the product or service by providing a better solution that will create a good image is very critical in organizations, including healthcare institutions. This will be necessary to undertake bearing in mind that, it is relatively easy to get customers but difficult to retain them and more difficult to get them back. Complaints are likely to feature consistently in any working environment that involves the interactions of humans. This needs to be addressed in a more rational and realistic manner, since they form part of the business (Mosora, 2012).

The Concept of Service Quality

Service quality is considered a key factor in customer-related services. In addition, service quality is a correlate of the differences (or gaps) between the way customers envisaged the outcome of the service and the way service providers render their services (Asubonteng, McCleary & Swan, 1996; Parasuraman, Zeithaml, & Berry, 1985). In effect, a gap model called SERVQUAL (service quality) was developed by Parasuraman, Zeithaml and Berry (1988). SERVQUAL which is a scale developed to measure service

quality consists of five dimensions: reliability, responsiveness, assurance, empathy and tangibility.

The first dimension is what is termed as *reliability*. Reliability in this respect is concerned about the ability to provide services which are accurate and dependable. In healthcare delivery, this is critical since it involves human lives, well-being, and survival. The second dimension is *responsiveness* of the system. Responsiveness here is concerned about the willingness to respond to customers' needs promptly. With regard to healthcare, a system of healthcare delivery is deemed responsive when it is able to anticipate and adapt appropriately to the current and future health needs so as to ensure better services and health outcomes (Mirzoev & Kane, 2017). The third dimension is *assurance.* The tenet of assurance here is about employees' courtesy and knowledge, and their capability of conveying trust and confidence. It is important for service providers to convey message of assurance to their customers since patients are often in state of despair at the time of seeking healthcare (Misra-Hebert, Santurri, DeChant, Watts, Sehgal, & Aron, 2015).

Another dimension of SERQUAL is *empathy.* Empathy with regard to service quality is concerned with the provision of individualized attention and care to customers. Patients usually seek sympathy, empathy, and compassion from healthcare providers when they seek services and care. This is a critical component of patients' conceptualization of service quality (Sinclair, Beamer, Hack, McClement, Bouchal, Chochinov, & Hagen, 2017). The final dimension is *tangibility.* Tangibility here is concerned with evidence which is physical in nature in the service facility (i.e. communication equipment and personnel geared towards customer care). Patients consider the tangibles to be equally

important part of service delivery and as such, consider the tangibles in service quality assessment (De Jager, Roux, & Ayadi, 2011).

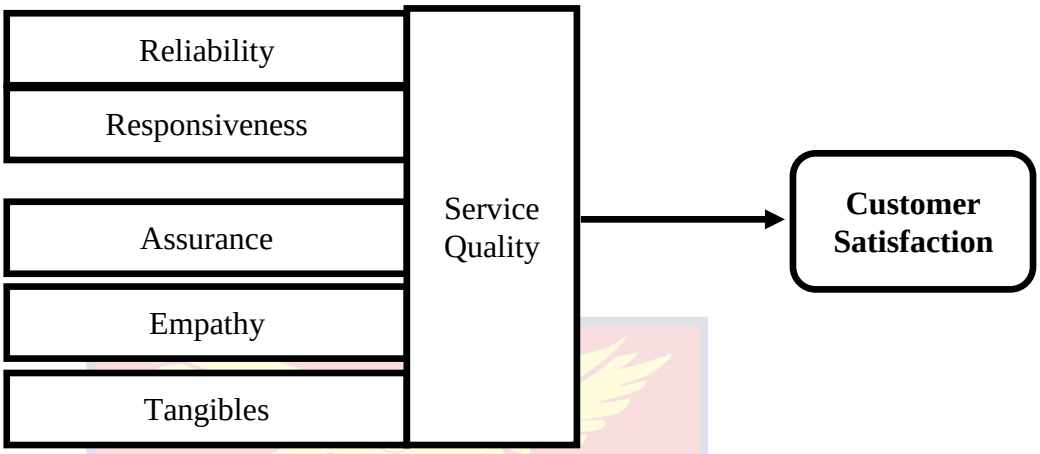

Figure 1: Customer Care Framework for Service Quality

Source: Parasuraman, Zeithaml, & Berry, 1988

SERVQUAL has been applied in several sectors (health, tourism and hospitality, and airlines) and has been found to be successful (Akama&Kieti, 2003; Lau et al, 2005). However, several researchers are skeptical about SERVQUAL. Babakus and Boller (1991) had a poor model fit when they applied SERVQUAL dimensions. Additionally, Cronin and Taylor (1992) were skeptical about its applicability.

With the skepticism and the limitations that are inherent in the SERVQUAL model, Cronin and Taylor came out with SERVPERF model, which is a performance-based model. They proposed that if service quality is measured in terms of performance alone, it would be sufficient. As such, they advocated for the use of SERVPERF as opposed to SERVQUAL since the former was found to be more adequate and precise measurement. Their work was based on extensive review of the existing literature at the time and empirical data. This model was widely accepted and applied in several sectors.

Cunningham, Young and Lee (2002) and, Jain and Gupta (2004) confirmed its sufficiency and adequacy in measuring service quality.

Kano, Seraku, Takakashi and Tsuji (1984) developed a customer satisfaction model. This model is concerned with quality management and marketing techniques used to measure clients' satisfaction. This model laid emphasis on three categories of attributes that influence clients' satisfaction. The three attributes are; basic, excitement and performance factors. The basic factors (or dissatisfiers) are concerned with minimum requirements that will cause the clients' or customers' dissatisfaction if not fulfilled and also not likely to cause the customers' satisfaction if even fulfilled. They are requirements that clients see to be normal and therefore expect them to be so. For instance, the customer expects the urinal of the hospital to be tidy.

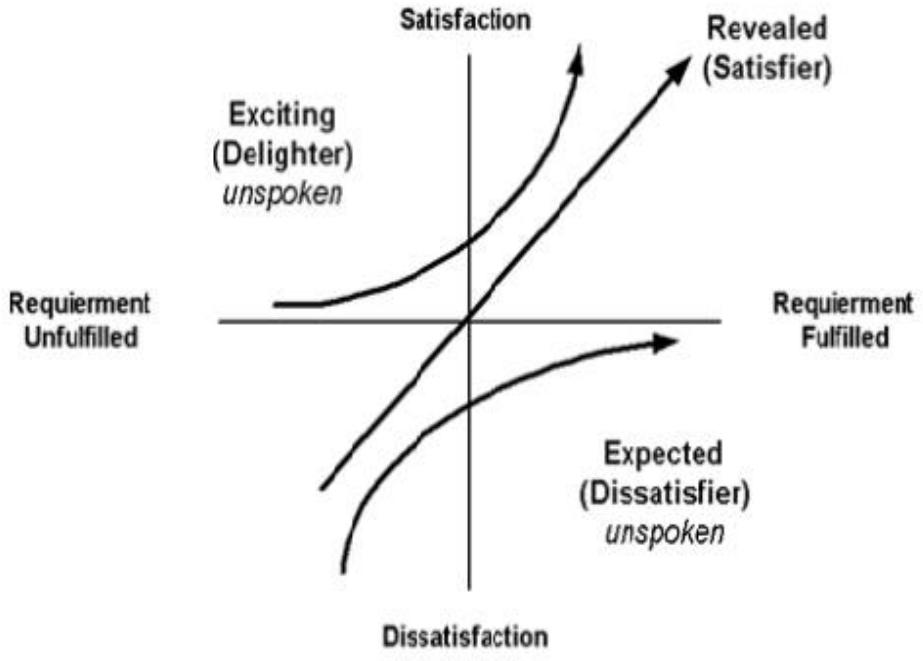

Figure 2: Customer's Satisfaction and Providers' Ability

Source: Kano, Seraku, Takakashi, & Tsuji, 1984

The second category is the *excitement factors* (or delighters) refer to factors that increase the satisfaction of the customers if fulfilled. However, they do not cause the customers' dissatisfaction if not fulfilled. An example is the provision of free blood pressure measurement for people who accompany patients to the hospital. The final category is what has been termed *performance factors.* Performance factors (or satisfiers) are directly related to customers and they cause satisfaction if performance is high but cause dissatisfaction otherwise. For instance, if there was a negative attitude of a nurse towards a patient, it will cause patient dissatisfaction.

Other models and frameworks based on concepts in healthcare have been widely used in the service literature. One of such models which has been widely accepted and applied in the health service sector is the Client-Oriented, Provider-Efficient (COPE) services (Engenderhealth, 2003). COPE is a process that helps healthcare staff to continuously improve on the quality and efficiency of their services at the health facility and ultimately makes healthcare services more receptive to clients or patients. It provides clients with practical and easy-to-use tools, which enables them to identify problems and develop solutions by using local resources to address these problems. In addition, it lays emphasis on staff involvement, self-assessment, ownership of services and teamwork. The COPE approach is based on two main assumptions:

Recipients of healthcare services are not passive patients waiting to be seen by experts. In this case clients or patients are responsible for making decisions about their own healthcare and indeed have rights for high quality services and care. Healthcare staff may have the desire to perform their duties

well. However, they will not be able to provide customers with the needed high-quality service if they lack administrative support and critical resources.

The underlying principle of COPE is to identify gaps between best practices and actual practices with the aim of coming out with recommendations that will lead to improvement. COPE uses four steps to achieve best practice by adopting a continuous quality improvement process. The four steps are; information-gathering, action plan development and prioritizing, implementation of the action plan, and follow-up and evaluation.

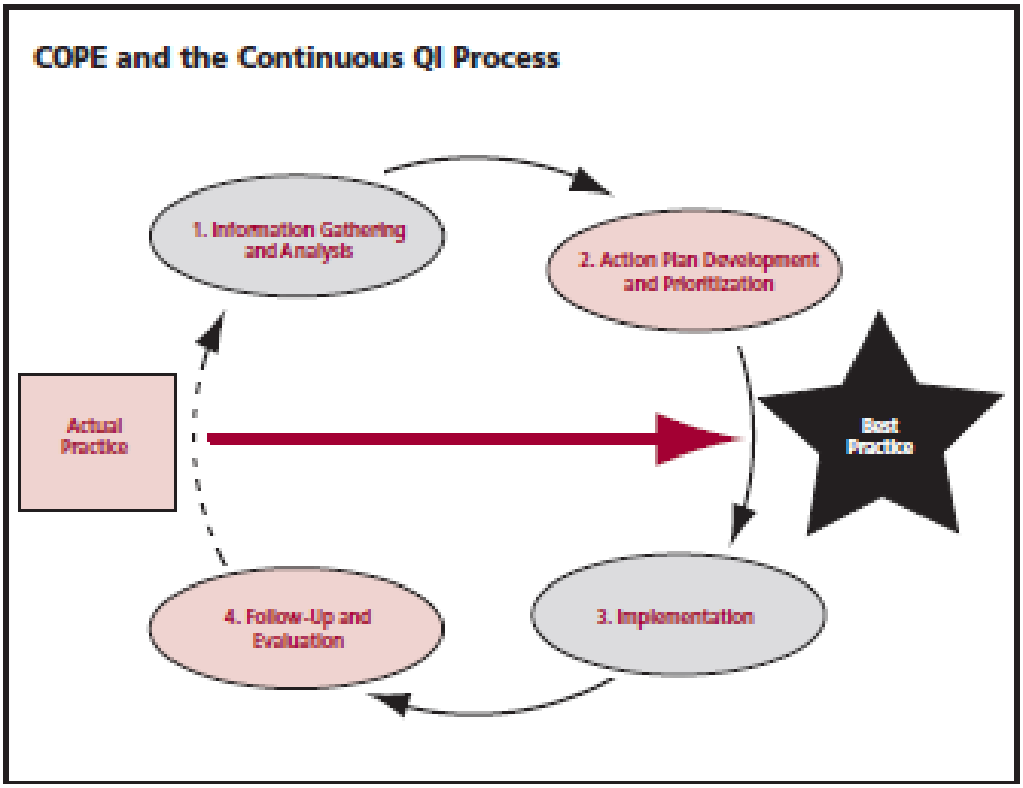

Figure 3: COPE and the Quality Improvement (QI) Process

Source: COPE Handbook, 2003

Information-gathering is a process of using client interviews, client-flow analysis (CFA), record review and self-assessment to identify problems. With regard to action plan development and prioritizing, it is concerned with refining a problem, prioritizing, recommending solution and deciding on when

and who will address the problem. The implementation of the action plan involves the staff applying the solutions agreed upon in the action plan development and prioritizing. Follow-up and evaluation involve evaluation of the Action Plan, further information gathering and the findings informing the development of new Action Plan for the cyclic process to begin again.

Ko and Pastore (2005) also came out with a reliable and valid measurement of service quality. Employing this model, service quality was operationalized into four constructs – programme quality, interaction quality, outcome quality and quality of the physical environment. The four main dimensions are described as follows:

Program quality is concerned with the customer's perception about how excellent the program is. This usually depends on the customer's experience with the service he or she receives;

Interaction quality basically focuses on how service is delivered. It is influenced by two main sub-dimensions namely client-employee interaction and inter-client interaction. The behaviour and attitude of service provider towards a customer (i.e. client-employee interaction) could affect the service delivery. In addition, client behaviour during service delivery may also affect the service that another client receives (inter-client interaction);

Outcome quality is the dimension that focuses on the outcome of the service provided and is an indicator of conception of quality. This is about the expected benefits of the service received by the clients or customers; and

Quality of the physical environment refers to the constructed facility in which the delivery of services occurs rather than the natural or social

environment. One of the most important aspects in service quality which has been determined is physical environment.

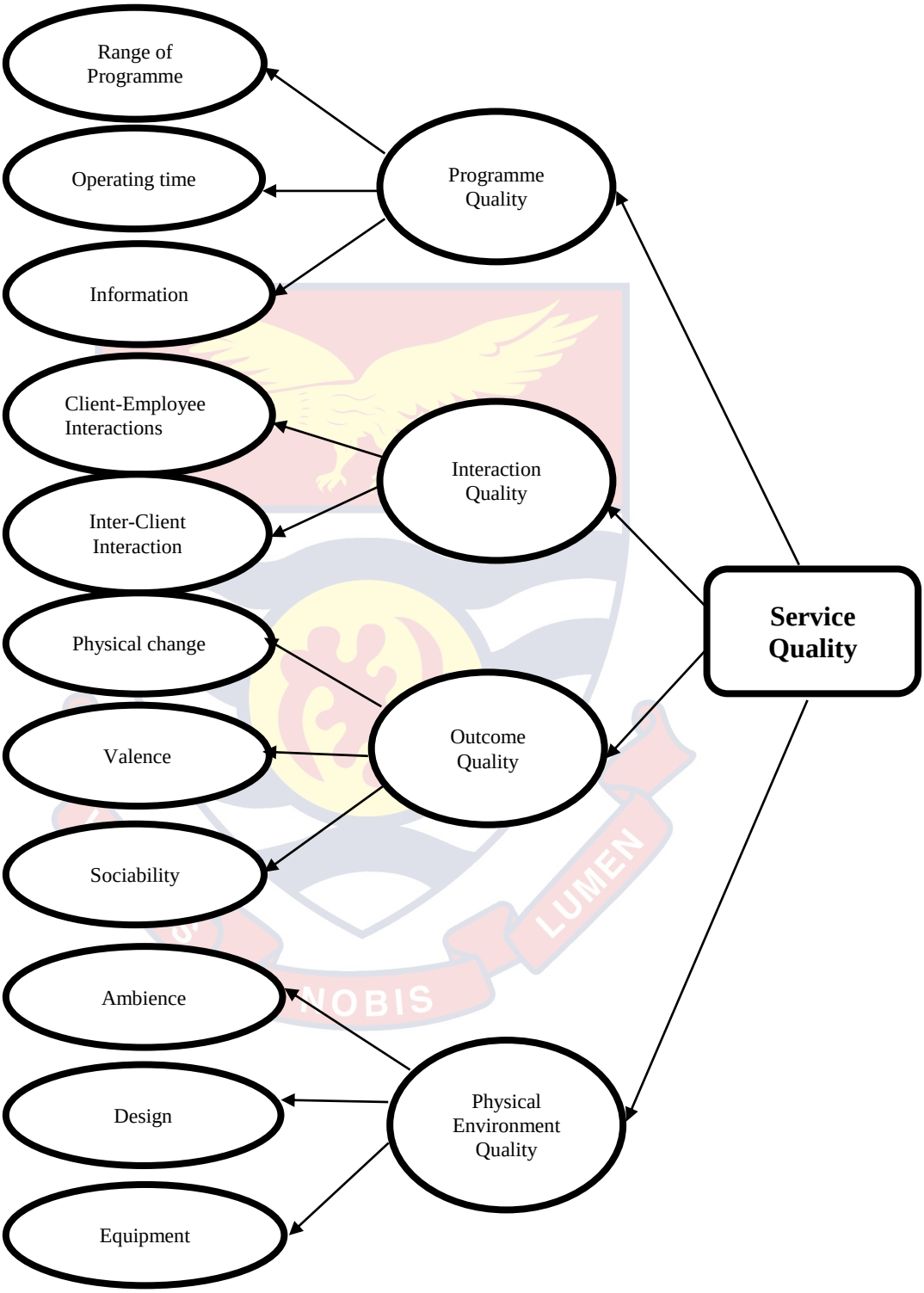

Figure 4: Hierarchical Model of Service Quality

Source: Ko & Pastore, 2005

Conceptual Framework for the Study

Quality is a comprehensive and multifaceted concept. Experts generally recognize several distinct dimensions of quality that vary in importance depending on the context in which a Quality Assurance effort takes place. These dimensions put in place transforms into customer care and satisfaction. There are several concepts of quality which have guided research in recent times. The researcher in this study relied on Brown, Franco, Rafeh and Hatzell's 1993 research outcome. The conceptual framework that informed this study was based on Brown, Franco, Rafeh and Hatzell's (1993) conceptualization of quality of health services. This model was chosen because it encapsulates many of the dimensions associated with the afore-mentioned models. According to the authors one can identify nine (9) elements or dimensions in the delivery of quality healthcare services (Figure 5). These nine dimensions are effectiveness, efficiency, technical competence, interpersonal relation, access to service, safety, continuity, physical aspect and choice. Each dimension addresses a different perspective that affects health service delivery (Brown et al., 1993).

Effectiveness is concerned with the capability of producing the desired result. For customer care in health services, effectiveness refers to the extent to which medications achieve desired results or the extent to which the patient receives the required outcome of the medical procedure and treatment. For instance, a vaccine is effective when it is capable of producing the desired effect (protection against disease) in a patient. A hernia surgical procedure is effective when the patient is entirely free from hernia after the surgical procedure.

Efficiency in the framework refers to the act of performing a given task in the most economical manner. In this study, efficiency refers to serving customers promptly without wasting too much of their time. It means quick response time to customers' needs. It also means giving customers who visit the health facility value for money.

With regard to *technical competence* in healthcare, it refers to the ability of the staff to serve patients in the most professional manner. It includes the knowledge, skill and practices required to successfully accomplish a task (serve a customer).

Interpersonal relation in the framework is concerned with how well staffs relate with both colleague and customers or clients of a particular organization. However, for the purpose of this study, the focus will be on how well service providers relate with patients. Good interpersonal relations place value on the customer, respect, friendliness and politeness as they try to serve the customer.

Access to Service involves quality healthcare which provides both financial accessibility (affordability of service) and geographical accessibility (good road network and the physical distance between the community and the health facility). *Safety* according to the framework, deals with putting measures in place to ensure that any customer who enters the facility to seek service is safe from physical and emotional harm.

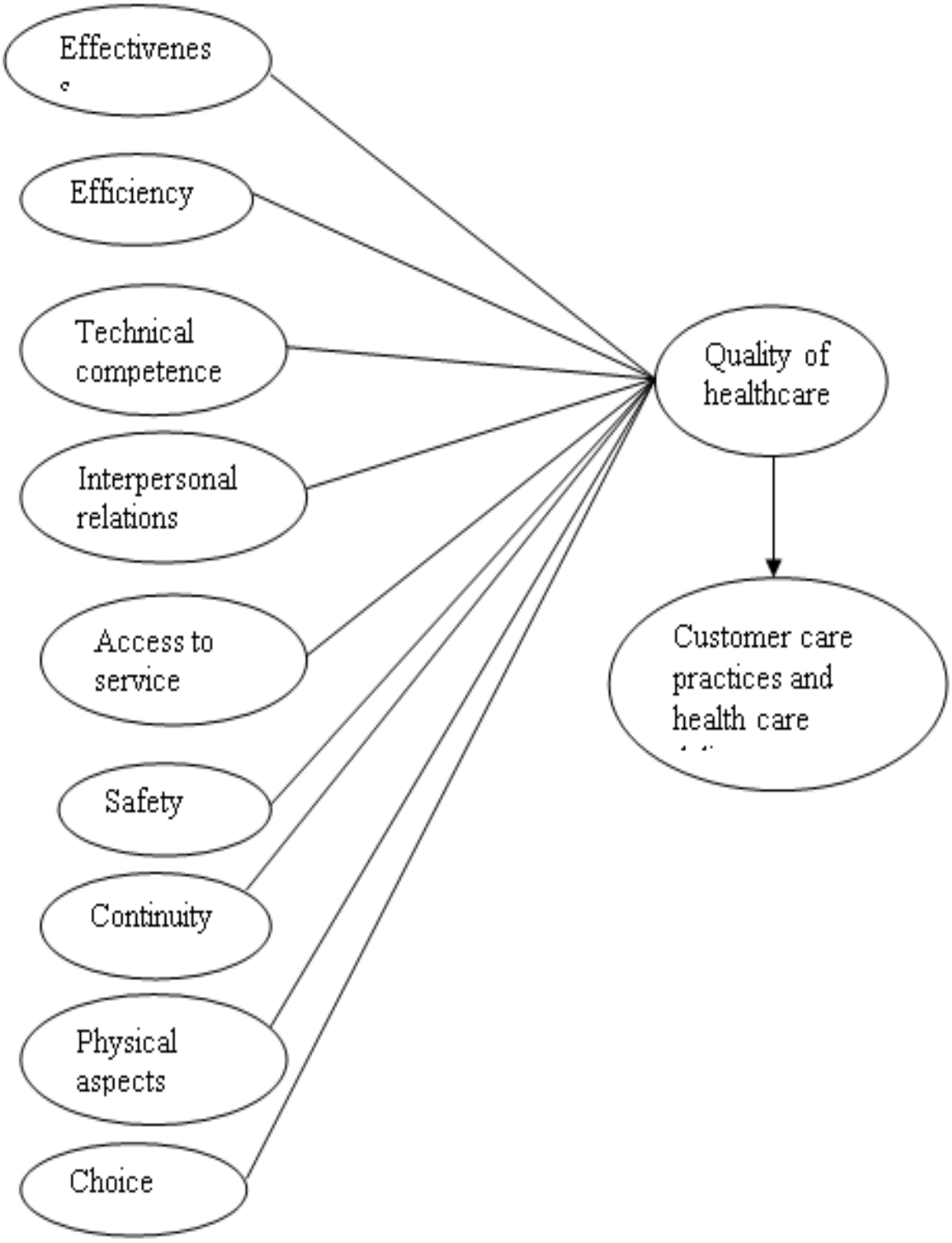

Figure 5: Customer Care Framework for Sustainable Healthcare Delivery System

Source: Brown, Franco, Rafeh, & Hatzell, 1993

Another tenet of the framework is *Continuity*. This refers to the provision of quality healthcare in a continuous manner. There must be

consistency in providing quality service. This encourages customers to develop trust, confidence, and loyalty for the health service providers and the system as a whole.

The *Physical aspects* consist of the beauty of the vicinity, building, as well as internal and external cleanliness. Quality service should be provided in a more hygienic and attractive environment. The final tenet in the framework is *choice.* It involves the choice that the client has to make regarding the treatment being offered to him or her. There must be enough information available to the client in order for him/her to make an informed choice regarding treatment. Client-centeredness should be placed at the core of healthcare and service delivery.

It is however important to note that each of the above elements do not operate in isolation. They depend on the characteristics of the health facility and the socio-demographic characteristics of the clients or patients, with the later mainly influencing the perceived quality of care and satisfaction. As such the framework was adapted to suit the context of this study. The supremacy of the customer is recognised by customer satisfaction philosophy. The marketing concept supports the view that the key to achieving organizational goals consists of determining the needs and wants of market target and providing the desired satisfaction more efficiently and effectively than competitors (Kotler, 2001).

From the afore-mentioned view, one can argue that the concept of customer satisfaction refines the impression of marketing on customer needs and wants. The customers' concern and experience with the healthcare organization should pave way for integral part of its philosophy and

accompany the concept of customer satisfaction. Customer satisfaction has become a business word for organizations that strive for distinction and excellence from others. The idea of the customer being very important dates as far back as when business management studies recognized marketing as an essential discipline (Koeber, 2011). This is however, new in healthcare delivery and service provision, especially in public health facilities. The following will be done by satisfied customers: Will tell others about how good the product on market is; will buy the product again; will pay little or no attention to other competing products; and will leave other products and begin to consume products which give him/her much satisfaction.

Weick's theory on health communication provides a link to customer care and satisfaction. The enactment phase of the theory which suggest that customers and healthcare providers must develop the best communication strategies gives room for customers to communicate well their health issues to providers. The act of communication is dependent on the socio-demographics of the client. Tannen (1990, 1995, 2002) suggests that women and men talk in different genderlects, or gender-specific dialects (Loosemore & Galea 2008). Women tend to engage in rapport talk, or relationship-oriented talk, whose primary function is to build understanding and empathy within a wider group. By contrast, she argues, men tend to engage in report talk, or task-oriented talk, whose primary function is to produce solutions to problems. Tannen suggests, in fact, that inter-gender communication is a form of inter-cultural communication (Basow & Rubenfeld, 2003). Hobgood et al., (2002) found out that good communication skills help build respectful and effective

relationships with patients, their relatives, and colleagues. It also helps to show personal leadership, resolve conflicts, and motivate others.

In the selection phase, decisions are made about ways of increasing the understandability of communication. This would also give room for healthcare providers to understand the health issues of their clients and hence good customer care and satisfaction is achieved. Zamanzadeh et. al. (2014) in a study found out that Self-confidence in nurses showed the extent to which they are familiar with their roles and its influence in the consequences of cancer and its treatment. The study further found out that some nurses were of the view that doctors had towards caring. In other words, they measured the effectiveness of the work of a nurse by an increase in the patient's longevity; they believed that because their work could not be effective in curing the disease, then it did not matter how they communicate with the patient (Zamanzadeh et. al., 2014). Additionally, lack of confidence caused them to make technical aspects important and ignore the effectiveness of nurse-patient communication in improving the patient's conditions.

In the retention phase, processes are used to preserve what was learned by creating a repertoire of experience about what worked and what didn't. Communication is essential to help patients understand their health situation, problems, and treatment plan (da Silva & Rodrigues, 2015).

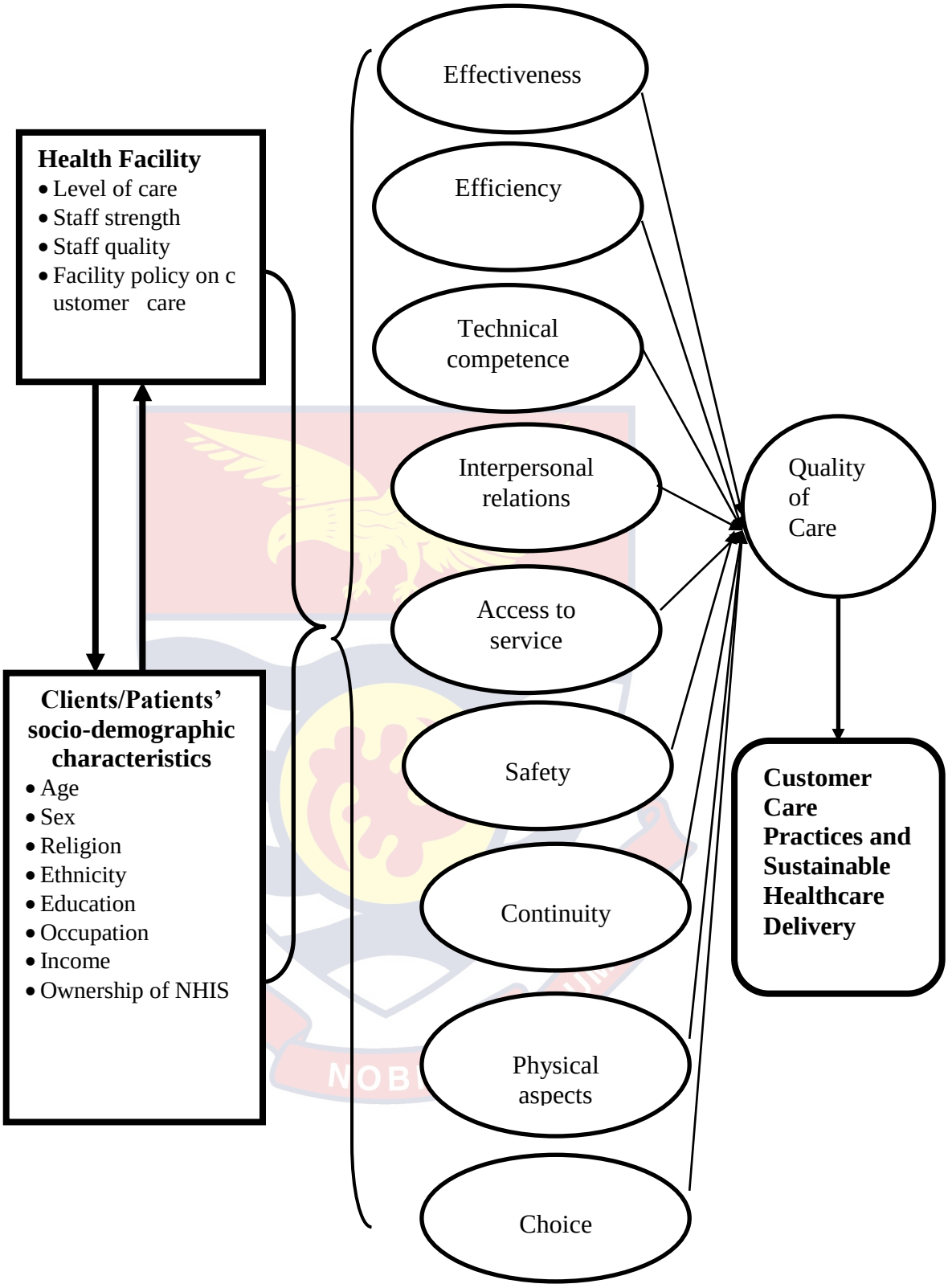

Figure 6: Modified Conceptual Framework for the Study

Source: Adapted from Brown, Franco, Rafeh, & Hatzell, 1993

A person with strong communication skills can manage any unpredictable professional situations (Pereira & Puggina, 2017). George, Rahmatinick, and Ramos (2018) found the evidence that patient-centred communication develops a holistic relationship with the patients. Positive correlation was revealed between effective communication of healthcare professionals and the improved health status of the patients (Oh et al., 2001; Laidlaw et al., 2001; Alotaibi, 2018). Most diagnostic decisions come from the history-taking component of the interview (Peterson, Holbrook, Von Hales, Smith & Staker, 1992). However, studies of healthcare providers-patient visits reveal that patients are often not provided the opportunity or time to tell their story / history, often due to interruptions, which compromise diagnostic accuracy. Incomplete stories /history leads to incomplete data upon which clinical decisions are made (Peterson, Holbrook, Von Hales, Smith & Staker, 1992). When interruptions occur, the patient may perceive that what they are saying is not important and leads to patients being reticent to offer additional information. The bottom line is that when patients are interrupted, it is a deterrent to collecting essential information and it hinders the relationship. This may lead to a wrong diagnostic accuracy which had adverse effect on the continuity of quality healthcare and patients' safety.

CHAPTER THREE

REVIEW OF EMPIRICAL LITERATURE ON CUSTOMER CARE

Introduction

In this chapter, an extensive review of the existing empirical studies in the area of customer care in organizations has been provided. This chapter covers issues relating to the meaning of customer care and how it has been employed to study a wide range of issues relating customer care. It covers areas such as what is customer care, relevance of customer care, history of customer care, challenges of customer care to healthcare service providers, concept of customer satisfaction, customer care practice in public university hospitals in Ghana and preventive health education. The chapter also explores literature relating to added drug prescription, impact of customer care on sustainable healthcare delivery. In addition, the chapter synthesizes literature on the role of IT in customer care in healthcare delivery. Literature for the review was obtained by searching online repositories including Google scholar, Medline, PubMed, and EBSCO host. Some specific journals were also searched for empirical studies on customer care in healthcare delivery. In addition, some edited books and reports were also consulted for the review.

Meaning and Importance of Customer Care

Torpie (2014) defined 'Customers' as generally well people who enjoy elevated status by virtue of their potential to purchase goods or services. Patients, on the other hand, are (by current definition), not well. Their status is greatly reduced by illness or injury that renders them vulnerable, frightened, often in pain, medicated, exhausted and confused. In spite of these limiting

factors, patients sometimes have to make important, often complex, decisions in a short time frame (Torpie, 2014). The 'goods' customers purchase are a return to health and the 'services' they seek often require an unspeakable level of trust in their 'service provider'. It makes little sense to relate to patients as traditional 'customers' in a business model that simply doesn't fit.

In furtherance to the above definition of who a customer is, Customer service is an organizational philosophy of activities created to enhance customer satisfaction while assisting organizational leaders in generating revenue and income (Chen, Feng-Hsiang, & Wu, 2013). Customer service is a major part of the service industry, which includes healthcare (Mathies & Burford, 2011). Customer service not only influences customers but also affects employees and organizations both negatively and positively depending on customer outcomes (Lin & Liang, 2011). In the past 30 years, there have been several studies on customer and patient satisfaction in healthcare (Hawthorne, Sansoni, Hayes, Marosszeky, & Sansoni, 2014).

The importance of customer service may result in variation of focus with regards to product or service, industry and customer. Giving your patients the necessary care and demonstrating it through your services brings high return to the hospital in relation to investment made on time, effort and money. Natuhwera (2011) has indicated that the only reason for businesses to exist is to serve a customer. A customer is a person who enables people to earn a living and also enable government to exist and function. It is therefore imperative to practice quality customer service in order to satisfy the clientele. Quality customer care is related to attitude, our approach to thinking and a

philosophical approach of doing business that lay emphasis on a strong commitment and sincere dedication to satisfying customers.

Ngahu (2001) advocated that customer satisfaction should be made a priority of every company and in our case healthcare organisation by calling for the adoption of a customer orientation. Balunywa (1995) and Ngahu (2001) are of the view that, the major reason for customers choosing one product over another is probably due to the product meeting their needs better in terms of ease of use, service, or ability to do what it promises to offer. Furthermore, Ngahu (2001) noted that building market share is another reason for one to become customer care driven.

Findings from research have shown that market shares cannot be maintained with unique features alone since competitors will imitate you. Market share growth can be sustained through the loyalty of customers and provision of excellent service. Being customer care driven means positioning customers at the heart of business operations and to let all management decisions, policies and strategies guided by the needs of customers. According to a study of what makes a company excellent by Zike (2000) (as cited in Natuhwera, 2011) 43 high performing companies were interviewed with the view to finding out what makes them so successful in an increasingly dynamic competitive environment where many companies are facing closure. The study revealed that all high performing companies have a common set of basic operating principles of which some emphasized customer care driven service. It was also discovered that companies which perform excellently provide unparalleled customer care service, quality and reliability. Furthermore, these

companies show strong commitment to customer satisfaction and have the tendency of adhering to the business they know.

Customer orientation is reflected in the quality that customers get at all levels of the company (Ekpei, 2015). Customer care in healthcare organizations boosts the hospital image, operational efficiency, customer relations, competitive advantage and profitability. In addition, it enables the hospital to cope with a rapidly changing environment and highly demanding patients. This realization is due to the emphasis laid on provision of customers' need by the hospital that is customer care oriented. This is done through quality and efficiency in service delivery. A paper presented by Mulwana (2005) (as cited in Natuhwera, 2011) at Uganda manufacturers' seminar showed that a major tool for market penetration is customer care service. Mulwana (2005) like Balunywa (1995) noted that businesses always anticipate succeeding in order to increase their earnings every other time. This achievement requires basic strategies that can attract and retain customers and this can be done by making use of the major tool of high quality customer care services.

Additionally, Mulwana (2002) emphasized that high quality customer care does not only delight and satisfy customers but also gives the biggest benefit of creating loyal customers. The writer therefore noted that the customer care process means the delivery of quality service that can satisfy the customer. However, hospitals often do not give much attention to the importance of staff care which is also vital for the hospital, since staffs are also hospital customers. Two types of customers who enjoy the services of organizations were identified by Balunywa (1995).

These are external people who buy from the business and those who are within the organization (i.e. the employees) that can make things happen in the organization and handle the external ones. Balunywa referred to the first type as “kings” and the second type as “royalty”. His argument is that organizations which are consistently triumphant are characterized by a committed customer care base, healthy profits and happy people. It was further noted that if staff had job satisfaction, customers are likely to receive good service from their (staff) delivery. Employers who treat their staff like kings are more likely to have a motivated and committed workforce that is interested and willing to deliver quality service. Quality customer care attracts and maintains loyal customers. It is worth nurturing loyal customers. This eventually leads to them buying more regularly. Moreover, the cost of selling to these loyal customers is almost non-existent as compared to finding new customers which is an expensive venture.

Customers who are satisfied with the services of a hospital are likely to recommend it to others. However, dissatisfied customers are also likely to complain to an average of ten other customers and potential customers, multiplying the damage reputation factor to the hospital. Giving customers good communication and open attention as well as good listening ears will make clients want to come to you over and over again. Customer care also means doing what it takes to make customers wanting to return to your organization all the time. Furthermore, desire for good customer care helps the hospital to improve upon its services. Many organizations have recently put in place mechanism that allows them to capture feedback at the point of their experiences with care. For instance, a leading UK travel company, National

Express has notified passengers to send text messages whilst on the bus (National Express Travel, 2012). This has been shown to be useful, as it allows organizations including healthcare organizations to improve their customer service before the customer defects, thus increasing the likelihood of the customer returning next time. Technology has made it increasingly easier for healthcare organizations to obtain feedback from their customers. Community blogs and forums enable customers to give detailed explanations of their experiences, be it negative or positive, with a company/organization.

Otal (1994) put forward that growth and profits are accelerated primarily by customer satisfaction which is highly correlated with customer loyalty. Loyalty of a customer is a direct result of customer satisfaction that is largely influenced by the value of customer care provided along or with product or service to the customer. A satisfied customer is one whose expectations have been met and with such a customer organization tend to benefit in the following ways:

Positive word of mouth: customers are more likely to recommend the good service to their friends, relatives and colleagues. The business will therefore succeed on the basis of credible and positive image;

Creates a competitive edge: Offering excellent customer care gives much competitive edge over competitors mainly because positive service differentiation involves improving all the people's aspect of business such a straining and motivation which are all difficult to replicate and achieve; and

Job satisfaction: a pleasant and conducive atmosphere springing out from good customer care will not only lead to improved moral commitments but also improved customer satisfaction which will ultimately result into fewer

complaints. Good customer care would eventually decrease labour turn over, cardiac symptoms and absenteeism.

Empirical Findings on Customer Care Experiences

Customer care experiences or Patient experience is regarded by healthcare policy frameworks in several countries as a core component of healthcare quality, alongside clinical effectiveness and patient safety (Al-Tannir et al., 2017). Patient experiences of engagement with care plans is conceptualized as patients' experiences of care, and as feedback received from patients regarding these experiences (Footman et al., 2018). The World Health Organization (WHO) uses the term 'responsiveness' to refer to a measure of patient experience of a healthcare system. Responsiveness is included in patient satisfaction and quality of care literature, but is a distinct entity that refers to the way individuals are treated and the environment in which they are treated when seeking health care. The responsiveness of a healthcare system is determined by eight key indicators: autonomy, choice, communication, confidentiality, dignity, prompt attention, quality of basic amenities, and support (access to family and community support networks) (Mohammed et al., 2018). From this several studies have been carried out to access the patients experience with the healthcare system. Some of these empirical studies are discussed in this section of the thesis.

Rapport et al. (2019) carried out a study that examined perceptions of hospital care, through in-depth, qualitative data capture and as a result, to gather rich, patient-driven information on user experience and satisfaction in the Australian healthcare setting; and identify influencing factors. Focus

groups were undertaken in four St Vincent's Health Australia (SVHA) hospitals in 2017 where participants discussed responses to eight questions from the Press Ganey Patient Experience Survey. The results showed that good communication and high-quality information at arrival and discharge were found to be important to patients. Communication breakdown was also evident, further exacerbated by a range of environmental factors such as sharing a room with others. Overall, patients' felt that while their spiritual needs were well-supported by the hospital staff at all SVHA hospitals, it was the clinical teams prioritised their emotional needs. It was therefore concluded that patient-centred care needs careful planning with patients involved at entry and exit from hospital. Focused communication, environmental changes, attending to complaints, and clearer discharge strategies were recommended.

Similarly, a study by Abbasi-Moghaddam et al. (2019) was conducted to find out how the patients evaluated service quality of clinics at teaching hospitals affiliated with Tehran University of Medical Sciences in Iran. The cross-sectional study was conducted in Tehran in 2017 and 400 patients were randomly selected from four hospitals. Data were collected using a questionnaire. The findings from the study indicated that among eight dimensions of health service quality, the patients were more satisfied with physician consultation, services costs and admission process. The highest and lowest mean scores were related to physician consultation (Mean = 4.17), and waiting time (Mean = 2.64), in that order. The total mean score of service quality was 3.73 (± 0.51) out of 5. Outpatient services were assessed as good, moderate and weak by 57.5, 40 and 2.5% of the patients, respectively. There was a significant relationship between the positive perception of service

quality and reason for admission, source of recommendation, gender, education level, health status, and waiting time in the clinics ($p < 0.05$). The study therefore concluded that the majority of the patients had a positive experience with visiting clinics and perceived service provision as good.

Also, Leonardsen et al. (2017) carried out a study with the aim to provide treatment for patients who otherwise would need hospitalisation. Patients were recruited from five municipal acute wards in south-eastern Norway during the period from June 2014 to June 2015. A total of 479 patients responded, median age 78.0 years and 41.8% men. A total of 68 patients participated in the retest. Testing of convergent validity revealed an overall weak to moderate correlation. Kappa statistics showed from fair to good test-retest agreement. Most problems were related to continuity and transition, while fewest problems were related to respect for patient preferences. A higher Charlson comorbidity score was the only variable that was negatively associated with patient experience. Patients reported problems in several items of the PPE-15 after discharge from decentralised acute wards.

Pouragha and Zarei (2016) studied the effect of outpatient service quality on patient satisfaction in teaching hospitals in Iran. The results showed that the majority of patients had a positive experience in the outpatient departments of the teaching hospitals and thus evaluated the services as good. Perceived service costs, physician consultation, physical environment, and information to patient were found to be the most important determinants of outpatient satisfaction. It was therefore concluded that to improve the quality of consultation, providing information to the patients during examination and consultation, creating value for patients by reducing costs or improving

service quality, and enhancing the physical environment quality of the clinic can be regarded as effective strategies for the management of teaching hospitals toward increasing outpatient satisfaction.

Ways in which Hospitals Improve Customer Care Practices

Customer Care Practices in Hospitals

Several researchers have undertaken different types of studies on the commonest and best forms of practices that need to come under a comprehensive customer care service in the health sector. While Abbiw (2010) reports that bed call support and preventive health education are the two commonest forms of customer care practices to be seen in most health facilities, Addae (2007) focuses on drug prescription and DeLancey (2008) on psychological support and hourly rounds. It may be noted that patients on admission often have the need to call on ward nurses and doctors to come to them for help.

Depending on the ailment that a patient is suffering from, the number of calls may vary (Agyare, Mensah & Osei-Asante, 2006). In most hospitals, there is virtually no limitation on the number of bed calls that a patient can make. But in order to ensure that there is some level of equity in care and attention, hourly rounds are practiced to ensure that in an hourly interval, nurses attend to all patients in the ward (Akerele, 2010). Moreover, patients who go through certain kind of diseases that have a tone on their psychology are given emotional guidance and support. A typical example of this type of care is the Voluntary Counselling and Test (VCT) section of university hospitals in Ghana. In most health facilities, it has been found that

psychological support is related to preventive health education and drug prescription education, whereby patients are given thorough education on how not to contract the same kind of diseases and health problems they report to the hospitals. All these are different ways and means by which customer care is rendered in various university hospitals in Ghana. This aspect of literature is reviewed along Preventive Health Education, Bed Call Support, Added Drug prescription Service, Psychological support and Hourly Rounds.

Preventive Health Education

Preventive health education has been defined as a system of training given to health service users to ensure that they are acquainted with basic practices that will keep them in good health and general wellbeing (Anand, Sippel & Aynsley-Green, 2008). The issuance of preventive health education has been explained to be a major primary health care agenda. Which include recognizing that the motive of primary health care is to ensure that people gain awareness of the very health matters that affect their everyday life (Popper, 2009).

Through preventive health education, Anand, Sippel and Aynsley-Green (2008) has stressed that customer care among patients visiting various university hospitals in Ghana can be achieved. This is because most of the everyday cases of ailment and diseases that they report to the hospitals tend to make the hospitals choked up for quality time with health practitioners. Supporting the earlier position, Descartes (2002) adds that once this primary health care goal is achieved, public health care becomes enhanced. Relating the definitions of primary health care and public health, it can be argued that

when preventive health education is used to promote primary health care, public health care delivery will be improved. This according to the World Health Organisation (2012), primary health care seeks to organize health services around people's needs and expectations. Meanwhile, public health is said to be achieved when there is the prevention of diseases, prolonging of life, and promotion of health through organized effort (Winslow, 1920).

Bed Call Support

Bed call support is an in-house support system that is given to patients who are admitted to various hospitals. From a global perspective, bed call support is supported and lauded by the WHO as rapid support system that ensures that all patients on admission get the needed attention they require from health professionals (Anand, Sippel & Aynsley-Green, 2008). On a localized level, the Ghana Health Service has accepted the use of bed call support as a mandatory public health care delivery module among all university hospitals in Ghana (Descartes, 2002).

Research shows that the use of bed call support into the Ghanaian health system started with the four major teaching hospitals namely; 37 Military Hospital, Korle Bu Teaching Hospital, Komfo Anokye Teaching Hospital and the Tamale Teaching Hospital (Popper, 2009). Due to the influence of the practice in enhancing customer care, it was adapted further by all government hospitals and polyclinics, under which the university hospitals fall. Bed call support ensures patients on admission receive an alert system that makes it possible to reach health workers taking care of them at the ward on a prompt basis. At the highly sophisticated levels, these alert systems are IT

supported so that the service providers can receive signals on a mobile device (Popper, 2009). Commonly though, Ghanaian university hospitals use an alarm system that rings a bell, calling the bed number of the patient in need of urgent attention. This system has been found to be effective in public health delivery as it ensures that patients receive tailored customer-oriented care.

Added Drug Prescription Service

In Ghana, the issuance of drug and the prescription of drugs are controlled by the Ghana Pharmaceutical Council. This is backed by a drug administration legislation to ensure that the right drugs get into the right hands from the right people. The relevance of such legislation is in the fact that when the wrong drugs get into the wrong hands, they can be very deadly and detrimental (Parsons, 2011). The practice whereby hospitals make a dedicated effort to offer added drug prescription services to patients to ensure that patients are given thorough education on drug use can therefore be lauded as an effective campaign in the public health delivery agenda.

If public health care delivery concerns itself with efforts that provide informed choices to service users, then the need for service users to be acquainted with informed choices on drug use is a laudable initiative. Once patients are given drug prescription service that teaches them on the effective ways to use drugs, chances that repeated admissions to the hospital for the same health concerns will be minimized (Alderson, 1998). It has been noted that in most cases, when patients go to the hospital, all the attention for superior customer care is placed directly on the doctor (Royal College of Surgeons of England, 2010). Other service providers such as nurses,

laboratory technicians, and especially pharmacists are given very minimal attention when it comes to providing customer care. For this reason, pharmacists do not put in any concerted effort to ensure that patients are given the best of education on drug use. The use of added drug prescription service is hence a means of making this weakness a thing of the past.

Psychological Support

Many people do not think they would receive any kind of care apart from the issuance of drugs and injections when they go to the hospital. But there are several theories including the post modernism and social construction theories that suggest that effective public health care delivery is not achieved only through the traditional application of medicine as a discipline or profession (Alderson et al, 2004). There are some cases of health problems that demand that patients receive psychological and other social support to ensure that they endure their agonies. Examples of these health problems have been outlined by Parsons (2011) to include incurable diseases and diseases or accidents that leave patients with permanent defects and damages. Because some of these cases are never going to be eradicated through medicine, it is only prudent that as part of an enhanced customer service, patients be taken through psychological support systems such as guidance and counselling (Royal College of Surgeons of England, 2010).

The advantage that comes with such psychological support is that it helps patients in understanding their health problems. Once such understanding is built, they are better informed on how to approach or handle the health problems. Above all, a good psychological support takes the

patient's mind from the health problem so that the patient can be assured of longevity (Parsons, 2011). In various university hospitals in Ghana, there are counselling units that give various forms of psychological support to patients who need them. It has however been admonished that the scope of clientele that receive these services be increased because the focus is currently on HIV/AIDS, accident patients, patients due for surgery, women with child birth problems and tuberculosis patients (Bendelow & Williams, 1995).

Hourly Rounds

Hourly rounds may be explained as the practice of intentionally checking up on patients at a hospital ward (Armstrong, 1983). This means that hourly rounds are a health care based service rendered specifically to patients on admission. Hourly rounds may be contrasted with bell call support in two specific ways. In the first instance, bell call support requires the attention or presence of the service provider only at a time that the service user calls for support but for hourly rounds, the service provider must be around on an hourly basis, whether or not the service user needs support. In effect, hourly rounds refer to a service that the service provider gives to the service user as a means of ensuring that service users are responding to treatment and that they are not under any critical medical situations.

The second difference that hourly rounds have from bell call support is that in the case of bed call support, the patient targets the ward attendant, who is normally a nurse (Bendelow & Williams, 1995). With the hourly rounds however, the attention is not on the ward attendant only but on other service providers, particularly doctors. At the various university hospitals in Ghana,

the practice has been to ensure that hourly rounds are never missed by service providers (Moynihan, 2003). However, Bendelow and Williams (1995) noted that some of the hospitals are faced with lack of permanent doctors and so the task of attending to patients on an hourly basis is often left in the hands of nurses and health assistants (Alderson et al, 2004).

How to Improve Customer Care in Public Hospitals

The positive impacts of customer care in public hospitals cannot be achieved if customer care in itself is not improved. Writing on factors in improving customer care therefore, Akiwumi (2011) opines that all health departments in the Ghanaian university hospitals must have a comprehensive quality assurance programme that serves as an evaluation and monitoring tool for checking the activities of the hospitals. Similarly, it has been stressed that the absence of quality assurance on the customer care of hospitals creates a situation whereby there is an imbalance in the service scope at the hospitals with other aspects of care receiving more attention than customer care (Ghana Health Service, 2004).

On their part, Anarfi et al (2013) state that an era where there is an integration of customer care into the core service structure of university hospitals in Ghana will ensure that there is an improved customer care (Ensor & San, 2009). This is a very important point to consider because in most cases, customer care is not regarded as part of the associated service requirements of most health facilities in Ghana. It is for this reason that Agyepong et al. (2017) argue that having a customer-centred health service delivery would be the foremost approach to achieving improved customer care

in public hospitals. Given that in most cases, hospitals relegate the core needs of customers to the background and only focus on how to make profits or to avoid losses (Hougen & Sesiah-Lewis, 2008).

Use of comprehensive Quality Assurance programme

At the global level, the WHO and other international organisations responsible for public health delivery such as the United Nations Educational, Scientific and Cultural Organization (UNESCO) has made it a core responsibility to ensure the promotion of quality assurance in primary health care across the globe. Quality assurance has been explained to be an evaluation and monitoring system that is aimed at overseeing the delivery of high standards of services (Gupta, Verhoeven & Tiongson, 2009). In the health sector, quality assurance is not a new term as health facilities and other health care outfits undergo various forms and stages of quality assurance. Due to the impact and results that comprehensive quality assurance programmes of various countries have produced, the researcher recommends its reproduction in university hospitals in Ghana. Currently, the Ghana Health Service has its own quality assurance programmes but these programmes have been criticized as not being comprehensive enough. For instance, it has been noted that the only areas of public health delivery that the service gives its attention to are in the areas of pharmaceuticals and the training of health professionals.

Once the health training institutions complete training health professionals and the pharmaceutical companies finish producing drugs, quality assurance surveillance on their output of work is merely zero (Duclos, 2002). But for customer care in public hospitals to be improved, health service

providers should be checked on a regular basis for the level of customer satisfaction they render to their customers. Once this is done, there would be the need for service providers to be more attentive to customer care, knowing that the quality assurance programme will expose their inadequacies.

Integration of customer care into the core service structure of University hospitals

According to a study conducted on customer care delivery in the university hospitals in Ghana, Greene (2003) observed that, one thing that has been found to be clearly absent from most government hospitals and for that matter University hospitals in Ghana is a customer care unit. The common practice has been to concentrate the activities of the hospitals on traditional health care delivery such as laboratory services, nursing care, pharmacy services, specialist care, ward services, and consultation services with doctors.

At the Kwame Nkrumah University of Science and Technology Hospital and Cape Coast University Hospital for instance, there are separate units of each of the sectors listed earlier. However, none of the hospitals has a separate unit for customer care service. Clearly, what this implies is that the hospitals are not committed to customer care as an integral part of their structure and programme (Duclos, 2002). With the success of having a separate customer care unit in university hospitals at places such as Oxford, Johannesburg, and Cairo, it has been said that such units be created to monitor the scope and rate of customer care services that the university hospitals deliver (Johnson & Schoeni, 2003). Once such units are developed and the hospitals see customer care service as part of their core service structure, they

will be bounded in a more committed manner in ensuring that customer satisfaction is assured (Brent, 2010). What is more, such customer care units will have their own programmes, activities, agenda, and budget that will ensure that the promotion of some of the customer care practices are adhered to.

Improved doctor-patient ratio

Puig-Junoy and Ortun (2003) note that there is no way doctors can deliver detailed customer oriented care in the conduct of their everyday duty when they do not have enough time to spend with a single patient. This is because according to the positivism theory, excellent customer care takes place in an environment where the doctor sees himself as part of the problem that the patient presents (Duclos, 2002). In effect, the doctor must have enough time to clearly diagnose the problem, prescribe remedies, receive feedback from patient and have a follow-up to ensure that there is total recovery.

Meanwhile, in the Ghanaian situation, there is scarcity of doctors and other health professionals. This inadequacy has been so severe in some cases that expatriate doctors are imported from other countries, particularly from Cuba (Brent, 2010). In such a working setting where doctors have several people waiting behind their doors, for which reason they must rush patients through consultation, there is clear evidence that the type of customer care service advocated by the positivism theory will be very difficult to be achieved. Available literature and research work that have reported success with enhanced doctor-patient ratio indicate that university hospitals in Ghana

should find means of improving the doctor-patient ratio if customer care will be achieved for improved public health delivery. Once patients report to hospitals, they need to have a feeling that they are visiting a place where their interest is being put first because the health care provider has sufficient time to listen to them and attend to their problems.

Enhanced Doctor-Patient Relationship

According to the social construct theory, doctors and other health service providers ought to have a very positive relationship with service users to ensure assured customer satisfaction. It must be noted however that the achievement of such relationship that ensures and guarantees coherent coexistence between doctors and patients does not come about automatically (Johnson & Schoeni, 2003). It has been said that it is only in a state of regulated training that this objective can be achieved (Keane & Moffitt, 1998).

In essence, the training of doctors and other health service providers must be incorporated with training in aspects of interpersonal relationship and coexistence. There are reviewers who actually contend that the selection of students into medical schools and other health training facilities must be the starting point for getting health service providers who make healthy customer relationship their focus. What reviewers belonging to this school of thought argue is that before students are admitted, they must be checked to possess natural skills on interpersonal relationship (Agyare, Mensah & Osei-Asante, 2008). There is however a different school of thought that believes that the same objective as advocated by the earlier group can be achieved if the curricula of health workers are embedded with these interpersonal relationship

skills. It must be emphasised that a healthy doctor-patient relationship holds the key to improving customer care and customer satisfaction in university hospitals and for the achievement of enhanced public health delivery because most of the customer care practices are human-cantered, having so much focus on the attitude of service providers to work.

Improvement in the Quality of Health Infrastructure and Facility

In the section where customer care practices were reviewed, it was realized that a lot of focus was given to patients who are placed on admission at the various university hospitals in Ghana. The implication is that customer care delivery is a very expensive road to thread even though it could be very advantageous (Agyepong et al. 2017). As part of the agenda for achieving comprehensive customer care programmes, several hospitals across Africa, particularly in Nigeria, South Africa and Mauritius have reported of extensive investment into the raising of the standards of facility and infrastructure (Johnson & Schoeni, 2003).

The concept here is that the end game to all customer care agenda is for the customer to have assured and guaranteed recovery from disease (Agyare, Mensah & Osei-Asante, 2008). In effect, if there are facilities and infrastructure that can give the patient any kind of medical service that the patient requires, then clearly greater part of the call for customer care delivery will be achieved (Agyare, Mensah & Osei-Asante, 2008). In the Ghanaian context, there is need for a concerted effort that aims at improving available health facilities. At the same time however, one should not lose sight of the fact that Ghana is still a developing country, which does not have the luxury of

focusing its entire national budget in one sector. In effect, a model that is currently in use in Guinea Bissau, where instead of having several non-functional and inactive health facilities, the government is focusing attention on having fewer health facilities with well stock modern equipment and tools should be replicated in Ghana (Keane & Moffitt, 1998).

Customer Care Factors that Impact Sustainable Healthcare Delivery

Many schools of thought exist on what the impact of improved customer care would be on health care delivery. Generally, almost all authors (Aryeetey & Harrigan 2010; DeJong, 2011; Popper, 2009) whose works were reviewed agreed that improved customer care would lead to sustainable health care delivery. However, the realization of sustainable health care systems seems to be debatable. For example, DeJong (2011) points out that in a health care setting where customer care is prioritized, the general health of the populace is enhanced. Supporting the argument, Aryeetey and Harrigan (2010) stressed that improved public health is achieved because the patients are given maximum priority in the delivery of health care, leading to the right usage of drugs, better prevention of diseases and generally improved rates of recovery from sickness.

Brobby and Ofosu-Barko (2012) on their part, touch on the impact that improved customer care has on available health facilities, arguing that for countries like Ghana where there are limited health facilities and personnel, it is always important that customer care be focused on the promotion of primary health care so that diseases and sicknesses will be prevented among the populace. When there is the prevention of diseases, less number of people will

report to health facilities, thereby ensuring that the few who report receive the best of service. It has been posited that whenever there is minimal pressure on health facilities, the need to have a robust and committed budget on health spending becomes a thing of the past (Curtis & Taket, 2009). In the Ghanaian setting therefore, government would have the luxury of committing budget to other sectors of the economy.

Sustainability in Healthcare Delivery

Sustainable Development

Health service management issues have become global, socio-psychological and environmental governance phenomena and the concerns of all citizens at every scale of society. Thus, the acceptable phrase for the main task of most health managers since 1987 has been 'sustainable development' (SD). It is understood to ensuring a balance between economic development, social equity and Health service sustainability (Mensah & Casadevall, 2019).

In other words, sustainable Healthcare development became common use in the human development literature after the Brundtland Report of 1987. The concept has thus been employed to imply development of that factor is not only current exploitation and utilization of resources, but the one that considers generational needs particularly health and its implementation in the future. The World Commission on Environment and Development (WCED) defined SD as 'development which meets the needs of the present without compromising the ability of future generations to meet their own needs'. The European Union is a strong advocate of the Declaration at the 1992 United Nations Earth Summit in Rio de Janeiro. According to Dalal-Clayton et al.

(2003), five years after the Rio Earth Summit the UN General Assembly Special Session review meeting in 1997 revisited the issue of national strategies for SD. There was a set target date of 2002 for introducing such strategies in all countries. Indeed, the Millennium Development Goals (MDG) has the question of SD among its broad themes by enjoining countries to: 'integrate the principles of SD into country policies and programmes and reverse the loss of environmental resources, including health matters' (McArthur, 2014).

At the 2002 World Summit on Sustainable Development, Paragraph 145 of the Plan of Implementation urged nations to: continue to promote comprehensible and synchronized approaches to institutional frameworks for SD at all levels and as appropriate, the formation or strengthening of existing authorities and mechanisms necessary for policy-making, coordination and implementation and enforcement of laws. The healthcare industry is facing an era of substantial change and transition. The growth of populations results in demographic shift and the gap between the rich and the poor even becomes wider. This phenomenon leads to significant increase in demand for health services in both the developed and the developing world.

The healthcare system is concurrently coming under increasing pressure from rising input costs regarding energy, water and carbon. This is influencing many governments to re-assess the value of sustainability within the health system. The growing effect of climate change has also been recognized to be a driving force for the continuous rising cost and demand for health services globally. Rising temperatures will also increase the need for energy-hungry air conditioning; rising sea levels will put coastal hospitals at

risk of flooding; changing weather patterns and damaging natural disasters will increase demands for services (World Health Organisation, 2008).

As a result, the health sector is facing an unprecedented scale of change that will require public, private and non-governmental organizations to come together to identify and develop innovative solutions in order to make available resources and work harder towards creating a sustainable model of health. "Sustainability" means different things to different people. Sustainability could be defined as the ability or capacity of something to be maintained or to sustain itself. It is about taking what we need to live now, without jeopardizing the potential for people in the future to meet their needs. An activity is said to be sustainable, if it is able to continue perpetually. Hence continuity of healthcare is implied in this study.

The term "sustainability" when applied institutionally within a university hospital context, is the development of a process or management system that helps to create a vibrant campus economy and high quality of life while respecting the need to sustain natural resources and protect the environment. Sustainable programmes are those that result from an institution's commitment to the "tripe bottom line" namely environmental, social and economic health or wellbeing. Sustainability is usually a balancing act since it has both individual and institutional applicability. According to a KPMG's (2012) report, the *Expect the Unexpected: Building business value in a changing world*, there are 10 sustainability 'mega-forces' which will dramatically change how healthcare is conceived and delivered in the decades to come. Of the 10 mega-forces, healthcare is highly exposed to Climate Change, Population Growth, Water Scarcity, Energy and Fuel, Food Scarcity,

Urbanization and Wealth. Potentially, the sector is also exposed to Material Resource Scarcity and Ecosystem Decline.

The healthcare sector is coming under increasing pressure as a result of the shift and expansion of global populations. The phenomenon of aging populations and extended life expectancy in the developed world have led to an increasing prevalence of chronic, expensive-to-treat diseases, disabilities and a rising shortage of healthcare workers to cope with the rising demand. The developing world is also saddled with rapid economic growth and increase in emerging middle class that have resulted in dramatic increase in demand for health services in spite of government's struggle to bring social services to remote and underserved populations, often for the first time (Bhote, 1996). Increasing affluence has also created a series of new challenges for the healthcare industry as the gap widens between the rich and the poor, resulting in a disparity in the availability and quality of care. Moreover, as more people move into the ranks of the middle class, the impact on the disease profile has been dramatic as changing diets result in increasing levels of obesity and diabetes.

The response to the growing needs for healthcare services requires investment in those services and the infrastructure required to support it. The combination of rising energy costs, scarce resources and climate change are challenges which are critical to the operations of healthcare providers. For one, this connection/relationship as an immediate and dramatic effect on the health of the global population: water scarcity and climate change are increasing the incidence of drought and famine leading to significant malnourishment and disease in many regions of the world, while rapidly rising

costs for food and energy are – in some cases – compelling families to make difficult choices between putting food on the table and paying the bills (Drucher, 1996). These challenges increase the cost of health services delivery and put healthcare facilities at risk within the healthcare industry. Energy in particular is a difficult challenge: It is estimated that US hospitals spend US$8.5 billion per year on energy and consume almost twice the energy per square foot of traditional office space. Hospitals in Brazil are reported to account for 10.6 percent of the country's commercial energy use (WHO, 2009).

Consequently, the cost of operating health systems will dramatically increase as energy, food and water begin to consume larger proportions of healthcare budgets. These costs will continue to have impact on both private and public organizations operating in this sector. Pharmaceutical companies, who use a significant amount of water and energy in the development and manufacturing of treatments, will see input costs soar and will be compelled to increase prices while health systems seek to reduce the financial burden of care. Managing waste has also become a key concern for healthcare providers. At the institutional level, the cost of waste disposal will continue to increase and create new challenges for the environment. For instance, poor waste disposal and management in Nigeria, has led to high levels of contamination of many rivers and basins in the country. This led the Mercer Quality of Living Report to name Port Harcourt one of the 25 dirtiest cities in the world (Mercer Quality of Living Report, 2011).

Key Themes of Sustainability

On-going research points to four key themes that consistently come up when the top of the list is considered. Research from Johnson Controls (2010) suggests that any or all sustainability initiatives must: decrease operating costs across the organization; reduce the environmental footprint (emissions, waste, water and energy); secure its own support and funding (by paying for itself in some way); and educate and engage stakeholders (employees, partners, customers and community).

If organizations begin to learn about sustainability, they start by first talking about managing operating costs before secondly reducing their environmental footprint. Many healthcare organizations (particularly those familiar with Johnson Controls) quickly move to the topic of energy efficiency because it is seen as an area that offers the most opportunity to reduce costs, reduce environmental impacts and pay for itself through energy efficiency savings. It should be noted that the "engage stakeholders" theme is much more significant and important than one realizes.

Johnson Controls (2010) finds that virtually all sustainability initiatives are seen as important ways to engage and motivate employees, build a more loyal culture in an organization, and strengthen a brand and your share of the market. Sustainability can be used as a competitive differentiator, helping a healthcare organization attract patients that value and support organizations that are sustainable. However, without a meaningful communication programme that creates visibility, momentum and enthusiasm, it will be difficult to maintain support and receive benefits from sustainability strategies

and programmes. Managing to the triple bottom line without telling anybody about sustainability misses the point.

An organization may have many questions when deciding to incorporate sustainability into their strategy, operations and decision making criteria. Questions typically fall into five categories (Ngahu, 2001).

1. Improve our ability to fulfill our mission;

How can we create a more innovative and talent-rich culture?

How can we impact patient outcomes?

2. Reduce our environmental footprint;

How do we meet our environmental commitments?

How do we use less natural gas, electricity and water?

3. Improve financial results;

How do we lower our costs per square foot or meter?

How can we improve our competitive position in geographic region?

4. Educate and engage stakeholders;

How can we improve our image in the community?

How can we increase the number of volunteers or donations?

5. Secure support and funding.

How do we pay for these programmes?

Building a Sustainability Solution

When it comes to driving sustainability solutions, the process can be simplified to four key steps (John Solutions, 2010):

1. Set strategy and policy for the organization, for a business unit or even for a select workplace

2. Build the information and analytical platform to measure and monitor sustainability strategies and programmes
3. Develop programmes and projects to accomplish the strategy and goals
4. Develop communications programmes to drive engagement with stakeholders.

These steps can be undertaken in different order, depending on where a healthcare organization is today. For example, if the leadership team has already made some sustainability commitment such as energy efficiency or greenhouse gas reduction, then there may be less need to dedicate significant time to developing these strategies (It should be noted that setting a target is not by itself the same as developing a strategy – and there are plenty of organizations today with a commitment, but no strategy). Establishing and validating the information and analysis platform within the organization represents a critical step in developing a solution. Metrics are important, whether they are created internally or derived from external sources. Measurement and tracking helps an organization determine if its strategies, projects and communications are achieving its goals (Baird, 1999). Finally, as pointed out earlier, any sustainability solution should include a significant communications and engagement dimension. Without it, a healthcare organization does not get the visibility, the momentum or the credit for the work. To put it simply, communications is a critical element in any sustainability initiative.

New Approaches to Healthcare Delivery – Driver of Sustainable Healthcare

The context of rising populations, scarce resources and financial limitations will require governments and healthcare providers to develop new approaches to the delivery of care. There is a growing body of evidence that technology can be brought to bear on these challenges to not only provide care to remote or underserved populations, but to also reduce the overall system costs of health. For example, tele-health – the remote exchange of data between a patient and a healthcare professional – has been proven to enhance patient care and reduce costs. In the UK, the Department of Health (UK & DoH, 2006) launched the Whole System Demonstrator programme to build a body of evidence for the integration of health and social care provision through tele-health and tele-care. The results show that by leveraging technology, the health system was able to achieve a 20 percent reduction in emergency admissions, a 14 percent reduction in elective admissions and a 45 percent reduction in mortality rates (Santon, 1999).

According to Lord Crisp, former NHS CEO and Honorary Professor at the London School of Hygiene and Tropical Medicine, "Tele-medicine, rightly in my view, is seen as central to the improvement of health and life in developing countries" (Kotler, 1997). The combination of electronic health records, mobile health devices, virtual teamwork and electronically-enabled disease and knowledge management has also emerged as a platform for catalyzing the transformation of healthcare, particularly in the developing world. In China, for example, the government is engaged in a programme to drive universal access to health services by developing the technologies and infrastructure required for a national eHealth programme. In one fell swoop,

the Chinese government expects to extend access-to-care to more than 1.3 billion people. The government also plans to build 30,000 hospitals across the country which – if constructed within sustainable guidelines – will provide substantial dividends to the health of a large portion of the world's population (Anderson, 1982).

It is important to recognize that both eHealth and telehealth require a significant investment in technology and infrastructure, as well as a supportive policy environment to ensure change effective and sustainable. Again, the participation of the private sector will be critical, particularly in building the basic infrastructure to support these emerging technologies.

Organizational Readiness

According to John Control Inc. (2010), here are some indicators that a healthcare organization may be ready to take action: A numerical target or commitment binding the organization to some kind of resource commitment in energy, water, emissions and/or space; Participation and/or collaboration in prominent global non-governmental organizations such as the World Resources Institute, the World Wildlife Fund, the Carbon Disclosure Project, Healthcare without Harm, Practice Green health, Global Health and Safety Initiative, and others;

A committed senior leader with on-the-record comments, the existence of a sustainability coordinator and cross-functional teams, and/or dedicated budget to funding sustainability initiatives; and a big action and/or announcement by a leading competitor in the area of sustainability. It is worth noting that the "enemy" in most sustainability initiatives is inertia and

organizational complexity. First, a "doing things the way we've always done them" point of view virtually ensures that sustainability initiatives would not get off the ground. Second, organizational complexity can often prevent finding the right sponsor to drive the desired change around sustainability. It requires finding someone within the organization that has the following profile: The person "owns" the commitment around meeting an environmental target; the person has access to funding or can approve financing to budget and approve the necessary investments to meet the target; and the person has the internal influence and leverage to force unwilling participants to get on board.

In addition to top management commitment and cultural fit, healthcare organizations that have had the greatest success in creating an environmentally responsible organization have done so primarily through designating and supporting a person that can lead and integrate the various sustainability programmes throughout their organization. One way that some organizations have operationalized sustainability is to use the triple bottom line as part of their decision making criteria. For example, when considering a strategy or programme, does it help the organization improve its results in at least one (preferably two or more) of the following areas: economic prosperity, environmental stewardship or social responsibility (Ngahu, 2001).

Public Private Partnerships – A critical response to Healthcare Sustainability

Creating a sustainable healthcare system is a significant challenge. Existing healthcare facilities will need investment to become more energy-

efficient, while new infrastructure is likely to be built to more exacting requirements. Governments and system administrators will need to play a leading role through increased investment, supportive policy development and innovative solutions. But there is also a role for the private sector to play (Balunywa, 1995). Over the past two decades, governments have increasingly come to recognize that the burden of infrastructure provision is not something public sector they can meet alone. Government health departments generally do not have the capacity to provide all of the skills and expertise necessary to handle large or complex construction or technology projects. The private sector therefore has a role to play in terms of bringing specialist expertise in these areas of managing large and complex risks within programmes and writing its own performance through bearing those risks and providing finance to projects.

A key issue for government is therefore how to get value from these arrangements. Competitive tendering of Public Private Partnership (PPP) contracts is one way to do this. The development of new facilities also offers ample opportunity to reduce the cost and environmental impact of healthcare. Most hospitals built under a PPP model now include stringent sustainability requirements, particularly in relation to energy efficiency and the use of sustainable building materials. Indeed, a growing number of contracts now include specific requirements that are designed to enhance long-term sustainability, while setting targets for energy and cost reduction.

Contracts for services and infrastructure development can be structured to directly reward sustainability outcomes and, as a result, provide incentives for greater performance and innovation in sustainability. For example, the

recently inaugurated Royal Children's Hospital in Melbourne, Australia was developed with sustainability requirements built into the tendering process. The design brief required the use of fresh air, natural light, water systems and recycling, as well as energy and greenhouse gas targets. The contract also included performance parameters and evaluation criteria to ensure that the facility would continue to meet all of the requirements through the project's delivery and operation phases (Levit, 1990).

Around the world, the PPP model is being adapted to deliver increasingly innovative programmes to address specific issues, particularly in the developing world. For example, the use of cook stoves is believed to contribute to the death of more than 1.9 million people per year, largely from lung and heart disease because the stoves produce significant pollution (Grönroos, 1984). In response, a global programme has been launched to bring together private enterprise, government funding and non-governmental support in a PPP that aims to provide 100 million clean burning stoves to villages in Africa, Asia and South America. The project received about US$50 million in seed funding from the US Government which will sit alongside US$10 million in funding from more than a dozen other partners including multilateral organizations and corporate sponsors. These types of innovative partnerships will be central to developing sustainable healthcare solutions. However, more activity will be needed, especially in creating the IT and telecommunications infrastructure necessary to support new approaches to healthcare delivery such as telehealth and eHealth. In part, this will require governments to create a supportive policy environment that encourages private investment and sets out clear rules of engagement for participation. It will also

require private and non-governmental organizations to step up to explore and develop opportunities that deliver sustainable solutions and quantifiable benefits to the health system.

Sustainability Innovations

While various innovations are being carried out across the healthcare continuum it is critical to step back and analyze if the current trend of fragmented investments, technological developments and institutions can effectively address the huge and growing unmet demand for healthcare services in Ghana. Global experience shows that often sustainability of innovations is the driving force that balances growth and technical advances to the needs of the population and fosters better targeted and integrated innovations (Johnson Controls, 2010). To ensure sustainability, innovations would need to be:

Holistic – spanning across the value chain;

Cost-effective – minimal costs for desired outcomes;

Affordable – optimal prices based on target market; and

Recognized – awareness on relevance and usage.

While stakeholders need to constantly focus on these aspects to drive long-term frugal innovations, concerted efforts are also required to strengthen factors that significantly contribute to building an environment of sustainability.

Improvements in technology: Technology in the last two decades has revolutionized the way healthcare is delivered. The use of customized technology has the potential to impact patients and providers alike by

enhancing the quality of delivery, reduction in turnaround time of workflows and thus the overall cost, besides bringing in higher accountability into the system. Illustrations of customized technological advancements that have already been implemented include telemedicine, tele-monitoring, HMIS, m-health, smart cards, mobile clinical devices and the use of palmtops (Fornell, 1992).

Improvement in quality of human resources: To support technological developments, policy makers and industry leaders would also need to focus on availability and quality of human resources with suitable skill sets and appropriate deployment at different levels of the health care set-up: private and public, urban and rural, and prevention and cure. The Ghanaian academia would also need to link human resource development and training gaps to national health strategies and the dynamic needs of the industry.

Improvement in research capabilities: Ghanaian academia and corporate organizations also need to substantially invest into building adequate research capacity to investigate and report key issues that affect the health system and policy for further improvements. Enhanced research capacities, complemented by quality human resources and relevant technology, will help create a more holistic and progressive approach to create a health system in which innovations are undertaken on a sustained basis.

Future Dimensions of Sustainability

While the Ghanaian healthcare has been witnessing a trend towards innovations, more of such innovations are needed to solve the issues faced by our very large and diverse population. While a number of opportunities and

improvement areas exist across the healthcare spectrum – from financing to delivery, there is need for a cohesive strategy that fosters an environment for sustainable innovations.

Innovations need to progressively adopt a prevention focus along with the existing provision-focus by implementing a larger number of novel and easily accessible prevention and wellness strategies. WHO estimates that "at least 80 percent of premature heart disease, stroke and type 2 diabetes and 40 percent of cancer could be prevented through healthy diet, regular physical activity and avoidance of tobacco products" highlighting the need to adopt a mix of population-wide and individual promotion and prevention interventions (WHO, 2010). Related changes would also be required across various aspects of the healthcare spectrum including national investments, policies, human resources planning, and training and above all, political commitment. The Government plays a critical role in driving this shift.

In addition to this orientation shift, it is essential for all relevant stakeholders to plan and implement innovations in tandem in order to drive a more unified and sustainable approach to innovations. While this is a challenging task, it also sets the stage for the ecosystem to leverage the core strength areas of each of the stakeholders including the Government, private providers, medical technology companies, pharmaceutical companies, health insurers and academia. Private players play a dual role in encouraging innovative provision of health services. Along with improving patient and disease coverage, efficiency of operations, quality of care and profitability, they also play a pivotal role in addressing the broader 'affordability' and 'accessibility' issues by collaborating with the Government and infusing the

public system with their capital, expertise, efficiency and innovative approaches.

Increasingly Public Private Partnerships are being viewed as a much needed solution to achieve the shared goal of universal health coverage (Richter, 2004). While a number of PPPs have already been implemented over the last decade, this phenomenon would need to be scaled up to achieve the desired national health outcomes. The Government plays a crucial role in driving innovations to address the financing and delivery gaps of the country. It also plays an all-encompassing role of setting long and short term health care policies and regulations. It is thus, critical for the Government to proactively establish systems that enable collaborations among the various stakeholders to develop an environment of creative-thinking, incubate new solutions and encourage early implementers and adopters.

While there exists no defined "best" standard for systems that nurture an environment of sustainable and innovative healthcare management, the government and the industry must continue to invest adequately in new cost-effective and efficient financing and delivery models; provide financial support for R &D; provide necessary incentives; engage actively with the academia and industry to identify and recognize exemplary efforts. There are many possibilities and opportunities for sustainability in healthcare. There is no one right way for an organization to become more sustainable. There are many resources and experts that one can turn to for assistance. Most importantly, healthcare leadership needs to decide what the best next steps are for their organizations. Some organizations are waiting for others to define sustainability for them, and provide guidance on what to do and when to do it.

Leading healthcare organizations are taking the time now to consider and define sustainability to fit their organization, their mission and their values.

Customer Care Practices at Kwame Nkrumah University of Science and Technology (KNUST) and University of Ghana (UG) Hospitals

According to a report on the KNUST Heath Services (2012), it was underscored the practice of the OPD staff in endeavouring to identify patients in a queue who need immediate attention and ensuring that such patients were among the first to be seen by a doctor. In a related development, the OPD of University of Ghana (UG), Legon runs a specialist clinic with nurses assigned on week days mostly in the afternoons (University of Ghana Hospital Report, 2012). It also undertook measures such as getting additional doctors employed to reduce the waiting time of patients at the OPD. Meanwhile, ward in-charges and members of staff had been ensuring that each shift was adequately covered with skilled mix of staff in order to ensure safe practice and quality health care.

Nurses were encouraged to administer oral medications at the bedside of patients (KNUST Health Services, 2014). Meanwhile, it was agreed that bedside rails should be provided for patient beds to prevent them from falling off their beds (KNUST Health Services, 2014). This development appears to lend credence to bed call support, which is considered by the Ghana Health Service as a mandatory public health care delivery module among all university hospitals in Ghana (Descartes, 2002). Similarly, UG hospital had ensured that its patients on detention received appropriate nursing care intervention as their conditions demanded. This included administration of

medicine, wound dressing among other standard practices (KNUST Health Services, 2014).

While insecticide treated mosquito nets were to be provided for patients, particularly for the windows of children's wards, KNUST Health Services (2014) enjoined nurses to equally ensure that laundry books were utilized to avoid shortage of bed sheets. On the other hand, UG had its Pediatric staff members attend workshops organised both internally and externally to appraise themselves with contemporary issues in pediatric nursing. UG improved its theatre services by ensuring that the supply of material resources was generally adequate and prompt for the delivery of both peri-operative and anesthetic services (Annual Report, 2012).

According to KNUST Health Services (2014), ward-in-charges ensured proper supervision of the work done by junior/rotation nurses and set goals and targets to foster the effectiveness of their training. They were urged to ensure that nurses' tables, nurses changing rooms and treatment rooms on the wards were kept tidy and clean. Nurses on duty were also tasked to supervise and ensure that ward cleaning was completed before visitors began entering the wards. In another development, KNUST Health Services (2014) posit that nurses on the wards ensured proper documentation in the nurses notes and report books. Meanwhile, it had been the practice for ward in-charges at University of Ghana to undergo workshops on customer care, after which they were expected to brief other staff on the importance of good customer care to clients and relations (UG Health Services, 2011). Indeed, nurses on the ward were not left out of training workshops, which equipped

them with more knowledge and skills to meet the heath care needs of their clients.

Workshops had been organised regularly for nurses who were in turn encouraged to transfer training to their colleagues, at least, within one week after attending workshops (KNUST Health Services, 2014). However, it was agreed that the Hospital should arrange to finance half of the cost involved in attending workshops (KNUST Health Services, 2014). Besides regular workshops for its staff, UG on the other hand ensured regular staff meetings to evaluate care performance for subsequent improvement. Furthermore, general ward rounds once weekly had been organised, giving the staff opportunity to learn management of the client's condition at hand.

Achievement of WHO Healthy Nation Target

Once the health care system gives attention to customer care service, there are several benefits that this produces. One of this has been found to be an improved health state of the populace (Bigman & Fofack, 2010). What this means is that customer care practices can lead to an expanded advantage of ensuring that Ghana as a country can be described as a healthy nation. According to the WHO, a healthy nation is one that achieves the Millennium Development Goal, which ensures that there is improved primary health care and low mortality rates (Greene, 2003).

Indeed, in a state of health care delivery where some of the major customer care practices discussed in section 2.1 is lacking, the most consequential outcome will be that primary health care will be negatively affected. This is because health care delivery will not have the individual user,

around whom primary health care delivery should revolve in mind. The profitability that mothers will receive poor ante natal care could also be high (Bigman et al., 2000). The most expected result of this situation will therefore be that mothers will attempt to deliver but lose either their lives or the lives of their babies. Customer care is therefore important if Ghana wants to achieve the WHO target as a healthy nation. It must be stressed that in a healthy nation where the local populace attend to their jobs with improved public health care delivery, productivity of such countries can be guaranteed to go up because there will always be sound mind and body to work (Bigman & Fofack, 2010).

Creation of a Literate Drug Population

A literate drug population has been explained as a group of people who have a high level of awareness on the use of drugs (Oliver, 2000). The phrase 'use of drugs' may be explained further to represent a situation whereby a person knows the right drug to use to treat the right ailment and at what dosage. Most often than not, when the service user base of a country does not receive the kind of added drug prescription service, the consequence is that they become handicapped when it comes to the use of basic drugs. They also lack knowledge on basic drug principles and as such benefit very little from drugs that are given to them even by health professionals (Brent, 2001).

It is against this background that when the customer care services that are currently in practice at the various university hospitals is sustained, creation of a literature drug population could be attained. As a matter of fact, research has given account of instances where patients develop health complications not because of the original health problems they reported to the

hospitals but because of a wrong application of drugs given to them after consultation (Bigman et al., 2000). While some patients take drugs on an overdose basis, others take the wrong drugs, causing allergies and other complications. Even in some cases, it has been said that some patients combine the wrong drugs, causing reactive effects on them. In a drug literate population, all these complications can be assured not to occur or occur at a very minimal rate.

Assurance of Better Approaches to Prevention of Diseases

Prevention has been said to be better than cure. This means that a healthy population that knows the various rudiments of preventive health approach can be guaranteed of an indirect curative health. The prevention of diseases has been said to be a process that is not very difficult to follow (Bigman & Fofack, 2010). However, when not well delivered, a preventive health approach could be a dangerous practice (Leder, 2000). The basis for this argument is that in their quest to achieving preventive health, most service users use the wrong methodologies, some of which have critical effects and implications (Oliver, 2000). It is for this reason that Brent (2001) admonishes health providers to commit a routine time schedule as part of public health delivery.

From the customer care practices outlined for the university hospitals in Ghana, it has clearly been stated that the hospitals have a committed preventive health care programme that they take patients through. As long as this practice is allowed to continue in a manner that is not rush and hasty, service users can be guaranteed of not becoming victims of poor approaches to

prevention of diseases. In a recent report, it was stressed that some patients who receive preventive health assistance risk a situation whereby they will refuse to take their health condition to the hospital with the thinking that they can go about the treatment of disease when in actual fact, the health conditions they face demand professional attention (Pfeffer, 2004). As part of their programmes therefore, the university hospitals should be seen to be raising awareness on the nature of diseases that must be rushed for professional attention if the approach to prevention of diseases cannot be a successful one.

Improved Rates of Recovery from Sickness

Even though different people will recover from diseases at a different rate depending on the nature of their disease, studies have actually showed that there are key factors that improve the rate of recovery from diseases in people (Liberman et al., 2002). This means that when two people with some key variables such as age, gender and cultural background suffer from the same disease, their rates of recovery could be different, depending on the recovery factors that are at their disposals.

In their study, Gupta, Verhoeven and Tiongson (2009) identified one of these recovery factors as excellent customer care that is given to patients. They explained further that customers who are taken through various customer care practices stand a better chance of recovering quickly from their ailments because the approach to recovery ceases to be a one-tier but a two-tier procedure. By two-tier procedure, patients who receive customer care services do not have to worry about taking up the task of recovering from their diseases all alone because their health service providers also concern themselves with

this same objective. Meanwhile, when patients are going to recover from their diseases at a quicker rate, there are so many auxiliary benefits that this can bring. For instance, less time is going to be spent at the hospital and so more time will be spent on one's economic activities, leading to improved productivity. The general wellbeing of people can also be guaranteed so that people can go about their social lifestyle in a more integrated manner (Greene, 2003).

Less Pressure on Health Facilities and their Finances

The patient is not the only beneficiary when there is a rigorous customer care system in place. As a matter of fact, the issue of public health delivery, which is the focus of the current research spans beyond the scope of the service user to include service providers and for that matter, public health facilities (Greene, 2008). In Ghana, one general problem that the Ghana Health Service identifies itself with is the doctor-patient ratio, where it has been reported that doctors handle too many patients than is ethically approved. Apart from the doctors, the general availability of health infrastructure and facility has also been found to be highly inadequate for the demand on health service that these facilities receive.

Greene (2008) found that the best way to correct the situation is to devote more national resources to the health sector so that there will be more health infrastructure and facilities procured. They also suggested for the training of more health professionals to fill out the vacancies that exist. However, in a counter study, Puig-Junoy and Ortun (2003) identified the weakness in the earlier suggestion, arguing that Ghana is still an infantile

economic state that cannot have the luxury of putting all its eggs into one basket. In effect, the best strategy to use to reduce the pressure on health facilities is to ensure that fewer people attend to these health facilities. As customer care practices improve the health of the populace through preventive health and higher recovery from diseases, the significance consequence is that not many people will need the services of doctors and health facilities and so the latter strategy can be achieved in reducing the pressure on health facilities and the finances of the health facilities.

Satisfaction of Patients with the Care Services

Several studies have been conducted on the satisfaction of patients. From these studies while some show that patients are satisfied with care they receive at the hospitals, others have also shown contrary findings. For example, a study by Kotzian (2009) on the determinants of satisfaction with health care system found that of the different types of health system output, the restoration of physiological health are no longer crucial for satisfaction among patients in his study.

Also, Kleefstra, Zandbelt, de Haes and Kool (2015) studied the trends in patient satisfaction in Dutch university medical centers. The study comprised 58,055 inpatients and 79,498 outpatients. The study was a quantitative study. Specifically, the study employed a time series design. The study adopted a stratified sampling technique which falls in line with the quantitative study design. The sample size was very large and this has given the authors the statistical power to conduct rigorous statistical analysis. The authors did the analysis by specifying how they analysed the data to achieve

each objective. This is very commendable. The results were in line with the objectives set for the study. Expressly, the results showed that there was a significant positive trend and improvement on national level and hospital level, especially in outpatient departments on the level of patients' satisfaction. Improvement was especially seen on the dimensions "information" and "discharge and aftercare". The authors also clearly made their readers aware of some of the strength and limitations inherent in their study.

Ali, Nikoloski and Reka (2015) also did a study on satisfaction and responsiveness with health-care services in Qatar. They found that both, satisfaction and responsiveness rates were high. Gender, nationality and, to some extent, income and age were significant sociodemographic determinants of satisfaction, with non-Qataris and females, having higher levels of satisfaction. Cost, previous experience with the same health provider and provision of medical insurance for a particular health provider were the attributes significantly correlated with general satisfaction. The results are consistent when the analysis is applied to the correlates of responsiveness.

In general, the methods employed were appropriate as they fall in line with the study design. The study employed a number of procedures to ensure quality control of the data they gathered. The instruments the authors used were validated instrument from existing studies such as the World Health Organisation. The authors also employed various means to analyse their data in other to achieve the specific objectives of the study. Specifically, they used logit and probit models to ascertain the various relationships and associations among variables. The sample size for the study was also relatively large. Findings were well-presented which showed clearly how each objective was

achieved. The discussion of the findings was discussed in light of previous evidence. This was done by synthesising the findings with current literature they reviewed in their context and various parts of the world. They also compared the results with the existing studies and gave various reasons for the similarities and disparities in study findings. The conclusions and recommendations the authors pointed out were also in line with the study findings. The recommendations had the various actors pointed out to do what to achieve a specific desired outcome, thus patients' satisfaction. Despite this, as the authors acknowledged themselves, the study, the authors could not account for clustering inherent in the dataset which they could have used multilevel analysis to account for. They did not also find GPS variable in their data. Also, looking at the topic in question, a mixed method approach would have strengthened the study since some of the issues would have been well-explained by the qualitative results.

On the contrary some of the studies showed that patients are not satisfied with the type of healthcare they received at various facilities they visited. For example, Al Qadire and Alkhalaileh (2017) studied the determinants of public satisfaction and perception of national healthcare services availability in Jordan. The study sought to assess Jordanian public satisfaction with healthcare services. The results showed that higher proportion of Jordanian patients was not satisfied with the healthcare services provided. The determinants of patients' satisfaction were not completely dependent on the actual medical or nursing care. The study was a quantitative study that employed a descriptive cross-sectional approach. The approach for the design was in line with the objective of the study. The sample size for the

study was 571 which was relatively large. Although the authors gave a flow chart of how they arrived at the final sample of 571, how these participants were recruited to take part in the study was not well elucidated. In other words, the sampling approach the authors used to sample the respondents was not specified. In addition, the authors have outlined that because of the variation in satisfaction measurement tools, they developed their own tool which was not systematically validated, which may threaten the internal and external validity of our results. The authors could have used validated instruments or gone through the process of validating the instrument through psychometric validation. The variation in measurements used limited their ability to compare and discuss the results of their current study in the light of regional and international studies.

In a similar study in Jordan, Al-Refaie (2013) also found that hospital performance has no significant effect on patient satisfaction and revisit intention. This result indicates that the patients were facing troubles in admission, registration, waiting time, and response time for results of medical tests. Also, the hospital stays, hospital facilities, service quality, and patient security culture are found significantly important in achieving patient satisfaction and revisit intention. Further, the interaction with patients' requirements and needs significantly related to service quality and hospital stay. The study had a clear general objective and well stated specific objectives. The methodology, quantitative methods that was applied seemed very appropriate. Despite this, the kind of analysis the authors carried out did not match the objectives that were set for the study. The authors also failed to acknowledge the strength and weaknesses of their study. This should have

been added to make readers more aware of the various lapses in the manuscript.

A study by Berendsen et al. (2009) did a study on the transition of care: experiences and preferences of patients across the primary/secondary interface–a qualitative study. The purpose of this study is to (a) explore experiences and preferences of patients regarding the transition between primary and secondary care, (b) study informational resources on illness/treatment desired by patients and (c) determine how information supplied could make it easier for the patient to choose between different options for care (hospital or specialist). The results showed that patients find it important that they do not have to wait, that they are taken seriously, and receive adequate and individually relevant information. A lack of continuity from secondary to primary care was experienced. The patient's desire for free choice of type of care did not arise in any of the focus groups. Hospital discharge information needs to be improved. The interval between discharge from specialist care and the report of the specialist to the GP might be a suitable performance indicator in healthcare. Patients want to receive information, tailored to their own situation. The need for information, however, is quite variable. Patients do not feel strongly about self-chosen healthcare, contrary to what administrators presently believe.

Assefa and Mosse (2011) conducted a study to assess the perceived levels of clients' satisfaction with health services rendered at Jimma University Specialized Hospital. The study was a cross sectional study conducted from March 1-8, 2010 on a sample of 422 service users of the hospital using systematic random sampling technique. The results showed that

the overall client satisfaction level with the health services rendered at the hospital was 77%. Satisfaction was reported to be highest (82.7%) with the way the doctors examined them and on the other hand dissatisfaction was reported to be highest (46.9%) by respondents with the time spent to see a doctor. Furthermore, satisfaction with the health care was found to have a significant association with the age of the respondents (p=0.034) and educational level of the respondents (p=0.003). It was concluded that the study showed higher clients' satisfaction level in the University Specialized Hospital when compared to previous studies in the same hospital as well as other similar studies in the country.

Lack of drugs and supplies, poor information provision, long waiting time, poor cleanliness, lack of privacy and inadequate visiting hours, were found to be the major causes of dissatisfaction. Therefore, the hospital management should understand these weak service areas and plan for a better service delivery. The study had a relatively large sample size. The sampling was also done systematically. However, the authors failed to account for missing values in their reporting of their results. Again, the authors did not show the method they used to calculate the sample size. This sample size calculation was neither guided by any relevant information nor guided by any sample size determination technique.

Kagashe and Rwebangila (2011) also carried out a study on the patient satisfaction with health care services provided at HIV clinics at Amana and Muhimbili hospitals in Dar es Salaam. The main objective was to determine satisfaction of HIV patients with health care services provided at the HIV clinics and specifically, to determine patients' satisfaction with the general

physical environment of the clinic and with services offered by doctors, nurses, laboratory, and pharmacy. The results patients at showed that the patients at the hospital were either very satisfied (44.3%) or satisfied (55.7%) and none were unsatisfied, while at MNH clinic 1.1% patients were very satisfied while (94.7%) were satisfied and (4.2%) were unsatisfied with health care services provided. Lack of privacy when consulting with doctors and the dispenser contributed to patients' unsatisfaction with the services. They therefore concluded that most of the participants were satisfied with the services provided at the two clinics.

However, at MNH, a few patients were unsatisfied due to lack of privacy during consultation with doctors and with the pharmacy services. The study employed a quantitative approach. This approach was very vital since the design of the study was in line with the positivist paradigm. That notwithstanding the authors could have employed a mixed method approach to gain various perspectives on the patients' satisfaction. The qualitative aspect would have been vital in the sense that satisfaction is not based on only the qualitative nor the quantitative dimension alone. But it is based on both the qualitative experience as well as the quantitative aspect of patients' assessment of their experience. In addition to this, the sample size that guided the study was stated, nonetheless, they did not adequately describe the way they sampled the respondents and how they got to their specific unit of analysis.

Khamis and Njau (2014) also carried out a study on patients' level of satisfaction on quality of health care at Mwananyamala hospital in Dar es Salaam, Tanzania. The aim of the study was to determine patients' level of satisfaction on the quality of health care delivered at the out-patient

department (OPD). The results showed that patients' level of satisfaction mean gap score was (2.88 ± 3.1) indicating overall dissatisfaction with the quality of care. The level of dissatisfaction in the five service dimensions were as follows: assurance (-0.47), reliability (-0.49), tangible (-0.52), empathy (-0.55), and responsiveness (-0.72). It was concluded that patients attending OPD at Mwananyamala hospital demonstrates an overall dissatisfaction on quality of care. Hospital management should focus on: improvement on communication skills among OPD staff in showing compassion, politeness and active listening, ensure availability of essential drugs, and improvement on clinicians' prescription skills.

Quintana et al. (2006) did a study on the predictors of patient satisfaction with hospital health care. They used a validated inpatient satisfaction questionnaire to evaluate the health care received by patients admitted to several hospitals. This questionnaire was factored into distinct domains, creating a score for each to assist in the analysis. In the univariate analysis, age was related to all domains except visiting; gender to comfort, visiting, and intimacy; level of education to comfort and cleanliness; marital status to information, human care, intimacy, and cleanliness; length of hospital stay to visiting and cleanliness, and previous admissions to human care, comfort, and cleanliness.

The timing of the response to the mailing and who completed the questionnaire were related to all variables except visiting and cleanliness. Multivariate analysis confirmed in most cases the previous findings and added additional correlations for level of education (visiting and intimacy) and marital status (comfort and visiting). The study adopted a quantitative

approach. The sampling for the study was well-explained and timebound. The authors also gave the duration they used for their data collection. The Sample size was large enough. The authors used validated questionnaires as their data collection tools. The limitations were also rightly acknowledged.

Park et al. (2016) did a study on public satisfaction with the healthcare system performance in South Korea. The study proposed a comprehensive three-factor model of healthcare system performance satisfaction. Among the three factors, the quality of care had the largest impact on satisfaction with the healthcare system, suggesting that is the most important determinant of consumers' satisfaction with their healthcare system. Regarding the relationships between public satisfaction and demographic and socio-economic variables, residence and marital status were significant predictors of the satisfaction level. Although the study had large sample size, nonetheless, the authors did not provide the means by which they sampled the respondents. In addition, they also did not specify the various limitations inherent in their study.

Xesfingi and Vozikis (2014) also did a study on what shapes patient's satisfaction in countries' health care systems. They found that there was strong positive association between citizens' satisfaction and public health expenditures, number of physicians and nurses, and the age of the patient, while there is a negative evidence for private health spending and number of hospital beds. Xesfingi and Vozikis (2016) studied patient satisfaction with the healthcare system. The aim of this paper is first to assess the degree of patient satisfaction, and second, to study the relationship between patient satisfaction of healthcare system and a set of socio-economic and healthcare provision

indicators. The study showed that there is a strong positive association between patient satisfaction level and healthcare provision indicators, such as nurses and physicians per 100,000 habitants, with the latter being the most important contributor, and a negative association between patient satisfaction level and number of hospital beds. Among the socio-economic variables, public health expenditures greatly shape and positive relate to patient satisfaction, while private spending on health relates negatively. Finally, the elder a patient is, the more satisfied with a country's healthcare system appears to be.

Stepurko, Pavlova and Groot (2016) studied overall satisfaction of health care users with the quality of and access to health care services: a cross-sectional study in six Central and Eastern European countries. The results indicate that about 10-14 % of the service users are not satisfied with the quality of, or access to health care services they used in the preceding year. However, significant differences across countries and services are observed, the highest level of dissatisfaction with access to outpatient services (16.4 %) was observed among patients in Lithuania, while in Poland, the level of dissatisfaction with quality of outpatient and inpatient services are much lower than dissatisfaction with access. The study also analyses the association of users' satisfaction with factors such as making informal payments, inability to pay and relative importance of service attributes stated by the service users.

Also, Aydin and Kaya (2019) did a study on factors affecting patient satisfaction with healthcare system of Turkey. The quantitative analysis analyzed the changes in patient satisfaction level by years and will try to find out how individual and country level factors are important for satisfaction with

healthcare system of Turkey. The study revealed that 14 % of the service users are not satisfied with the quality of, or access to health care services they used in the preceding year. Based on these findings, healthcare providers and planners can focus to improve at least one component of health system performance responsiveness.

Peer and Mpinganjira (2011) also did a study which showed that service quality is able to explain less than half of the variance in positive behavioural intentions while patients' overall satisfaction is able to explain over three quarters of the variance in positive behavioural intentions. The study thus concluded that patients' overall satisfaction has more explanatory power over positive behavioural intentions than perceived service quality. Patients overall satisfaction is a good mediating variable between service quality perceptions and positive behavioural intentions.

Spatial Variations in the Customer Care Practices

Geographic variation has long been considered as an important case-mix variable in its relationship with patient and clinical outcomes (Fisher et al., 2003). A number of factors explain the importance of geographic variation in measuring health status and customer care practices. First, many systems of health care are organized on a geographical basis. Hence, distribution of health care resources was tailored to respond to local demands. Second, health care facilities such as hospitals and clinics are concentrated in specific locations, turning geography into a predictor of health utilization and outcomes. Third, there's substantial evidence that "area effects" are drivers of health inequality, after controlling for social and economic factors. These "area effects"

represent relationships between area characteristics and individual behaviour which can't be explained by individual attributes alone.

A geographic influence is rarely explored, but several studies (e.g Footman et al., 2013; Rechel et al., 2011) suggests that a geographic variation plays a key role in satisfaction with the healthcare system performance. In the study by Soria-Saucedo, et al. (2016), the habitants in Gyeonggi, the province surrounding the capital city, had lower satisfaction with the healthcare system performance than those in Seoul (the capital city) and Busan (the second largest city). The regional distribution of the healthcare facilities and the medical workforce are weighted toward to the largest cities, such as Seoul and Busan. Facilities in these cities were likely to make more profit (Chun, Kim, Lee & Lee, 2009) compared those in the other areas. Of the 43 tertiary hospitals in the country, almost one half are in Seoul. Furthermore, the distribution of hospital care facilities, particularly tertiary hospitals that offer complex treatment with highly skilled specialists and cutting-edge medical equipment as well as superior services, is concentrated in Seoul and Busan. The authors explained that this may explain lower satisfaction with the healthcare system performance among habitants in Gyeonggi.

In Ethiopia, Dejen, Soni and Semaw (2019) did a study on the accessibility analysis for healthcare centers using gravity Model and Geospatial Techniques. This was measured by distance travelled and traveling time. Specifically, their study was carried out to analyze the distribution and spatial accessibility of healthcare service centers by using Geospatial technologies in Gamo Gofa zone of SNNP (Southern Nations and Nationalities People) region, Ethiopia. The authors used satellite data, DEM

(Digital Elevation Model), road network, population data and healthcare service centers location data for further analysis by using Access Mod extension 4.0 to Arc GIS 9.3.1 software. 30- and 60-min traveling time were considered to analyze the accessibility by means of walking and motor vehicle as the mode of transportation. It was found that 12.62%, 36.60%, 29.10% and 59% peoples of the total population were able to access the healthcare service centres by means of 30-min walking, 60-min walking, 30-min walking and motor vehicle and 60-min walking and motor vehicle respectively. Health and disease management is key to social, cultural and economic development of any society so this approach offers considerable benefit. The methodology the authors employed was appropriate. The various methods the authors employed were appropriate. For example, they reviewed recent literature that informed the discussion of their results. They also situated their work within a given theoretical framework. The sample size for their study was large enough for rigorous statistical analysis. For example, the authors carried out geographically weighted regression, to determine the spatial variation, they also carried out multi-level analysis to account for the clustered nature of the data. Despite these, the authors failed to specify some of the limitations in their work including their inability to control for certain key variables in their study. They also failed to acknowledge the strength and weaknesses of the study.

In India, Raju, Wajid, Radhakrishnan and Mathew (2020) did a study on the accessibility Analysis for Healthcare Centers using Gravity Model and Geospatial Techniques The spatial accessibility index is measured using the Modified Three-step Floating Catchment Area which incorporates emergency

factors in addition to travel time in travel impedance function. The findings showed that all hospitals are currently found to be collectively located near to the city Center and wards located in the periphery of the city having very low spatial access to healthcare facilities. The index also aids in delineating the healthcare deprived areas and over-served areas within the city. This identification is essential for the future planning of new healthcare services, to improve the capacity and ease of access to the existing healthcare facilities. The model of this investigative study can be extended further to all cities to assist in the pre-planning for provision of adequate healthcare facilities. Such information will be advantageous, to public health officials and policy/decision makers involved in urban expansion planning, for ensuring better and quicker access to health services with minimum delay in the event of emergencies.

Mello-Sampayo (2020) did a study on spatial interaction model for healthcare accessibility. The spatial healthcare accessibility improves as the demand for healthcare increases or the opportunity cost of traveling to and from healthcare providers decreases. The empirical application used different spatial econometric techniques and multilevel modelling to evaluate the spatial distribution of existing hospitals in Texas and their social and economic correlates. To control for spatial autocorrelation, spatial autoregressive regression models were estimated, and geographically weighted regression models examined potential spatial non-stationarity. The multilevel modelling controlled for spatial autocorrelation and also allowed local variation and spatial non-stationarity. The empirical analysis showed that healthcare accessibility was not stationary in Texas in 2015, with areas of poor

accessibility in rural and peripheral areas in Texas, when using hospitals' location and county data. The model of spatial interaction applied to healthcare accessibility can be used to evaluate policies aiming at the provision of health services, such as closures of hospitals and capacity increases. The methodology employed were appropriate. The sample size was relatively large. Nonetheless, the sampling approach was not specific. It did not provide details pertaining to how the unit of analysis was selected.

A study by Lindelow (2004) on understanding spatial variation in the utilization of health services. The findings show that health care quality is a significant and important factor in women's choice of delivery location. In particular, both the presence of maternity staff and a broader service range make it more likely that women choose a facility-based delivery. They also found that quality is not a significant determinant in decisions about outpatient visits, while physical access, education, and economic variables are important. The findings hence suggest that the impact of quality may be service specific, and that although certain dimensions of quality may have little or no impact on outpatient visits, they may be important determinants of the use of other health services. As developing countries to continue to face difficult trade-offs between quality and physical access in the allocation of resources, it will be important to deepen our understanding of how individuals make health care choices. The results presented in this paper are a step in the right direction.

Phillips (1979) also did a study on the spatial variations in attendance at general practitioner services. The paper presents an analysis of results from a behavioural survey of attendance patterns at general practitioner services in West Glamorgan. Respondents in six selected survey sites were questioned

regarding a range of surgery attendance behaviour. In many cases, respondents were not attending their nearest general practitioner and hence were not conforming to the nearest-centre hypothesis. A number of features distinguished the attendance patterns of higher and lower social status respondents and these were analysed using knowledge of variables which have been found to influence consumer behaviour in other spheres. Personal mobility, age of respondent, pre-school age children in households and place of former residence were included to examine their influence on attendance patterns. Personal mobility of respondents did to some extent influence distance travelled to general practitioner surgeries, although this was status-related also. Age of respondent did not appear to influence significantly distances travelled. More importantly, "place of previous residence" appeared to produce a type of "inertia" in that certain respondents were maintaining links with general practitioners in areas where they formerly lived and the resulting flows were termed "relict patterns of travel" to surgery. The implications of these findings for the planning of primary health care services are considered.

Hays, Kearns and Moran (1990) did a study on spatial patterns of attendance at general practitioner services. Geographical theory suggests that consumers will travel to the centre nearest to their residence which offers a particular service. This is a weak indicator of surgery attendance patterns in Gisborne, New Zealand. Nearby surgeries were attended, rather than the nearest available. Various attributes of the practices and the patients were examined to discover their influence on attendance patterns. The distribution of the practices themselves had a significant effect upon relative surgery

attendance. Prior knowledge of services was particularly important in determining surgery selection and continued attendance. This accounted for the spatially unconstrained attendance of many Maori. Greater personal mobility enabled higher income households to travel further to attend. Conversely, the less mobile were spatially bounded. The study design for the study was appropriate. Various quality control measures were employed to gather accurate data including discouraging members from answering on behalf of other family members. Despite this, the study did not indicate the number of people who constituted the population of the study. In most cases, the relatively higher the sample size, the higher the ability to run rigorous statistical techniques. The authors again failed to provide the sampling approach they adopted to select the 169 sample from the population.

In 2011, Comber, Brunsdon and Radburn (2011) did a study on the spatial analysis of variations in health access. They analysed the relationship between public perceptions of access to general practitioners (GPs) surgeries and hospitals against health status, car ownership and geographic distance. The study adopted a quantitative approach to achieve the object of the study that was clearly stated. However, the authors failed to propose hypotheses in their study. At the methodology section, the authors also did not explain in detail the sampling approach they used to sample the respondents for their study. Although they mentioned that they employed a stratified sampling. Nonetheless, the exact steps they followed to do the stratification were missing from their study. The analysis that were employed were also appropriate. Specifically, the authors employed the use of geographically weighted regression. This method helped the authors to achieve the spatial variations in

the terms of access to healthcare among different characteristics of the population. The authors also did a great job by specifying the various models they employed in their analysis. they did this by specifying each of the regression equations in their methodology. The results were also appropriately presented. The maps in the study were clearly shown with various keys for easy interpretation. It was found that respondent long term illness, reported bad health and non-car ownership were found to be significant predictors of difficulty in accessing GPs and hospitals. Geographic distance was not a significant predictor of difficulty in accessing hospitals but was for GPs.

The impacts of bad health and non-car ownership on the difficulties experienced in accessing health services varied spatially across the study area, whilst the impacts of geographic distance did not vary in the study. The authors also acknowledged the various limitations inherent in their study. Typical among them were they indicated that survey respondents were simply asked about their perceptions of access to 'hospitals' which, depending on their personal experiences may include children's hospitals and long stay psychiatric facilities. Another limitation they pointed out was he attitudes survey captured the degree of difficulty experienced in accessing services but not the underlying reasons for that difficulty. The authors could have dealt with this by employing a mixed method approach. The authors also acknowledged that, they used geographic distance to the nearest facility, which may or may not be the facility actually used by the survey respondents. However, the responses do provide an indication of the exclusion experienced by a robust sample of the population in the study area.

Shah, Bell and Wilson (2016) also did a study on the spatial accessibility to health care services in Canadian urban areas. They examined spatial accessibility to family physicians using the Three-Step Floating Catchment Area (3SFCA) method to identify neighborhoods with poor geographical access to health services and their spatial patterning across 14 Canadian urban settings. The study had clear objective which was outlined at the background of the study. With the methods that were employed to guide the study, the methods were well explained which were also in line with the objective of the study.

Specifically, the study design was in line with the objective of the study. The analysis employed for the study was appropriate. For example, the authors employed Anselin's local indicator of spatial association (LISA), a local form of Moran's I for statistical confirmation and identification of clusters in urban fabric. The LISA measures whether the 3SFCA accessibility score of a neighbourhood (i.e., index of spatial access to PHC services) is closer to the values of its neighbours or to the average of the urban area. The results suggest that the three methods, Simple Ratio, Neighbourhood Simple Ratio, and 3SFCA that produce City level access scores were positively correlated with each other. Comparative analyses were performed both within and across urban settings to examine disparities in distributions of health services. This was done with cluster analysis which was very appropriate as it has the ability to grouping cases into clusters. In other words, cluster analysis is used to group cases of data based on the similarity in responding to different variables. It came out that neighborhoods with poor accessibility scores in the main urban settings across Canada have further disadvantages in relation to

population high health care needs. They concluded that there are substantial variations in geographical accessibility to PHC services both within and among urban areas. Despite the strength of the study, the authors failed to clearly indicate the strengthen and weaknesses of their study. For instance, the authors failed to acknowledge or account for time dimension in their analysis. In addition, the authors could have employed a mixed method approach to gain deeper understanding of some of the issues they studied.

CHAPTER FOUR

REASERCH METHODS

Introduction

This chapter discusses the methods of data collection which includes: research philosophy, research design, study area, organisation sources of data, sampling procedures, acquisition of data, description and definition of variables, data processing and management issues and data analysis. Also, deliberated on in this chapter are the limitations to data collection.

Research Philosophy

Philosophy is considered very important in social sciences research since it serves as the foundation on which the entire work is built – conceptualization, data collection, analysis, interpretation, and presentation of the final research results. There are two dominant research philosophies in social sciences research; positivism and interpretivism. The positivist philosophy is associated with quantitative methods, while the interpretivist philosophy is associated with qualitative methods (Creswell, 2012). In recent times, mix method research has been able to draw on the philosophical foundations of both positivism and interpretivism, to give rise to a new paradigm known as pragmatism.

Positivist Paradigm

Positivist paradigm is derived largely from the philosophical ideas of the great French philosopher known as August Comte (Kaboub, 2008). Those who hold this paradigm are of the view that observation and reasoning are the ultimate means of understanding human behaviour. Positivists hold the view

that true knowledge comes from the experience of the senses and can only be obtained through scientific inquiry. Thus, the focus of positivist paradigm is uncovering the truth and reporting it through empirical means by ensuring objectivity. Scholars and researchers who share positivist paradigm classify positivism into three viewpoints; epistemological methodological and idealistic or philosophical views that include principles, morals, and ethics. Positivists are of the view that the universe is guided by permanent and universal laws of causation and occurrences. These occurrences are often complex but could be overcome by reductionism which places emphasis on accurate measurements that will result in objectivity and reproducibility.

Positivist researchers often use quantitative analysis, confirmatory analysis, deductions, and laboratory experiments as their methods of inquiry. In the view of Goetz and LeCompte (2004) positivism is usually in line with empiricism, whereas non-positivist paradigms such as interpretivism often make use of phenomenology or hermeneutics methods of inquiry. In spite of the paradigm being widely accepted and utilized among researchers, it has suffered some critiques, especially by interpretivist philosophers. For instance, many argue that philosophy has not been able to prove beyond doubt how researchers can adequately uncover and present truth that is independent of the mind (Hughes, & Sharrock, 2016).

Interpretivist Paradigm

The interpretivism paradigm came about mainly as a critique to positivism. It encompasses a wide range of research conventions, but often regarded as a shift from an "old paradigm" which is positivism to a "new

paradigm" in research which includes: interpretivist, critical, constructionist, feminist, and post-modern paradigms. Interpretivism is concerned with the centrality of meaning and understanding of the social world. Those who hold this paradigm are of the view that there is no universal truth. Thus, the reality is socially constructed (Myers, 2009).

The interpretivist paradigm assumes that social reality is created largely in the human consciousness as a creation of the mind. Based on this ideology, interpretivists disagree with positivist paradigm by conceiving that knowledge or what constitutes reality is subjective and natural. There is also the postulation that individuals are proactive in the creation of their own realities. Interpretivists are of the view that human beings participate freely in the creation and construction of social reality. This paradigm assumes an ideographic position about science and therefore posits that epistemological ideas should not be informed by universal principles(O'Connor, Netting, Thomas, 2008).

The methods of inquiry often employed by interpretivist researchers include; exploratory analysis, field experiments, ideographic experiment induction, and qualitative content analysis (Ogilvy, 2006). From a methodological perspective, interpretivism is concerned with qualitative methods which are vital to understanding how participants view a given social phenomenon(Myers, 2009). The use of qualitative methods helps to avoid researchers imposing meaning upon their research participants. A number of approaches such as participant observation, ethnography, and phenomenology are often used by interpretivist researchers. They also employed methods such as in-depth interview, focus group discussion, photography, and documentary

analysis in their studies(Iivari, 2007). The two dominant paradigms in social science as evident in the above discussion have their respective advantages and disadvantages based on their unique viewpoints about our social world. Researchers adopt and align their studies with either of the two or both paradigms based on their method of inquiry. The blending of the two philosophies to inform the conduct of a particular social inquiry is what gave rise to the pragmatism.

Pragmatism

This is a modern philosophical foundation or paradigm that guides the conduct of mix method in social science research. It involves bringing together both positivism (quantitative) and interpretivism (qualitative) to inform the conduct of social science research (Johnson, Onwuegbuzie, &Turner, 2007).The pragmatists hold the philosophical view that researchers should employ all procedures that are appropriate to their studies. As such, it is prudent to use as many methods as possible and appropriate when trying to address a research problem. Thus, drawing from the strength of both positivism and interpretivism to inform studies that seek to understand a social phenomenon in totality (Tashakkori & Teddlie, 1998). Greene and Caracelli (1997) assert that researchers are obliged to report the multiple worldviews or philosophical positions that they hold. Thus, in mix method research, it is important to acknowledge the worldviews and also collect both quantitative and qualitative data for uncovering reality. Even though pragmatism is considered a dominant philosophical foundation for mix method research, there are also emerging philosophies that are aligned with mix method,

including transformative research perspective which advances the need for addressing issues of social justice for under-represented groups (Mertens, 2009).

Paradigmatically, mixed method research employs pragmatism as a philosophical foundation. The logic of pragmatic studies involves the use of induction (or discovery of patterns) deduction (testing of hypotheses and theories) and abduction (uncovering and employing the best set of explanation for understanding results obtained from the data analysis)(Morgan, 2007). Given the focus of this thesis, (including the objectives and the research hypothesis) and in line with the mixed method of inquiry that was employed, pragmatism is thus considered the most appropriate for this thesis.

Research Design

A research design is a blueprint or plan, structure, and strategy of a scientific inquiry that is conceived in a way that is appropriate to a given study so as to help adequately answer the research questions and achieve the study objectives (Kumar, 2011). Mixed method is an emerging research method that has developed based on the need to draw on the strength of both quantitative and qualitative research techniques. A number of mix method study designs have been identified over the years. This includes; the convergent parallel design, the exploratory sequential design, the explanatory sequential design, and the embedded design. With each design clearly having their strength and weakness, researchers often adopt one that they deem as appropriate based on their study focus. In this thesis, I adopted the *embedded design* to guide the study. The reason for the embedded design is to gather both quantitative and

qualitative data simultaneously or sequentially but to have one form of data offering a supportive role to the other (Creswell, 2012).

In this study, the qualitative data is providing a supplementary role to the quantitative data. The idea is that the qualitative data will help explain the observed relationship between the variables of interest and also provide contextual in-depth understanding of the customer care issues. Both quantitative data (questionnaire administration) and qualitative data (in-depth interviews) were collected for the study. However, both sets of data were analysed separately, with each of them addressing different research questions. It is important to note that even though both sets of data were collected, the overall design emphasized quantitative approaches to research since quantitative data was needed to test the study hypotheses. Given the focus, research objectives and research hypothesis of this study, the embedded design was thus considered appropriate.

Profile of the Study Organizations/Institutions

The study focused on two public University hospitals in Ghana – KNUST which is located at Kumasi in the Ashanti region and the UG, located at Legon in the Greater Accra region.

Kwame Nkrumah University of Science and Technology (KNUST) Hospital

The KNUST hospital begun as a dressing station in 1952 and has since grown by additions and modifications into a full-fledged 100-bed hospital. The Hospital is bounded to the North by Ayeduase/Kotei, to the south by Bomso, to the West by Ayigya/Accra-Kumasi express road and to the East by

the University Commercial Area. The Hospital currently provides services to a population of over 200,000. These include 21,000 students, 30,000 staff and dependents; and about 150,000 people from over 30 surrounding communities. The KNUST hospital was primarily established to provide healthcare to members of the University community. With time, the hospital extended its services to the general public, including the surrounding communities which have witnessed rapid growth in population.

The Hospital is governed by a board called the Health Services Management Committee which constitutes selected members of the University Community, including Federation of University Senior Staff Association of Ghana (FUSSAG), Tertiary Education Workers Union (TEWU), Student Representative Council (SRC), Convocation and Academic Board representatives, etc. The Board makes decisions and approves policies for the smooth operation of the Hospital. The Board plays an advisory role in relation to the activities of the University Hospital Management Team. The Vice-Chancellor appoints the Chairman of the Board. The Board plays an important role in shaping policies that can affect customers. The hospital's management is responsible for the strategic direction of the hospital. It is the management that formulates and oversees the implementation of policies in the hospital. The Management Committee is made up of the Director of Health Services, the Health Services Administrator, the Chief Nursing Officer, Pharmacists and the hospital's Accountant. The role of management is ensuring that good customer care is not compromised.

The expanded management of the hospital is made up of Unit Heads (UH) which makes decisions for the Hospital. The UH make up the strategic

level management that implements policies of the Hospital. They are the bridge between top management, staff and the patients who are regarded as customers. By virtue of their role in the wards and sections, they better appreciate customer concerns and relate same to top management for decisions to be made. They are very key individuals as long as customer care and quality healthcare delivery is concerned. The general staff who work closely with the patients play pivotal roles in promoting good customer care. They form the operational level of management that actually carries out planned policies and decisions. The general staff comprises Pharmacists, Anesthetists, Midwives, Nurses, Ward Assistants, and Administrative staff. An institution can be judged as having good customer care practices only when the general staff play their respective roles well in ensuring that customer expectations are met if not exceeded.

The KNUST hospital's range of services includes but not limited to out-patient/in-patient services, radiology services, laboratory/diagnostic services, surgery services, obstetrics and gynecology, and public/occupational health. The others include dental care, pharmaceutical services, eye care, theatre services, students' clinic National Health Insurance Scheme (NHIS) and Voluntary (HIV/AIDS) Counselling and Testing (VCT).

The University of Ghana (UG) Hospital

The University of Ghana hospital, which is also known as the Legon hospital is located behind the Legon Police station at a distance of 12.6 kilometers off the main Accra-Aburi road. This hospital was built and commissioned in 1957 and is officially owned by the University of Ghana. It

is a 100-bed capacity hospital which is generally, referred to as a quasi-governmental hospital. It comprises of General Wards, Pediatric Unit, Maternity Wing, Casualty and Emergency Ward, Dental Unit and Operating Theatre. Just like the KNUST hospital, the UG hospital was originally set up to provide healthcare and services to members of the university community. However, demand for healthcare necessitated the decision to extend services to the general public

The Hospital has also established a Primary Health Care Outreach Programme aimed at teaching and advising students, pregnant women, nursing mothers and the general public about personal hygiene, good diet, child care, including immunization against childhood communicable diseases, family planning and school health services. The main referral point of the hospital is the Korle-Bu Teaching Hospital. However, referrals to Korle-Bu are very minimal because the hospital has introduced some specialist consultancy services.

Aside from the internal governance structure, the Legon hospital has a Hospital Management Committee appointed by the University Council to oversee the running of the Hospital in terms of policy formulation. Meetings are held quarterly and decisions reached are implemented by the Director and the Hospital Administrator. The Hospital's Management is the internal structure responsible for the implementation of policies in the hospital. The Management Committee is made up of the Director of Health Services, the Health Services Administrator, the Chief Nursing Officer, Pharmacist and the Hospital Accountant. Decisions are reached at the following meetings; doctors

meetings, nurses-in-charge meetings, sectional heads meetings and quality assurance meetings.

The expanded management in the hospital is made up of sectional heads. Moreover, the expanded management is responsible for making decisions for the hospital. The sectional heads make up the tactical level management that implements policies of the hospital. They are the bridge between top management, staff, and the patients. By virtue of their role in the wards and sections, they better appreciate customer concerns and relate same to top management for decisions to be made. They are very key individuals as long as customer care and quality healthcare delivery is concerned. Sectional heads meetings are held on a quarterly basis to discuss problems of the various departments and take decisions which are expected to be implemented by the hospital's administrator.

The general staff who work closely with the patients play pivotal roles in promoting good customer care. They form the operational level of management that actually carries out planned policies and decisions. The general staff comprises Nurses, Anesthetists, Ward Assistants, Midwives, Pharmacists and Administrative staff. The University of Ghana's Hospital provides the following services such as out-patient/in-patient services, maternal Care, radiology services, Laboratory/diagnostic services, surgery services, obstetrics and gynecology, and public health services. Other services include dental care, pharmaceutical services, eye care, ultrasound scanning, laundry services and accident and emergency services. The hospital also runs specialist clinics in the areas of surgery, obstetrics and gynecology, pediatrics, internal medicine, diabetics, dermatology, E.N.T, and orthopedics. University

hospitals are committed to providing the best possible care to their customers while at the same time endeavour to improve their services, including customer care.

Study Setting

University of Ghana Hospital

The University of Ghana hospital also known as the Legon Hospital was built and commissioned in 1957 and officially owned by the University of Ghana. The Legon hospital was set up almost the same as the university was found in Achimota School West Compound. Legon hospital is a quasi – government hospital with a total of 617 beds. The facility comprises of the General Ward, Maternity Wing, Casualty and Emergency Ward, Paediatric Unit, Dental Unit and the operating theatre. Originally, the Legon hospital was set up to cater for the health needs of students, staff and their dependents but have now extended their mandate to cater for people outside the university community. The University of Ghana hospital have a staff of 296 consisting of Medical Officers 29, Dentists 3, Nurses 138, Pharmacists 2, Laboratory technologists 16, Catering staff 13, Administrative staff 7, Accounts officers 18, Medical Records officers 14, Transport 5, X ray 2, Physiotherapy 2, Diet therapist 2, and Housekeeping 37 (UG Hospital Annual Report, 2017).

Governing Board

Aside the internal governance structure, the Legon Hospital has a Hospital Management Committee appointed by the University Council to oversee the running of the Hospital in terms of policy formulation. Meetings

are held quarterly and decisions reached are implemented by the Director and the Hospital Administrator.

Management Structure

The Hospital's Management is the internal structure responsible for the implementation of policies in the Hospital. The Management Committee is made up of the Director of Health Services, the Health Services Administrator, the Chief Nursing Officer, Pharmacist and the Hospital Accountant. Decisions are reached at the under listed meetings:

a) Doctors meetings
b) Nurses-in-Charges meetings
c) Sectional Heads Meetings and
d) Quality Assurance Meetings

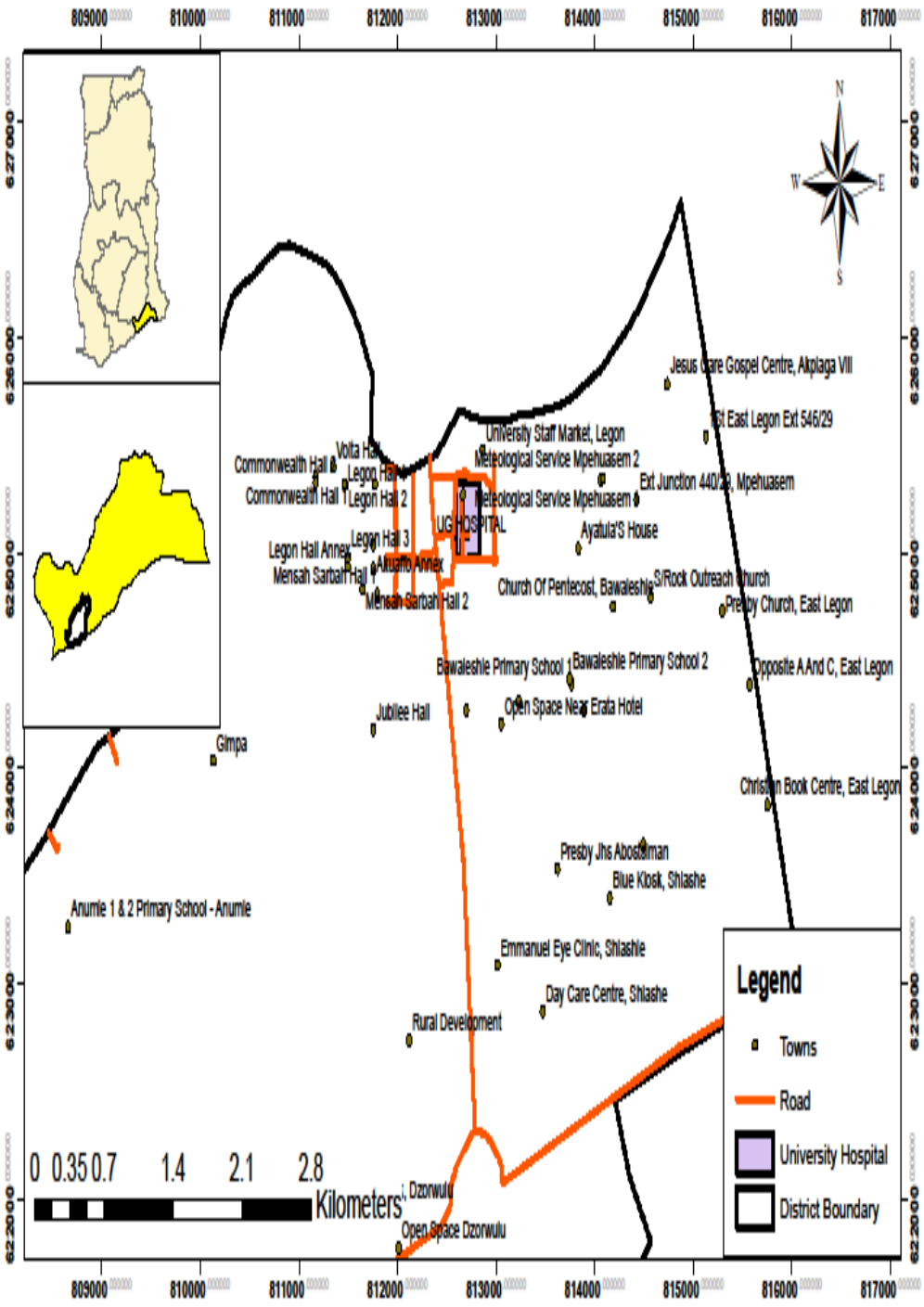

Figure 7: University of Ghana Hospital

Source: GIS Unit of Department of Geography and Regional Planning, UCC, 2019

Sectional Heads

The expanded management in the Hospital is made up of Sectional Heads. Moreover, the expanded management is responsible for making decisions for the Hospital. The Sectional Heads make up the tactical level management that implements policies of the hospital. They are the bridge between top management, staff and the patients. By virtue of their role in the wards and sections, they better appreciate customer concerns and relate same to top management for decisions to be made. They are very key individuals as long as customer care and quality healthcare delivery are concerned. Sectional Heads Meetings are held on quarterly basis. Problems of the various departments are discussed and decisions taken are implemented by the Hospital Administrator.

General Staff

The general staff who work closely with the patients play pivotal roles in promoting good customer care. They form the operational level of management that actually carries out planned policies and decisions. The general staff comprise Nurses, Anesthetists, Ward Assistants, Midwives, Pharmacists and Administrative staff.

Range of Healthcare Services

The University of Ghana Hospital provides the following services such as out-patient/in-patient services, maternal Care, radiology services, Laboratory/diagnostic services, surgery services, Obstetrics and gynecology, and public health services. The others include dental care, pharmaceutical

services, eye care, ultrasound scanning, laundry services and accident & emergency services. The hospital also runs specialist clinics in the areas of surgery, obstetrics and gynecology, pediatrics, internal medicine, diabetics, dermatology, E.N.T and orthopedics.

Kwame Nkrumah University of Science and Technology Hospital

The University Health Services begun as a dressing station in 1952 and has since grown by additions and modifications into a full-fledged 100-bed hospital. The Hospital is bounded to the North by Ayeduase/Kotei, to the south by Bomso, to the West by Ayigya/Accra-Kumasi express road and to the East by the University Commercial Area. The Hospital currently provides services to a population of over 200,000. These include 21,000 Students, 30,000 Staff and dependants; and about 150,000 people from over 30 surrounding communities, including Ayigya, Bomso, Ayeduase, Kotei, Boadi

The KNUST Hospital was primarily established to provide health services to students, the staff and their dependents of the University. However, it has currently extended its services to the general public and also provides health services to the thirty surrounding communities which have rapidly increasing population. The Hospital therefore plays the role of a District Hospital.

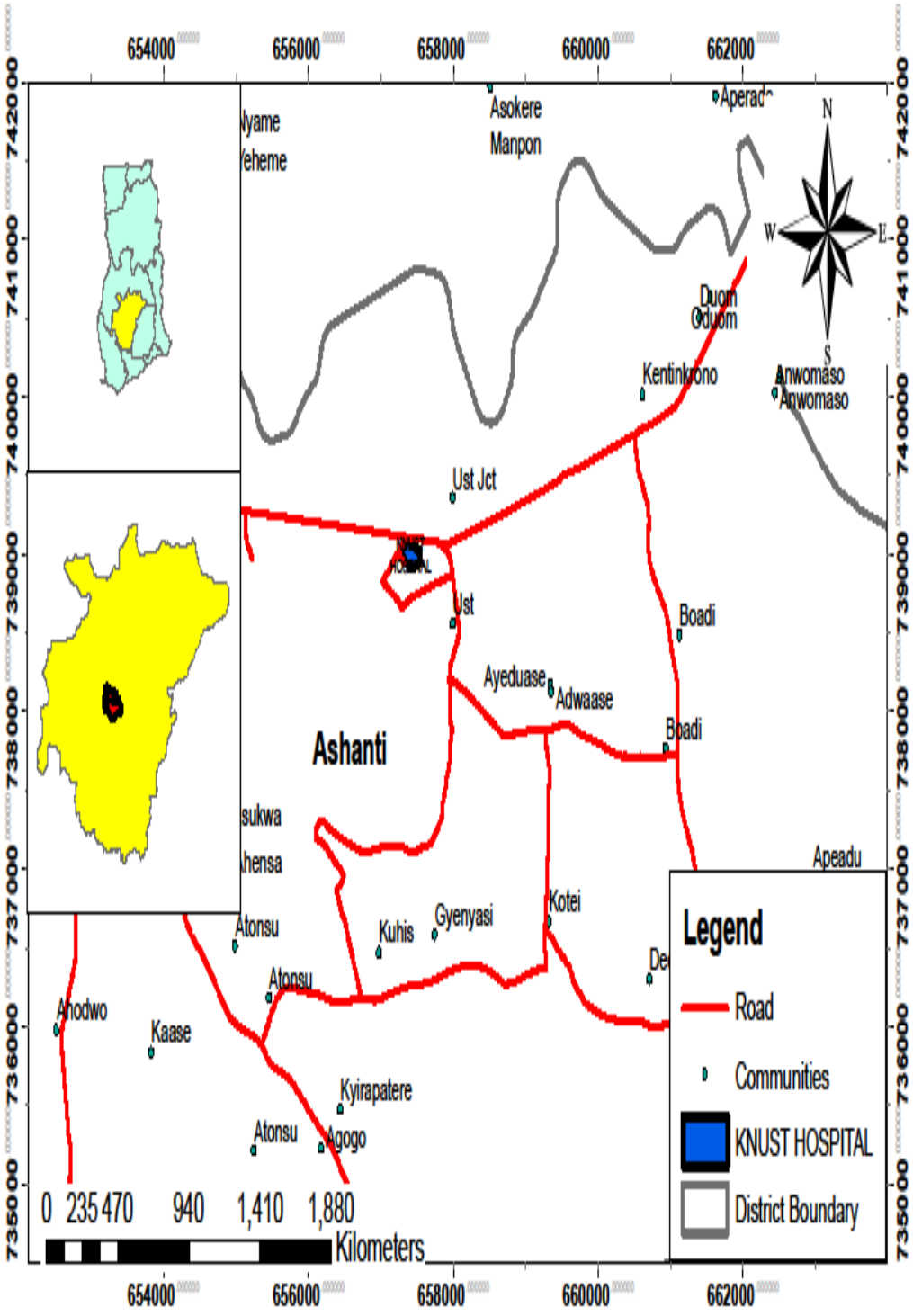

Figure 8: Kwame Nkrumah University of Science and Technology Hospital

Source: GIS Unit of Department of Geography and Regional Planning, UCC, 2019

The KNUST hospital has a staff of 210 consisting of Medical Officers 15, Dentists 3, Nurses 138, Pharmacists 4, Laboratory Technicians 11,

Laboratory Assistant 1, General Nurses 78, Midwives 22, Nurse Anesthetists 6, Physician Assistant 1, Radiographers 2, Sonographer 1, Administration 6, Accounts 4, Medical Records 7, Transport 5, X ray 2, Library Assistants 1, Messenger 1, Stores Superintendents 2, Nurse Assistants 13, Security 3 and Cleaners 12

Governing Board

The Hospital is governed by a Board called the Health Services Management Committee which constitutes selected members of the University Community including FUSSAG, TEWU, SRC, Convocation and Academic Board representatives, etc. The Board makes decisions and approves policies for the smooth operation of the Hospital. The Board plays an advisory role in relation to the activities of the University Hospital Management Team. The Vice-Chancellor appoints the Chairman of the Board. The Board plays an important role in shaping policies that can affect customers. Hence, the nature and type of policies approved by the Board can affect customer care and quality of healthcare delivery.

Management Structure

The Hospital's Management is responsible for the strategic direction of the Hospital. It is the management that formulates and oversees the implementation of policies in the Hospital. The Management Committee is made up of the Director of Health Services, the Health Services Administrator, the Chief Nursing Officer, Pharmacists and the Hospital Accountant. The role of management is ensuring that good customer care is not compromised.

Unit Heads

The expanded management of the hospital is made up Unit Heads which make decisions for the Hospital. The Unit Heads make up the tactical level management that implements policies of the Hospital. They are the bridge between top management, staff and the patients. By virtue of their role in the wards and sections, they better appreciate customer concerns and relate same to top management for decisions to be made. They are very key individuals as long as customer care and quality healthcare delivery are concerned.

General Staff

Customer care is everyone's job; it is not for a specific department. The general staff who work closely with the patients play pivotal roles in promoting good customer care. They form the operational level of management that actually carries out planned policies and decisions. The general staff comprise of Nurses, Anesthetists, Ward Assistants, Midwives, Pharmacists and Administrative staff. An institution can be judged as having good customer care practices only when the general staff play their respective roles well in ensuring that customer expectations are met if not exceeded.

Range of Healthcare Services

The KNUST hospital's range of services include but not limited to Out-patient/in-patient services, radiology services, laboratory/diagnostic services, surgery services, obstetrics and gynecology, and public/occupational health. The others include dental care, pharmaceutical services, eye care,

theatre services, and students' clinic. The rest are National Health Insurance Scheme (NHIS) and Voluntary (HIV/AIDS) Counselling and Testing (VCT).

Target Population

The target population was staff of the respective hospitals and patients (in and out patients) within the ages of 18 years and above. The in - patient should have been on admission for more than 3 days at the University of Ghana and the Kwame Nkrumah University of Science and Technology Hospitals. The study employed this group of people because they are adult patients and have used the facilities and could express their views on the care they have received.

Inclusion criteria for patients

i. Must be a patient (in/out patient) of the facility
ii. Patients 18 years or above (adult patients);
iii. In Patients must be on admission for more than 3 days from the day of visiting the hospital.

Inclusion criteria for staff members

i. Must be 18 years or older, and
ii. Should be a staff member.
iii. Should work at the facility for a minimum of 1 year

Sources of Data

The study made use of primary data collected from patients (in – patients and out – patients) and staff at University of Ghana Hospital and the

Kwame Nkrumah University of Science and Technology Hospital through the use of a questionnaire. However, it was also supplemented with secondary data from the organisations annual reports and quarterly reports from the Ghana Health Service (GHS) and Ministry of Health (MOH).

Sample Size

Qualitative Data

The choice of a sample size for the in-depth interview was guided by the need to obtain rich data and ensure that the staffs of the hospitals were fairly represented. Thus, 30 staff (15 each) from KNUST and University of Ghana Hospital were purposively selected for the study with the concept of saturation in mind. This is because an in-depth interview is of the essence in getting diverse information from individuals. In spite of this, the sample size was adjusted in the course of the data collection bearing in mind the concept of saturation and adequacy in qualitative data collection (DiCicco-Bloom & Crabtree, 2006).

Quantitative

The sample frame for the quantitative data was the population of patients who had visited the UG and KNUST hospitals in the year 2017. A proportion of 0.005 was calculated on the total number of patients who visited the hospitals in 2017. A total sample size of 1,278 was arrived at, which is made up of 638 for university of Ghana and 640 for the KNUST hospital was438 (see Table 1).

Sampling Procedures

Quantitative Data

The target population for the quantitative data was the patients. The stratified sampling technique was used. First the patients were put in strata as in – patients and out patients. With respect to the in-patients a sample frame was generated from the hospital records on patients who have been on admission for at least 3 days and are aged 18 years or above. Random sampling with replacement was used to select the sample needed. Sampling with replacement was used because a patient may be sampled twice due the fact that s/he may be sampled on another after his/her first participation. With the out-patient, those who have received services from the facility convenience sampling was used to select the respondents till the required sample was attained. Convenience sampling method involves getting your respondents wherever you can find them and typically wherever is convenient. Hence, out-patients who were present at the health facility on the day of research did not take part in the study. However, its main disadvantage of selection bias was catered for using the inclusion criteria.

Table 1: Sampling Procedure

University	Population (N)*	Sample (n)
University of Ghana		
Out Patient	118,973	595
In – patient	8,597	43
Total	127,570	638
KNUST		
In – Patient	3,085	15
Out patient	125,000	625
Total	128,085	640

*Population figures are based on visit to the facility in 2017

Source: Authors Compilation, (2017)

Qualitative Data

The target population for the qualitative data was staff of the University of Ghana Hospital and the Kwame Nkrumah University of Science and Technology Hospital. The study employed a purposive sampling technique to select respondents for the in-depth interview. Purposive sampling allows an initial understanding of the situation, and to identify relevant groups with experiences relating to the topic under study (Palinkas, et al., 2014). It produces a sample where the included groups were selected according to specific characteristics that were considered to be important. This technique was used because the study selected staff of the University of Ghana Hospital and the Kwame Nkrumah University of Science and Technology Hospital.

Methods of Data Collection

A questionnaire, an interview schedule and an in-depth interview guide were used to collect data from the target population. The study was a survey and the data collection method of interviews and questionnaire were administered by Research Assistants. Self-administered questions were administered to the healthcare providers and the patients who can read and write. However, the Research Assistant were there to explain and clarify issues to the respondents. For the patients, since the study did not allow the use of confidential records of patients to identify them for the interview, informant consent was sought from the health care authorities to inform them about the study. The health authorities then provided details to the patients they delivered services to and then introduced the research team to the patients who were willing to participate in the research. The research team then provided all the needed information about the research to the patients and provided them with informed consent forms to be filled and signed. The patients who took part in the study were allowed to select their own time and place of convenience for the interview to take place. After this, the interviews with the various patients who agreed to be part of the study were conducted. Each interview was recorded and filed notes were also taken for non-verbal cues and other issues that were not captured in the interview process. Each interview lasted approximately 27 minutes. With the staff of the hospital, the aim and purpose of the study was explained to them and those who agreed to participate in the study were made to fill and sign a consent form that they are participating in the study by their own will and not being forced to do so. Those who agreed, the time that was convenient for them to be interviewed

was set. At the set time, the interviews were conducted in places that were devoid of any distraction by colleagues or noise.

Data Collection

Data collection took place in November and ended in December 2018. A total of 1,218 structured questionnaires were administered to out and in patients above 18 years and 30 in-depth interviews were conducted to staff of the hospital at the University of Ghana hospital and the Kwame Nkrumah University of Science and Technology. An average time of thirty minutes was used to complete the questionnaires and 45 minutes for the interviews.

Data Collection Instruments

Two main research instruments were used for the data collection. These were the questionnaire and an in – depth interview guide (see Appendix A and B respectively). The questionnaire was used for the quantitative component of the study and an in – depth interview guide for the qualitative. In designing the instrument, a literature search was conducted to identify relevant questions that would reflect and answer the objectives of the study.

Data Processing and Analysis

Quantitative Data

The data collected were checked for completeness and accuracy and kept in a safe. The data was entered in a pre-designed template in the Statistical Product for Service Solutions (SPSS) software, version 23. The entered data were validated with the hard copies to ensure accuracy and

consistency in response and also to eliminate data entry errors. The data were analysed in Stata version 14 and findings presented using descriptive (frequency and percentages, mean and standard deviation) and inferential statistics. The results are presented in tables. Bivariate and multivariate analysis was conducted. Chi square was used for the bivariate analysis and binary logistic regression was used for the multivariate analysis.

Binary Logistic Regression was used based on the assumption that the dependent variable was dichotomous in nature and the data should not have any outlier. This approach helped to explain the relationship between the dependent variable and the independent variables of the study and allowed for the calculation of the odds of an event occurring or not occurring. The dependent variable is client satisfaction and the explanatory variables that were used for the binary regression are: age, sex, level of education, religion, health insurance subscription, ethnicity and place of residence and income level.

Qualitative data

For the in-depth interviews, recorded interviews were transcribed and coded inductively. Information gathered from the transcription was categorised under common themes and issues identified by the researcher. Content thematic analysis was used to analyse the data.

Pre-test

Pre-test of the instruments were done to determine the reliability and validity of the instruments. A pre-test of the research instrument was carried

out in University of Cape Coast (UCC) hospital in Cape Coast in Cape Coast Metropolis. Sixty (60) patients and 5 staff were randomly selected to pilot the questionnaire. This was done to assess the logical sequence of the items and to clarify the wording of the questionnaire, the feasibility of the design procedure for data processing analysis, reliability of the data collection tools and any potential problems. The pre-testing revealed the reactions of respondents to the research procedures and to questions related to sensitive issues such as sexual intercourse and experience. The feedback obtained from the pre-test was used to modify some of the questions to improve comprehension as well as logical flow. After the pre-testing, the necessary revisions were made in the instrument before the actual study was carried out.

Ethical Considerations

Ethical clearance was sought from the Ethical Review Committee of the Research and Development Division of the Ghana Health Services. Ethical clearance was also sought from the Institutional Review Board of the University of Cape Coast (UCCIRB) (see Appendix D). In addition, permission and approval was sought from the University of Ghana Hospital and Kwame Nkrumah University of Science and Technology Hospital to conduct the research. Other ethical issues that were adhered to were informed consent and confidentiality.

An informed consent forms were given to the respondents in order to seek for their consent before the collection of data through interviews. Participation of the participants was voluntary. If he or she did not want to

participate, there were no consequences. They were informed that anyone may refuse to part-take in the study at point in time within the course of the study.

Furthermore, the issue of privacy and confidentiality were also adhered to. Interviews were conducted in an enclosed place to ensure privacy. Confidentiality, which according to Babbie (2007) is to conceal the identity of respondents, was adhered to. This is pertinent in order to protect the rights of all the respondents. The study achieved this by not sharing or discussing any information given by the respondents, with a third party. Moreover, information gathered from respondents were only used for the purpose for which it was collected.

CHAPTER FIVE

RESULTS AND DISCUSSION

Introduction

This chapter presents and discusses results of the study. The results are grouped into two sections. The first section on the quantitative data and the second section captured the results from the qualitative data. Key issues presented include: background characteristics of respondents, communication of service providers, attentiveness of service providers, respectfulness of service providers, safe care of clients, client satisfaction, customer care practices, perspectives of patients on customer care, and patients' perspectives on service quality and innovative ways of improving future customer care practices.

Quantitative Data

Background Characteristics of Respondents

The background characteristics of the respondents are essential in appreciating the dynamics in the group and a good grasp of these characteristics helps in understanding the results of the study (Barnard, 2013). This section, therefore, covers the sex, age, marital status, religious affiliation, ethnicity, and level of education.

The total number of 1,010 (526 from UG hospital and 484 from KNUST hospital) which was represented by 49 percent males (50% for UG hospital and 48% KNUST hospital) and 51 percent females (50% for UG hospital and 52% KNUST hospital). The age of respondents ranges from 18 – 60+ years.

Table 2: Background Characteristics of Respondents

Variables	University of Ghana Hospital	KNUST Hospital	Total
	n=526	n=484	N=1,010
Sex			
Male	50.0	48.4	49.2
Female	50.0	51.6	50.8
Age			
18 – 19	6.7	26.9	16.3
20 – 24	28.1	52.3	39.7
25 – 29	24.5	9.3	17.2
30 – 34	14.5	3.7	9.3
35 – 39	8.2	2.5	5.4
40 – 44	7.0	2.5	4.9
45 – 49	4.2	0.8	2.6
50 – 54	3.4	0.6	2.1
55 – 59	0.9	0.2	0.6
60 +	2.5	1.2	1.9
Marital status			
Never married	55.7	86.6	70.5
Married	35.7	10.1	23.4
Separated	4.8	0.6	2.8
Divorced	3.2	1.0	2.2
Cohabitation	0.6	1.7	1.1

Table 2 Continued

Religion			
Christian	80.2	92.8	86.2
Islam	16.4	5.8	11.3
Traditional	1.7	0.4	1.1
Buddhist	0.4	0.2	0.3
Others	1.3	0.8	1.1
Ethnicity			
Akan	42.0	72.1	56.4
Guan	5.9	2.9	4.5
Ga/Damgbe	14.3	6.6	10.6
Ewe	21.7	10.9	16.5
Mole Dagbani	8.7	2.1	5.5
Others	7.4	5.4	6.5
Level of education			
No formal education	3.4	0.8	2.2
Primary	2.3	1.3	2.3
JSS/JHS/Middle	5.7	2.3	4.0
Secondary	19.0	7.6	13.6
Higher	68.6	88.0	77.9

Source: Field data, (2019)

Table 2 shows that the respondents were predominantly aged 20 – 24 years and 25 – 29 years. For instance, about 40 percent of the respondents (28% for UG hospital and 52% for KNUST hospital) were aged 20 – 24 years (see Table 2).

Results from the study showed that majority of the respondents (were never married, 71 percent (56% for UG hospital and 87% for KNUST hospital). The highest proportion of respondents was Christians, thus, 86 percent of the respondents (80% for UG hospital and 93% for KNUST hospital). With respect to ethnicity, the highest proportion of the respondents were from the Akan ethnic group. Thus, 56 percent of the respondents (42% for UG hospital and 72% for KNUST hospital) and majority of the respondents had higher education (see Table 2).

Communication of Service Providers

In order to understand the effectiveness of communication, the researcher sought to find out if service providers introduce themselves; including displaying their name, title and their role in the department. The results showed that 29 percent of service providers in KNUST Hospital were displaying their name tags, title and their role in the department. The same was observed in UG Hospital, where only 38 percent were displaying their name tag, title and their role in the department. In overall terms, it was observed that one out of every three service providers in UG Hospital and KNUST Hospital were displaying their name tags, title and their role in the department (see Table 3).

Table 3: Easy Identification of Service Providers by Respondents

Variables	University of Ghana Hospital N=526	KNUST Hospital N=484	Total N=1,010
Service providers introduce themselves (name, title, role)			
No	62.4	71.5	66.7
Yes	37.6	28.5	33.3
Service providers wear ID /badges so they can be easily seen and read			
No	50.4	35.7	43.4
Yes	49.6	64.3	56.6
Service providers are friendly and welcoming			
No	9.3	14.1	11.6
Yes	90.7	85.9	88.4
Service providers fully explain the services the hospital provides to me			
No	22.1	50.4	35.6
Yes	77.9	49.6	64.4
Service providers are polite whenever they talk to me			
No	10.8	11.2	11.0
Yes	89.2	88.8	89.0
Service providers communicate adequately with me when I visit this facility			
No	14.3	23.4	18.6
Yes	85.7	76.6	81.4

Source: Field data, (2019)

Also, about 88 percent (88.4%) of respondents (91% for UG and 86% of KNUST) said that service providers were friendly and welcoming. It was

observed that nearly about 57 percent (56.6%) of the respondents (50% from UG and nearly 64 percent from KNUST hospitals, respectively) suggested that service providers wear ID badges so they can be easily seen and read (see Table 3).

Furthermore, the highest proportion of respondents (81.4) said the service providers either communicate adequately with them when they visit (86% for UG hospital and 77% of KNUST hospital)] or talk to them politely whenever the service providers talk to them [89 percent (89% for UG hospital and 89% of KNUST hospital)] (see Table 3).

Attentiveness of Service Providers

In this study, attentiveness is denoted by the extent to which service providers engage customers (patient/client) immediately, explain procedures in a language customers understand, explain and apologize for delays, displayed competence and had knowledge in what they were doing, responsive to patients (prompt attention) and by extension whether the behaviour of employees instil confidence in customers. Table 4 is a display of the results from this issue in relation to attentiveness of service providers to the hospitals.

Table 4: Attentiveness of Service Providers

Variable	University of Ghana Hospital	KNUST Hospital	Total
	n=526	n=484	N=1,010
Service providers attend to me (patient/client) immediately			
No	27.0	37.8	32.2
Yes	73.0	62.2	67.8
Services providers explain procedures in a language I understand			
No	11.4	12.6	12.0
Yes	88.6	87.4	88.0
Service providers explain and apologize for delays			
No	31.8	46.5	38.8
Yes	68.2	53.5	61.2
The behaviour of employees instil confidence in me			
No	17.1	28.9	22.8
Yes	82.9	71.1	77.2
Health providers displayed competence and had knowledge in what they were doing			
No	4.9	9.5	7.1
Yes	95.1	90.5	92.9
The system in this facility is responsive to patients (prompt attention)			
No	19.0	23.6	21.2
Yes	81.0	75.4	78.8

Source: Field data, (2019)

Results from the study showed that majority (77.8%) of the respondents [77 percent (83% for UG hospital and 71% of KNUST hospital)]

were of the view that the behaviour of employees instil confidence in them (see Table 4) and health care providers displayed competence and had knowledge in what they do (93%) (95% for UG hospital and 91% of KNUST hospital)] (see Table 4).

The highest proportion of the respondents [78.8 % (81% for UG hospital and 75% of KNUST hospital)] suggested that the system in this facility is responsive to patients (prompt attention) (see Table 3). Also, majority of the respondents [88% (89% for UG hospital and 87% of KNUST hospital)] were of the view that service providers explain procedures in a language that they understand (see Table 4).

Respectfulness of Service Providers

The level of respectfulness of service providers is another key element of customer care. In this study, respectfulness of service providers is denoted by the extent to which service providers treat customers with respect and dignity, respect differences in values, culture and beliefs; show empathy and consideration in words and actions and treat customers as a partner and a member of health care team. Table 5 displays the results from those variables in relation to respectfulness of service providers in UG and KNUST hospitals.

First, to understand the level of respectfulness of service providers, the study sought to find out if service providers treat customers with respect and dignity. It came out that majority (88%) of service providers in both KNUST and UG hospitals service providers treat customers with respect and dignity.

Table 5: Respectfulness of Service Providers

Variables	University of Ghana Hospital	KNUST Hospital	Total
	n=526	n=484	N=1,010
Service providers treat me with respect and dignity			
No	10.8	13.2	12.0
Yes	89.2	86.8	88.0
Service providers respect differences in values, culture and beliefs			
No	15.8	34.3	24.7
Yes	84.2	65.7	75.3
Service providers show empathy and consideration on in words and actions			
No	19.2	17.6	18.4
Yes	80.8	82.4	81.6
Service providers treat me as a partner and a member of health care team			
No	31.0	37.4	34.1
Yes	69.0	62.6	65.9

Source: Field data, (2019)

In UG hospital, over 89 percent (89.2%) of service providers treat customers with respect and dignity. Whilst in KNUST hospital, nearly 87 percent (86.8%) of service providers treat customers with respect and dignity. Overall 88 percent of service providers treat customers with respect and dignity.

The highest proportion of the respondents [75% (84% for UG hospital and 66% of KNUST hospital)] suggested that service providers respect the difference in values, culture and beliefs of their clients (see Table 5). Whereas approximately 82 percent (81.6%) of the respondents stated that service providers show empathy and consideration in their words and actions.

Safe Care of Clients

The level of safe care of clients is an absolute imperative in customer care delivery. In this study, safe care of clients is denoted by the extent to which the hospital service providers deliver the service right the first time; materials associated with the services delivery are visually appealing; enough sign- posts in the hospital to give directions, uninterrupted supply of running water, customers feel physically safe in the hospital, hospital outdoor surroundings are well maintained and attractive, customers feel their belongings are safe in the hospital, customers feel secure in this facility, customers can receive all basic healthcare services, customers feel the service providers understand their needs, and lastly, the employees appear clean and neat. Table 6 illustrate the results from this study in relation to safe care of clients in UG and KNUST hospitals.

Table 6: Safe Care of Clients

Variable	University of Ghana Hospital	KNUST Hospital	Total
	n=526	n=484	N=1,010
The hospital always delivers the service right the first time			
No	11.2	19.6	15.3
Yes	88.8	80.4	84.7
Materials associated with the services delivery are visually appealing			
No	22.1	15.5	18.9
Yes	77.9	84.5	81.1
There are enough sign- posts in the hospital to give directions			
No	38.8	22.3	30.9
Yes	61.2	77.7	69.1
There is an uninterrupted supply of running water			
No	25.1	22.1	23.7
Yes	74.9	77.9	76.3
I feel physically safe in the hospital			
No	8.6	10.5	9.5
Yes	91.4	89.5	90.5
Hospital outdoor surroundings are well maintained and attractive			
No	11.2	10.3	10.8
Yes	88.8	89.7	89.2

Table 6 continuation

I feel my belongings are safe in the hospital			
No	11.2	12.6	11.9
Yes	88.8	87.4	88.1
I feel secure in this facility			
No	7.4	9.3	8.3
Yes	92.6	90.7	91.7
I can receive all basic healthcare services here			
No	8.6	12.4	10.4
Yes	91.4	87.6	89.6
I feel the service providers understand my needs			
No	7.6	10.5	9.0
Yes	92.4	89.5	91.0
The employees appear clean and neat			
No	3.4	3.9	3.7
Yes	96.6	96.1	96.3

Source: Field data, (2019)

The highest proportion of the respondents [81 percent (78% for UG hospital and 85% for KNUST hospital)] suggested that materials associated with the services delivery are visually appealing (see Table 6). Whereas approximately 69 percent of the respondents (61% for UG hospital and 77% for KNUST hospital) stated that there are enough sign- posts in the hospital to give directions (see Table 6).

Majority of the respondents [91 percent (91% for UG hospital and 90% for KNUST hospital)] felt physically safe in the hospital. Whiles nearly 9 in 10 of the respondents (approximately 9 in 10 for UG hospital and approximately 9 in 10 for KNUST hospital) stated that the hospital outdoor surroundings are well maintained and attractive (see Table 6). Almost all of the respondents felt secured in the facility, thus, 92 percent of the respondents (92% for UG hospital and 90% for KNUST hospital)

Client Satisfaction

The level of client satisfaction is an absolute necessity in customer care service delivery. In this research, client satisfaction is denoted by the extent to which the hospital customers/patients are satisfied with the overall experience in the particular hospital, will recommend this hospital to other potential patients, accept to pay higher prices for services and will come again when customers have the opportunity as shown in Table 7.

The highest proportion of the respondents [84 percent] (97% for UG hospital and 81% for KNUST hospital)] were satisfied with the overall experience in the hospital (see Table 7). Whereas about 88 percent of the respondents (89% for UG hospital and 87% for KNUST hospital) stated they will recommend this hospital to other potential patients (see Table 7).

Table 7: Client Satisfaction

Variables	University of Ghana Hospital	KNUST Hospital	Total
	N=526	N=484	N=1,010
I am satisfied with the overall experience in this hospital			
No	12.7	18.8	15.6
Yes	87.3	81.2	84.4
I will recommend this hospital to other potential patients			
No	10.8	13.2	12.0
Yes	89.2	86.8	88.0
Accept to pay higher prices for services of this hospital			
No	56.3	52.2	54.3
Yes	43.7	47.7	45.6
I will come again when I have the opportunity			
No	13.1	15.3	14.2
Yes	86.9	84.7	85.8

Source: Field data, (2019)

Although respondents were satisfied with the overall experience in the hospital, less than half (46%) of the respondents (44% for UG hospital and 48% for KNUST hospital)] accepted to pay higher prices for services of the hospital. Whiles nearly 9 in 10 of the respondents (approximately 9 in 10 for UG hospital and approximately 9 in 10 for KNUST hospital) stated that they will come to the hospital again when they have the opportunity (see Table 7).

Overall Customer Care

Generally, there was a good customer care service among the two hospitals under investigation. Approximately 79 per cent (88% for UG and 84% for KNUST) suggest that there was good customer care from service providers at the two hospitals (see Figure 9).

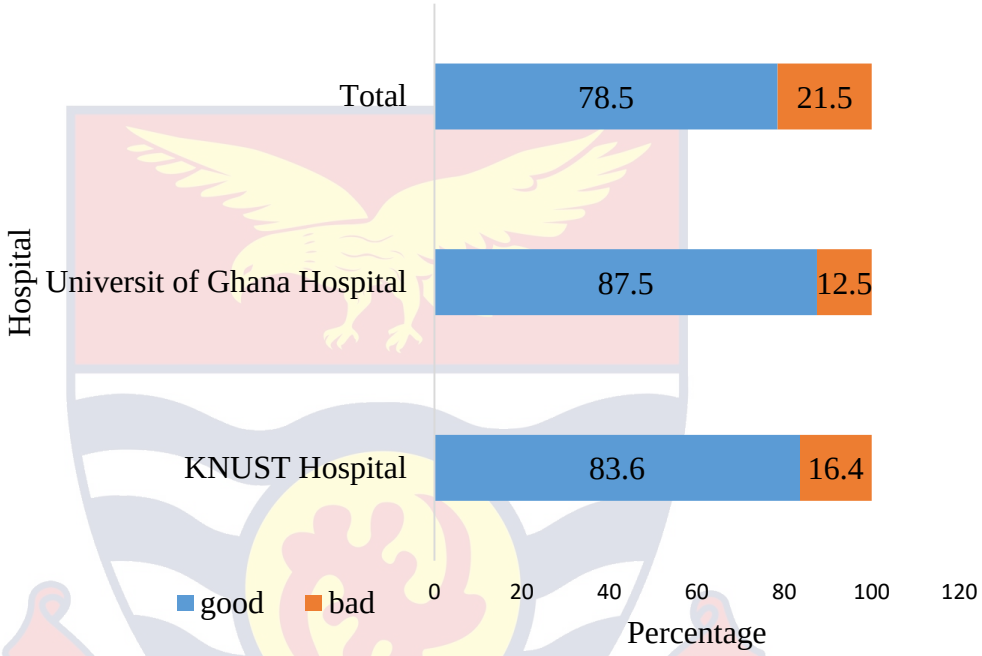

Figure 9: Overall Customer Care

Source: Field data, 2019)

Logistic Regression Analysis on Customer Care Experience and Type of University Hospital

The likelihood of experiencing good customer care was higher (OR=1.82, CI= 1.29 – 2.55) for respondents from University of Ghana Hospital compared to those from Kwame Nkrumah University of Science and Technology Hospital (see Table 8). Also, a statistically significant relationship was expected and this assumption was confirmed by the study. Based on the

available evidence, the researcher failed to accept the null hypothesis that there is no spatial variation in customer care practices between the two university hospitals.

Table 8: Logistic Regression between Customer Care Experience and Particular University Hospital

Variable	Odds Ratio (OR)	Confidence Interval (CI)
University Hospital		
Kwame Nkrumah University of Science and Technology Hospital	Ref	Ref
University of Ghana Hospital	1.82**	1.29 – 2.55

Ref = Reference Category *p<0.10 **p<0.05 ***p<0.001

Source: Field data, (2019)

Logistic Regression Analysis on Customer Care Experience and Satisfaction of Patience

The likelihood of experiencing good customer care was higher (OR=29.57, CI= 19.27 – 45.38) for respondents who were satisfied with the overall experience in the hospital (see Table 9). In addition, a statistically significant association was expected and this assumption was confirmed by the researcher. On this premise, the researcher failed to accept the null hypothesis that there is statistically significant relationship between customer care experience and satisfaction of patients.

Table 9: Logistic Regression on the Association between Customer Care Experience and Satisfaction of Patients

Variable	Odds ratio	Confidence interval
Satisfied with the overall experience in the hospital		
No	Ref	Ref
Yes	29.57***	19.27 – 45.38

Ref = Reference Category *p<0.10 **p<0.05 ***p<0.001

Source: Field data, (2019)

Qualitative Data

Service providers in the health care sector are increasingly required to put in place adequate and reliable facilities to ensure efficiency and effectiveness in taking good care of clients or patients who access health care services. Therefore, based on the existing body of knowledge and guided by the established methodology, qualitative data was collected in two University Hospitals using a semi-structured interview guide to solicit the views of key informants.

The interviews sought to provide clarity and insight into the current customer care practices; the use of Information Telecommunication (IT) in customer care relations; major changes over the years, availability of 24 hours service; what can be done to ensure sustainable health delivery in relation to customer care; necessity of online service platform; and satisfaction with customer care in these two University Hospitals (University of Ghana (UG) in Accra; and Kwame Nkrumah University of Science and Technology

(KNUST) in Kumasi). The key informants were purposively sampled for the study. There were 13 respondents in all. Out of that number, eight (8) of them were from the UG, and five (5) from KNUST. Table 10 shows the detailed categories of the respondents (Table 10).

Table 10: Categories of the Participants Interviewed

	KNUST Hospital
1	Senior Medical Officer, Male (38 years)
2	Chief Nursing Officer and Manager, Female (58 years)
3	Head of Records Unit, Male (43 years)
4	Principal Medical Officer, Male (55 years)
5	Principal Dental Officer, Male (54 years)
6	Principal Nursing Assistant in charge of the male's ward, Male (38 years)
	UG Hospital
7	Female, Deputy Director (60 years)
8	Male, Medical records (46 years)
9	Male, Hospital administrator (61 years)
10	Female, Senior pharmacist, the pharmacy department (46 years)
11	Male, Dental surgeon (44 year)
12	Female, Senior Accounting Officer (33 years)
13	Female, Nursing officer (31 years)
14	Male, Director of the University of Ghana Health Services (57 years)

Source: Field data, (2019)

Current Customer Care Practices of Public University Hospitals: The Evidence

As a first step in understanding the spatial variations in the customer care practices in the two selected hospitals, it was important to qualitatively ascertain current customer care practices of each hospital, making in-depth deductions from the responses of key informants interviewed. Observed customer care practices include adequate communication with clients, service providers deliver the service right the first time: materials associated with the services delivery are available on time, and visually appealing, enough sign-posts in the hospital to give directions, customers feel physically safe; and hospital outdoor surroundings are well maintained and attractive. Observations on the current status of customer care were varied but also convergent in certain aspects. For instance, there were observed commonalities on the importance of an OPD as the" *the main eye of the hospital*" and the administration has made efforts to enhance it to make it as customer-oriented as possible.

Significant variations were observed between the two hospitals, so were similarities. The following are some key responses from KNUST hospital regarding current customer care practices undertaken.

A male interviewee had this to share during the interview:

> *Well, the OPD is the main point of call, it's the main eye of the hospital. At the OPD, there is an enquiry desk, nurse's station, a receptionist where people can go to. We have a policy where every staff is expected to have a name tag so that clients can identify the people they receive care from. We also have a line*

which is available to everybody to call to the hospital if they have any enquiries. We train our staff to have a friendly attitude and disposition towards their patients when they enter the facility. So for us, our customers are very important to us and we treat them well in terms of our scheme of things. (Interviewee 1, Male, KNUST hospital).

Another participant had this to say:

Customer care? From the OPD? O you come, we will receive you as nurses, okay you go to the records and you are given a card. Then we ask you to wait. Now we are doing the electronic so you give your small card to the nurses and they also call you and check your vitals and see if you are very sick and we send you to the emergency room or if we see that you are not so severely sick, we send you to the consulting room and from there, you go to lab and the results are brought in. If you are to be admitted, the nurses will be called and if there is the need to call a nurse to prepare you for the ward, then the ward receives you on a well-prepared bed, because we inform the ward that we are bringing a patient and they prepare for us nicely. (Interviewee 2, Female, KNUST hospital).

To support this another participant also stated that:

Formerly, because of the customer care that we have to enhance to avoid time spent at the OPD and the various unit to be cut off, I think last year's September we shifted from the manual operations to electronic, So from the electronic, when we started

it, time at OPD and records has drastically reduce because we don't pick folders anymore. When you come, we get your ID card, input it and assign you to a consulting room so it has reduced about 80 percent of time spent here. Also, we have designated areas from triaging at the various consulting rooms. So as and when you are assigned to the consulting room, there and then the nurse will take your particulars. Unlike before where they queue at one station for their vitals to be taken, and this has cut down the wasting time and also the patient staff relationship is also enhanced and the doctors also interact with their patients, so that their complaints would be heard. I think these are some part that we have improved upon. (Interviewee 3, Male, KNUST hospital).

The participants at University of Ghana Hospital also shared their views on Current Customer Care Practices. The following quotes illustrate their views.

A female participant had this to share:

"Well, just like any other place, we have done a lot of training sessions on customer care. We have customer evaluation unit and then a customer, how do we call it, committee on customer care for best practices. We have a complaint unit for the customers to lodge their complaints. We operate the entire hospital on a committee system to allow each and every hand to be on deck. We have a number of committees we ran at the hospital. So, generally, everyone has something to do. It is not as if it is only management.

These committees work towards management and are supposed to give report to the management team. (Interviewee 1, Female, UG hospital).

A male participant also stated that:

Okay. It is some that the hospital started with some time back. A team was formed and there are some few things that were put in place. When the team was formed, some issues came up concerning how we relate with patients and things that should be easily accessible to the patients in case the patient need it. With regards to how to deal with patients, there were some few trainings that were done; yes. The training was done across board, meaning, all the staffs were involved. We used not to have a place where a patient could make a complaint. For that matter, when those things came up and meeting with the quality assurance people, I mean those things were put in place. (Interviewee 2, Male, UG hospital).

To confirm this another participant stated that:

We first and foremost organize a series of training for almost all the staff on customer care within the last 2 years. So every member of staff has gone through that training. The university also organizes similar type of training for key people in the hospital. We have our quality assurance in place and we have committees for the various departments; one of their major roles is to come out with ways of improving customer satisfaction. They give periodic reports to the house management team and they will take up issues from there and see how best we can run it. We have our suggestion

boxes scattered all over and occasionally we pick them to see the problems that we are facing. We also go round to see the problem first hand and see how best we can handle it. Sometimes you just have to do a staff reshuffle to get certain things done. When our doctors or new staffs come, we give them serious orientation at the office on how to take care of our clients. We instill into them that the university is a peculiar place unlike other places. There are certain things you cannot do. (Interviewee 3, Male, UG hospital).

The use of IT to Improve Customer Care

A distinctive factor in the practice of customer care, both spatially and temporally, is the application of information technology, the extent of its application, the availability of internal competencies to ensure its optimization. In this regard, the researcher directly posed a question on the use of IT and its reflection in customer care relations in both hospitals: Key responses emerging include:

Yes, IT is driving our customer care because we realise that the days that folders were being used was affecting quality delivery. So currently we have introduced what we call the electronic medical record. It is a novel project by us. That software has not been used by anyone else. The patient's details are captured upon entry, visit the doctor and go to the pharmacy without carrying any folder. (Interviewee 4, Male, KNUST).

Another female participant added that:

> *I mean now we are using IT so we don't pick cards. It is a paperless system that we are running now. So you go to the record section and you are assigned to the dental department. You come here and we pick your number and we attend to you. So if that is it then we are using IT. (Interviewee 2, Female, KNUST hospital).*

Temporal Variations in Customer Care

On the objective of deducing the temporal variations in customer care, the researcher used a set of retrospective probing questions to understand the specific changes that have taken place in both hospitals in recent history. Observed changes in KNUST hospital in the last 8 years include, but not limited to: introduction of "the enquiry desk", "a client satisfaction survey" "respect and dignity". Others indicated that the "the OPD is not overcrowded" like it used to be some eight years back. Also, patients can now "gain access to their records" due to improved communication systems. All these changes have made significant improvements in the hospital's attention to customer care.

Key responses included:

> *Yes, so the enquiry desk wasn't there initially and it has been introduced. We also have a PA system at the OPD that every morning we use to educate clients and tell them the processes involved here. If there are topical medical condition that they have to be educated on, we use that to educate them also, we also*

encourage them to talk to doctors if there are any complains. (Interviewee 1, Male, KNUST hospital).

Another participant added that:

In 2011, we did a client satisfaction survey and we asked the patients their satisfaction after seeing the doctor and more than 60 percent said they were satisfied. We asked specific questions like whether the doctor explained their condition to them and they said Yes. Our doctors have been trained to explain patient's disease condition to them.

Another participant stated that:

Between us and the clients, if you walk around the hospital, we have the patients chatter printed everywhere- what the patients' responsibility are and the nurses and doctors etc. So that is one way of letting the patients know their rights. In terms of the clients and service providers as well, we also put up boldly that the service provider is not an adversary to the client and so, even though we are protecting the client, we are also protecting our staff. They shouldn't use verbally abusive language on our staff. But in terms of, like among the staff as well, the hospital has strict disciplinary policies. I mean the administrators, the director and then the matron who are the chief administrators of the hospital, anytime there is any conflict among staff, they ensure that it's resolved. Or if any staff goers overboard, then the person is reprimanded.

To confirm this, a male participant also stated that:

> *For me, before I joined KNUST, I was at Komfo Ankoye Teaching Hospital. The difference between us and other is that, the OPD is not overcrowded. We make sure that immediately the OPD is full, the director will call that we get doctors to go there to clear up the place so we make sure patients don't spend too much time here. On the average, patients reporting and going out is usually 1 – 3 hours which is quite rare in our part of the world (Interviewee 1, Male, KNUST hospital).*

A male participant also stated that:

> *I think, initially, you couldn't just gain access to your records, you can't even ask and they will say what do you want? But now the patient is supposed to know his/her condition. I have been here for 20 years and things have changed, we have more nurses who are more educated. We have the degree and the masters who are in the system who knows that the patient has the right to know what is wrong. Initially, you couldn't go to a nurse and ask about your condition, about what is wrong with you but now, a patient can come and you can explain the condition of the patient to him or her. To the patient? A lot has change. We respect our patients, we don't care whether you have money or not. I will say sometime in the maternity ward some years ago, you can go there and the Midwife looks at you, maybe the bag you wear or something. But this time it is not so, whether you have or not, you are a patient and you are our client. It is because of the patient*

that is why we are here, if they are not there, you can't dress from your house and come. (Interviewee 1, Male, KNUST).

Another also stated that:

Providing information to clients about their condition: over the years, we were having a small number of consulting rooms and doctors were not many so the work were overwhelming on the doctors also the interaction between doctors and clients were not encouraging, now that we have 8 consulting rooms filled with doctors, the doctors and patients have time to relate. So if there is any ailment or information that the patient wants to ask, they are free to do so. The nurses, they don't consult with some of the nurses in the consulting room so that confidentiality is also assured. (Interviewee 1, Male, KNUST hospital).

In addition, a male participant stated that:

When I was employed here, the new ward was not built. The OTMC wasn't built so as time by and it was built, some of the specialist care has moved to that place and they don't consult at the main OPD, they are separated to be attended at the new block and also, patients have their own self admission room. .... You will see that, we have changed some positions and also, the OPD areas has been redesigned and it has created enough spacer for patients and staff. Painting wise, you see the lawns, everything is nice. Infrastructure and vegetation is nice in helping treatment. (Interviewee 3, Male, KNUST hospital).

At the OPD it used to be benches but now we have a bit comfortable chairs. I know that as for the wash rooms, the one for the female is two and the one for the males too it is two. … Formally, antenatal was done at the OPD, in the open space but now, they have a whole building for antenatal. It is a new building for the antenatal. (Interviewee 6, Female, UG hospital).

Over the years, we were not having some specialist doctors and now we have Gynecological, Orthopedics, Ear, Nose and Throat (ENT) services, Pediatrician Specialists and also physician specialists. Previously, for about 15 years that I have worked here, it wasn't like that. We have specialists care now. (Interviewee 3, Male, KNUST hospital).

About 2 or last year, the hospital entered into a contract with a company that supplies every medicine for the hospital. I know that, they don't collect money upfront, as and when you make the sales, and then they come for their money. So medicine wise, we are more than probably 60 or 70 percent. We have enough due to that contract. I have forgotten their name, they have been doing that with some of the hospitals in Accra and Kumasi. (Interviewee 3, Male, KNUST hospital).

It is like you are chasing a mirage because if someone comes and spends like 30 minutes, and tomorrow he spends 20 minutes, he still thinks he has come to wait for a long time. So we're actually trying to improve on our waiting times. We have a dairy where we give appointments. Ghanaians don't keep to time; you give them

an appointment to come at 10 and they will come at 10:30 and when they come they think they have an appointment. So sometimes it's even difficult to implement policies but we try within the constraints. When they come we cannot send them away and tell them you've missed your appointment. And so we try to cut down the waiting time with the appointment system. We are making some progress within that area but I think there is still room for improvement. (Interviewee 5, Male, UG hospital).

I think we are improving in treatment safety. Of course research is abounding so day in day out we try to discard outmoded treatment option and we try to adapt evidence based models. So I think in this hospital, treatments are fairly safe. ...I don't want to mention names. The quality of the things we use here are fairly okay so we don't injure patients by using sub-standard stuff for their treatment. (Interviewee 5, Male, UG hospital).

I think we should enhance customer and staff relationship more. So that the customer will gain confidence in the staff who work here, and also confidentiality must also be assured. So I think staff should be trained through workshops to be able to be equipped with that knowledge. (Interviewee 3, Male, KNUST hospital).

"I can't talk about that. I have never heard that there is shortage of medicines and logistics here because we have two separate stores. One is mainly for medical items; anything medical is there. Then we have the general stores. So I have never heard of shortage of any medication. (Interviewee 6, Female, UG hospital).

I think one of the biggest things is the concept of core business. What is it that is our core business? That is the main question that the university asks itself. And they answer that the university education is their core business; academia. Health, unfortunately is considered as not core even though ironically, you have to be healthy to fulfill your work…. We are still pressing on; the battle is not over yet. There might be one or two excuses. (Interviewee 8, Male, UG hospital).

That is a very appropriate step. It is the second phase of our implementation of our software system. I just pray and hope it comes to past. If you look around you will see a lot of suggestion boxes. At the OPD we have carved out an area where the in charge is the one who is supposed to receive complaints from the clients. I guess that for some of us, criticism is not rejected. We take it as some of the most important ingredients to make sure that we improve the system. Sometimes we may be so relax thinking that all is well just like the adage that says that when you are living in a room alone you never know that there are cobwebs but somebody coming from outside easily see it. So I think this is one of the aspects that we have to be mindful of. (Interviewee 8, Male, UG hospital).

"Nothing has changed. Maybe the only thing that I can say has changed is the building at that side which was even built before I was posted to the children's ward but now, there is an issue with it.

Also, the emergency department that was built down there is one of the changes. (Interviewee 7, Female, UG hospital).

If you have the money available then most times you will get the medicine although sometimes there may not be some drugs at the pharmacy. So you will get it unless it is a financial thing that will not make you get the medicine. So, if your money is there you can get it. (Interviewee 7, Female, UG hospital).

"That one, I can't say much about it because I don't really know what goes into it because the last time we had a meeting with the vice chancellor, what we were made to understand was that the university is not certain, whatever. So we don't join that argument. (Interviewee 7, Female, UG hospital).

"What can you say about displaying professionalism in service delivery: Equipment are better than before. When I came here at first, nurses were supposed to carry patients but now we have porters who do that job. So for that side it helps. These are improvements in that regard. In terms of equipment, they are bringing the monitors and things to make the work easier. (Interviewee 7, Female, UG hospital).

From the above responses it is clear that patients have very peculiar needs that sometimes make them require attention to feel that their health is the priority of the service providers. This calls to question the availability of 24-hour service at the two hospitals. The responses indicate that both hospitals have "24-hour service and 7 days in a week". This was one of the

distinguishing similarities observed between the two hospitals. However, in spite of the relevance of this constant availability of service to customer care, there is still the question of quality of the service delivered and the question of whether this places a strain on hospital resources such as staff.

Ensuring Sustainable Health Delivery in Relation to Customer Care

A key premise of this study was the realization that patients are highly vulnerable and often confuse due to their poor health. In that vulnerable condition, patients are still required to make critical, often complex decisions within a short time frame regarding their health. This critical process makes patients a unique type of customers that require special attention. In the above responses, it was clear that a customer care desk has been introduced, specifically to address this issue in both hospitals; i.e. to assist patients in decision making regarding their health and ultimately improve service delivery.

However, in order to ensure that both service providers and clients get closer as much as possible and at the same time address the grievances of patients, continuous improvement in customer care is needed in as a critical component to ensure sustainable healthcare delivery and by extension, the achievement of SGD 3, thus ensuring healthy lives and promote wellbeing for all at all ages. In this line of thought, the researcher sought to uncover various requirements to ensure sustainable health delivery in relation to customer care by using introspective questions such as: Will it be appropriate to have an online service platform where patients and service providers can interact about

their health conditions? The participants expressed their views in various ways.

For example, a female participant shared this:

> *All that I can say which I have in the beginning is finances. Even though we do look at finances, we don't turn down our patients. Someone comes with nothing but we still care for the person. There are a lot of people we have nursed here with some owning between 6,000 and 7,000 Ghana cedis but they are left to go. Because of administrative stuffs and the back and forth of the money, the hospital cancelled the health insurance. (Interviewee 7, Female, UG hospital).*

However, one of the participants shared a concern about how patients sometimes bypass the protocols to see the care providers directly. This is what one of the participants at UG hospital had to tell during the IDI.

> *How do you feel about an online platform for this facility? Well, it is advisable. What I have noticed here is that patients do the I know him so I will go to him directly thing which I think is not appropriate. There should be right channels. So if there is a center like that which all the department are on it, it will help but I just hope that if the complaints are sent will they be taken. Sometimes you will set these things up and just to know that everything that is sent there is not useful. (Interviewee 7, Female, UG hospital).*

Some of the participants also indicated the areas they feel should be looked at. For example, a male participant had this to share:

> *I think there should be a number of areas that have to be looked at: staff and staff development where we are looking at attraction and retaining of staff, training of staff and making sure that they become specialized so that the institution can become self-sustaining. Number two, infrastructure; there is the need to improve the infrastructure of the place and lift the equipment base also up so that things that we could do but were unable to do because we didn't have the supporting gadgets can be done. The other thing will be improvement in preventive maintenance culture in the system. The other way is to sustain the software and electronic advancements made so far. We need to also mentor the young, build strong system from strong individuals so that when such people leave the system doesn't fall to the ground. I think this is what we need. (Interviewee 8, Male, UG hospital).*

Some of the participants also indicated how existing systems have been used to help ensuring Sustainable Health Delivery in Relation to Customer Care. For example, during the IDI, a participant shared how they receive complains from the email portal that is accessible by everybody. This is what a participant shared during the IDI:

> *Within the University, there is an email portal that is accessible by everybody and we had times where the University sends complains about the hospital and immediately it gets there, we pick it up, call a meeting, investigate and see how we can address*

so that is already available. It is about how it is used. Sometimes, you may get someone raising an issue there which may not be true. We have had an instance where somebody came to the OPD and sent an email to the platform that there is no Doctor in the hospital but there was a doctor in the hospital. It's about how the system is managed but such platform is available. (Interviewee 1, Male, KNUST hospital).

Another participant added that:

Yeah, it depends on what you will go and put on the platform. For instance, you can't come and take my diagnosis onto the platform. If you come and we don't receive you well, that is not good. I can't say we are 100 percent perfect, maybe when I came to the hospital, a nurse spoke with me rudely, or I wasn't received well, or when I was given an injection, I was spoken to anyhow, No! If you bring it up, then we can also speak to our nurses. (Interviewee 2, Female, KNUST hospital).

Another participant said this:

"Yeah I think it is right, it is a good initiative if the hospital implement it. We have a website but I don't know whether it is open for people to bring their contributions. But nevertheless, we have some suggestion box at vantage points here. If anyone wants to bring any suggestions and also complaints, anything at all, they are welcome to put their suggestions in the box. But I think the internet one will also help. (Interviewee 3, Male, KNUST hospital).

This quote also illustrates how there is a discrepancy between what ought to be and what exist:

> *Theoretically, it is good but I always say that, from my practice that will be dangerous. The reason is that, you always need a professional evaluation. If you are not careful and you are still relying on the phone and other technologically aided platforms, you may go into trouble. I think that, you get time to do all manner of things so if you are sick, if you find something unusual with your life, you should come. Of course, there are bigger platforms now that we can access, so we don't need to duplicate and create one on our own. The general ones are there, if Google, Wikipedia, health direct, webmed, you can go and read all those things there, but those things themselves don't solve problems, you must look for a practitioner to interpret your condition to suit your situation, otherwise you will be in your house doing everything internet and before you realise, you are closer to the hospital. (Interviewee 4, Male, KNUST hospital).*

Challenges and Opportunities for Improvement in Customer care

As aforementioned, there is an increasing recognition that the economic cost of delivering healthcare will always have to be considered in an effort to provide solutions to healthcare challenges and improve the general health systems. This is even more critical in the quest to deliver on SDG 3, especially in developing countries and even more so in University hospitals. There are a range of different issues and challenges that need to be addressed

for successful delivery of satisfactory customer care in a hospital. Some of these challenges are particularly unique to the University Hospitals investigated, while others are generic. A number of major challenges, including inadequate staff, poor hospital financing, processes national health insurance, inadequate communication with clients, lack of special diet for special patients among others were discovered. Below are some responses depicting key challenges and suggestions on how to deal with them:

A male participant had this to share:

> *Why we are not getting there as we are expected to is because of 1, staff attitude; the fact that people have been here for a very long time and they know that oh yes they have been rooted and unlike private institutions where you can hire and fire, that is not the case here. Some people tend to be slow in falling in line. There are competitive environment. Formally the university health services seemed to be the best place to work in but now the ministry of health and Ghana Health Service condition of work have taken over this. So some people have some attitude as though they can move anywhere so are not putting up their best. Another thing is that, because of the low attrition rate of our doctors, we have to start retraining some the people we engage and sometimes the culture of practice of customer care at other public institutions are imported into this system so you don't have total control over that. If that is brought to your notice then you can do something about it. They represent our faces before the public. (Interviewee 8, Male, UG hospital).*

This was confirmed by another male participant

> *Surely so. I mean not only customer care reforms but its sustenance because you can do a reform here but without sustainability of it, you will fall flat. We know that health service delivery is growing; it is not static. ...There should be an active desk looking at customer service and an avenue to send staff to other institution of great customer service repute within the sub region or even outside the country; exchange programs. (Interviewee 8, Male, UG hospital).*

Another participant also indicated how the challenges can be resolved.

> *The main OPD and the continuous training. We want to make it as part of our appraisal. We want one item about the mental health. To find out why people are not preparing to deliver well. Customer care comes with spaces, we need a larger consulting room, look at this consulting room. The place is busy and we need other things like some infrastructure so that when the patients come they feel comfortable. (Interviewee 9, Female, UG hospital).*

A male participant at KNUST hospital also stated that:

> *"We need to work on the consciousness that they are our 'Kings' and 'Queens' and also we need to work on ourselves to know that, without them we don't have a job so if you can drive that home over and over, then we can do a little more for them . The report should be a whole campaign where we set a period where our focus will be on customer care where we go out to lets people*

know hat, the hospital is changing because of the customer care. (Interviewee 1, Male, KNUST hospital).

A female participant also added that:

"You see, this hospital is a university hospital so we were thinking we should reserve some specific rooms for students and staff. But still, if you have about 40 or 50 staff coming in the morning, they will still have to queue so we try to distribute them around the room so that they go back early to work. Maybe what I will say is that, we need more hands, more doctors since if we have more doctors or nurses, you will spend less time here. (Interviewee 2, Female KNUST hospital).

To further support this, another participant was of the view that:

For me I think we still have a lot to do in terms of customer care and it is a mind-set in Ghana and Africa where the healthcare provider is seen as a king. But we have to try to make the patient know that, we are offering service to them and if they don't come to the hospital, there is no job for us. When that is drum in and the health workers are made to understand that the patient is vulnerable and so when they come to our facility, we should do what we can to improve service delivery. (Interviewee 1, Male, KNUST hospital).

In addition to this, one participant also shared that:

What we can do, I think we are doing all we can do. I think we should have more doctors. Because when you come to the OPD, we have more patients, outnumbering the doctors, so if we had

more doctors and patients. Like Saturday I came here to see what was happening and there were plenty patients at the OPD compared to doctors. We have about 8 consulting rooms, why don't we have like 4 doctors? So if we do this, patient's time wouldn't be wasted here. They will come and go quickly, we have a lot of lab technicians for instance, and patients wouldn't stay for more than 1 hour. If we have more equipment's that can hasten their lab results, when you go to the pharmacy we have more hands filling all the windows, patients will not spend more time here. So all personnel's at the health facility should be increased, not only doctors but nurses and all personnel. I think we should employ more hands. (Interviewee 2, Female, KNUST hospital).

Another male interviewee from KNUST stated that:

I think we sustained what we have been able to achieve, one we have to also encourage the staff, staff motivation must be there so that they give out their best to serve their clients so that they can also bring out good services to them and also continue to provide the necessary drugs that they need. Not that we prescribe about 4 drugs and the patient wouldn't get one. And also, the lab that we do here need more equipment for the diagnosis to be done and not that we have to send out samples outside for people to do it. I think as time goes by, we need all those equipment. In a few weeks or months, we will be inaugurating our MRI scan, it is ready, it is left with the inauguration. Recently, our radio department has

also seen new digital X-ray machines and they have been installed and operating. (Interviewee 3, Male, KNUST hospital).

Perspectives of Patients on Customer Care Delivery

To provide a well-balanced and detailed view on customer care, the researcher further sought the views of patients or customers who patronize the services of the two hospitals. Already it has been established in the previous sections that one major reason for the existence of every health facility is attributable to customers and without them, the facility cannot survive. This is not just a notion. Existing evidence indicates that there has been an increased recognition that in order to deliver an excellent service to customers, healthcare facilities need to provide services which meet the expectations of customers and in most cases, this implies providing services focused entirely on the customer.

In the same line of thought, this study included a purposive probing of patient perspectives on customer service using a series of open-ended questions including: What's your general impression regarding customer care in this hospital? How important is customer care? Can you say that, before you came here, your expectations have been met? How they treat you, are you motivated to come back here again? Will you say the services that you receive is of quality? What can the facility do to ensure proper services? These set of open-ended probing led to the following patient based-perspectives on customer care in the two university hospitals.

General Impression Regarding Customer Care in the Public University Hospitals

To provide broader context for the research, it was important to find out from all the patients their general impression regarding customer care in these hospitals studied and the benefit the hospital will derive from quality customer care implementation. Key responses to the question included:

> *The staff are not troubling us. The only issue is that, especially when it comes to diet, the coordination between the kitchen and those who bring the normal food and those who are fed with special food like the diabetic people has to be improved. (Patient, Male, 55 years old).*

Another respondent added that;

> *I think so far my impressions have been good. The last time I came here, it was midnight and there was no electric power. But with the staff, I have not had any issues with them just that, they have been a few delays. When the power went off, I had to wait. They had to get power on before they started taking care of us. (Patient, Male, 28).*

To support this, a male patient also stated that:

> *For me it has been very cool and I think there has been some improvement. The last time I was here to now, I would say this time around it is better. So there has been an improvement. (Patient, Male, 25).*

A female patient also stated that:

> *"It is okay, I guess. It is just very slow. A lot of people really come here so it takes a very long time for them to attend to us. (Patient, Female, 22).*

Another female patient was of the view that:

> *"It is normal…I mean it is good. There has been a lot of improvements for the time I have been coming here. This improvement is all round. (Patient, Female, 20).*

A male patient also said this:

> *"Oh, it is good. The nurses are good and then the doctors too are good. Whatever you want they will do it for you. Then they have love for humanity so. So far, my experience with them has been positive. (Patient, Male, 21).*

Another male patient was of the view that:

> *Customer care is good but with the modern age of digitization, it is lacking. I've had a positive experience for my time here. (Patient, Male, 31).*

Importance of Customer Care to Patients

To provide patient centered appreciation of customer care, the researcher sough to find out from all the patients how important is customer care to them and the benefit the hospital will derive by proving quality customer care services. Key response to this question includes:

> *It is how, as a German will say aww no! The first, you know, when a patient come, they come. Yeah it's Very important to me. I live in*

Madina new road, and there is a polyclinic there but people complain so much about the staff there and it's so bad there. But here, my experiences have been okay. (Patient, Male, 55 years old).

Another participant indicated the importance of care to patients as follows:

It is very relevant to me. I see it as the patient is already not well and has come seeking for help. So how you relate with the person even from the very beginning can bring some relief to the person no matter the bad condition the person might find him or herself in; because of the better customer care you provide, that can bring some relief to the person even before the medical care. So I believe the customer care is very important. (Patient, Male, 28)

A male patient also said:

Customer care in what sense? It is very important because erh…sometimes people are not well, instead of you to take your time to talk to them and even make them okay, some of them can be very rude. Yeah, so it is very necessary. (Patient, Male, 25).

In addition, a female patient was of the view that:

Oh yes! I think it is very important to me because you might not know the problem of a customer until you go and interact with the person; then will you the kind of problem the person is facing. (Patient, Female, 22).

Another female patient shared her view on the importance of patient care this way:

> *"I think, I did a test which guarantees my health care. Customer care is supposed to be the best because some hospitals when you go there even the nurses don't give you the face; when you want to ask something from them, you will be feeling shy or you may be afraid to ask because maybe they will be harsh on you. So for a hospital, I think regardless of the patients' status you have to be good to the person because you don't know what the following day may be. (Patient, Female, 20).*

A male patient added that:

> *I consider it very important. I mean, the care that is the customer care is like a medium of interaction. So the response given is also part of the health contribution. (Patient, Male, 31).*

Meeting Patients' Expectations in Customer Care

In order to ensure effective evaluation of the customer care, it was important to find out from all the patients if their expectations in customer care has been met at the present hospitals visit.

Key responses to this question included:

> *My expectation is to be strong and go home. That is why I came here. By God's grace, when I compare now to before, things are getting better. (*Patient, 36 Years, Female).

Another patient said:

> *"The first time I came here, my expectation was met and probably exceeded but this time around, I have to go to work but I have spent the whole day here. (*Patient, 28 Years, Female).

To support this, a 25 year old male patient said:

> *"Yes. I came to check on something and when I came, two different nurses have worked on it. So my expectations have been met. They've given me what to do to get to that normalcy. I am satisfied with my care. I will give it to them…they have improved. (*Patient, 25 Years, Male).

In addition to this a female patient also stated that:

> *"No because, as I said the kind of attention and the diagnosis they gave, I thought they could have done something more. Even when I left, the drugs they gave did not work. They said it was allergies but it wasn't…if he had taken his time to do more testing who would have found out that really it wasn't allergies and it would have actually made me feel better. (*Patient, 22 Years, Female).

Patient Motivation for Repeated Visits

To understand how patients value customer care, the researcher sought to find out from the patients were if they were willing to make a repeat visit to the same hospital in the case of another health issue.

Key response to this question included:

> *"Yeah, I will come back here, because of what they do. One thing I don't like about this place is the Insurance that is not covered. So I*

*will wish that they accept the insurance and consider us because I don't have money" (***Patient, 40 Years, Female).**

A female patient added that:

*Mmm…Oh, they take good care of me. You know with humans, each one of us have the attitude and the way they were brought up. Some people are fine but not everybody. I am okay with the treatment they give me (***Patient, 36 Years, Female).**

Perspectives on Services Quality Service

To provide further context for the research, it was important to find out from all the key informants their general impression with the quality of service in this hospital, what it meant for a hospital and the benefit the hospital will derive from quality implementation.

Key responses to this question include:

"Yes, I think so. My first occasion I will say yes, but today, if I am to rate, I will rate is 8/10 because of the delay" **(Patient, 28 Years, Male).**

Another male patient aged 25 years had this to also share:

"Oh, yeah. This, yesterday was really my first time here and I really enjoyed how things were. I think things are computerized here so before you get to the next point here, the person knows about the necessary things to pick up to the next level. So I think that is some kind of improvement. Before you get to the consulting room, there are two nurses to ensure that everyone is in the queue. They give numbers so no one can skip or give their forms to

someone ahead of them; everyone has to go with the numbers. So they are making sure that their customer care does not bring segregation or any kind of division. Just as we have the numbers, we are going with the numbers and they are monitoring how things should go" **(Patient, 25 Years, Male).**

Another patient aged 40 years rated the care received as:

*"Mmm…it is okay. I will give them 60 percent (***Patient, 40 Years, Female)**

Male participant added that:

*"Yes, it makes me feel comfortable to continue to access care in this facility". (***Patient, 28 Years, Male).**

A young male patient also rated the care received as very good and had this to say:

"Yes. If I am to score them on a 1-100 score, I would give them 90"(**Patient, 21 Years, Male**).

To support this, a 31 year patient also said that:

"Well, on a scale of 1-5 I would say 3" **(Patient, 31 Years, Male).**

Patient-Centered Assessment of Customer Care

In order to ensure patient centered assessment of customer care, it was important to find out from all the patients what the facility could ensure proper services at the hospital.

The main responses to this question include:

"They should work on the insurance because it will help us very well and I believe with the doctors too, it will help them. Because,

if you are to be discharged from the hospital and you can't pay the bill, then you will remain here right? So when you don't have money or there is no other person to help you, you will be here at the facility so if the insurance works here, then the insurance can reduce the financial burden that we go through. They write the drugs for us to go and buy yet the bill is also high. They tell us the bill doesn't cover drugs" **(Patient, 40 Years, Female).**

Another male participant indicated the need to regularly educate the staff:

"The need to educate the staff on a regular basis. Because new technologies are coming. That is what I will say, education (**Patient, 55 Years, Male)**

*Oh…I mean, the…I don't know…but I'm guessing probably if there were more doctors or something. And also the lab, I realised some delays and so if there could be more labs too, it will be better" (***Patient, 28 Years, Male)**.

To probe further on patient centred perception of customer care, the research sough to find out if it will be appropriate for the hospital to have an interactive online platform where people will seek clarification or if the hospital can employ ICT in its service delivery.

Key response to this question included:

"Well, you may say I am old school because I will prefer a one on one interaction because the way things are going, you can't avoid the new technology so it has to come off" **(Patient, 55 Years, Male).**

Another participant stated that:

> *If it is a paid service why not. But for free I don't think it will work. Because they have a lot of workload already. If you are going to get help, it might be delayed you know* **(Patient, 28 Years, Male)**

A male participant also recounted the need for in-service training as follows:

> *"Through in-service training. They are to train more in terms of their human relation because customer care is really important but I don't know if they can bring in some kind of platform for them to connect with patients while patients have left the hospital, so that they will calling and checking up on them. If they can do that it will be a plus to them when they call the customers to find out how they are doing once a while; the patients that they are treating, they should call them the same week they are leaving the hospital to find out how they are faring and giving them ways they can improve their health. So there should be an online platform, especially with the students and the literates in terms of computer literacy. So there should be an online platform where patients can comment and ask questions about some health issues. I think that will be relevant"* **(Patient, 25 Years, Male).**

Some of the participants also stated the need for communication as follows:

> *"I'm still on the communication…someone may come here and be feeling shy to ask a nurse for help so will just go and sit waiting for a nurse to come and call her or for them to mention her name but I think you can just go one on one to the person and welcome her and ask her why she came to the hospital. I think the online*

*platform will help…that will boost some people's knowledge because when they come here and they don't get the understanding here, they can go on the platform to get it there. Like these red-red things there, if the person does not understand why it is there, he or she can go on the platform and read about why they use that thing" (***Patient, 42 Years, Male)**.

One patient also indicated how sometimes it is stressful to see a doctor and therefore advocating for the need to make the online platform stronger.

"I think I will come to the case of seeing a doctor because my first visit here when I was coming for review was quite stressful. It was quite stressful. I came as early as 9:00 because when they were discharging me, they told me that the surgical review is around 2pm and that when I come early and the doctor see me, the person might take me in and all the things he has to but when I came here I didn't see anything like that. Secondly too, as at 2pm there were no doctors here for the surgical wards. I think that is what I didn't like so if they can improve on that it will be good. The online platform would have been very nice because this time around, everywhere you go that is what is done there…ICT everywhere. Yeah, so that one will be better. Even without it, with what they are having now, they have all your information on their system so if the ICT comes, that will be helpful but without it we can manage it as it is now" (**Student, 21 Years, Male**).

Discussion

This section of the thesis discusses the results in relation to previous studies and the theoretical underpinnings of the study as well as the conceptual framework adapted.

Customer Care Experiences

Customer care experiences or Patient experience is regarded by healthcare policy frameworks in several countries as a core component of healthcare quality, alongside clinical effectiveness and patient safety (Al-Tannir et al. 2017). Various sections of the customer care experiences are discussed as follows.

Communication of Service Providers

Communication within the healthcare continuum is one of the indispensable tools to achieve stated goals. The communication between provider patients as well as provider and provider are very vital to customer care practices (GHS 2009). By this, patients always expect providers to give them adequate information about their condition which will inform how the patients will comprehend and adhere to treatment or preventive guidelines. In essence, communication should be in the language that the patient can easily comprehend and feel comfortable to ask question should the need be.

Situating the findings of the study on communication of service provers and how that can affect customer satisfaction with Hierarchical Model of Service Quality, the model postulates that inter-client interaction and sociability are key determinants in defining how patients will rate the service

quality. The findings can also be discussed in light of previous empirical studies. For example, according to Madula, Kalembo, Yu and, Kaminga (2018), effective healthcare provider-patient communication is a key element in optimal service delivery. In order to build a good relationship, there is a need for healthcare providers and patients to communicate effectively. The results from this current study showed that only a small (28% in KNUST and 38% in UG hospital) proportion of healthcare providers were displaying their name tags, title and their role in the department. Nonetheless, from the clients who receive healthcare from these providers it was evident that the majority 88 per cent (91% for UG and 86% of KNUST) said that service providers were friendly and welcoming and also indicated that healthcare providers talk to them politely. These findings corroborate what previous researches found in Ghana and other parts of the world.

In Ghana the study by Mensah (2015) at the university of Cape Coast Hospital and University of Ghana Hospitals indicated that healthcare providers communication increases patient's satisfaction with health delivery. Specifically, it was discussed that staff, especially medical doctors give elaborate information on the treatment and health condition of patients. The possible explanation Mensah gave to his findings was that the university hospitals serve the most elite class, who are senior members (lectures and senior administrators), senior and junior staff, dependents of the university workers, and the public around the university environment, they are therefore conscious about their health and engage doctors and medical staff in effective interpersonal communication on issues pertaining to their health.

Attentiveness of Service Providers

Attentiveness and timely delivery of services and medical intervention in general is one of the surest ways to save lives. In most instances if not all cases, the moment clients or patients visit a health facility, they are expected to be attended to within a given shortest possible time. This is even more critical when the patient is in an emergency situation (GHS, 2009). According to Aghamolaei et al. (2014) patients perceive that priority care is significant for quality healthcare and therefore in these special environment (university compound) management should concentrate in providing senior and junior members with efficient and timely care to ensure effective teaching and learning.

In this study, attentiveness was denoted by the extent to which service providers engage customers (patient/client) immediately, explain procedures in a language customer understands, explain and apologize for delays, displayed competence and had knowledge in what they were doing, responsive to patients (prompt attention) and by extension whether the behaviour of employees instill confidence in customers. Results from the study showed that majority of the respondents [77 percent (83% for UG hospital and 71% of KNUST hospital)] were of the view that the behaviour of employees instill confidence in them and health care providers displayed competence and had knowledge in what they do.

The findings in the present study is consistent with what was found by Mensah (2015) who indicated that university workers and students do not join queues, and they are given a special service at the hospital based on the fact the hospitals were established to serve the university community. Aghamolaei,

et al., (2014), confirm that priority care in specialized institutional hospitals promote a sense of ownership by staff and workers who always feel proud to utilize services at those hospital. Thus, they are of the view that quality healthcare is delivered to them since the medical staff also understand the core mandate of the institution of which all the majority are workers. This probably explains some of the pathways by which the participants in the study receive attentive services from the care givers at both hospitals. Situating the findings of the study within the framework that guided this study (Figure 6), attentiveness is a function of effectiveness and efficiency which are very critical components of sustainable healthcare delivery. This is critical in the sense that once service providers are attentive to the grievances of their patients, they are able to offer advice or care that suits the needs of these patients. On the other hand, when care providers are not attentive to the needs and concerns of their patients, they might not be able to offer the kind of care and services their patients demand. All these in effect might undermine the quality of care patients might receive.

Respectfulness of Service Providers

The level of respectfulness of service providers is another key element of customer care (GHS 2009). *As spelt out in the customer care handbook (2009 p.16), patients or clients expect to be treated with respect and dignity and not referred to as cases. It is therefore imperative for healthcare providers to always respect the rights of the clients in the course of performing their duties without prejudice to clients' medical condition, ethnic background, political affiliation, educational level or other personal and*

social variables of the client(GHS 2009 p16). In this study, respectfulness of service providers is denoted by the extent to which service providers treat customers with respect and dignity, respect differences in values, culture and beliefs; show empathy and consideration in words and actions and treat customers as a partner and a member of health care team. These findings confirm previous studies which indicate that satisfied patients will have a revisit intention to the facilities based on the service provided to them (Akbaba, 2006). However, Nwankwo et al., (2010) found that providing unsatisfactory service in regards to doctor's responsiveness, length of getting an appointment, access to core treatment and hours of operation could negatively impact a patient's satisfaction with quality healthcare (Yousapronpaiboon & Johnson, 2013). The findings also support the conceptual framework and theory that was adopted to guide this study. Specifically, the hierarchical model indicated that several factors affect patient's satisfaction. The interpersonal component of the model is concerned with how well employees relate with both colleagues and customers or clients of a particular organization. It is argued that good interpersonal relations place value on the customer, respect, friendliness and politeness as they try to serve the customer.

Safe Care of Clients

The level of safe care of clients is an absolute imperative in customer care delivery. In this study, safe care of clients is denoted by the extent to which the hospital service providers deliver the service right the first time; materials associated with the services delivery are visually appealing; enough

sign- posts in the hospital to give directions, uninterrupted supply of running water, customers feel physically safe in the hospital, the hospital outdoor surroundings are well maintained and attractive, customers feel their belongings are safe in the hospital, customers feel secure in this facility, customers can receive all basic healthcare services, customers feel the service providers understand their needs and lastly, the employees appear clean and neat. The findings in this study showed that majority of the respondents in both hospitals indicated that there was safe care of clients. These findings resonate with what were found in previous studies. For example, Mensah et al. (2015) indicated that safe care of clients constitutes the vital component of the healthcare delivery process.

This finding is noted earlier in studies by Al-Hawary (2011), and Çelik and Sehribanoglu (2012) that safe care in terms of physical environment, cleanliness, seating and modern clinical equipment has a larger effect on perception of quality healthcare of hospitals. In addition, the findings confirm the postulates in the conceptual framework adapted for the study. In addition, the GHS handbook (2009) on customer care stipulates that *"one of the greatest expectations of patients/clients is to feel safe in the hospital environment and throughout the care delivery process. Major safety issues can occur when there are weaknesses in the system such as medical errors"* (p.17). The findings on the safe care of clients confirms the objectives of the Ghana health service to deliver safe care to their clients which invaluably leads to customer loyalty, compliance with treatment, trust building, reduction in anxiety and bring more clients as and when the need be.

Client Satisfaction

The benefits that are associated with clients' satisfaction to the healthcare deliver continuum should always motivate service providers to overcome any impediment to achieve customer satisfaction (GHS 2009). Mulugeta et al. (2019) are of the view that patient satisfaction has been described as the value and reaction of patients towards the care they receive. As a result of this the level of client satisfaction is an imperative in customer care delivery. In this study, client satisfaction is denoted by the extent to which the hospital customers/patients are satisfied with the overall experience in this hospital, will recommend this hospital to other potential patients, accept to pay higher prices for services of this hospital and will come again when customers have the opportunity. The results showed that the higher proportion of the respondents in both hospitals were satisfied with the overall experience in the hospital and even stated that they will come to patronise the hospital again when they have the opportunity. This results on the post-visit intention supports a previous study by Kitapci, Akdogan and Dortyol (2014) on the impact of service quality dimensions on patient satisfaction, repurchase intentions and word-of-mouth communication.

They found that respondents were willing to come back to seek services at the health facility. In terms of the overall satisfaction, the results confirm several studies conducted in Ghana and other parts of the world (Xesfingi & Vozikis, 2016) including Ethiopia (Mulugeta, et al, 2019), Sri Lanka (Kalubowila, et al 2017), China (Zhang, Wang, Yu, & Zhao, 2018), Tanzania (Khamis & Njau, 2014) and Greece (Papanikolaou & Zygiaris, 2014). This was also confirmed by the narrations in the qualitative part of the

study where by some patients scored the caregivers 90 percent out of 100 percent. In addition, the qualitative data also revealed that some of the patients are ever ready to re-visit the healthcare facilities. Nonetheless, one of the participants during the qualitative interactions stated that health insurance is not covered for some of the ailments they present and as a result pleaded that this should be incorporated in all service deliveries. Situating these findings in existing policies from Ghana health service, the Handbook on customer care (2009) require health care providers to respect, deliver services in a timely manner, and display professionalism in the course of delivering their duties. The results obtained in this current study seems to suggest that the healthcare providers in the two university hospitals studied conform to the regulations that are spelt out in their handbook relating to delivery of care to patients which was confirmed by the high level of satisfaction the patients reported.

Spatial Variations

The study findings on the spatial variations showed that generally, there was good customer care among the two hospitals under investigation. Majority of the respondents, (79%) (88% for UG and 84% for KNUST) suggested that there was good customer care from service providers at the two hospitals. The majority of the respondents from the various study settings felt that they are physically safe in the hospital, outdoor surroundings are well maintained and attractive andrespondents felt secured in the facility. These findings are similar to what has been found in previous studies in other settings. For example, the study by Lindelow (2004) on understanding spatial variation in the utilization of health services showed that health care quality is a significant and important factor in women's choice of delivery location. In

addition to this, it was also found by Hays, Kearns and Moran (1990) that patients will travel to the centre nearest to their residence which offers a particular service for which they think are well maintained and attractive as well as the feeling of being secured in the facility.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter concludes the research formally by summarising the research process, outlining the main findings, drawing some conclusions, contribution to knowledge and the literature and limitations and arears for further studies.

Summary of the Study

Healthcare delivery, especially in the public sector is considered multifaceted and often linked with the socio-political and economic ideology in practice, thereby influencing rights and responsibilities with regard to healthcare delivery. The study assessed the existing customer care practices in two selected public university hospitals in Ghana.

The study mainly used primary data from the University of Ghana Hospital and Kwame Nkrumah University of Science and Technology Hospital and where appropriate secondary data was also used from the MOH, GHS policy reports to augment the primary data source. The study made use of both quantitative and qualitative approaches. The target population was patients (in and out patients) within the ages of 18 years and above who have been on admission for more than 3 days at the University of Ghana and the Kwame Nkrumah University of Science and Technology Hospitals and staff of the respective hospitals. A total of 1,010 questionnaires and 30 in-depth interviews were conducted.

The quantitative data was entered in a pre-designed template in the Statistical Product for Service Solutions (SPSS) software, version 23. The entered data were validated with the hard copies to ensure accuracy and consistency in response and analysed using STATA version 14. The qualitative data was analysed manually and relevant themes were generated.

Key Findings

The following are the key findings that emanated from the study. These have been grouped based on the specific objectives of the study.

The first specific objective was customer care experiences of patients in the two selected public university hospitals in Ghana and the key findings were:

1. Generally, it was observed that one out of every three service providers in UG Hospital and KNUST Hospital were displaying their name tags, title and their role in the department;
2. Also, about 88 percent of the respondents (91% for UG and 86% of KNUST) said that service providers were friendly and welcoming;
3. Majority of respondents stated the service providers either communicate adequately with them when they visit (81%) (86% for UG hospital and 77% of KNUST hospital) or talk to them politely whenever they engage service providers [89 percent] (89% for UG hospital and 89% of KNUST hospital);
4. Majority of the respondents [78 percent] (81% for UG hospital and 75% of KNUST hospital)] suggested that the system in this facility is responsive to patients (prompt attention);

5. Majority of the respondents [88 percent] (89% for UG hospital and 87% of KNUST hospital) were of the view that service providers explain procedures in a language that they understand;
6. Majority the respondents [75 percent] (84% for UG hospital and 66% of KNUST hospital) suggested that service providers respect the difference in values, culture and beliefs of their clients.

The second objective was to assess the level of satisfaction of patients with the care/services received at the two selected hospitals and the key findings were:

1. The highest proportion of the respondents [84 percent] (97% for UG hospital and 81% for KNUST hospital)] were satisfied with the overall experience in the hospital;
2. Indeed, 88 percent of the respondents (89% for UG hospital and 87% for KNUST hospital) stated they will recommend the hospitals to other potential patients;
3. Although respondents were satisfied with the overall experience in the hospitals, less than half (46%) of the respondents (44% for UG hospital and 48% for KNUST hospital) accepted to pay higher prices for services of the hospital; and
4. Nearly 9 in 10 of the respondents (approximately 9 in 10 for UG hospital and approximately 9 in 10 for KNUST hospital) stated that they come to the hospital again when they have the opportunity.

The third objective is to analyse the spatial variations in the customer care practices in the two selected hospitals and the key findings were:

1. Generally, there was good customer care among the two hospitals under study. Majority of the respondent, [79 percent] (88% for UG

and 84% for KNUST) suggest that there was good customer care from service providers at the two hospitals;

2. The highest proportion of the respondents [81 percent] (78% for UG hospital and 85% for KNUST hospital)] suggested that materials associated with the services delivery are visually appealing;
3. Over 90 percent (91%) of the respondents (91% for UG hospital and 90% for KNUST hospital)] felt physically safe in the hospital;
4. Nearly 9 in 10 of the respondents (approximately 9 in 10 for UG hospital and approximately 9 in 10 for KNUST hospital) stated that the hospital outdoor surroundings are well maintained and attractive; and
5. Almost all of the respondents felt secured in the facilities, thus, 92 percent of the respondents (92% for UG hospital and 90% for KNUST hospital).

The fourth and fifth objectives chronicle how customer care practices in the two hospitals have evolved over the last decade and innovative ways to improve on customer care. The key findings were:

1. Patients are getting more inclined to ICT applications in healthcare and demanding for hospitals to go beyond just static procedures of delivering health care towards addressing other patient needs such as "good communication" with patients, transparency with patients and timely service delivery;
2. In both hospitals, customer care has become an absolute imperative. And so both hospitals are making incremental efforts to deploy more ICT applications to meet their client needs need further improvement;

3. Major changes in both hospitals include: introduction of "the enquiry desk", "a client satisfaction survey" "respect and dignity". Others indicated that the "the OPD is not overcrowded" like it used to be some eight years back. Also, patients can now "gain access to their records" due to improved communication systems. All these changes have made significant improvements in the hospitals attention to customer care;
4. As a result of increased appreciation for customer care, coupled with increasing demand for personalized service delivery by customers/patients, some hospitals are placing a premium on customer feedback; and
5. While finance remains a critical challenge for both hospitals, other challenges such as "poor staff attitude", "poor staff retention" and "re-training" and "emerging competition" in the provision of health services varied spatially and temporally.

Conclusions

Based on the results and discussion and the key findings, it was concluded that service providers were friendly and welcoming. They communicated adequately with respondents and talk politely with them. Service providers respect the difference in values, culture and belief of the clients.

It concluded thatthere was good customer care among the two hospitals under study. Materials associated with the services delivery are visually

appealing and clients or respondents felt physically safe and secured in the hospital.

It can also be concluded that respondents were satisfied with the overall experience and the health facilities and stated they will therefore, recommend the facility to potential clients but they were not willing to pay higher prices for the same services they received.

Finally, with Spatio-temporal variations, it is concluded that major changes in both hospitals include: introduction of "the enquiry desk", "a client satisfaction survey" and "respect and dignity" measures and the innovative ways improve customer care are ICT applications "good communication" with patients, transparency with patients and timely service delivery.

Recommendations

Based on the key findings obtained from the study and the conclusions drawn, the following recommendations are being made:

1. It is recommended that since the greater proportion of the respondents showed they had positive experiences at the various hospitals, management in the various hospitals should continue with the good practices such as being friendly, welcoming, communicate effectively with patients, explain procedures in a language that they understand and respecting the values, culture and beliefs of their clients.
2. Also, although there is high level of patients' satisfaction, the management in the various hospitals should adopt new and innovative measures to ensure there is an increase in the proportion of patients' satisfaction. It would be important for the university hospitals

management to have a means by which they could improve current flow of Internally Generated Fund (IGF). Such increases in IGF can ensure that management supervise the provision of expanded scope of service to the public Management should therefore champion the introduction of outstanding and prestige services that can guarantee that the hospitals would have some form of moral obligation to ask for more in terms of how much the public pays for the services offered by the hospitals.

3. Also, there is the need for the administration of the various hospitals studied to increase the number of workers in the various hospitals especially with key staff like doctors, to be able to serve the ever-increasing number of patients visiting these facilities.
4. In addition, there is the need to improve upon the communication as well as timely service which has become very important for customers. Therefore, even in cases where there is adequate staff, these staff need to be consistently trained to keep up with changing customer trends both in time and in space. Again, making reference to the importance of adequacy and appropriateness of communication, service providers need to at all times display their name, title and their role in the department.
5. There is also the need to mainstream health insurance, finance and sustainable healthcare delivery. This can be done by mainstreaming health insurance with university hospital financing in order to improve sustainable health delivery and by extension customer care. This can be done by automating health insurance processing, i.e. online

processing of insurance claims such that the delays in payment are removed. If the insurance process is properly automated taking into account recent advances is in payment systems in Ghana, patients can renew their insurance with mobile payment system and hospitals can access patient health insurance data in real-time.

6. It is recommended that that the hospital management should take a second look at the competencies of their staff. The study results indicated the groups of staff with most questionable levels of competence were the non-clinical staff. Indeed, the roles played by such non-clinical staff are equally important as the frontline service providers. There is the need for more avenues for such staff to improve on their levels of knowledge, skills and experience. For the clinical staff, it is recommended that further continuous training among them should be re-enforced by the hospital management. For example, after every number of years of practice, clinical staff should be made to take up advanced courses in their field of study. This may ensure that the service providers come to terms with changing trends in their area of professional practice so that they can serve current and potential clients better by using more advanced, and sophisticated technology in their service delivery.
7. Again, it is recommended that all university hospitals should have customer care divisions that are not directly under the Ministry of Health but the Ministry of Manpower and Social Welfare. This could ensure independence and accountability in the area of customer care in the various hospitals. Periodic research and development is needed by

all the university hospitals so as to come out with regular and timely evidence based report on the level of progress with the practice of customer care in the various university hospitals. Supervisory, evaluation and monitoring roles should be consciously intensified to ensure that service providers adhere to laid down instructions and principles on customer care.

8. There is the need for leadership and management at the hospital to be more proactive to meeting the needs of the health care providers i.e. staff in terms of their conditions of service, work environment and the enactment of humane policies. This will promote friendly work environment for staff to give out their best. The enforcement of customer care practices and procedures should be well aligned to workable structures to facilitate easy provision of service delivery.
9. Regular staff engagement on new ways of service provision in terms of capacity building and empowerment could enhance their competence and skills in customer care issues. This may also enable them to be abreast with patient's needs and expectations and make sure they are fully met. It is also recommended that staff should be encouraged to understand the various interests and complexities associated with their clients and stakeholders so they could manage these complexities in the process of health care delivery. Current and potential clients of the hospital should be educated on regular basis to understand the limitations of the facilities and the efforts made to improve upon them. This regular interaction will increase patient's confidence and enhance patient-staff relationship.

Limitations of the Study

Despite the fact that the response rate was high and issues of validity and reliability were addressed, there are some inherent limitations in this study. Firstly, the study was conducted in just two public university hospitals. Thus, the study was limited to only the Kwame Nkrumah University of Science and Technology and the University of Ghana hospitals out of the three (3) public university hospitals in Ghana. Accordingly, the researcher could only make contextual generalization of the findings since the data may not represent the reality of what happens in all the public university hospitals and clinics in general. In this regard, the findings of this study have to be interpreted with caution. With the limited number of facilities used in this study, there is the need for a nationwide study which will provide a more accurate depiction of the situation. However, despite the above inherent limitation of this study, results of the study have provided a meaningful insight into customer care in two important public university hospitals in Ghana and how it can inform future research and public policy on the delivery of sustainable health service which remains critical in the achievement of SDGs 3. The study was a cross-sectional study and therefore, can only establish association but not causality. Second, there is also the need to acknowledge the fact that some of the participants might give social desirable results. However, this was minimised by carefully explaining the objective of the study to the participants before it begun.

Areas for Further Studies

In terms of meeting customer expectations, the study recoded mixed responses. This suggests that even within the same hospital, the level of satisfaction of customers is seen to vary over time. Based on this observation, it was deduced that while it is vital to understand the geographic and temporal variations in customer satisfaction, it is also very crucial to pay attention to micro variations in customer satisfaction across departments and units within the same facility in order to identify problematic areas and address them. It is recommended that further studies be conducted on the inter/intra departmental variations in customer care delivery in order to evaluate the level of customer satisfaction at the departmental level.

The application of ICT in health care requires further investigation to establish clearly the safe, relevant and efficiency parameters of ICT in sustainable healthcare delivery since in both Universities, it was recorded that ICT has become a prominent means of aiding customer care

It was further noted that while customers are steadily pushing the frontiers of communication in customer care, hospitals are beginning to take interest in gaining feedback from customers. It will be useful to further investigate the potential for real-time communication platforms, particularly icon-based mobile applications and how these could be deployed in specific cases to enhance customer care**.** Further studies could also look at the use of Geo-spatial analysis to access impact distance to health facility and customer satisfaction.

Contributions to Knowledge

This study set off to evaluate the customer care initiative towards Sustainable Health Delivery in Public University Hospitals in Ghana. Existing studies within the context of Ghana indicated that very little empirical literature exists on customer care in healthcare (Dwamena, 2012). In addition, the spatio-temporal dynamics of customer care in healthcare has barely been investigated in the scientific literature in Ghana, even though it is evident elsewhere (Jensen, Lukic, & Gulis, 2018; Gayawan, 2014; Sahoo & Ghosh, 2016). This study therefore attempted to address the following key questions: a) what are the customer care experiences of patients in public university hospitals in Ghana, b) does customer necessarily translate into patients' satisfaction, c) are there spatio-temporal variations in the customer care practices among key staff in the two selected public universities in Ghana, and d) how can customer care be improved upon in the two selected hospitals? In this regard, the following are some key knowledge contributions from this study:

1. The evidence in this study indicates that customers are gradually tuning into the need for hospitals to go beyond just static procedures of delivering health care towards addressing other patient needs such as "good communication" with patients, "good staff attitude" towards patients, timely service delivery and even an appealing physical environment;
2. Observations from studies conducted by Atkinson, Macnaughton, Saunders, and Evans, (2010) highlight the impotance of technology in the geography of care. This study builds on that but also includes time

dimension; temporal changes in customer care between two hospitals. A key knowledge contribution is that across hospitals customer care has become an absolute imperative. However, while the current status of customer care varies significantly both spatially and temporally, it is also convergent in certain aspects, especially in the use of ICT as a means of improving customer experience. Patients are getting more inclined to ICT applications in healthcare and for that matter, hospital administrations are making incremental efforts to deploy more ICT applications to meet their client needs;

3. As a result of increased appreciation for customer care, coupled with increasing demand for personalized service delivery by customers/patients, some hospitals are placing a premium on customer feedback. This is seen in the introduction of customer satisfaction surveys. Through this study, it was noted that customer surveys need to be made an integral part of an effective customer service package. This implies, making customer survey a seamless continuous process rather than a periodic activity. This will ensure continuous improvement in customer care;
4. Key responses indicated that "finance" is regarded as the common denominator of sustainable health care delivery in both hospitals. This is critically linked to the national health insurance scheme and its associated administrative and financial challenges. Aside financial challenges, some of these challenges are particularly unique to University Hospitals include "poor staff attitude", "poor staff retention" and "retraining" and "emerging competition" in the

provision of health services. The presence of one of these factors normally has a significant impact on customer care. The presence of two or more of these challenges in the midst of increasing completion will have devastating impact on the ability of the hospital to deliver sustainable care;

5. In terms of meeting customer expectations, the researcher recorded mixed responses which can be summed up clearly in a response such as: "*The first time I came here, my expectation was met and probably exceeded but this time around, I have to go to work but I have spent the whole day here".* This suggests that even within the same hospital, the level of satisfaction of customers is seen to vary over time. Based on this observation, it can be deduced that while it is vital to understand the geographic and temporal variations in customer satisfaction, it is also very crucial to pay attention to micro variations in customer satisfaction across departments and units within the same facility in order to identify problematic areas and address them and
6. In the context of developing a concept and or a methodology, the study has made some innovations by bringing the conflicting views of customers, service providers and top management perspectives to avoid the issue of blame game in poor healthcare service delivery which can be brought about by paying sincere attention to customer care. Thus, the proposed framework (Figure 10) adopts the system worldview to argue that the three stakeholders are equally important but often tend to blame one another for service failures. Thus, the proposed framework seeks to call for the inter-dependence of the

various actors in the delivery of sustainable healthcare services in public healthcare institutions as recognised by the present study.

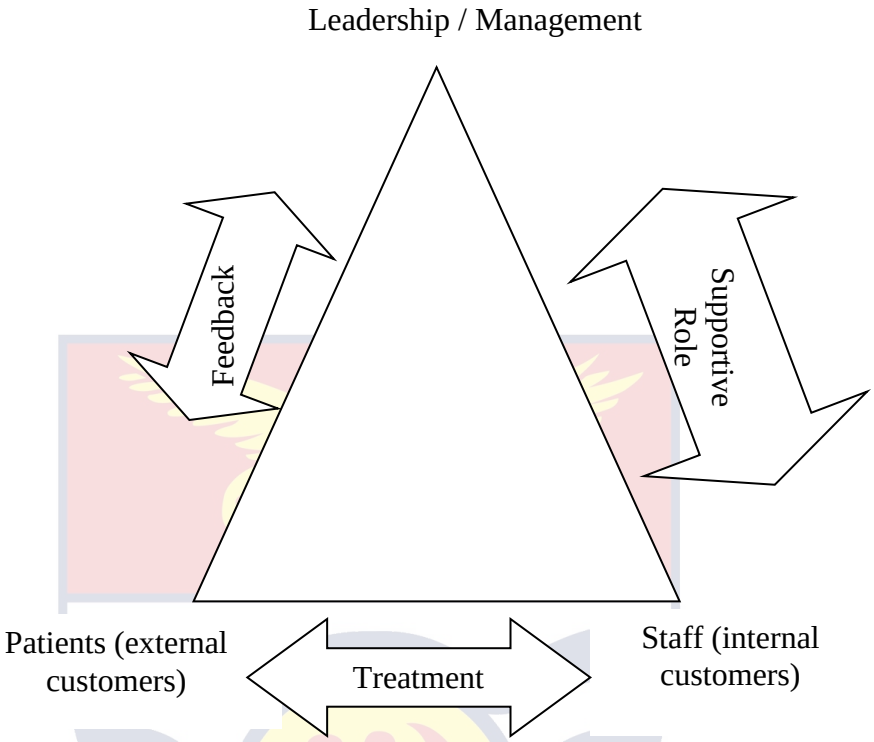

Figure 10: Proposed Frame work for Effective Partnership in Healthcare Delivery

Source: Author's Construct, 2019

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APPENDICES

APPENDIX A: QUESTIONNAIRE
UNIVERSITY OF CAPE COAST
COLLEGE OF HUMANITIES AND LEGAL STUDIES
DEPARTMENT OF GEOGRAPHY AND REGIONAL PLANNING

Dear respondent

I am conducting a search work on the topic "Spatio-temporal assessment *of customer care practices among public university hospitals in Ghana.*". I kindly request your assistance to help fill this questionnaire honestly and frankly. I assure you that the information provided will be treated and heldin confidence and solely used for academic purposes. Thank you for your time.

100	**BACKGROUND CHARACTERISTICS**					
101	Sex	a. Male [ ] b. Female [ ]				
102	Age (completed years – last birthday)	…….				
103	Marital status	a. Never married[ ] b. Married [ ] c. Separated [ ] d. Divorced [ ] e. Cohabitation [ ]				
104	Religion	a. Christian [ ] b. Muslim [ ] c. Traditional [ ] d. Buddhist [ ] e. Other [ ]				
105	Ethnicity	a. Akan [ ] b. Guan [ ] c. Ga/Adamgbe [ ] d. Ewe [ ] e. Mole Dagbani [ ] f. Others (specify) ……..…….				
106	Level of education	a. Noformal education [ ] b. Primary [ ] c. JSS/JHS/middle [ ] d. Secondary [ ] e. Higher [ ]				
107	Occupation	…….				
108	Hospital	University of Ghana Hospital [ ] Kwame Nkrumah University of Science and Technology Hosp.[ ]				
200	Importance of customer care to patients***1 (least) - 5 (highest)***	**1**	**2**	**3**	**4**	**5**
	STATEMENT In evaluating the ***Customer Care*** in this hospital, it is ***important*** to me that….					

201	The hospital always delivers the service right the first time					
202	Materials associated with the service delivery are visually appealing					
203	There are enough sign-posts in the hospital to give me directions					
204	There is an uninterrupted supply of running water					
205	Employees recognize me by name each time I visit the hospital					
206	There is reliable transportation to and from the hospital					
207	The hospital address complain I make quickly					
208	The variety of food and beverages available meets health needs					
209	The price I pay is right given the quality of food and beverages					
210	I feel physically safe in the hospital					
211	Employees are respectful, polite and courteous					
212	Hospital's outdoor surroundings are well maintained and attractive					
213	I am kept informed about when services will be performed					
214	In resolving a complaint I make, the hospital treats me with respect					
215	The hospital is well lit					
216	I am given security and safety tips in the hospital					
217	Furniture in the hospital is visually appealing					
218	Information about the hospital is readily available					
219	The hospital has accurate records of me as a patient					
220	My dealings with the hospital remain confidential					
221	I can easily reach the hospital by telephone					
222	The food and beverages they serve taste well					
223	The employees appear clean and neat					
224	The hospital's equipment appears modern					
	In evaluating the ***Customer Care*** in this hospital, it is ***important*** to me that…. ***1 (least) - 5 (highest)***	**1**	**2**	**3**	**4**	**5**
225	Employees anticipate my needs					
226	Employees fully explain the services the hospital provides to me					
227	I can easily reach the hospital by mail					
228	Employees respond promptly to my demands					
229	Employees understand my specific requirement					
230	Employees give me personalized attention					
231	Employees are always willing to attend to my needs					
232	Staff have knowledge, experience and skill to					

	handle my needs					
233	There is anuninterrupted power supply					
234	Employees appear honest, credible and trustworthy					
235	Employees are approachable and friendly					
236	My bills are accurately presented					
237	The hospital has a functioning website					
238	The hospital's website is interactive					
239	I feel my belongings are safe in the hospital					
240	If a problem occurs, I am assured it will not happen again					
241	The first person I complain to handles my problem					
242	The hospital has a range of services that meet my needs					
243	The behaviour of employees instil confidence in me					
245	Health providers gave me adequate information about my condition					
246	Health providers treated me with respect and dignity					
247	Health providers displayed competence and had knowledge in what they were doing					
248	Availability of medicines and medical commodities					
249	Timely service delivery					

300	Section 3: This section deals with what your intentions are likely to be, given your experiences in this hospital. If I receive ***high-quality service*** in this Hospital, I will…	**Yes**	**No**
301	Come again when I have the opportunity		
302	Recommend this hospital to other potential patients		
303	Accept to pay higher prices for services of this hospital		
304	Be prepared to use other services/facilities of this hospital that I have not used in the past		
305	Be satisfied with my overall experience in this hospital		

Section 4: Overall quality assessment and Customer Care
Answer YES or NO to the following questions by ticking the appropriate box

400	**Question**	**Yes**	**No**
401	This hospital is accessible (Geographically and Financially)		
402	Service providers communicate adequately with me when I visit this facility		
403	Service providers in this facility are competent		
404	Service providers in this facility show me the courtesy		
405	This facility is a credible one		
406	This facility is reliable (I can access services here at all times)		
407	The system in the facility is responsive to patients (prompt attention)		

408 I feel secure in this facility
409 I can receive all basic healthcare and services here
410 I feel the service providers (Nurses and Doctors) understand my needs

Thank you very much for your help in completing this questionnaire.

APPENDIX B: INTERVIEW GUIDE
UNIVERSITY OF CAPE COAST
COLLEGE OF HUMANITIES AND LEGAL STUDIES
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF GEOGRAPHY AND REGIONAL PLANNING
In-Depth Interview Guide for Service Providers

A. Background Information

1. Sex
2. Age.....
3. Current Position.....
4. How many years altogether have you been working as [ ]

B. Customer Care Experience

5. Can you tell me about the current customer care practices you undertake in this hospital? *Probe for customer care practices that are related to IT*
6. Given that you have been in this facility for quite a long time. What can you say have changed in terms of customer care over the years? *Ask in relation to*
   - Providing information to client about their condition
   - Respect and dignity
   - Timely service delivery
   - Safe treatment experience
   - Excellent physical environment
   - Displaying professionalism in service delivery
   - Availability of medicines, medical commodities (logistics)
7. What can this facility do in terms of customer care as a way of ensuring sustainable healthcare delivery in this facility? *Probe for customer priority*.
   - Probe but don't list! E.g. Having service representatives to respond to patients calls, Supervision of Service

representatives, - Online customer service centre, responding to patients' complaints.

8. Do you think the existing customer care practices in this facility can ensure sustainable healthcare delivery? Probe for *how* and *why*!
9. How important is customer care to the overall healthcare delivery system?
   - Do you think your facility is doing enough in terms of customer care? Probe for reasons *why*.
10. Do you think there is the need for customer care reforms in this hospital?
    - Probe for reasons and possible reforms.

UNIVERSITY OF CAPE COAST
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In-Depth Interview Guide forPatients

A. BACKGROUND INFORMATION

1. Sex
2. Age.....
3. Highest Level of Education attained.....
4. Religion.....
5. Occupation.....
6. Marital status
7. How long have you been accessing care in this facility .....?

B. Customer care experiences at the facility

8. Can you please tell me about your general impression regarding customer care in this facility? Probe for experience
9. How important is customer care to you when you visit this hospital?
   - Probe for why.
10. Do you think the current customer care practices at the facility make you feel comfortable to continue accessing care in this facility?
    - Probe for service quality
11. In your opinion, can you say you receive the best possible care from the service providers anytime you visit this facility? Probe for communication, competence, credibility, reliability, and responsiveness.
12. Do you think your expectations (before coming to the hospital) have been met when you visit this hospital? Probe for *why*.

13. In your opinion, how can this hospital improve customer care?
    - Probe for the use of ICT in healthcare delivery.
14. Do you have anything else to say concerning the quality of care you receive in the hospital in general, and customer care in particular?

Thanks so much for your time

APPENDIX C: CONSENT FORM
UNIVERSITY OF CAPE COAST
COLLEGE OF HUMANITIES AND LEGAL STUDIES
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF GEOGRAPHY AND REGIONAL PLANNING

CONSENT FORM/INFORMATION SHEET FOR SERVICE PROVIDERS

I am Moses Maclean Abnory, a PhD student at the Department of Geography and Regional Planning, University of Cape Coast. As part of my academic work, I am conducting a study on **"Spatio-temporal assessment of customer care practices among public university hospitals in Ghana"**. In line with the study, I will like to interview you for some information regarding customer care practices in this hospital. Your participation in this interview is paramount to the success of the study. The information you will provide in this interview will be tape-recorded and later transcribed to be used for the analysis, but you are assured of confidentiality and anonymity as your name will not be included. The results of the study will be shared with participating health institutions. There is, however, no direct financial benefit for your participation in this study. You reserve the right not to respond to any question that you consider confidential and you are at freedom to back out of the interview at any point without reproach. The interview process will take approximately 25 minutes. I, therefore, crave for your indulgence and co-operation in this interview by signing below if you have read this information or it has been read to you and you have agreed to participate in this interview.

Thank you in advance.

....

Respondent Facilitator

Date: .....

For any further clarifications, you can please contact the following people

Prof. Akwasi Kumi-Kyereme
Department of Population and Health, UCC

Mobile: 0244255234
E-mail:akkyereme@ucc.edu.gh

Prof. Kwabena Barima Antwi
Department of Geography and Regional, UCC

Mobile: 0246143986
E-mail:
kantwi@ucc.edu.gh

APPENDIX D: ETHICAL APPROVAL LETTER

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309/ 0244207814
E-MAIL: irb@ucc.edu.gh
C/O Directorate of Research, Innovation and Consultancy

OUR REF: UCC/IRB/A/2016/281
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

9TH NOVEMBER, 2018

Moses M. Abnory
Department of Geography & Reg. Planning
University of Cape Coast

Dear Abnory,

ETHICAL CLEARANCE –ID: (UCCIRB/CHLS/2018/09)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled ***Assessment of Customer Care practices among public university hospitals in Ghana.*** This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research.

The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST