UNIVERSITY OF CAPE COAST

QUALITY OF HEALTHCARE DELIVERY AND UTILISATION OF HOSPITAL SERVICES AT THE UNIVERSITY OF CAPE COAST HOSPITAL

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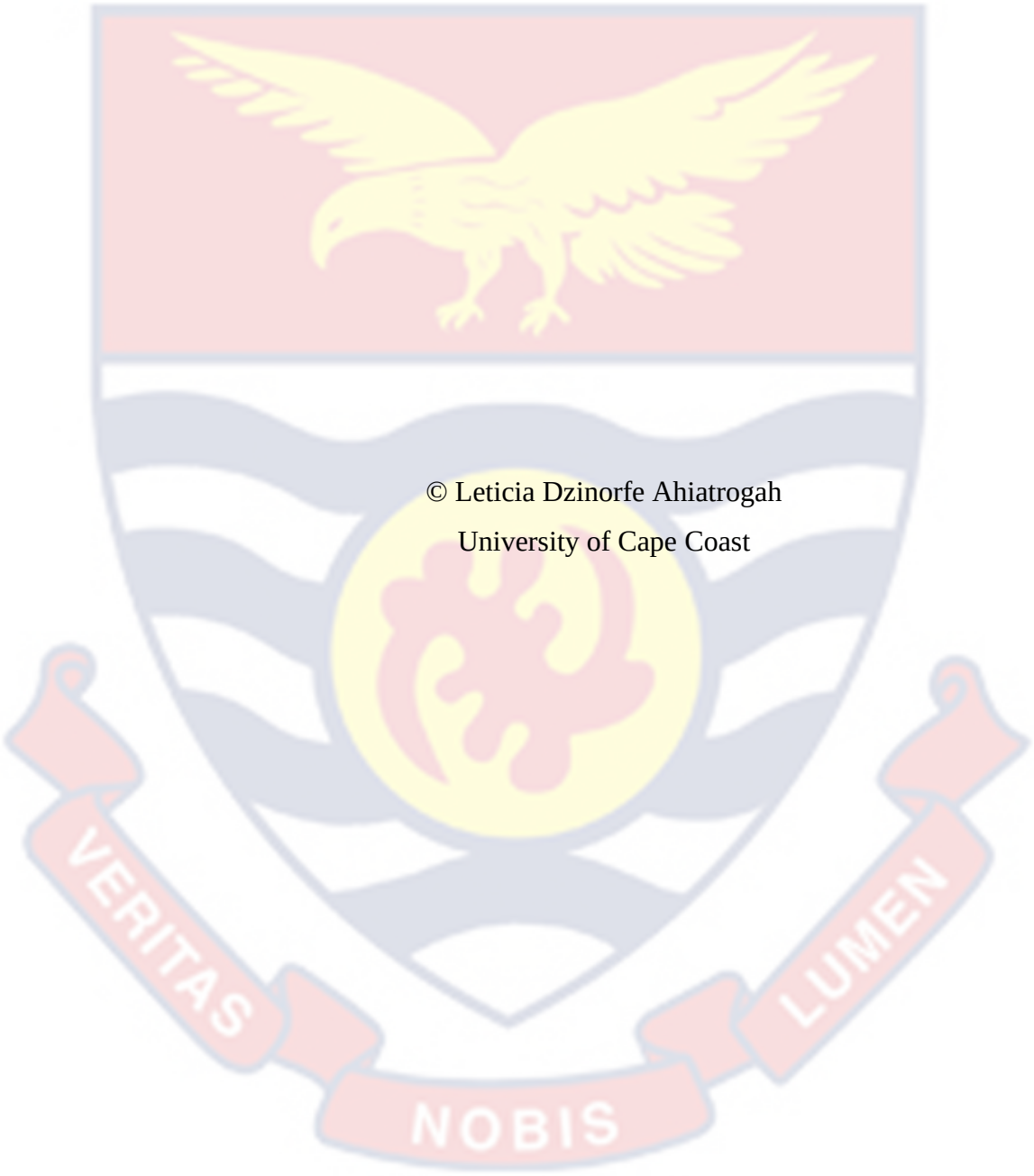

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BY

LETICIA DZINORFE AHIATROGAH

Thesis submitted to the Department of Integrated Development Studies, School for Development Studies, University of Cape Coast, in partial fulfillment of the requirements for the award of Master of Philosophy degree in Development Studies.

JANUARY 2023

DECLARATION

Candidate's Declaration

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

Candidate's Signature: …… Date: …….

Name:…….

Supervisor's Declaration

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

Supervisor's Signature: …… Date: …….

Name: …….

ABSTRACT

This study assesses the quality of healthcare delivery and utilisation of hospital services at the University of Cape Coast Hospital. Using the realist research paradigm, this study adopted the mixed research approach and used a descriptive research design. A sample of 370 respondents was computed from a population of 5046 with the help of Yamane's sample size calculator. The research applied stratified sampling and a simple random sampling approach, using a structured questionnaire and an interview guide to collect the data. The data was analysed using crosstabulation and logistic regression. The findings revealed that the junior and senior staff have insufficient knowledge of their rights to quality healthcare. Also, the results showed a consensus among the junior staff and senior members that the service quality rendered by the hospital is satisfactory. Finally, the study revealed that the respondents' service quality perceptions and background characteristics are significant determinants of hospital utilisation. It was recommended that the hospital management put measures in place to ensure quality healthcare services. It further recommends that the hospital roll out client education programmes such as rights to quality healthcare awareness campaigns to improve clients' knowledge of their rights to quality healthcare services. This can take the form of enhancing the visibility of the Patients Charter and the Ghana Health Services Code of Conduct at the hospital.

KEY WORDS

Healthcare Delivery

Quality of Service

Right to Quality Healthcare

University of Cape Coast

University of Cape Coast Hospital

Utilisation of Hospital Sevices

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However, I am entirely responsible for any errors and omissions that may be found in this thesis. Finally, I wish to thank all my colleagues and friends for their unending friendship and support, and all those who helped me in diverse ways to make the writing of this thesis a reality.

DEDICATION

To my Dad, Prof. Paul Dela Ahiatrogah

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LIST OF ACRONYMS

DUHS	Directorate of University Health Services
EHS	Environmental Health Section
GHS	Ghana Health Service
GoG	Government of Ghana
HeFRA	Health Facility Regulatory Agency
MoH	Ministry of Health
NHIS	National Health Iinsurance Scheme
OPD	Outpatients Departments
PHC	Primary Health Care
SPSS	Statistical Package for Social Sciences
UCC	University of Cape Coast
UDHR	Universal Declaration of Human Rights
UHS	University Health Services
UHSC	University Health Services Committee
VIF	Variance Inflationary Factor

CHAPTER ONE

INTRODUCTION

Healthy life is at the core of development, because healthy human resources are needed to combine the factors of production in the most effective manner (Aduo-Adjei & Owusu, 2015). Yet, healthy life cannot be achived without the provision of quality healthcare services. Service quality is central to customers' decision to utilise healthcare services at a particular hospital. In many healthcare facilities, service quality is generally viewed as the output of the service delivery system and is further linked to the customer's perception. Costumers form opinions about healthcare service quality from a host of contributing factors (Asri, Ali, Habbe & Rura, 2017). Thus, many development experts consider healthcare quality as critical factor in the development drive of nations (Bisimwa, Nuwagaba & Musigire, 2019).

In the health sector, service quality emphasises technical (clinical) quality and functional (non-clinical) quality. The former focuses on the skills, accuracy of procedures, and medical diagnosis, while the latter refers to how health services are provided to the patients (Alhassan et al., 2015). Healthcare system's quality in a country has implications for morbidity and mortality and the population's quality of life (Ofosu-Kwarteng, 2012). As a result, many African countries have introduced interventions to transform their health systems (Clancy & Collins, 2010; Gaur, Xu, Quazi & Nandi, 2011). Yet, healthcare quality and its effect on utilisation remain a debate in the literature to date. To this end, this study investigates the healthcare service quality of the University of Cape Coast Hospital and its effect on the utilisation of the hospital by the Staff of the University of Cape Coast (UCC).

Background of the Study

Service quality is central to customers' decision to utilise a particular product or service (Bisimwa et al., 2019). In many organisations, service quality is generally viewed as the output of the service delivery system, and it is further linked to the customer's perception (Alhassan et al., 2015; Ofosu-Kwarteng, 2012). According to Bannerman, Offei, Acquah, and Tweneboa (2002), poor quality of healthcare results in the loss of customers` lives, revenue, material resources, time, morale, recognition, trust, respect, individual and communities apathy towards health services, all of which contribute to lower effectiveness and efficiency. The patient's perception of the quality of care is critical to understanding the relationship between quality of care and health services utilisation, which is now considered an outcome of healthcare delivery.

Across the African continent, the healthcare sectors are widely believed to provide low-quality care for patients, resulting in poor health outcomes and a drastic reduction in people's confidence in the health sector (Daniels et al., 2017). But recently, countries like Ghana have made significant progress in affordability and accessibility to healthcare since introducing the National Health Insurance Scheme (Aikins, Ahmed & Adzimah, 2014; Frimpong, 2016). Since then, scholars have underscored the need for healthcare providers to develop quality orientation in their healthcare delivery since the issue of quality in the health sector is relatively more important than in other sectors, given its attendant risks and the severe consequences for wellbeing and longevity (Rashid & Jusoff, 2009; Padma, Rajendran & Sai Lokachari, 2010; Tabibi, Gohari, Shahri, Aghababa, 2012; Tenkorang, 2016; Anabila, Kumi, & Anome, 2019).

The quality of service in public hospitals in Ghana varies, not meeting patients' expectations (Atinga, Abekah-Nkrumah & Domfeh, 2011; Turkson, 2009; Abuosi, 2015; Tenkorang, 2016). Because of rising concerns about healthcare quality, the public healthcare sector has recently come under intense scrutiny. The media highlighted missing babies, high maternal and child mortality, lack of modern facilities, wasted time, overbearing attitudes and negligence of health personnel (Ofosu-Kwarteng, 2012).

The University of Cape Coast Hospital is a public health facility that takes care of students and university workers to promote academic work. Suppose Ofosu-Kwarteng's finding applies to the University Hospital, then staff, students, and university community members must wait at the hospital for an average of one and a half hours before accessing their needed healthcare services. This could have profound productivity implications for the University of Cape Coast, forcing the university community members to look elsewhere for healthcare services.

Supportively, the attribution theory holds that when clients form perceptions about the services or products, it will go a long way to affect their choice of using them. Hence, healthcare service quality calls have taken on an added steam, thus setting the agenda for mainstreaming healthcare service quality management as a paradigm for enduring service excellence in Ghana's public hospitals (Ofosu-Kwarteng, 2012; Tenkorang, 2016).

During the 2014 State of the Nation Address of Ghana, President John Mahama noted that patients` satisfaction and quality healthcare delivery should focus on healthcare delivery (State of the Nation Address, 2014). This concept of satisfaction or quality is used in measuring the fulfilment of a service provider

on the one hand and service recipients on the other hand. Thus, ensuring patients` satisfaction encourages their continuous utilisation of public healthcare facilities, making it imperative for health facilities to provide services that offer the clients maximum value and satisfaction.

In the clients` quest for service delivery, they choose quality as the single most important criterion in selecting a service provider, except in the extreme cases of the very poor, who may most often than not be cost-conscious. But people's choice of the healthcare provider will not be solely cost, no matter how poor the person is, due to humans' risk nature. This is in line with the prospect theory, positing that people think about expected utility relative to a reference point rather than the absolute outcome. It holds that people are risk-averse and will act as such. Therefore, when it comes to healthcare services, the clients will choose quality over cost due to humans' risk-averse nature. Though difficult to measure, client satisfaction remains one major performance determinant, and as such, many health facilities consider it a crucial element in designing their business objectives (Munusamy, Chelliah & Mun, 2010).

More so, McColl-Kennedy, Vargo, Dagger, Sweeney, and Kasteren (2012) averred that the health service industry had witnessed significant shifts in emphasis from doctor-driven to patient-oriented approaches, with increasing emphasising patients as co-creators of value (Osei-Frimpong, 2017). The patient–customer approach is increasing in influence and dominance and has a significant stake in healthcare decisions today than ever before. This is because the patients and their various employers or organisations have paid so much attention to their staff's health needs due to their impact on productivity and the economy's general well-being.

Woefully, the incidence of injuries and abuses that occur because of inappropriate health workers' decisions and attitudes at the health centres are mostly less known, if not wholly unknown, to the authorities and the general public. In that regard, Ofosu-Kwarteng (2012) opined that the public knows so little about abuses and inefficiencies at health centres because there is no systematic mechanism for gathering information about such injuries and abuses. While many recent quality healthcare improvement efforts of the government of Ghana, such as the provision of health infrastructure, and equipment, the introduction of the NHIS and its subsequent reviews, and the adjustments of the salaries of health workers, among others, are commendable and show great promises, they seem to have overshadowed the need for constant monitoring to examine the quality of services provided by these facilities and its effect on utilisation by the patients.

Furthermore, the healthcare system of every economy and institution within the economy has implications for the economy and its institutions. Johnson (2019) noted that healthcare institutions' quality directly affects the people's quality of life within such institutions. Indeed, an organisation's success or failure depends primarily on the employees' quality of life (Sterman, 2000). Krekel, Ward and De Neve (2019) also observed that employees' well-being significantly influences their performance and organisational outcome.

Also, it is worth mentioning that the quality of the available healthcare system determines the quality of life of a given organisation's employees at any point (Özer, Başgöze & Karahan, 2016). Özer et al. explained that when the healthcare system is weak and ineffective, the employees will grow sick and eventually become unproductive, and vice versa, ceteris paribus.

Many variables can affect the consumer in selecting a healthcare provider. These variables may be the quality, personnel, physical characteristics, customers (their background characteristics), experience, location of the medical establishment, and recognition (Agyapong, Afi & Kwateng, 2018). Specifically, with respect to quality of the healthcare service, the background characteristics of the clients and their knowledge of their rights to quality healthcare (Ofosu-Kwarteng, 2012) represent major determinants of quality perceptions and utilisation decisions. This is in line with the attribution theory position, which states that schema influences how people interpret new information based on their pre-existing beliefs.

According to Tsai and Kang (2019), there is a positive relationship between service quality and behavioural intentions, which may be regarded as indicators of either retention or dejection from the utilisation of a service. This position of the literature reiterates the position of the theory of reciprocity. The reciprocity theory explains how committed, and loyal customers will be when their desired quality or perceived quality standards are met. Mohsan, Nawaz, Khan, Shaukat and Aslam (2011), in a varied opinions, posited that service quality is not an accurate predictor of behavioural intention (loyalty) and that while there could be satisfaction without it leading to loyalty, it is practically impossible to have loyalty without satisfaction. A possible explanation for this could be that repurchase intentions may be influenced by factors other than quality since the customer may not necessarily chase every quality due to their status and purchasing power (Agyapong et al., 2018).

While the work of Cristobal, Flavian and Guinaliu (2007) and Mohsan et al. (2011) strongly suggest a sequential causal relationship between service

quality and behavioural intention (utilisation), which follows common logic, the complexity of human behaviour and actions, coupled with contradictory evidence in literature such as Baker and Crompton (2000) suggest the need for a careful examination of the relationship among the constructs. For instance, Kassim and Abdullah (2010) concluded that there is a clear, strong relationship between service quality and repeated purchase or utilisation. This study assesses the quality of healthcare delivery at the University of Cape Coast Hospital and its effect on the utilisation of the hospital by the Staff of the University of Cape Coast (UCC), one of the basic categories of customers or persons the hospital was established to cater for to promote the healthy academic environment.

Statement of the Problem

Regardless of all the efforts by the Government of Ghana (GoG), Ministry of Health (MOH), Ghana Health Services (GHS) and all other stakeholders to improve the status and quality of healthcare delivery in Ghana, many citizens complain about the quality of care given to them at these public hospitals (Ofosu-Kwarteng, 2012). The underdeveloped healthcare facilities in many countries have compelled many public sector organisations to take up the challenge of providing improved healthcare to their employees. Paying attention to employees' health needs increases staff retention rates. The underlying argument is that employees offered healthcare through their employers are more productive and more able to focus on their work (Morrissey, 2018).

Many higher education institutions provide faculty members, staff members and students with health care. Unfortunately, many of these institutions face the distinct challenge of educating students and responding to the healthcare needs of their employees, students and members of the

surrounding communities. Spiralling healthcare cost among the employees and students alongside diminishing state support for higher education affects the finances of these institutions rendering them unable to respond efficiently to the health care needs of their members. These challenges have implications for the quality of healthcare delivered by these institutions.

The University of Cape Coast hospital provides services to the university and the surrounding communities. The hospital is licensed as a Primary Health Care (PHC) Facility by Ghana's Health Facility Regulatory Agency (HeFRA). The hospital has, over the years, performed creditably in the Central Region peer review programme. This notwithstanding, clients who access the hospital perceive the quality-of-service evidence suggesting that university employees have consistently perceived the UCC health facility's services as poor (Joy FM Report, 2019-03-29).

Furthermore, it appears the competitive spirit that drives service quality in the private healthcare sector is lacking in Ghana's public hospitals (Yesilada & Direktor, 2010). For instance, it has been suggested that waiting time in Ghana's public hospitals is about one to two hours longer than in private hospitals (Basu, Andrews, Kishore, Panjabi & Stuckler, 2012). Though service quality generally has been extensively researched in diverse fields (Freeman, 2014), the service quality and utilisation nexus has received limited attention in development literature, especially in healthcare in higher educational institutions.

It is assumed that these incidents of poor healthcare service make the staff and other hospital clients very sceptical, giving them reasons to look elsewhere for healthcare services. Others have also argued that the decision to

access healthcare at the facility varies across the different clients because staff's background characteristics and knowledge of their health rights shape their choice of healthcare services providers. These claims, however, have not been tested empirically. This study, therefore, contributes to the debate surrounding the perception of healthcare delivery, quality and access to the UCC hospital. This study assesses the quality of healthcare delivery by the UCC Hospital to the Staff of UCC and its effect on the utilisation of the hospital by the staff.

Purpose of the Study

The general objective of the study was to assess the quality of healthcare delivery by the University of Cape Coast Hospital to the University of Cape Coast staff.

Specific Objectives of the Study

The specific objectives of the study were to:

1. assess the patients` (staff's) knowledge of their rights to quality healthcare services;
2. assess the quality of healthcare services provided to the staff;
3. analyse the effects of the quality of healthcare services on the utilisation of the hospital by the staff
4. examine the effects of background characteristics of the University staff on the utilisation of the hospital.

Research Hypotheses

Based on the study's specific objectives, the following alternate hypotheses were formulated to guide the study.

1. Staff category associates significantly with the staff's knowledge on their rights to quality healthcare services
2. There is a significant association between staff category and the quality of the health services received from the hospital
3. Quality of healthcare delivery significantly affects staff's utilisation of the hospital
4. Background characteristics of staffs significantly contribute to their utilisation of the hospital

Significance of the Study

The results of this study will be of practical use to the hospital management, the staff of the university, the university management, policymakers across the country, the Ghana Health Service, other stakeholders, and the general consumer public of hospital services as they reflect the situation on the ground regarding the status of healthcare delivery to clients at the University of Cape Coast. Understanding or knowing the quality of healthcare services given to the staff of the UCC by the University Hospital that was mandated to do so has both practical and theoretical significance. Of national essence is that this study's findings develop lessons to serve as guiding principles for improving the healthcare delivery systems across the nation. This promotes national development since quality healthcare delivery across the country means people's quality of life.

Practically, the insightful findings and recommendations of this study serve as guiding or underlining principles for the University Hospital Management to improve the healthcare delivery systems, specifically the quality of services given to the staff of the University of Cape Coast, who, by

statute, remain one of the basic customers the hospital was mandated to serve, making them enhance their services for patients' satisfaction and confidence in their services and the dignity of the highly respected institution and staff.

It will also help the hospital administration and management know what patients value or the expected satisfaction or quality of services the clients anticipate in their healthcare service delivery, which will assist them in quality assessment planning. Also, it will create awareness among the hospital staff on the need to see patients as recipients of healthcare services and as people who have rights that must be protected and respected. To the university staff, other hospital clients, and the general public, it will create awareness of their rights to quality healthcare services and have their voices heard or their views in the hospital's planning and management.

Delimitation

A single study cannot cover an entire spectrum of a phenomenon, such as the quality of healthcare delivery and its effect on utilisation. The study is delimited to the healthcare services quality of the University Hospital and how it affects the utilisation of the hospital. Within the specified domain or scope, the study conducts an in-depth and objective analysis of the problem void of prejudices and biases. The study should have ideally looked at the general impact or effect of the quality of healthcare delivery offered by the university hospital on the hospital's utilisation by the clients, consisting of students, staff, and dependents. However, the study focuses on the staff due to the time available for the study. The study also used only the university hospital due to its proximity, homogeneity of customers, and concentration per its mandates.

Limitations

Though the results of the study are valuable, there are some limitations. They include: the items in the questionnaire were closed-ended items that demanded closed optional responses. This close response limited respondents' choice of response. In other words, the questionnaire was more about the issues the researcher taught relevant to arrive at the study's objectives with insights from the literature and did not give room for the respondents to express their feelings and views.

Furthermore, the study was constrained by time factors considering the period for writing and submitting the research report. Besides, the researcher was also faced with limited access to literature information on the study area due to the unavailability of a well-resourced database management system and documentation of cases on service quality offered by the university hospital to its clients. This was also because many incidences have not been reported and published for national attention.

Another limitation encountered was that some respondents may have difficulty reading and understanding the questions posed in the questionnaire. In addressing or reducing this limitation's effect, the study used simple language in writing the questionnaire. Also, the researcher explained the instrument to the respondents, who encountered challenges in understanding it. Despite these possible limitations, the study's findings are unaffected and could be reasonably generalised to Ghana and other countries with similar characteristics.

Definition of Terms

In this study, staff refers to the University of Cape Coast employees. It comprises both teaching and non-teaching staff.

Background Characteristics, as used in this study, refer to an individual's traits and demographics as contained in Section A of the questionnaire for this study.

This study defines healthcare delivery as the functional and non-technical aspects, emphasising the human interaction between the healthcare service provider and the clients.

Healthcare Delivery is the provisioning of healthcare services to clients. In essence, this study defined healthcare delivery as all facets of the healthcare system that prevent, treat and restore clients to their original state or provide medical needs.

Knowledge of patients` rights in this study refer to awareness on standards that allow all patients to access quality healthcare services with dignity, freedom, equality, justice, and peace.

As used in this study, utilisation refers to the staff's intention to continue to patrinise healthcare at the university hospital.

Organisation of the Study

The study is organised into five chapters. The first chapter deals with the introduction, which comprises the background to the study, a statement of the problem, the study's objectives, research questions, the significance of the study, delimitation, limitations, and the organisation of the study. The second chapter focuses on the literature review, including the theoretical, conceptual, and empirical reviews, while chapter three covers the research methods employed for the study. It discusses the research paradigm, design, approach, sample and sampling procedure, instrument, and instrument reliability.

The last section of the chapter deals with systematic methods adopted to gather and analyse the data (data processing tools and analytical techniques). The fourth chapter presents the findings and discussion of the results. Finally, chapter five summarises the findings, conclusions, recommendations, and suggestions for further studies on the phenomenon.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter contains the literature review. The fundamental purpose of reviewing the literature is to understand the present study's subject area and pinpoint research gaps to be addressed in the current study (Lose, Nxopo, Maziriri & Madinga, 2016). The study extracted information from several electronic and print sources thought to be closely related to the topic and concepts under study, using the keywords in the topic in archieval databasese such as google scholar. In reviewing the literature in the field of the study, the study derived topics in this chapter from the study's objectives. This chapter examined the servqual model, attribution, reciprocity, and prospect theories. It also focussed on the context of healthcare delivery, the code of conduct of health professionals by the Ghana Health Service, and quality healthcare service since the study is anchored on the formation of values, attitudes, perceptions, and behaviour of consumers.

Theoretical Review

A theoretical review examines the theories that a researcher chooses to guide a particular research or study. This section explains the study's theories and models the issues or assumptions guiding the study. Specifically, the attribution theory, reciprocity, and prospect theory, since the study is about consumer satisfaction and service utilisation. A theoretical review explains the theories behind the study's modelling.

Servqual model

After studying four service settings such as retail banking, credit card services, repair and maintenance of electrical appliances, and long-distance telephone services, Parasuraman, Zeithaml and Berry (1985) created a model of service quality, SERVQUAL model. The SERVQUAL model defines service quality as the difference between a customer's expectations for a service offering and their views of the service they received (Parasuraman et al., 1985). The SERVQUAL model measures the consumer's impression of the service quality, which is dependent on the size of the gap between expected and perceived service, which is dependent on the gaps that are under the control of the service provider, such as service delivery, marketing, and so on (Parasuraman et al., 1985). Consumer evaluations of the service delivery process and the service's results are used to determine how well the service is provided (Parasuraman et al., 1985). According to Parasuraman et al. (1985), good service quality satisfies or surpasses the customer's expectations.

Initially, the SERVQUAL model consisted of 10 elements of service quality: tangibles, reliability, responsiveness, communication, credibility, security, competence, courtesy, customer understanding, and access (Parasuraman et al., 1985). Eventually, the number of elements was whittled down to five (Tangibles, Reliability, Responsiveness, Assurance, and empathy) as some criteria overlapped (Parasuraman et al., 1988). Notably, Chingang Nde and Lukong (2010), Ladhari (2009), (Shahin (2005), and Buttle (1996) have all utilized the SERVQUAL paradigm for assessing service quality in different research. However, Cronin and Taylor (1992), Tse and Wilton (1988), and Magi and Julander (1996) believed that quality is best measured by customer

satisfaction as opposed to mere perception, elaborating that customer satisfaction is a function of the customer's expectations and perceptions of performance, which led to the creation of the expectancy - disconfirmation paradigm. Aside from that, this study also considers quality as a predictor of utilisation which the SERVQUAL model cannot explain. This led to the adoption of the attribution, reciprocity and prospect theories.

Attribution theory

In order to understand inter-functional relationships, it is necessary to understand what the parties involved, in this case, healthcare service providers and clients, believe to be the cause or foundation of their relationship. Attribution theory is uniquely suited to this situation. Fiske and Taylor (1984) opined that in attribution theory, parties involved in a relationship would naturally wonder, “Why is this happening?” hoping that if they understand its cause, they might be able to predict its future course. Early theorising suggests that people’s attributions about their own and others’ behaviour are informed by information about the stimulus, beliefs based on prior experiences, and motivation to make attributions (Heider, 1958; Jones & Davis, 1965; Kelley & Michela, 1980).

Hewett, Shantz, and Mundy (2019) averred that the most straightforward application of this tripartite framework (attribution theory) is the main effects model in which information, beliefs, and motivation independently predict attributions. However, this perspective over-simplifies and hides nuance in the attribution process. Although people actively engage in cognitive sense-making activities, these often occur quickly (Hewett et al., 2019). So, individuals are unlikely to make cognitive distinctions between, for

example, information about the stimulus and general beliefs about the organisation; instead, these two factors may work in concert (Kelley, 1973; Weiner, 1985). Therefore, this perspective ignores the possible ways in which situational information, personally held beliefs, and motivation interact to inform attributions.

According to the attribution theorists, Kelley (1973) and Weiner (1985), schema influences how people interpret new information based on their pre-existing beliefs. According to Geva and Mintz (1997), schemata is a working hypothesis about some aspect of the environment and maybe a concept of the self (self-schema), other individuals (person schema), groups (role schema), or sequences of the events in the environment (scripts). Once a schema is formed, people would tend to resist the change. Another important element of this theory is heuristics. People use these rules to test their schemata and process information. Because of the use of heuristics, cognitive biases occur, resulting in attribution errors.

With the attributive theory, this study assumes that a positive perception of the university hospital's healthcare services will lead to a corresponding increase in access and utilisation by the staff. On the other hand, if there is a negative perception, the staff will seek healthcare needs elsewhere, affecting their productivity concerning time, money, and general motivation to give off their best to help meet their departmental goals and the university as a whole. This theory was adopted to explain how attribution would affect the patronage or utilisation of the university hospital. However, the attributive theory could not help explain the perceptions that staff may have on the qulity of healthcare services. Thus, the theory of reciprocity was adopted to overcome such gap.

Reciprocity theory

The theory of reciprocity emanates from the ground-breaking works of Malinowski (1922), Simmel (1950), Levi-Strauss (1957), Homans (1958), and Gouldner (1960). However, many researchers have applied reciprocity in various fields and shown strong support for the role of reciprocity in relationship development and maintenance. The diversity of its applications demonstrates that reciprocity is well-recognised in social science literature. According to Gouldner (1960), reciprocity addresses the processes governing social interaction among individuals, the pattern of exchange through which the mutual dependence of people, brought about by the division of labour, is realised.

The importance of reciprocity to social systems is reflected in its descriptions as "the vital principle of society" (Thurnwald, 1932) and a "key intervening variable through which shared social rules are enabled to yield social stability" (Gouldner, 1960). Gouldner (1960) noted that the fundamental principles of reciprocity lie in the embedded obligations created by exchanges of benefits or favours among individuals. This concept, which Gouldner termed the 'generalised norm of reciprocity,' evokes duties toward others based on past behaviours. This norm serves as a stabilising function and a "starting mechanism" in that it helps initiate social interaction and create a social structure in the form of status duties (Gouldner, 1960).

Although not one of the most frequently cited works in social science research regarding reciprocity, The Wealth of Nations (Smith 1776) stresses that welfare-enhancing exchange is based on the actors' utilitarian mindset. Smith (1776, p12) remarked, "it is not from the benevolence of the butcher, the

brewer, or the baker, that we expect our dinner, but from their regard to their interest. We address ourselves, not to their humanity but their self-love, and never talk to them of our necessities but their advantages". In a matter of labour relations, cooperation between companies, or consumer relations, the give and take that cooperation is understood to mean exchange (under certain conditions) and is generally ascribed to utilitarian deliberations on the part of the participants.

Following Schneider, White, and Paul (1998), the theory of reciprocity explains how committed and loyal customers will be when their desired quality or perceived quality standards from service are met. Reciprocity theory implies a behavioural response wherein benevolent actions or good deeds get rewarded while hostile ones or poorly received actions are castigated or discarded. The theory explains how parties concerned are obliged to reciprocate good and bad actions mutually. One party's action obliges the other party to reciprocate that action as a compensating movement. "Such shared prospects put the parties in a relationship of sure rewards that set the tone not only for current behaviour but also indicate future possibilities" (Hadi, Aslam & Gulzar, 2019).

Consequently, a basis is established for a future strong relationship between the parties, a commercial or social transaction. Corollary to the above, it is prudent to coin a safe assumption that sustainable service quality can win continuous utilisation or patronage of goods and services or, more specifically, customer loyalty. In furtherance to the above, the findings of Schneider et al. (1998) are very relevant regarding their conclusion that, generally, customers' perceptions of service quality and the global climate for service pointed to a strong reciprocity in the mutual relationship of sustainable service quality and

customer loyalty. Given this empirical evidence from the literature, this study considers how the UCC Hospital's service quality influences the utilisation of the hospital by the staff.

Prospect theory

Prospect theory, first propounded by Kahneman and Tversky (2013), was an alternative principle to the expected utility theory to explain how individuals make decisions under risk conditions. Kahneman and Tversky realised that the expected utility theory model did not fully describe how individuals make decisions in risky situations. Therefore, there were instances in which the choices of a decision-maker could not be predicted. For example, they pointed out that expected utility theory does not explain how framing can change the individual's decision, nor does it explain why individuals exhibit risk-seeking behaviour in some instances and risk-averse behaviour in others. The prospect theory explains that people usually over-weigh low probability outcomes and under-weigh outcomes with moderate to high probabilities, which the expected utility theory fails to explain (Kahneman & Tversky, 2013). The theory holds that people use subjective probabilities rather than objective probabilities to weigh the values of possible outcomes.

According to Edwards (1996), the prospect theory is a behavioural model that shows how people decide between alternatives that involve risk and uncertainty. It demonstrates that people think of expected utility relative to a reference point rather than absolute outcomes. Prospect theory was developed by framing risky choices, indicating that people are loss-averse (Asri, Ali, Habbe & Rura, 2017). Since individuals dislike losses more than equivalent gains, they are more willing to take risks to avoid a loss. Due to the biased

weighting of probabilities and loss aversion, the theory leads to loss or gain patterns concerning risk. Prospect theory has been applied in diverse economic settings, such as consumer choice, labour supply, and insurance (Barberis, 2013).

In cognitive psychology, prospect theory describes how people choose between probabilistic alternatives involving risk, where the probabilities of outcomes are uncertain. It emphasised that people make decisions based on the potential value of losses and gains rather than the outcome and evaluate them using some heuristics (Rowe & Boulgarides, 1992).

In prospect theory, the utility of a product is a function of perceived attributes coded as gains and losses to make decisions (Kahneman & Tversky, 2013; Thaler, 1985). Thus, this gain/loss framework is highly amenable to considering service quality, satisfaction, and dissatisfaction. Consumers evaluate their experiences by comparing what they receive with what they pay for a service (Roggeveen, Tsiros, & Grewal 2012). Quality service is perceived if what customers pay for matches what they receive in return (Smith, Bolton, & Wagner 1999). Poor service quality occurs when a customer does not match what they pay, resulting in a perceived loss (Roggeveen, Tsiros, & Grewal 2012). Such a loss can be money, time, convenience, or social and psychological costs (Kotler & Armstrong 2013; Zeithaml, Bitner & Gremler 2012). These situations will shape the consumer's future decisions on the consumption of the service.

In this study, the prospect theory describes how the UCC staff will choose between the university hospital and nearby hospitals. The prospect theory is relevant to the study because it helps explain why the UCC staff choose

a different hospital when they perceive the University hospital's services as inferior. This is because human beings are risk-averse and always make choices to minimise or avoid losses. It is also worth mentioning that a person's risk appetite or tolerance is part of his or her background traits.

Conceptual Review

This section of the thesis discusses the concept used for the study. This section examines healthcare quality, patients` knowledge of their health rights and responsibility, and utilisation.

Healthcare Service Quality

Although human values and perceptions are widely subject to situations and culture, openness, confidence, motivation, and commitment cannot be over-emphasised as the foundations of any quality culture. However, traditional practices and attitudes towards authority, mutual support, and individual responsibility actively resist improvement in most instances, if not all. Consequently, it leads to a culture of low expectations and quality, vertical command structures, restricted information, and a negative view of accountability and responsibility.

Healthcare service quality is an essential element of customer perception and constitutes the dominant feature of consumers' evaluation of pure healthcare services (Zeithaml, Bitner, & Gremler, 2009). Unlike tangible products, services come with many distinctive characteristics, such as intangibility, inseparability, heterogeneity, and perishability, complicating their evaluation and increasing the incidence of perceived risk (Parasuraman et al., 1985). Parasuraman et al. (1988) defined service quality as a focused evaluation that reflects a customer's perception of reliability, assurance, responsiveness,

empathy and tangibles. These dimensions represent how consumers organise information about service quality in their minds' (Zeithaml et al., 2009).

On a more general ground, service quality dimensions involve providers, clients, and managers in a structured process to explicitly identify clients' needs and design service processes using key features to meet those needs. Ovretveit (1992) recognised three stakeholders or components of quality: clients, professionals or service providers, and management quality. The client's quality, Ovretveit noted, addresses what the client wants from the service provider. Professional quality indicates whether the service meets the needs defined by professional providers and referrers and correctly carries out techniques and procedures that are believed to meet the client's needs. The management quality aspect concerns the most efficient and productive use of the resources within limits and directives set by higher authorities and buyers or consumers. Ovretveit (1992) emphasised that quality healthcare services or systems should give patients what they want and need at the lowest cost.

From the client's perspective, quality healthcare is one, which meets their needs, and is delivered courteously and on time (Brown, Franco, Rafeh, & Hatzell, 1998). The client wants services that effectively relieve symptoms and prevent illness or restore them to their health status. This is because satisfied clients are more likely to comply with treatment and continue using health services. Per the provider, quality care implies that they have the skills, resources, and conditions necessary to improve the patient's health status and community according to current technical standards and available resources (Ofosu-Kwarteng, 2012). Providers' commitment and motivation depend on

carrying out their duties in an ideal or optimal way. Providers tend to focus on technical competence, effectiveness, and safety.

Healthcare quality comprises structures, processes, and outcomes (Donabedian, 1980). Donabedian explained that structure refers to the attributes of the settings in which care occurs, which includes the attributes of material resources such as facilities, equipment, and money; human resources such as the number and qualifications of personnel; and of organisational structures such as medical staff organisation, methods of peer review and methods of reimbursement. Process denotes procedures in giving and receiving care and includes the patient's activities in seeking care and carrying it out and the practitioner's activities in making diagnoses and recommendations or implementing treatment.

The outcome represents the effects of care on the health status of the patients or clients, which is mainly seen in improvements in the patient's knowledge and salutary changes in the patient's behaviours, put under a broad definition of health status, and is the degree of patient's satisfaction with the care received. It is common knowledge now to say that patient satisfaction is increasingly being recognised as an important measure of outcome and quality of care given to patients; the patient's willingness to seek medical advice or comply with treatment to a large extent depends on the level of satisfaction gained or perceived from the care received.

Measuring Service Quality

According to Kotler (2012), service encompasses intangible actions performed by one party to another, but it does not lead to any physical object ownership. In healthcare settings, healthcare providers' services involve

diagnosing and treating patients, public health interventions, surgical and non-surgical management, and pharmacological and non-pharmacological management of patients with the primary aim of preventing or curing a disease (Agyapong et al., 2018). As Kotler (2012) defines, quality is 'the totality of features and characteristics of a product or services that bear on its ability to satisfy stated or implied needs. Therefore, this study conceptualises service quality as patients' judgment of the complete healthcare delivery package to meet and surpass their stated and implied needs.

However, literature continues to measure service quality dimensions variedly. Brown, Franco, Rafeh and Hatzell's (1998) views have been adapted and applied to this study. Brown et al. (1998) opined that the quality dimension encompasses effectiveness, efficiency, technical competence, interpersonal relations, access to service, safety, community, physical aspect, and choice. They explained effectiveness as the degree to which desired results (outcomes) of care are achieved through appropriate diagnosis and treatment; efficiency as the ratio of the outputs of services to the associated costs of producing those services, taking into consideration both materials and time resources; technical competence as the degree to which tasks carried out by health workers and facilities meet expectations of technical quality (according to clinical guidelines). Interpersonal relations such as respect, courtesy, responsiveness, empathy, effective listening, and communication are exhibited between clinic personnel and clients.

Access to service is the degree to which healthcare services are unrestricted by geographic, economic, social, organisational, or linguistic barriers. Safety is the level of trust, confidentiality, and privacy in the service

and the degree to which the risks of injury, infections or other harmful side effects are minimised. Continuity is the degree to which consistent and constant care is provided, including the value of visiting the same provider and continuing treatment. The facility's physical appearance, cleanliness, comfort, and amenities are physical aspects. And choice as the client's choice of appropriate provider, insurance plan, or treatment. This study undertakes iterative improvements that regrouped these dimensions into four broad dimensions: communication, physical environment, operations and treatment, and management quality, a scale developed by Dagger, Sweeney, and Johnson (2007). It represents a holistic approach to ensuring quality healthcare delivery and total customer satisfaction.

Dagger et al. (2007) explained that communication (interpersonal quality) reflects the relationship developed and the dyadic interplay between a service provider and a user (Brady & Cronin 2001; Grönroos 1984). Major elements in this dimension are manner (attitude and behaviour), information exchange, and relationship (Bitner, Booms & Tetreault, 1990; Brady & Cronin, 2001). The physical environment quality defines the complex mix of environmental features such as atmosphere and other tangibles that shape consumer service perceptions (Gotlieb, Grewal & Brown1994).

Operations and treatment embody the service provider's technical quality, determining how the outcomes are achieved (Grönroos 1984; McDougall & Levesque 1994). It refers to the service provider's technical competence, an interplay between expertise and outcome (Ware, Davies-Avery, & Stewart 1978). Lastly, management quality comprises the administrative service elements that facilitate a core service's production while adding value

to a customer's use of the service (Grönroos 1990; McDougall & Levesque 1994). Facilitating services is essential to delivering and consuming a core service while supporting elements augment the service but are not necessary to core service delivery (Grönroos 1990; Lovelock, Patterson, & Walker 2001). Quality comprises the customers' perceptions of timeliness, operation, and support the administration or management gives.

Consumer satisfaction as a measure of quality

Customer satisfaction has been defined in the literature as the personal feelings, meaning, and interpretation a consumer makes of a product or service following its usage (Solomon, 1996, Wells & Prensky, 1996). Bitner and Hubbert (1994) also opined that it is the assessment that a customer gives to a product after its usage regarding its superiority and inferiority. Most often, in the consumer market, customers who are satisfied with a product would convey good and pleasurable information about the product to others to convince them to patronise it or recommend it to them.

Converse to such reasoning is the notion that a dissatisfied customer of a product or service will not only cease subsequent patronage of the product but will also spread damaging or unhealthy information about the product to potential buyers or users in the way of discouraging them from buying such product or service. By expressing one's preference or satisfaction about a product, consumers or customers turn to supply the valuations needed to choose among alternative strategies of services or care to give to patients (Donabedian, 1987).

Healthcare Service Utilisation

Acquah, Koomson, Ekumah and Osei-Kufour (2015) observed that the demand for and the supply of healthcare frameworks represent the main healthcare utilisation theories. On the demand side, O'Donnell (2007) opined that people might not utilise the healthcare provided to them despite the many policy interventions, though it would likely benefit them. Acquah et al. (2015) added that the demand and supply of healthcare inform utilisation. However, as the demand and supply sides interact, one cannot distinguish between their components. For instance, in situations where healthcare quality is poor, the public will have little interest in utilising it (Kalin 2011).

Vogel (1988) suggests that an improvement in the quality of services would compensate for the negative effects of prices, knowing that the relatively longstanding practice of the mission health facilities gives fairly conclusive evidence that people will pay for quality healthcare and there is ample evidence that the poor can and will pay for some health service when the services are available, and their quality is perceived to be high. United Nations International Children's Emergency Fund (UNICEF) (1990) re-echoed this same position and opined that the trend towards decreased demand for services could be reversed when efforts are made to improve the services before a system of payment is introduced.

This perspective seems to be widely accepted and supports the prospect theory, as discussed in the earlier sections. There are numerous examples where under-utilisation of health facilities is directly attributable to the poor quality of the services, even as far as Van Luijk (1979); Annis (1981); and Kloos et al. (1987). However, several other factors affect or predict healthcare service

utilisation as; distance or physical location (Stock, 1983), cost or fees (Stanton & Clemens, 1989; Waddington & Enyimayew, 1990); type of care, availability of the facility, awareness about existing or alternative facilities (Yesudian 1984, Khan & Prasad 1988; Duggal & Amin 1989). This study tests background characteristics, knowledge of patients' health rights, and service quality since service quality, as defined in this study, comprises many of these factors or determinants due to the characteristics of the selected study facility.

Background Characteristics and Healthcare Service Utilisation

A review of the healthcare literature regarding patient decision-making related to healthcare services provides insight into the antecedents of selection. Much of the research focuses on patient satisfaction with the services focusing on the quality of services. Fewer studies have focused on the initial service provider selection dimensions, such as consumer characteristics or demographics. Since healthcare service utilisation is multifaceted, an exhaustive list of predicting elements must include user characteristics or demographics. Several studies posited that education (more highly educated people), age (younger people), income (people with higher incomes), and people without an existing (satisfactory) relationship with a services provider make an active choice more often (Burge, Devlin, Appleby, Rohr, & Grant, 2004; Exworthy & Peckham, 2006; Lako & Rosenau, 2009; Kiiskinen, Suominen-Taipale, & Cairns, 2010; Rademakers, Delnoij, & de Boer, 2011; Victoor, Delnoij, Friele, & Rademakers, 2012).

According to Robertson and Burge (2011), older patients, female patients, those who live further away from a hospital, less highly educated patients, and those with a bad experience with their hospital are more favourably

inclined towards the free choice hospitals. Also, patients perceived degree of choice or ability to choose or utilise a healthcare service facility was found to be influenced positively by family income, general state of health, willingness and ability to travel, and negatively by restrictions imposed by health insurers and employers, age, and gender (Hoerger & Howard, 1995; Lambrew, 2005; Fotaki et al., 2008). This study assessed the influence of background characteristics on the utilisation of the University hospital.

Service Quality and its effect on Utilisation

There is an inconclusiveness in the patients` perception, expectations, and satisfaction in the literature. Notably, McKinley, Stevenson, Adams, and Manku-Scott, (2002); and Conway and Willcocks (1997) viewed patient's expectations as probability judgments about the likelihood that a set of events will occur, while Kravitz (1996), viewed expectations on quality care as perceived needs, wants, importance, standards, or entitlements. These expectations may pertain to healthcare in general or a specific healthcare encounter such as a clinic visit or hospitalisation.

However, whether the patient's expectations are probabilities or values, understanding them is crucial because meeting these expectations may lead to greater satisfaction. Moreover, patients` expectations are becoming widely recognised as a reliable and important source of information about the quality of medical practice and significant steps towards making performance transparent comes with the publication of concrete figures on the quality of outcomes relevant to patients (Lawathers, Rozanski, Nizankovski & Rys, 1999).

Customer satisfaction or service quality and its impact on utilising the service have been duly studied in other sectors and industries, notably

marketing. However, it is not common in the healthcare sector. This study relied on literature in different sectors, most of which examined customer satisfaction and loyalty. Interestingly, the review found a positive link between customer loyalty and customer satisfaction. Even as far as 1996, Hallowell (1996) found a proven relationship between satisfaction and the world of motion.

Similarly, Moutinho and Smith (2000) found a positive relationship between satisfaction and retention. Also, a positive relationship was established between behavioural intentions and satisfaction by Methlie and Nysveen (1999) and Gilbert, Veloutsou, Goode and Moutinho (2004) in the mediating role of satisfaction between service quality dimensions and customer loyalty. Kasiri, Cheng, Sambasivan and Sidin (2017) found the mediating role quite significant; they further suggested that the relationship between functional quality and loyalty through satisfaction between the two dimensions was the strongest. Drawing on this empirical evidence, this study hypothesised that service quality influences utilisation.

Patients' Knowledge of their Health Rights

Donabedian (1980) asserted that quality comprises structures, processes, and outcome, where knowledge plays a crucial role in assessing all three elements. Ofosu-Kwateng (2012) averred those improvements in the patient's knowledge and salutary changes in the patient's behaviours are significant determinants of healthcare service quality perceptions and included them under a broad definition of health status and referred to it as the degree of patient satisfaction with care. An individual's knowledge of a given event or phenomenon shapes their perceptions about such events and phenomena. Thus, patients' knowledge of their rights shapes their quality perceptions. This

thinking reechoed the attribution theory's proposition, which holds that schema influences how people interpret new information based on their pre-existing beliefs and knowledge (Geva & Mintz 1997).

Empirical literature holds that the sources of knowledge of one's health rights emanate from the standards, codes of conduct, decrees, rules, and regulations governing healthcare service access and consumption (Dagger et al., 2007; Ofosu-Kwarteng, 2012; Tenkorang 2016). In Ghana, the sources of patients' health rights are the work standards and ethics of the Ghana Health Service, the Patients Charter, and other institutional arrangements and directives in accessing and consuming healthcare services.

Work standards and ethics of Ghana Health Service

Every organisation, profession, and the group has a working standard or rules of conduct or practice that guide all persons in the value creation process and system. The Ghana Health Service is no exception to this standard. Like many governmental institutions in Ghana, the Ghana Health Service code of ethics for nurses is a set of predefined moral guidelines that health personnel should adhere to in their delivery fields. Promoting, recognising, and respecting teamwork is essential towards quality service delivery to every Ghanaian. Regardless of age, gender, the essence of illness, way of life, political integrations, race, line of work, malady, religion, ethnicity or language, no citizen should suffer discrimination. The Code of Ethics and Conduct for the Ghana Health Service (GHS, 2008) spelt out the general moral principles and rules of behaviour for all service personnel in the Ghana Health Service.

The code, among other things, stated that the Service should be operated by persons of integrity trained to a high standard to deliver a comprehensive,

equitable service for the benefit of patients, clients, and society. Specifically, the code provides that health professionals respect all patients' rights and privacy and cooperate with the patients and their families during care. It is believed that when these codes are followed strictly, it will add up to the quality of service and satisfaction received by the patients since adherence to these codes of conduct form the basis of quality service delivery.

The Patients Charter in Ghana (2008)

Formalised in 1948, the Universal Declaration of Human Rights recognises the inherent dignity and the equal and inalienable rights of all human family members. And it is based on this concept of the person and the fundamental dignity and equality of all human beings, and the notion of patient rights was developed. In other words, what is owed to the patient as a human being, by physicians and by the state took shape largely thanks to this understanding of the person's basic rights. For instance, in Ghana, the 1992 Constitution of the Republic of Ghana, according to Chapter 5, deals with citizens' fundamental human rights and freedoms and all who reside within Ghana's territory. It guarantees a right to life, further enveloped by the Universal Declaration of Human Rights (UDHR), of which Article 3 is most important for this discourse. Article 3 says, "Everyone has a right to LIFE, liberty, and security of person."

The Patients' Charter is a document by the Ghana Health Service that spells out patients' rights and responsibilities when they go to a health facility. The Ghana Health Service is for all people living in Ghana, irrespective of age, sex, ethnic background, and religion, on the notion that it is managed with their taxes. The service requires collaboration between health workers, patients or

clients, and society to ensure optimal healthcare attainment. Quality healthcare delivery depends on teamwork among the health facilities, the professionals, and the clients. Therefore, health facilities must provide for and respect the rights and responsibilities of patients/clients, families, health workers, and other healthcare providers.

The Ghana Health Service expects healthcare institutions to adopt the patients' charter to ensure that service personnel, clients, and their families understand their rights and responsibilities. This Charter protects the patient's rights in the Ghana Health Service. It addresses issues relating to; the Right of the individual to accessible, equitable, and comprehensive health care of the highest quality within the resources of the country; respect for the patient as an individual with a right of choice in the decision of their health care plans; and the right to protection from discrimination based on culture, ethnicity, language, religion, gender, age, and type of illness or disability.

Ghana Health Service Patients' Chatter 2002 addresses: the right of the individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the country; respect for the patient as an individual with the right choice in the decision of their health care plans; the Right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability; and the responsibility of the patient/client for personal and communal health through preventive, promotive and simple curative strategies.

Carved out of these are 14 Patients' Rights, among which are: "the right to quality basic health care irrespective of his/her geographical location", "the right to know of alternative treatment(s) and other health care providers within

the service if these may contribute to improving outcomes," the right to complete information on their condition and management", "the right to the confidentiality of information obtained about him/her", among others which can be found in the Ghana Health Service Patients' Chatter 2002.

As the saying goes, 'there is no right without responsibility'; the patients` charter also contains patients' responsibilities to complete the cycle. Ofosu-Kwarteng (2012) opined that patient needs to understand that they are responsible for their health and should cooperate fully with healthcare providers. The patients` charter provided explicitly that patients are responsible for: providing the full and accurate medical history for their diagnosis, treatment, counselling, and rehabilitation purposes; requesting additional information and or clarification regarding their health or treatment; complying with prescribed treatment, reporting adverse effects, and adhering, to follow up requests; informing their healthcare providers of any anticipated problems in following prescribed treatment or advice; obtaining all necessary information, which has a bearing on their management and treatment including all financial implications; acquiring knowledge, on preventive, promotive, and simple curative practices and where necessary to seek early professional help; maintaining a safe and hygienic environment to promote good health; respecting the rights of other patients/clients and health service personnel, and protecting the property of the Health facility.

In as much as the ultimate liability and responsibility towards healthcare delivery is vested in the GHS, the patient must also know the rights and obligations they have under the laws of Ghana, as enshrined in the patient's charter. All patients must understand that services rendered at hospitals, clinics,

wards, health posts, and centres are not privileged. They are due rights that come with responsibilities.

Empirical Review

An empirical literature review concentrates on previous research results or findings that the researcher wants to study, compare, and cite to construct reliability, validity, correlations, and strength of the relationship between past study's constructs and the current one. Empirical literature review gives accounts of previous empirical studies (not theoretical analysis) that have been done on the topic or concepts under study by other researchers and the findings that emerged. Here, the key issues are the problems focused upon, the methodology employed, and the key findings and conclusions. This section presents empirical reviews on healthcare delivery status or services and their effect on the utilisation of the services.

Undoubtedly, healthcare delivery or service quality in general, as far as healthcare is concerned, has been widely studied in the literature, except how the status or quality of healthcare services impacts the hospitals' utilisation, which received very little attention, if not none.

Outside Africa, Choi, Cho, Lee, Lee, and Kim (2004), studied the relationships among quality, value, satisfaction, and behavioural intention in healthcare provider choice in South Korea. The study was based on data collected from 537 South Korean healthcare consumers and corroborated the causal sequence among these constructs suggested by the multi-attribute attitude model framework; thus, cognition (service quality and value) maps onto effect (satisfaction), which then maps onto conation (behavioural intention). Service quality emerged as a more critical determinant of patient satisfaction

than a value between the two cognitive constructs. Their results also showed that service quality and value significantly impact behavioural intention, while value assessment was influenced by perceived service quality.

Aragon, and Gesell (2003), examined patient satisfaction theory and its robustness across gender in emergency departments using a multi-group structural equation modelling investigation at the American College of Medical Quality. The study's investigation tested the patient-centred Primary Provider Theory of Patient Satisfaction across gender in national random samples of emergency patients. Using multigroup structural equation modelling, the results supported the model's robustness. The investigation offers an alternative paradigm for measuring and achieving emergency department satisfaction, hierarchically related to patient expectations, where the primary provider has the most significant clinical utility to patients, followed by waiting for the primary provider and then by nursing service.

Also, Alderman, Wilkins, Lowery, Kim, and Davis (2000) also examined the determinants of patient satisfaction in postmastectomy breast reconstruction in the United States of America using a multiple logistic regression model. A total of 212 patients were followed from 1994 to 1997, including 141 immediate and 71 delayed reconstructions. The study population consisted of 49 expanders/implants, 102 pedicle TRAM flaps, and 61 free TRAM flap reconstruction patients. The study showed a significant association between procedure type and patient satisfaction. However, because their (the authors mentioned above) contexts and other characteristics, environmental, political, economic, and socio-cultural as pertains to developed or western world differ totally from that of Africa, and Ghana to be precise, which is a

developing economy, their results cannot be strictly applicable to the Ghanaian context.

In Africa, Yegon (2013) assessed patient factors influencing satisfaction with healthcare quality in Kenya using a comparison of Ordered Logit and Ordered Probit regression Models. For the study, Yegon used a questionnaire to collect data from public and private/faith-based health facilities in Kenya. The study demonstrated that, provided that the proportional odds assumption is met, the ordered logit and the ordered probit regression models produce relatively similar results. It highlighted that patients' age, gender, education level, and employment status are significant in predicting their satisfaction with the quality of healthcare received.

In their study, Daniels et al. (2017) examined the use of standardised patients to assess the quality of healthcare in Nairobi, Kenya, in a pilot, cross-sectional study with international comparisons. On a more general ground, Adindu (2010) looked at the status of healthcare delivery in Africa under the topic "assessing and assuring the quality of health care in Africa." Adindu's study examines the importance of quality in healthcare, approaches to assessing and assuring quality and proposes strategies for improving the quality of services in Africa. Unfortunately, like in Europe and Africa, different situations exist among the individual countries on several grounds, making her generalisations inapplicable.

Down to the soil of Ghana, Lavy, Strauss, Thomas, and De Vreyer (1996) assessed the quality of healthcare, survival and health outcomes in Ghana. Their study analysed the effect of the quality and accessibility of health services and other public infrastructure on children's health in Ghana. They

focus on child survival, height, and weight using data from the Ghana Living Standards Survey III. The results suggest an essential role for public health policy in eliminating the rural-urban disparities in health status, particularly in improving rural children's health status and reducing their mortality rates.

Similarly, Ofosu-Kwarteng (2012) assessed healthcare delivery and customer satisfaction in Ghana using Koforidua Regional Hospital. The main objective of his study was to explore the level of satisfaction of outpatients with physicians, nurses, and pharmacists' services and provide information on outpatient's expectations of their services. Two hundred and twenty-one (221) respondents were used for the study. Interestingly, the analysis of results showed mixed findings. Regarding Physician and Nurses' human relations, the respondents rated Physicians far higher than Nurses. Responses from respondents about service provision and the environmental conditions of the hospital were varied. However, the results revealed that pharmacists' information on the issuance of drugs does not include the side effects of drugs.

Frimpong (2015) also assessed the service quality and patients' satisfaction with healthcare delivery in the Ashanti region in Ghana, emphasising the moderating effect of demography. Anabila, Anome and Kumi (2018) also assessed service quality in Ghana's public hospitals in Greater Accra and Ashanti Regions. Narrowing it down intensely, Anabila, Kumi and Anome (2019) also assessed patients' perceptions of healthcare quality in Ghana, focusing on public and private hospitals. All the above studies have one similarity. They either concentrated on one component of the phenomenon and left out the rest or widely generalised their studies without any reference that

even within the same state or country, different conditions exist such as economic, cultural and demographics.

More closely, Aduo-Adjei (2015) conducted a comparative study to assess the patients` satisfaction with quality healthcare in Ghana between the University of Ghana and the University of Cape Coast hospitals. However, his study looked at the general patients of the two hospitals. Different contexts and other characteristics, environmental, managerial, economic, and socio-cultural, exist between the two hospitals; hence his findings may not be relied upon for decision-making.

Conceptual Framework

The study's conceptual framework was designed based on the theories underlying the study- SERVQUAL model, attribution theory, reciprocity theory, and prospect theory, and the findings of various empirical studies reviewed. The need for the conceptual framework arises because the variables measuring the specific objectives did not flow directly from the theories underpinning the study, hence the need to review concepts and use them as proxies to measure the variables in the objectives.

The framework comprises four main variables: clients` knowledge of their rights, healthcare service quality, background characteristic of clients, and utilisation of the hospital. Healthcare service delivery quality given to the staff of UCC was proxied to be influenced by the service provider or the professional, the service provider's physical environment, and the management quality, as discussed in the literature review in the preceding sections. These dimensions or indicators or proxies using constructs as contained in the questionnaire. The

hospital's utilization was measured by constructs included in the questionnaire and the background characteristics.

The framework is presented in Figure 1. The utilisation of the hospital was measured numerically using multiple constructs as contained in the questionnaire in Appendix A. The study argues that quality healthcare services will positively be related to hospital utilisation by the staff. Furthermore, the study contends that clients' knowledge of their rights to quality healthcare would affect their perceived quality of healthcare services received at the hospital.

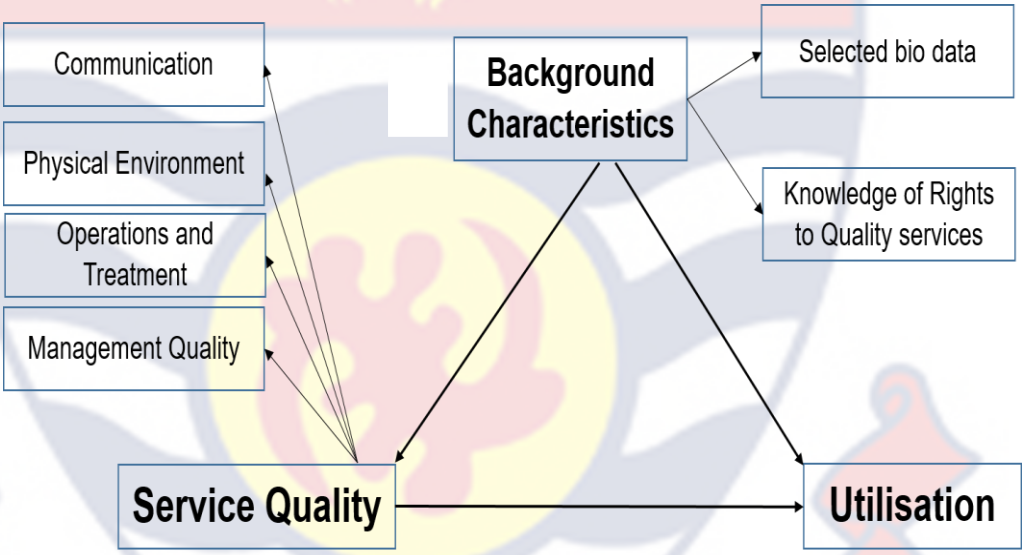

***Figure 1*: Conceptual Framework of Quality of Healthcare Delivery and Utilisation of Hospital Services**

Source: Author's Construct

The framework represents the specific objectives of this study, as contained in chapter one of this study. It is also imperative to mention that the constructs in the questionnaire in Appendix A were adopted and modified from previous studies that looked at the quality of healthcare services. Details of the instrument are in chapter three.

Chapter Summary

This chapter began by introducing the theories adapted and used in the study. It then presented the conceptual views of relevant concepts to this study and explained healthcare delivery's effect on utilisation. The literature suggests that there is inconclusiveness in the dimensions of service quality literature. The literature review also revealed that the effect of healthcare delivery on loyalty or service utilisation has long been studied and established in other industries and sectors but has received very little attention in healthcare literature. Finally, the chapter developed one conceptual framework based on the concepts reviewed and proxied to measure the variables in this study's objectives and provided the empirical justification for the study.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter looks at the systematic procedures used to assess the quality of healthcare services given to the University of Cape Coast staff and its effect on their hospital utilisation. This chapter presents a detailed discussion of the research paradigm, research design, research approach, definition, sources and measurement of variables, justifications, the instruments' validity, and data processing and analysis methods. It explains the various scientific methods used to achieve this study's objectives.

Study Facility

This study was conducted at the University of Cape Coast Hospital. The University of Cape Coast Hospital began as a sick bay linked to Adehye Hall in 1963, serving University students, faculty members and their dependents. The facility had progressed to the point where it was now known as the Directorate of University Health Services. The Directorate of University Health Services (DUHS) is one of the Directorates of the University of Cape Coast, under the Office of the Registrar. It consists of the University Health Services (UHS) (UCC Hospital) and the Environmental Health Section (EHS).

The Directorate is governed and regulated by the University Health Services Committee (UHSC) under the Chairmanship of the Pro-Vice-Chancellor of the University of Cape Coast, with representatives from the Academic Board, Convocation, Central Regional Health Directorate (CRHD), Senior Staff Association of Universities of Ghana (SSA-UoG, UCC), University Teachers Association of Ghana (UTAG, UCC), Tertiary Educational

Workers Union (TEWU), Graduate Students Association of Ghana (GRASAG), Student Representative Council (SRC) and DUHS.

The Directorate is a member of the Ghana Association of Quasi-Government Health Institutions (GAQHI) and a designated sub-Metro of the Cape Coast Metropolitan Health Directorate with five (5) functional Community-Based Health Planning and Services (CHPS) Zones located at Amamoma, Duakor, Kwaprow, Akotokyir, and OLA catchment areas. The Hospital has a Primary Health Care (PHC) Facility license from Ghana's Health Facility Regulatory Agency (HeFRA).

The Directorate is managed by a seven (7) member Management Committee chaired by the Director of DUHS and also included the Deputy Director of DUHS, the Deputy Director for Pharmaceutical Services (DDPS), the Health Services Administrator, the Accountant, the Nurse Manager and the Head of Environmental Health Section (EHS). The seventy (70) bed capacity Hospital provides preventive, curative, and public health services to the University community and the general public. The EHS supports services such as dislodging, fumigation, cleaning, inspection and all environmentally related hygiene practices in the University. The main clientele of the DUHS consists of students, staff and their dependents, casuals/temporary staff, pensioners, and the general public, who are classified as Private Patients.

Research Paradigm

This study is in line with the realism research paradigm. Hall (2012) averred that realism does not limit the range of topics to be researched, nor the methods that can legitimately be used to conduct research and can accommodate the mixing of qualitative and quantitative methods in use. Realism has been

applied to mixed-method research design in the literature by several writers, notably Miles and Huberman (1994), Henry, Julnes and Mark (1998), Sayer (2000), and Hall (2012). Pawson, Tilly and Tilly (1997) opined that the 'scientific realist' approach to evaluation in mixed methods plays a prominent role in evaluation. Henry et al. (1998) applied the realism paradigm for evaluation in which they argue that the objectives of their approach "will often be best served by a combination of quantitative and qualitative methods."

This study adopted the realism paradigm because the researcher intend to provide realistic, detailed, and unembellished representation of the quality of healthcare delivery and utilisation of hospital services among the staff in the University of Cape Coast. With this, the idealization of the imagination is rejected in favor of a rigorous examination of outer manifestations. As a result, the research topic is studied in details through the use of both qualitative data and quantitative data. This is best suitable as the data for this study comprises both qualitative and quantitative.

Research Design

This study employed a descriptive research design. Empirical research that seeks to describe or explain the current status of a phenomenon and establish associations or relationships between variables may be termed descriptive (Saunders et al., 2012). Descriptive research design emphasizes studying a situation to explain the current status of a phenomenon or variables and the association or relationships between variables. A descriptive research design was employed in this study to assess the quality of healthcare delivery by the University of Cape Coast Hospital to the University of Cape Coast staff and its effect on utilising the hospital.

Research Approach

Creswell (2007) asserted that the importance of illustrating the research approach is an effective strategy to increase social research validity. According to Creswell (2014), there are three main research approaches: the quantitative approach, the qualitative approach, and the mixed methods research approach. Hall (2012) postulates that the realism research paradigm uses the mixed methods research approach. The mixed methods research approach was chosen for this study because it allows for detailed examinations of the quality of healthcare delivery and the utilisation of hospital services by combining the strengths of the quantitative and the qualitative approaches to eliminate their drawbacks (Creswell, 2014).

Since the focus of this study is essential to the academic environment, the study, through observation, holds that some sectional heads of the hospital may have some explanations for some of the issues that may be important to achieving the goals of this study. Similar approach was adopted by Acquah, Koomson, Ekumah and Osei-Kufour (2015) to study utilisation of facility-based maternal healthcare services. Hence, the mixed methods research approach was employed to allow for the use of in-depth interviews to gather qualitative data from the sectional heads concurrently, who were selected at random. The study believes this qualitative data provides an alternative or added explanation to the quantitative results from the quantitative data.

Also, most of the previous studies on healthcare quality in Ghana employed a quantitative research approach, so this study believes that utilizing mixed methods would help explore the phenomenon in detail. Creswell and Clark (2017) averred that a mixed methods research approach ensures a

triangulated multilevel model that addresses different levels of analysis (macro and micro) within a system. Supportively, Teddlie and Tashakkori (2009) opined that mixed-method promotes a more precise and explicit understanding of the social issue concerning education, health, culture, and lifestyle.

Study Population

The population of this study includes all the various categories of persons who patronise healthcare services from the University of Cape Coast Hospital. It comprises all staff, students, and the general public in and around the University community.

Sample and Sampling Procedures

The study used three sampling procedures, purposive, stratified and simple random. The purposive sampling was used to select the teaching and non-teaching staff of the University of Cape Coast for this study because they are one of the main categories of clients the hospital was set up initially to serve. Also, they are one of the categories billed or tasked to help run the hospital. Also, the purposive selection of staff makes the sampling and data collection easier due to the limited time available for the study.

The stratified sampling technique was used for the study. This was considered appropriate for the study based on the assumption that the different categories of staff will perceive the services rendered differently, and so the decision to access the university hospital will differ. Therefore, the sampling process put the junior staff, senior staff and senior members into different strata. In addition, the three categories of staff are assumed to access healthcare based on various factors such as healthcare quality and demographic charateriestics

that are unique to each category like junior staff, senior staff and senior members.

Out of a total population of 5046, a sample of 370 was calculated using Yamane`s 1967 sample size calculator. The 370 was then expressed as a percentage of the population (370/5046), giving 0.0733, which was applied to each population strata to obtain the proportional sample distributions in Table 1. Finally, the study employed the simple random sampling technique to select the respondents from the stratified categories.

Table 1: Study Population and Sample Size

Status of the Respondent	Population	Calculation	Sample Size
Junior Staff	2578	2578*0.0733	189
Senior Staff	959	959*0.0733	70
Senior Members	1509	1509*0.0733	111
Total	5046		370

Source: Author's Construct, based on DHR, UCC data (2019)

Data Collection Instruments

A questionnaire was the main tool used for the primary quantitative data collection. The use of a questionnaire enabled the study to obtain more accurate information for answering the research questions and deciding on the research questions or objectives, and this is in line with the proponent that "questionnaires permit wider coverage for a minimum expense both in money and effort" (Osuala, 2001). The researcher designed the questionnaire using the research objectives as a guide, and some insights from the literature reviewed in chapter two.

A structured questionnaire containing closed-ended items or questions was used in the study. This also made the administration, coding and analysis of the data easier and less stressful. Also, the respondents' questionnaire was

deemed appropriate for the study because it provided a much quicker means of gathering information from a fairly large literate population. In addition, it was economical and easy to construct, and the questions were consistent and uniform. The questionnaire also allowed the respondents' anonymity by not requesting for the identity of the potential respondents, which made it easy for them to volunteer information without fear of victimisation (Kelly, 2016).

The instrument was in four sections. Section 'A' contains questions on demographics. Section 'B' looked at medical care and hospital attendance of staff (Utilisation). Section 'C' addresses issues on the quality of healthcare delivery at the University Hospital. Section 'D' contains questions on patients' rights to healthcare delivery. Respondents were required only to tick the applicable responses in all the questions.

The study also used an interview guide. The interview guide was designed by the researcher and reviewed by the assigned supervisor. The interview guide helped the study to gather further data (qualitative) on the phenomenon from the sectional heads at the University Hospital. This data serves as a supporting explanation of the quantitative results.

Validity and Reliability of the Instrument

The validity, in the context of this study, refers to how accurately the questionnaire was able to collect the responses from the respondents as intended by the study to tackle the specific objectives of the study. Furthermore, it is the degree to which the study accurately answers the questions it was designed to answer (Gravetter & Forzano, 2010). Both face and content validity of the questionnaire was ensured. The face validity of the study was granted by the researcher's peers, colleague workers and students, and some known players or

scholars within the university. They did so by helping preview and critique the wording and content of the instrument. The content validity, on the other hand, was determined by the expert judgment of the assigned supervisor and other professionals in the field of development studies.

The questionnaire was pre-tested using some staff of the University of Education, Winneba. Fifteen (15) respondents were selected for the pretesting of the instrument. Respondents were chosen among the staff because of their characteristics similar to those who were finally used in this study. The respondents were chosen at random and issued with the questionnaire. The pre-testing helped to correct ambiguity, wrong wording and unrealistic questions. As Ary, Jacobs, Sorensen and Razavich (2010) noted, pre-testing aims to identify and eliminate potential problems. Malhotra and Birks (2012) further stressed that pre-testing assists the study in improving upon the questionnaire in terms of wording, structure, format and organisation. The Cronbach alpha reliability coefficient obtained from the questionnaire was between 0.793 and 0.851, as shown in Table 2, which confirmed the reliaility.

Table 2: Cronbach Alpha Reliability Coefficient of the Questionnaire

Sections of the Questionnaire	Number of items	Cronbach's Alpha
Personal Characteristics	5	0.793
Healthcare quality	9	0.801
Patients` rights and Responsibility	13	0.823
Utilisation	5	0.851

Source: Author's Construct

Sample size (N) = 22

As indicated in Table 2, the reliability coefficients of the four constructs: demographics, healthcare status, patients` rights, responsibility, and effects on utilisation, were 0.793, 0.801, 0.823, and 0.851, respectively, which were deemed reliable (Creswell, 2014). According to Creswell (2014), scales with Cronbach's alpha coefficient of 0.70 or more are considered reliable. Based on the recommendations made during the validation process, few modifications were made in the questionnaire regarding items in the construct even though all the constructs scored the required Cronbach's alpha coefficient of 0.70 after the pre-test study.

Data Collection Procedures

The researcher collected the data from three different sources. One source is the junior staff who are mostly from the grounds and garden section and other technical units. The researcher obtains permission from their leaders and engages them to explain the questionnaire and the purpose of the study. Since some were not fluent in English, the researcher approached them with a personal interpreter who translated the items into the Fante dialect for them to understand and adequately provide the appropriate responses.

For the senior staff and senior members, the researcher moved from office to office during break time and early morning before office hours to meet the randomly selected staff. The researcher introduced herself, the study's purpose, and the need for participation to the potential respondents and issued the instruments to those who agreed to participate. Some of the respondents returned the completed questionnaire after 15 to 30 minutes, while others asked her to come back for it after the close of the work day. A similar approach was used to obtain qualitative data from the sectional heads at the hospital using

interviews, which lasted for about 10 minutes per a section head. With permission from the secional heads, the interviews were recorded on a voice recorder and and the process asted for three months (October to December 2020).

Data Processing and Analysis

Primary data from the field was edited to eliminate errors that respondents may have made. The data were coded to translate question responses into specific categories to organize and reduce research data into manageable summaries. Quantitative data were analysed using descriptive (crosstabulations) and inferential statistics (logistic regression). Statistical Package for Social Sciences (SPSS), version 26 and Microsoft Excel 2016 were used to process the data.

Descriptive statistics such as frequencies, mean, and standard deviations were used to describe the data, while inferential statistics, notably Chi-Square and logistic regression, were used to check the relationship between dependent (utilisation) and independent (perceived quality of healthcare) variables and estimate the effect of the independent variables on the dependent variable. These statistical tools became necessary because the responses to the items concerning the variables were measured using a unilinear scale. It is also noteworthy that the study employed heterogeneous analysis to explore the propositions made about the differences in the staff categories leading to the adoption of stratified sampling. Thus, the Chi-Square test in the crosstabulation output tests the association between the responses and the staff categories, while the qualitytative data were transcribed and analysed thematically. The analysed quantitative data were presented in tables, while the qualitatative were in texts.

Chapter Summary

This chapter presented the research methods employed to help arrive at the objectives of this study. It examined the research design, approach, study area, sample and sampling procedures, data collection instruments, data collection method, data processing tools and analytical framework, variable description, and empirical model specification. The study used a mixed-method research approach and employed the descriptive research design to describe the effects of the status of healthcare services offered to the staff of UCC and the utilisation of the hospital. With respect to the quantitative aspect, questionnaires were used to solicit primary data from the field, after which the data were entered into the SPSS for processing and analysis. The qualitative data were collected with use interview guides, and were organised into themes per the research objectives.

On the other hand, the qualitytative data were transcribed and analysed thematically. It is important to mention that the study used 370 out of the 5046 staff of the University of Cape Coast. Again, obtaining information from the respondents was interrupted by the busy working environments and the fear of disclosing sensitive or unauthorized information. These resulted in nonresponse by some of the potential respondents, while others did not participate in the study and thus the responses rate was 97.84 percent, which represents 362 respndents. Despite these challenges, the reliability of the instrument and the quality of the data were not affected.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the results and the discussion of the study. As required by the School of Graduate Studies handbook, it first presents the results based on the specific research objectives (after presenting the background characteristics). Subsequently, it discusses the results in a separate section. The discussion interprets the findings and concludes, referring to the theories and literature underpinning the study. Finally, the chapter presents a summary of the details of the chapter.

Background Characteristics of Respondents

The first section of the chapter deals mainly with the respondents' distribution by gender, age group, staff ranking, disability status, medical condition, dependents, income group, and marital status. The study grouped the population into three categories using the staff rankings. Table 3 presents descriptive statistics on background characteristics of the respondents.

Table 3: Background Characteristics of Respondents (N = 362)

Variable	Junior Staff		Senior Staff		Senior Members	
	Frequency	%	Frequency	%	Frequency	%
Gender						
Male	125	66.5	58	52.3	41	65.1
Female	63	33.5	53	47.7	22	34.9
Total	188	100	111	100	63	100
Age groups						
Below 26	22	11.7	10	9.0	2	3.2
26-30	20	10.6	18	16.2	0	0
31-35	29	15.4	32	28.8	13	20.6

Table 3 contiuned

36-40	33	17.6	32	28.8	12	19.0
41-45	28	14.9	8	7.2	17	27.0
46-50	18	9.6	6	5.4	4	6.3
51-55	22	11.7	2	1.8	4	6.3
56-60	16	8.5	3	2.7	11	17.5
Total	188	100	111	100	63	100
Disability Status						
Yes	27	14.4	3	2.7	1	1.6
No	161	85.6	108	97.3	62	98.4
Total	188	100	111	100	63	100
Number of Dependents						
None (0)	42	22.3	26	23.4	4	6.3
One (1)	21	11.2	10	9.0	8	12.7
Two (2)	35	18.6	21	18.9	6	9.5
Three (3)	26	13.8	20	18.0	15	23.8
Four (4)	20	10.6	16	14.4	18	28.6
Five (5)	17	9.0	11	9.9	4	6.3
Above 5	27	14.4	7	6.3	8	12.7
Total	188	100	111	100	63	100
Monthly Income Bracket						
Below GH₵1000	91	48.4	3	2.7	0	0.0
GH₵1000-2000	71	37.8	47	42.3	2	3.2
GH₵2000-3000	18	9.6	44	39.6	0	0.0
GH₵3000-4000	2	1.1	16	14.4	9	14.3
GH₵4000-5000	3	1.6	1	0.9	23	36.5
Above GH₵5000	3	1.6	0	0	29	46.0
Total	188	100	111	100	63	100
Marital Status						
Single	61	32.4	41	36.9	12	19.0
Divorced	25	13.3	0	0.0	5	7.9
Married	102	54.3	70	63.1	46	73.0
Total	188	100	111	100	63	100

Source: Fieldwork, (2020)

As indicated in Table 3, 188 out of 189 estimated sample of junior staff participated in the survey representing a response rate of 99.47 percent. All the 111 extemated sample of senior staff participated in the survey, while 63 out of the 70 sampled senior members participated in the survey representing a response rate of 90 percent. From Table 3, 125 males constituted 66.5% of the respondents against 63 females, comprising 33.5% of the respondents in the junior staff category. In the senior staff category, 58 males and 53 females represented 52.3% and 47.7% respectively. Also, there were 41 males against 22, representing 65.1 percent and 34.9 percent, respectively, in the senior member category. In general, there were more male respondents in all the three categories.

Table 3 further depicts that more junior staff (15.4%, 17.6%, 14.9%), senior staff (28.8%, 28.8%, 7.2%), and senior members (20.6%, 19.0%, 27.0%) respondents were within the age group of 31-35, 36-40, 41 – 45 years respectively. The combined percentage shows that 70.2 percent, 90 percent, and 69.8 percent of the junior staff, senior staff, and senior members were less than 45 years. Also, there were 22 (11.7%) junior staff, 10 (9%) senior staff and 2 (3.2%) senior members less than 26 years old who participated in the study. However, Table 5 shows that no senior member is within the ages of 26 to 30, while 20 (10.6%) junior staff and 18 (16.2%) senior members are within the age bracket of 26-30.

This study also assesses the disability status of the respondents. As indicated in Table 3, 27 (14.4%) out of 188 junior staff who participated in this survey are persons with disabilities. Also, three (2.7%) out of 111 senior staff and one (1.6%) out of 63 senior members who took part in this survey are

persons with disabilities. Again, the need for special medical service or attention as employees is also crucial as it indicates the respondents' level of utilisation of the University hospital. The results on respondents' need for special medical service or attention as contained in Table 3 shows that 43 (22.9%) out of 188, nine (8.1%) out of 111, and eight (12.7%) out of 63 junior staff, senior staff, and senior members respectively need special medical attention.

On the number of dependents, only a few of the respondents are not having dependents. That is, 42 (22.3%) out of 188, 26 (23.4%) out of 111, and four (6.3%) out of 63 junior staff, senior staff, and senior members, respectively. Most respondents have at least one dependent (146 out of 188, 85 out of 111, and 59 out of 63, representing 77.1 percent, 76.6 percent, and 93.7 percent of junior staff, senior staff, and senior members, respectively).

The income of a household affects every activity, including healthcare services. As shown in Table 3, the majority (86.2%) of the junior staff receive less than GH₵2000.00 as monthly income, the majority (81.9%) of senior staff receive between GH₵1000.00 to GH₵3000.00 as monthly income, and the majority of senior members take above GH₵4000.00 as monthly income.

Finally, in the background, the results in Table 3 show that the majority (54.3%) of junior staff are married. However, 32.4 percent are single, and 13.3 percent have divorced or separated from their marriages. Regarding senior staff, 63.1 percent are married while 36.9 percent are single. None of the senior staff have recorded any case of divorce. For senior members, a majority (73.0%) are married, 12 (19.0%) are single, and five (7.9%) have divorced their spouses. Marital status, just as the number of dependents, is likely to influence the

utilisation of a healthcare service provider. Therefore, it was appropriate for this study to assess the marital status of the respondents.

Analysis of the Specific Objectives of the Study

The second section of this chapter presents the results of the specific objectives of the study. As indicated earlier, this section employs descriptive statistical tools to analyse the data.

Staffs' Knowledge of their Rights to Quality Healthcare Services

The study's first specific objective was to determine respondents' views on patients` (staff's) knowledge of their rights to quality healthcare services. The results are presented in Tables 4 and 5. As shown in Table 4, 52 males and 34 females (totalling 86) indicated that they are poorly aware of their rights as patients when accessing healthcare services from the university hospital. Similarly, 64 males and 44 females (total of 108) indicated that they are fairly aware of their rights as patients when accessing healthcare services from the university hospital.

However, 75 males and 39 females (summing up to 114) indicated that they are aware of their rights as patients when accessing healthcare services from the university hospital, while 33 males and 21 females (summing up to 54) indicated that they are much aware of their rights as patients when accessing healthcare services from the university hospital. In all, 362 participated in the survey, constituting 224 males and 138 females. However, the Pearson's Chi-Square and the asymptotic significance were 1.140 and .768 respectively, which implies that sex category did not associate significantly with the staff's awareness on their rights as client of the University Hospital.

Regarding the second variable (Rights 2), which looked at their responsibilities as patients, 54 males and 35 females (totalling 89) indicated that they are poorly aware that rights go hand-in-hand with responsibilities and that they least know their responsibilities as patients. Similarly, 76 males and 43 females (a total of 119) indicated that they are fairly aware that rights go hand-in-hand with responsibilities and fairly know their responsibilities as patients. Also, 72 males and 43 females (totalling 115) indicated that they know rights go hand-in-hand with responsibilities and understand their responsibilities as patients.

However, only 22 males and 17 females (total of 39) indicated that they know rights go hand-in-hand with responsibilities and are much aware of their responsibilities as patients when accessing healthcare services. However, the Pearson's Chi-Square and the Asymptotic significance of 0.774 and .856 respectively. This indicated that sex category did not associate significantly with the staff's understanding that rights go with responsibilities, and awareness of their responsibilities as a client of the University Hospital.

Table 4: Knowledge of Respondents on their Rights to Quality Healthcare based on Sex

Variables	Scale	Sex		Total	Asymptotic	
		Male	Female		Chi^2	Sig
Awareness of rights as a client of the University Hospital	Poorly aware	52	34	86	1.140[a]	.768
	Fairly aware	64	44	108		
	Aware	75	39	114		
	Much aware	33	21	54		
Total Observations		**224**	**138**	**362**		
Understanding that rights go with responsibilities, and awareness of responsibilities as a client of the University Hospital	Poorly aware	54	35	89	.774[a]	.856
	Fairly aware	76	43	119		
	Aware	72	43	115		
	Much aware	22	17	39		
Total Observations		**224**	**138**	**362**		
Awareness that the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital	Poorly aware	69	40	109	1.264[a]	.738
	Fairly aware	70	49	119		
	Aware	72	39	111		
	Much aware	13	10	23		
Total Observations		**224**	**138**	**362**		
Awarenes that the hospital and its professionals act per the rights always as per my knowledge of the code of conduct	Poorly aware	73	46	119	2.206[a]	.531
	Fairly aware	71	48	119		
	Aware	69	34	103		
	Much aware	11	10	21		

Table 4 contiuned

Total Observations		**224**	**138**	**362**		
Awarenes of the patients` charter and its contents and acting in line with its provisions when accessing healthcare services at the hospital	Poorly aware	70	39	109	2.927[a]	.403
	Fairly aware	70	53	123		
	Aware	70	35	105		
	Much aware	14	11	25		
Total Observations		**224**	**138**	**362**		

Source: Fieldwork, (2020)

Furthermore, for the knowledge of the patients' charter (Rights 3), 69 males and 40 females (totalling 109) indicated that they are poorly aware the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital. Similarly, 70 males and 49 females (a total of 119) showed that they are fairly aware the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital. Also, 72 males and 39 females (a total of 111) showed that they are aware the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital.

However, only 13 males and 10 females (totalling 23) showed that they are much aware the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital. That notwithstanding, the Pearson's Chi-Square and the asymptotic significance of 1.264 and .738 respectively indicated that sex category did not associate significantly with the staff's awareness that the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital.

As part of the knowledge of patient's rights, the study also assessed the knowledge of the code of conduct. Table 4 shows that 73 males and 46 females (totalling 119) indicated that they poorly agreed the hospital and its professionals act per the rights always as per my knowledge of the code of conduct. Similarly, 71 males and 48 females (totalling 119) indicated that they fairly agreed the hospital and its professionals act per the rights always as per my knowledge of the code of conduct. Also, 69 males and 34 females (totalling

103) indicated that they agreed or were aware the hospital and its professionals act per the rights always as per my knowledge of the code of conduct. However, only 11 males and 10 females (totalling 21) indicated that they strongly agreed or were much aware the hospital and its professionals act per the rights always as per my knowledge of the code of conduct. That notwithstanding, the Pearson's Chi-Square and the asymptotic significance were 2.206 and 0.531 respectively. This implied that sex category did not associate significantly with the staff's awareness that the hospital and its professionals act per the rights always as per the codes of conduct.

Finally, the study also looked at whether the patients act per the provisions of the patients' charter when accessing healthcare services at the hospital. The results in Table 4 show that 70 males and 39 females (totalling 109) indicated that they were poorly aware of the patients` charter and its contents and least acted in line with its provisions when accessing healthcare services at the hospital. Similarly, 70 males and 53 females (totalling 123) indicated that they were fairly aware of the patients` charter and its contents and fairly acted in line with its provisions when accessing healthcare services at the hospital. Also, 70 males and 35 females (totalling 105) indicated that they were aware of the patients` charter and its contents and acted in line with its provisions when accessing healthcare services at the hospital.

However, only a few, 14 males and 11 females (totalling 25) indicated that they were strongly aware of the patients` charter and its contents and always acted in line with its provisions when accessing healthcare services at the hospital. That notwithstanding, the Pearson's Chi-Square and the asymptotic significance of 2.927 and .403 respectively, which indicated that sex category

did not associate significantly with the staff's awareness of the patients` charter and its contents and actions in line with its provisions when accessing healthcare services at the hospital.

None of the Chi-square statistics were significant for the association between sex category and staff's knowledge of their rights to quality healthcare services, which implied that sex category did not associated with the staff's knowledge of their rights to quality healthcare services. This result was not consistent with the finding by Beier and Ackerman (2003) that female staff expressed more knowledge on their rights to quality healthcare services than their male counterparts in Geogia Institute of Technology, United States of America. Similarly, the result in this study did not confirm the finding by Tetemke, Tefera, Sharma and Worku (2014) that male workers had significantly higher knowledge on occupational health and safety than the female workers in Ethiopia.

Okenna (2020) also cited employees' sex as one of the demographics characteristics to be considered in deliberations on rights to quality healthcare services, but cautioned that may not be needed in formal institutions that have similar conditions employment. As the Hewett et al. (2019) explained from the Attribution theory's point, people's attributions about their own knowledge of rights to quality healthcare services are informed by information about the stimulus, beliefs based on prior experiences, and motivation. Though gender did not play a role, Table 5 shows that knowledge of rights of the patients varied based on staff category. It could be seen that 41 junior staff, 41 senior staff and 4 senior members (totalling 86) indicated that they are poorly aware of their rights as patients when accessing healthcare services from the hospital.

Table 5: Knowledge of Respondents on their Rights to Quality Healthcare based on Staff Category

Variables	Scale	Staff Category			Total	Asymptotic	
		Junior Staff	Senior Staff	Senior Members		Chi[2]	Sig
Awarenes of my rights as a client of the University Hospital	Poorly aware	41	41	4	86	28.453[a]	.000
	Fairly aware	42	58	8	108		
	Aware	38	68	8	114		
	Much aware	18	21	15	54		
Total Observations		**139**	**188**	**35**	**362**		
Understand that rights go with responsibilities, and awarenes of my responsibilities as a client of the University Hospital	Poorly aware	50	33	6	89	33.937[a]	.000
	Fairly aware	42	69	8	119		
	Aware	31	73	11	115		
	Much aware	16	13	10	39		
Total Observations		**139**	**188**	**35**	**362**		
Awarenes that the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital	Poorly aware	58	45	6	109	35.791[a]	.000
	Fairly aware	31	77	11	119		
	Aware	43	58	10	111		
	Much aware	7	8	8	23		
Total Observations		**139**	**188**	**35**	**362**		
Awarenes that the hospital and its professionals act per the rights always as per my knowledge of the code of conduct	Poorly aware	64	47	8	119	22.126[a]	.001
	Fairly aware	34	73	12	119		
	Aware	32	60	11	103		
	Much aware	9	8	4	21		

Table 5 contiuned

Total Observations		**139**	**188**	**35**	**362**		
Awarenes of the patients` charter and its contents and acting in line with its provisions when accessing healthcare services at the hospital	Poorly aware	62	40	7	109	40.194[a]	.000
	Fairly aware	34	81	8	123		
	Aware	28	60	17	105		
	Much aware	15	7	3	25		
Total Observations		**139**	**188**	**35**	**362**		

Source: Fieldwork, (2020)

Similarly, 42 junior staff, 52 senior staff and 8 senior members (totalling 108) indicated that they are fairly aware of their rights as patients when accessing healthcare services from the hospital. Also, 38 junior staff, 68 senior staff and 8 senior members (totalling 114) indicated that they are aware of their rights as patients when accessing healthcare services from the hospital. However, 18 junior staff, 21 senior staff and 15 senior members (totalling 54) indicated that they are strongly aware of their rights as patients when accessing healthcare services from the hospital. In all, a total of 362 participated in the survey, constituting 139 junior staff, 188 senior staff and 35 senior members. However, the Pearson's Chi-Square and the asymptotic significance of 28.453 and .000, respectively, which implies that staff category associates significantly with the staff's awareness on their rights as client of the University Hospital.

Regarding the second variable (Rights 2), 50 junior staff, 33 senior staff and 6 senior members (totalling 89) indicated that they are poorly aware that rights go hand-in-hand with responsibilities and that they least know their responsibilities as patients. Similarly, 42 junior staff, 69 senior staff and 8 senior members (totalling 119) indicated that they are fairly aware that rights go hand-in-hand with responsibilities and fairly know their responsibilities as patients. Also, 31 junior staff, 73 senior staff and 11 senior members (totalling 115) indicated that they know rights go hand-in-hand with responsibilities and understand their responsibilities as patients. But, only 16 junior staff, 13 senior staff and 10 senior members (totalling 39) indicated that they know rights go hand-in-hand with responsibilities and are strongly aware of their responsibilities as patients when accessing healthcare services. However, the Pearson's Chi-Square and the asymptotic significance of 33.937 and .000

respectively. This means that staff category associates significantly with the staff's understanding that rights go with responsibilities, and awareness of their responsibilities as a client of the University Hospital.

Furthermore, for the knowledge of the patients' charter (Rights 3), 58 junior staff, 45 senior staff and 6 senior members (totalling 119) indicated that they are poorly aware the hospital makes the patients` rights and responsibilities as contained in the Patients` Charter available at vantage points at the hospital. Similarly, 31 junior staff, 77 senior staff and 11 senior members (totalling 119) showed that they are fairly aware the hospital makes the patients` rights and responsibilities as contained in the Patients` Charter available at vantage points at the hospital. Also, 43 junior staff, 58 senior staff and 10 senior members (totalling 111) showed that they are aware the hospital makes the patients` rights and responsibilities as contained in the Patients` Charter available at vantage points at the hospital.

However, 7 junior staff, 8 senior staff and 8 senior members (totalling 23) showed that they are strongly aware the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 35.791 and .000 respectively. The implication is that means that staff category associates significantly with the staff's awareness that the hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital.

Table 5 also shows that 64 junior staff, 47 senior staff and 8 senior members (totalling 119) indicated that they poorly agreed the hospital and its professionals act per the rights always as per my knowledge of the code of

conduct. Similarly, 34 junior staff, 73 senior staff and 12 senior members (totalling 119) indicated that they fairly agreed the hospital and its professionals act per the rights always as per my knowledge of the code of conduct. Also, 32 junior staff, 60 senior staff and 11 senior members (totalling 103) indicated that they agreed or were aware the hospital and its professionals act per the rights always as per my knowledge of the code of conduct.

However, only 9 junior staff, 8 senior staff and 4 senior members (totalling 21) indicated that they strongly agreed or were much aware the hospital and its professionals act per the rights always as per my knowledge of the code of conduct. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 22.126 and .000 respectively, which suggest that staff category associates significantly with the staff's awareness that the hospital and its professionals act per the rights always as per the codes of conduct.

Finally, the results in Table 5 show that 62 junior staff, 40 senior staff and 7 senior members (totalling 109) indicated that they were poorly aware of the patients` charter and its contents and least acted in line with its provisions when accessing healthcare services at the hospital. Similarly, 34 junior staff, 81 senior staff and 8 senior members (totalling 123) indicated that they were fairly aware of the patients` charter and its contents and fairly acted in line with its provisions when accessing healthcare services at the hospital. Also, 28 junior staff, 60 senior staff and 17 senior members (totalling 105) indicated that they were aware of the patients` charter and its contents and acted in line with its provisions when accessing healthcare services at the hospital.

However, only a few, 15 junior staff, 7 senior staff and 3 senior members (totalling 25) indicated that they were strongly aware of the patients` charter

and its contents and always acted in line with its provisions when accessing healthcare services at the hospital. That notwithstanding, the Pearson's Chi-Square and the asymptotic significance of 40.194 and .000 respectively. This means that staff category associates significantly with the staff's awareness of the patients` charter and its contents and actions in line with its provisions when accessing healthcare services at the hospital.

The heterogeneous analysis results indicated that junior and senior staff are fairly aware of their rights to quality healthcare services, while the senior members are aware. This result means that the awareness of rights to quality healthcare services is higher among the senior members than the junior and senior staff. It is clear that the junior and senior staff rated their knowledge of their rights to quality healthcare services at an average (2/4) on a scale of one to four while the senior members settled on above-average (3/4) on the same scale.

As a sectional head at the hospital put it, "the knowledge of the staff of their right to quality healthcare service vary based on the category." She continued by saying that the senior members always show that they know their left and right. However, she mentioned that the senior staff mostly act to abuse their privileges; hence, she is in a dilemma about whether they know their right. She also noted that the junior staff are so obedient and ready to listen to explanations and discussions when visiting the hospital. These assertions by the sectional head are not far from the results mentioned above. Another sectional head interviewed remarked, "the senior members have good knowledge of their rights, unlike the senior staff. For the junior staff, they are quite okay with it and also ready to learn and listen to us when we talk to them."

Overall, from the qualitative data gathered for this study, all the sectional heads interviewed ranked the senior members highest on the scale regarding their knowledge of their rights to quality healthcare services. However, they were all indifferent as to how to rate the senior staff and the junior staff. They opined that they are on average. One sectional head in her closing remark regarding this topic said, "knowing one's rights to quality healthcare is not about higher education, but a simple dialogue between healthcare service providers and clients, and continuous fruitful discussions strengthen that knowledge." Thus, there is a low level of knowledge of rights to quality healthcare services among the junior and senior staff of the University of Cape Coast, who forms two-thirds of the total population.

The point of discussion is that all the Chi-square tests were significant for the association between staff category and knowledge on rights to quality healthcare services, which implied that staff category associated significantly with the staff's knowledge of their rights to quality healthcare services. Again, the responses from the key informants suggested that senior members had better understanding of their their rights to quality healthcare services than the junior and the senior staff who had similar level of knowledge on their rights to quality healthcare services. The results contracted that of Aluko, Adebayo, Adebisi, Ewegbemi, Abidoye and Popoola (2016) that the rank of nurses in Nigeria, did not associate significantly with the nurses' knowledge of their rights to quality occupational healthcare services.

That notwithstanding, these findings confirmed the reports by Ofosu-Kwarteng (2012) that there was a low level of knowledge among patients with lower occupational rakns on their rights to quality healthcare services compared

those with higher occupoational positions in Ghana. This result reechoed the attribution theory's proposition, which holds that schema formed from pre-existing beliefs and knowledge influences how people interpret new information (Geva & Mintz 1997). In this respect, the senior members had higher schema than the junior members, which made the senior members to rate their knowledge on their rights to quality healthcare services, higher than the junior staff and the senior staff who espressed similar schema.

Empirical literature holds that the sources of knowledge of one's health rights emanate from the standards, codes of conduct, decrees, rules, and regulations governing healthcare service access and consumption (Dagger et al., 2007; Ofosu-Kwarteng, 2012; Tenkorang 2016). In Ghana, the sources of patients' health rights are the work standards and ethics of the Ghana Health Service, the Patients Charter, and other institutional arrangements and directives in accessing and consuming healthcare services. It could be that the senior members were more privy to those standards, while the junior staff and the senior staff were less privy to those sources of knowledge of one's health rights.

Staffs' Views of the Quality of Healthcare Services Received

This study's second specific objective is to examine respondents' views on the quality of healthcare serviced from the university of Cape Coast hospital. As explained earlier in chapters two and three, this study measures healthcare delivery quality from four dimensions such as communication by the hospital with their clients, physical environment of the hospital, operation and treatment (professionalism), and management quality. The results with respect to the communication dimenstion are presented in Table 6. It shows that 13 junior staff, 38 senior staff and 3 senior members (totalling 54) indicated that they

poorly agree that the nurses exhibit good human relations in their line of duty. Similarly, 63 junior staff, 72 senior staff and 11 senior members (totalling 146) indicated that they fairly agree that the nurses exhibit good human relations in their line of duty.

Also, 60 junior staff, 74 senior staff and 15 senior members (totalling 149) indicated that they agree that the nurses exhibit good human relations in their line of duty. However, 3 junior staff, 4 senior staff and 6 senior members (totalling 13) indicated that they strongly agree that the nurses exhibit good human relations in their line of duty. In all, a total of 362 participated in the survey, constituting 139 junior staff, 188 senior staff and 35 senior members. The Chi-Square and the asymptotic significance were 29.227 and 0.000, which indicated that staff category associates significantly with the staff's level of agreement that nurses exhibit good human relations in their line of duty.

Regarding the second construct under communication, five junior staff, 32 senior staff and one senior member indicated that they poorly agree that the nurses explain things to them in an excellent manner. However, 80 junior staff, 75 senior staff and 13 senior members indicated that they fairly agree that the nurses explain things to them in an excellent manner. Also, 49 junior staff, 79 senior staff and 18 senior members indicated that they agree that the nurses explain things to them in an excellent manner. But only 5 junior staff, 2 senior staff and 3 senior members indicated that they strongly or much agree that the nurses explain things to them in an excellent manner. The Pearson's Chi-Square and the asymptotic significance of 30.642 and .000 respectively shown that staff category associates significantly with the staff's level of agreement that nurses explain things to them in an excellent manner.

Table 6: Staff Category by Communication as a Measure of Service Quality

Variables	Scale	Staff Category			Total	Asymptotic	
		Junior Staff	Senior Staff	Senior Members		Chi^2	Sig
Communication as a measure of service quality							
Nurses exhibit good human relations in their line of duty.	Poorly agree	13	38	3	54	29.227[a]	.000
	Fairly agree	63	72	11	146		
	Agree	60	74	15	149		
	Much agree	3	4	6	13		
Total Observations		**139**	**188**	**35**	**362**		
Nurses explain things to me in an excellent manner.	Poorly agree	5	32	1	38	30.642[a]	.000
	Fairly agree	80	75	13	168		
	Agree	49	79	18	146		
	Much agree	5	2	3	10		
Total Observations		**139**	**188**	**35**	**362**		
The doctors exhibit good human relations in their line of duty.	Poorly agree	5	14	1	20	18.832[a]	.004
	Fairly agree	42	52	8	102		
	Agree	82	101	15	198		
	Much agree	10	21	11	42		
Total Observations		**139**	**188**	**35**	**362**		
Doctors give detailed explanations of issues during a consultation.	Poorly agree	3	15	1	19	13.607[a]	.034
	Fairly agree	53	50	8	111		
	Agree	70	105	19	194		

Table 6 contiuned

	Much agree	13	18	7	38		
Total Observations		**139**	**188**	**35**	**362**		
Pharmacists give detailed explanations on prescription, dosage, and side effects of drugs.	Poorly agree	3	16	2	21	19.354[a]	.004
	Fairly agree	63	68	8	139		
	Agree	66	76	20	162		
	Much agree	7	28	5	40		
Total Observation		**139**	**188**	**35**	**362**		
The hospital generally responds to an emergency in a professional manner.	Poorly agree	12	31	1	44	13.372[a]	.037
	Fairly agree	60	81	16	157		
	Agree	55	69	13	137		
	Much agree	12	7	5	24		
Total Observation		**139**	**188**	**35**	**362**		
The general customer relationship management of the hospital is outstanding.	Poorly agree	5	28	2	35	19.116[a]	.004
	Fairly agree	64	76	9	149		
	Agree	64	75	20	159		
	Much agree	6	9	4	19		
Total Observations		**139**	**188**	**35**	**362**		

Source: Fieldwork, (2020)

Furthermore, for the doctors, five junior staff, 14 senior staff and 1 senior members indicated that they poorly agree that the doctors exhibit good human relations in their line of duty. Similarly, 42 junior staff, 52 senior staff and 8 senior members showed that they fairly agree that the doctors exhibit good human relations in their line of duty. Also, 82 junior staff, 101 senior staff and 15 senior members showed that they agree that the doctors exhibit good human relations in their line of duty. However, 10 junior staff, 21 senior staff and 11 senior members showed that they strongly agree that the doctors exhibit good human relations in their line of duty. Accordingly, the Pearson's Chi-Square and the asymptotic significance were 18.832 and .004 respectively, which implied that staff category associates significantly with the staff's level of agreement that doctors exhibit good human relations in their line of duty.

Table 6 also shows that 3 junior staff, 15 senior staff and 1 senior members indicated that they poorly agreed the doctors give detailed explanations of issues during a consultation. Similarly, 53 junior staff, 50 senior staff and 8 senior members indicated that they fairly agreed the doctors give detailed explanations of issues during a consultation. But a huge 70 junior staff, 105 senior staff and 19 senior members indicated that they agreed the doctors give detailed explanations of issues during a consultation. However, only 13 junior staff, 18 senior staff and 7 senior members indicated that they strongly agreed the doctors give detailed explanations of issues during a consultation. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 13.607 and .034 respectively indicated that staff category associates significantly with the staff's level of agreement that doctors give detailed explanations of issues during a consultation

For the pharmacist, the results in Table 6 show that 3 junior staff, 16 senior staff and 2 senior members indicated that they poorly agree that the pharmacists give detailed explanations on prescription, dosage, and side effects of drugs. Similarly, 63 junior staff, 68 senior staff and 8 senior members indicated that they fairly agree that the pharmacists give detailed explanations on prescription, dosage, and side effects of drugs. But a huge 66 junior staff, 76 senior staff and 20 senior members indicated that they agree that the pharmacists give detailed explanations on prescription, dosage, and side effects of drugs. However, only a few, 7 junior staff, 28 senior staff and 5 senior members indicated that they strongly agree that the pharmacists give detailed explanations on prescription, dosage, and side effects of drugs. That notwithstanding, the Pearson's Chi-Square and the asymptotic significance were 19.354 and 0.004 respectively. This meant that staff category associates significantly with the staff's level of agreement that pharmacists give detailed explanations on prescription, dosage, and side effects of drugs.

For general response of the hospital in communication, 12 junior staff, 31 senior staff and 1 senior members indicated that they poorly agree that the hospital generally responds to an emergency in a professional manner. However, 60 junior staff, 81 senior staff and 16 senior members indicated that they fairly agree that the hospital generally responds to an emergency in a professional manner. Also, 55 junior staff, 69 senior staff and 13 senior members indicated that they agree that the hospital generally responds to an emergency in a professional manner. But, 12 junior staff, 7 senior staff and 5 senior members indicated that they strongly agree that the hospital generally responds to an emergency in a professional manner. Accordingly, the Pearson's

Chi-Square and the asymptotic significance of 13.372 and 0.037 respectively indicated that staff category associates significantly with the staff's level of agreement that the hospital generally responds to an emergency in a professional manner.

Finally on communication, 5 junior staff, 28 senior staff and 2 senior members indicated that they poorly agree that the general customer relationship management of the hospital is outstanding. But 64 junior staff, 76 senior staff and 9 senior members showed that they fairly agree that the general customer relationship management of the hospital is outstanding. Similarly, 64 junior staff, 75 senior staff and a huge 20 senior members showed that they agree that the general customer relationship management of the hospital is outstanding. However, only 6 junior staff, 9 senior staff and 4 senior members showed that they strongly agree that the general customer relationship management of the hospital is outstanding. Again, the Pearson's Chi-Square and the asymptotic significance of 19.116 and .004 respectively indicated that staff category associates significantly with the staff's level of agreement that the general customer relationship management of the hospital is outstanding.

Table 7 also contains the results on the physical environment as a measure of service quality. Table 7, shows that 4 junior staff, 15 senior staff and 3 senior members indicated that they poorly agreed the physical appearance of the facility is excellent. But, 48 junior staff, 55 senior staff and 12 senior members indicated that they fairly agreed the physical appearance of the facility is excellent. But a huge 74 junior staff, 90 senior staff and 14 senior members indicated that they agreed the physical appearance of the facility is excellent. However, only 13 junior staff, 28 senior staff and 6 senior members indicated

that they strongly agreed the physical appearance of the facility is excellent. Accordingly, the Pearson's Chi-Square and the asymptotic significance were 8.133 and 0.000 respectively. This indicated that staff category associates significantly with the staff's level of satisfaction with the physical appearance of the Hospital facility.

For the amenities, the results in Table 7 show that five junior staff, 15 senior staff and three senior members indicated that they poorly agree that the physical appearance of the amenities is ideal. Similarly, 56 junior staff, 74 senior staff and 13 senior members indicated that they fairly agree that the physical appearance of the amenities is ideal. But a huge 68 junior staff, 89 senior staff and 15 senior members indicated that they agree that the physical appearance of the amenities is ideal. However, only a few, 10 junior staff, 10 senior staff and four senior members indicated that they strongly agree that the physical appearance of the amenities is ideal. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 4.775 and .003 respectively showed that staff category associates significantly with the staff's level of agreement that the physical appearance of the Hospital amenities is ideal.

Table 7: Staff Category by Physical Environment as a Measure of Service Quality

Variables	Scale	Staff Category			Total	Asymptotic	
		Junior Staff	Senior Staff	Senior Members		Chi2	Sig
Physical Environment as a measure of service quality							
Excellentness of the physical appearance of the hospital facility.	Poor	4	15	3	22	8.133[a]	.000
	Fair	48	55	12	115		
	Satisfactory	74	90	14	178		
	Excellent	13	28	6	47		
Total Observations		**139**	**188**	**35**	**362**		
Idealness of the physical appearance of the amenities.	Poor	5	15	3	23	4.775[a]	.003
	Fair	56	74	13	143		
	Satisfactory	68	89	15	172		
	Excellent	10	10	4	24		
Total Observations		**139**	**188**	**35**	**362**		
Welcomingness of the general cleanliness of the hospital.	Poor	2	10	1	13	8.905[a]	.001
	Fair	32	56	11	99		
	Satisfactory	77	97	15	189		
	Excellent	28	25	8	61		
Total Observations		**139**	**188**	**35**	**362**		
Comfortableness of the hospital's physical environment	Poor	4	13	2	19	4.300[a]	.000
	Fair	58	81	18	157		
	Satisfactory	64	80	13	157		

Table 7 contiuned

	Excellent	13	14	2	29		
Total Observations		**139**	**188**	**35**	**362**		
There is very little or no degree of risk of injury at the hospital.	Poorly agree	10	10	4	24	3.839[a]	.004
	Fairly agree	66	82	15	163		
	Agree	54	80	15	149		
	Much agree	9	16	1	26		
Total Observations		**139**	**188**	**35**	**362**		
The hospital has ultra-modern equipment.	Poorly agree	4	11	2	17	4.410[a]	.000
	Fairly agree	61	75	10	146		
	Agree	67	90	21	178		
	Much agree	7	12	2	21		
Total Observations		**139**	**188**	**35**	**362**		
The capacity of the hospital is adequate.	Poorly agree	5	18	3	26	9.893[a]	.014
	Fairly agree	72	75	18	165		
	Agree	56	87	11	154		
	Much agree	6	8	3	17		
Total Observations		**139**	**188**	**35**	**362**		
The hospital is disability friendly.	Poorly agree	7	27	5	39	21.374[a]	.002
	Fairly agree	51	70	9	130		
	Agree	54	74	10	138		
	Much agree	27	17	11	55		

Table 7 continued

Total Observations		**139**	**188**	**35**	**362**		
There are directional signs at vantage points.	Poorly agree	7	14	3	24	7.250[a]	.008
	Fairly agree	37	53	9	99		
	Agree	55	88	13	156		
	Much agree	40	33	10	83		
Total Observations		**139**	**188**	**35**	**362**		
The general layout of the facility is outstanding.	Poorly agree	3	12	2	17	5.754[a]	.024
	Fairly agree	37	53	13	103		
	Agree	76	96	17	189		
	Much agree	23	27	3	53		
Total Observations		**139**	**188**	**35**	**362**		
The dressing and physical appearance of the staff of the hospital is very appealing.	Poorly agree	2	10	1	13	6.283[a]	.036
	Fairly agree	34	38	5	77		
	Agree	83	111	21	215		
	Much agree	20	29	8	57		
Total Observations		**139**	**188**	**35**	**362**		

Source: Fieldwork, (2020)

On cleanliness, the results in Table 7 show that two junior staff, 10 senior staff and one senior member indicated that they poorly agree that the general cleanliness of the hospital is welcoming. Similarly, 32 junior staff, 56 senior staff and 11 senior members indicated that they fairly agree that the general cleanliness of the hospital is welcoming. But a huge 77 junior staff, 97 senior staff and 15 senior members indicated that they agree that the general cleanliness of the hospital is welcoming. However, 28 junior staff, 25 senior staff and 8 senior members indicated that they strongly agree that the general cleanliness of the hospital is welcoming. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 8.905 and .001 respectively, which showed that staff category associates significantly with the staff's level of agreement that the general cleanliness of the Hospital is welcoming.

For the level of comfort offered by the physical environment, the results in Table 7 show that 4 junior staff, 13 senior staff and 2 senior members indicated that they poorly agree that the physical environment offers a high level of comfort. But 58 junior staff, 81 senior staff and 13 senior members indicated that they fairly agree that the physical environment offers a high level of comfort. Similarly, a huge 64 junior staff, 80 senior staff and 13 senior members indicated that they agree that the physical environment offers a high level of comfort. However, only a few, 13 junior staff, 14 senior staff and 2 senior members indicated that they strongly agree that the physical environment offers a high level of comfort. That notwithstanding, the Pearson's Chi-Square and the asymptotic significance of 4.300 and .000 respectively indicated that staff category associates significantly with the staff's level of agreement that the physical environment offers a high level of comfort.

For the risk of injuries, the results in Table 7 show that 10 junior staff, 10 senior staff and 4 senior members indicated that they poorly agree that there is very little or no degree of risk of injury at the hospital. However, a huge 66 junior staff, 82 senior staff and 15 senior members indicated that they fairly agree that there is very little or no degree of risk of injury at the hospital. Similarly, 54 junior staff, 80 senior staff and 15 senior members indicated that they agree that there is very little or no degree of risk of injury at the hospital. However, only a few, nine junior staff, 16 senior staff and one senior member indicated that they strongly agree that there is very little or no degree of risk of injury at the hospital. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 3.839 and .004 respectively. This suggested that staff category associates significantly with the staff's level of agreement that there is very little or no degree of risk of injury at the hospital.

For the state of the equipment, the results in Table 7 show that four junior staff, 11 senior staff and two senior members showed that they poorly agree that the hospital has ultra-modern equipment necessary to execute its mandates. However, 61 junior staff, 75 senior staff and 10 senior members indicated that they fairly agree that the hospital has ultra-modern equipment necessary to execute its mandates. Also, a huge 67 junior staff, 90 senior staff and 21 senior members indicated that they agree that the hospital has ultra-modern equipment necessary to execute its mandates. However, only a few, seven junior staff, 12 senior staff and two senior members indicated that they strongly agree that the hospital has the ultra-modern equipment necessary to execute its mandates. Therefore, the Pearson's Chi-Square and the asymptotic significance of 4.410 and .000 respectively indicated that staff category

associates significantly with the staff's level of agreement that the hospital has ultra-modern equipment.

On the capacity of the hospital, the results in Table 7 show that five junior staff, 18 senior staff and three senior members indicated that they poorly agree that the capacity of the hospital is adequate. However, a huge 72 junior staff, 75 senior staff and 18 senior members indicated that they fairly agree that the capacity of the hospital is adequate. Similarly, 56 junior staff, 87 senior staff and 11 senior members indicated that they agree that the capacity of the hospital is adequate. However, only a few, six junior staff, eight senior staff and three senior members, indicated that they strongly agree that the hospital's capacity is adequate. Therefore, the Pearson's Chi-Square and the asymptotic were 9.893 and .014, revealed that staff category associates significantly with the staff's level of agreement that the capacity of the hospital is adequate.

For the disability-friendly nature of the hospital, the results in Table 7 show that seven junior staff, 27 senior staff and five senior members indicated that they poorly agree that the hospital is disability-friendly. Also, 51 junior staff, 70 senior staff and 9 senior members indicated that they fairly agree that the hospital is disability friendly. Similarly, 54 junior staff, 74 senior staff and 10 senior members indicated that they agree that the hospital is disability friendly. However, 27 junior staff, 17 senior staff and 11 senior members indicated that they strongly agree that the hospital is disability friendly. Hence, the Pearson's Chi-Square and the asymptotic significance of 21.374 and 0.002 respectively meants that staff category associates significantly with the staff's level of agreement that the hospital is disability friendly.

Regarding directions and signs, the results in Table 7 show that seven

junior staff, 14 senior staff and three senior members indicated that they poorly agree that there are directional signs at vantage points at the hospital helping clients to locate the needed facilities. Similarly, 37 junior staff, 53 senior staff and 9 senior members indicated that they fairly agree that there are directional signs at vantage points at the hospital helping clients to locate the needed facilities. But 55 junior staff, 88 senior staff and 13 senior members indicated that they agree that there are directional signs at vantage points at the hospital helping clients to locate the needed facilities. However, 40 junior staff, 33 senior staff and 10 senior members indicated that they strongly agree that there are directional signs at vantage points at the hospital helping clients to locate the needed facilities. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 7.250 and .008 respectively indicated that staff category associates significantly with the staff's level of agreement that there are directional signs at vantage points.

On layout, Table 7 show that three junior staff, 12 senior staff and two senior members indicated that they poorly agree that the general layout of the facility is outstanding. Similarly, 37 junior staff, 53 senior staff and 13 senior members indicated that they fairly agree that the general layout of the facility is outstanding. But a huge 76 junior staff, 96 senior staff and 17 senior members indicated that they agree that the general layout of the facility is outstanding. Yet, 23 junior staff, 27 senior staff and 3 senior members indicated that they strongly agree that the general layout of the facility is outstanding. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 5.754 and .024 respectively showed that staff category associates significantly with the staff's level of agreement that the general layout of the hospital facility is outstanding.

The last construct on physical environment looks at the physical appearance of the workers too. The results in Table 7 show that two junior staff, 10 senior staff and one senior member indicated that they poorly agree that the dressing and physical appearance of the staff of the hospital is very appealing. Also, 34 junior staff, 38 senior staff and five senior members indicated that they fairly agree that the dressing and physical appearance of the staff of the hospital is very appealing. But a huge 83 junior staff, 111 senior staff and 21 senior members indicated that they agree that the dressing and physical appearance of the staff of the hospital is very appealing. Similarly, 20 junior staff, 29 senior staff and 8 senior members indicated that they strongly agree that the dressing and physical appearance of the staff of the hospital is very appealing. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 6.283 and .036 respectively revealed that staff category associates significantly with the staff's level of agreement that the dressing and physical appearance of the staff of the hospital is very appealing.

The third dimension of healthcare service quality looks at operations and Treatment (Professionalism). The results are presented in Table 8. Regarding the first construct, which looks at confidentiality and privacy, Table 8 show that five junior staff, 27 senior staff and four senior members indicated that they poorly agree that the hospital respects the confidentiality and privacy of clients. However, 62 junior staff, 73 senior staff and 10 senior members indicated that they fairly agree that the hospital respects the confidentiality and privacy of clients. Similarly, a huge 61 junior staff, 80 senior staff and 17 senior members indicated that they agree that the hospital respects the confidentiality and privacy of clients.

Table 8: Staff Category by Operations and Treatment (Professionalism)as a Measure of Service Quality

Variables	Scale	Staff Category			Total		
Asymptotic							
		Junior Staff	Senior Staff	Senior Members		Chi2	Sig
Operations and Treatment (Professionalism) as a Measure of Service Quality							
The hospital respects the confidentiality and privacy of clients.	Poorly agree	5	27	4	36	14.840[a]	.022
	Fairly agree	62	73	10	145		
	Agree	61	80	17	158		
	Much agree	11	8	4	23		
Total Observations		**139**	**188**	**35**	**362**		
The hospital exhibits a high level of trustworthiness.	Poorly agree	4	22	2	28	19.029[a]	.004
	Fairly agree	58	51	10	119		
	Agree	70	99	17	186		
	Much agree	7	16	6	29		
Total Observations		**139**	**188**	**35**	**362**		
The hospital acts to reduce or eliminate infections or other harmful side effects of treatments.	Poorly agree	7	18	3	28	11.600[a]	.032
	Fairly agree	75	77	17	169		
	Agree	53	85	11	149		
	Much agree	4	8	4	16		

Table 8 continued

Total Observations		**139**	**188**	**35**	**362**		
Results (outcomes) of care received through diagnosis and treatment are of high quality.	Poorly agree	4	11	1	16	7.436[a]	.014
	Fairly agree	61	62	12	135		
	Agree	57	98	18	173		
	Much agree	17	17	4	38		
Total Observations		**139**	**188**	**35**	**362**		
The ratio of services' outputs to the associated costs of receiving those services (considering monetary and time resources) is high.	Poorly agree	11	21	2	34	30.716[a]	.026
	Fairly agree	62	81	19	162		
	Agree	56	76	11	143		
	Much agree	10	10	3	23		
Total Observations		**139**	**188**	**35**	**362**		
The tasks carried out by health workers and facilities meet expectations and technical quality.	Poorly agree	8	16	1	25	14.924[a]	.051
	Fairly agree	67	77	16	160		
	Agree	57	88	15	160		
	Much agree	7	7	3	17		
Total Observations		**139**	**188**	**35**	**362**		
Healthcare services are unrestricted to gender.	Poorly agree	7	15	1	23	11.204[a]	.041
	Fairly agree	63	57	9	129		
	Agree	54	92	20	166		
	Much agree	15	24	5	44		
Total Observations		**139**	**188**	**35**	**362**		
Healthcare services are unrestricted to rank.	Poorly agree	35	26	5	66	16.993[a]	.009
	Fairly agree	53	77	11	141		

Table 8 contiuned

	Agree	43	77	13	133		
	Much agree	8	8	6	22		
Total Observations		**139**	**188**	**35**	**362**		
Healthcare services are unrestricted to disability status.	Poorly agree	7	23	3	33	16.618[a]	.011
	Fairly agree	45	62	9	116		
	Agree	63	92	16	171		
	Much agree	24	11	7	42		
Total Observations		**139**	**188**	**35**	**362**		
Waiting time at the hospital to access healthcare services or treatment is ideal.	Poorly agree	22	52	9	83	13.177[a]	.040
	Fairly agree	58	72	10	140		
	Agree	55	56	12	123		
	Much agree	4	8	4	16		
Total Observations		**139**	**188**	**35**	**362**		
The nurses' and doctors` general performance in their line of duty is commendable.	Poorly agree	9	16	1	26	6.582[a]	.034
	Fairly agree	52	57	10	119		
	Agree	68	100	18	186		
	Much agree	10	15	6	31		
Total Observations		**139**	**188**	**35**	**362**		

Source: Fieldwork, (2020)

However, only a few; 11 junior staff, eight senior staff and four senior members indicated that they strongly agree that the hospital respects the confidentiality and privacy of clients. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 14.840 and 0.022 respectively, indicated that staff category associates significantly with the staff's level of agreement that the hospital respects the confidentiality and privacy of clients.

For the trustworthiness, the results in Table 8 show that four junior staff, 22 senior staff and two senior members indicated that they poorly agree that the hospital exhibits a high level of trustworthiness. Also, 58 junior staff, 51 senior staff and 10 senior members indicated that they fairly agree that the hospital exhibits a high level of trustworthiness. But a huge 70 junior staff, 99 senior staff and 17 senior members indicated that they agree that the hospital exhibits a high level of trustworthiness. However, only a few, seven junior staff, 16 senior staff and six senior members indicated that they strongly agree that the hospital exhibits a high level of trustworthiness. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 19.029 and 0.004 respectively indicated that staff category associates significantly with the staff's level of agreement that the hospital exhibits a high level of trustworthiness.

Also in Table 8, the results show that seven junior staff, 18 senior staff and three senior members (totalling 28) indicated that they poorly agree that the hospital acts to reduce or eliminate infections or other harmful side effects of treatments. However, 75 junior staff, 77 senior staff and 17 senior members indicated that they fairly agree that the hospital acts to reduce or eliminate infections or other harmful side effects of treatments. Also, a huge 53 junior staff, 85 senior staff and 11 senior members indicated that they agree that the

hospital acts to reduce or eliminate infections or other harmful side effects of treatments. However, only a few; 4 junior staff, 8 senior staff and 4 senior members indicated that they strongly agree that the hospital acts to reduce or eliminate infections or other harmful side effects of treatments. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 11.600 and 0.032 respectively indicated that staff category associates significantly with the staff's level of agreement that the hospital acts to reduce or eliminate infections or other harmful side effects of treatments.

Table 8 also shows that only a few, four junior staff, 11 senior staff and 1 senior members (totalling 16) indicated that they poorly agree that the results (outcomes) of care received through diagnosis and treatment are of high quality. However, 61 junior staff, 62 senior staff and 12 senior members indicated that they fairly agree that the results (outcomes) of care received through diagnosis and treatment are of high quality. Also, 57 junior staff, 98 senior staff and 18 senior members indicated that they agree that the results (outcomes) of care received through diagnosis and treatment are of high quality. Similarly, 17 junior staff, 17 senior staff and 4 senior members indicated that they strongly agree that the results of care received through diagnosis and treatment are of high quality. Thus, the Pearson's Chi-Square and the asymptotic significance of 7.436 and .014 respectively indicated that staff category associates significantly with the staff's level of agreement that the results/ outcomes of care received through diagnosis and treatment are of high quality.

For the costs, the results in Table 8 show that 11 junior staff, 21 senior staff and 2 senior members indicated that they poorly agree that the ratio of services' outputs to the associated costs of receiving those services (considering

monetary and time resources) is high. But 62 junior staff, 81 senior staff and 19 senior members indicated that they fairly agree that the ratio of services' outputs to the associated costs of receiving those services (considering monetary and time resources) is high. Similarly, 56 junior staff, 76 senior staff and 11 senior members indicated that they agree that the ratio of services' outputs to the associated costs of receiving those services (considering monetary and time resources) is high. However, only 10 junior staff, 10 senior staff and 3 senior members indicated that they strongly agree that the ratio of services' outputs to the associated costs of receiving those services (considering monetary and time resources) is high. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 30.716 and .026 respectively indicated that staff category associates significantly with the staff's level of agreement that the ratio of services' outputs to the associated costs of receiving those services is high.

Table 8 also shows that eight junior staff, 16 senior staff and one senior member indicated that they poorly agree that the tasks carried out by health workers and facilities meet expectations and technical quality. Also, 67 junior staff, 77 senior staff and 16 senior members indicated that they fairly agree that the tasks carried out by health workers and facilities meet expectations and technical quality. Similarly, 57 junior staff, 88 senior staff and 15 senior members indicated that they agree that the tasks carried out by health workers and facilities meet expectations and technical quality. However, only a few, seven junior staff, seven senior staff and three senior members indicated that they strongly agree that the tasks carried out by health workers and facilities meet expectations and technical quality. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 14.204 and 0.051 respectively indicated that

staff category associates significantly with the staff's level of agreement that the tasks carried out by health workers and facilities meet expectations and technical quality.

Regarding the restriction of services, the results in Table 8 show that seven junior staff, 15 senior staff and one senior member indicated that they poorly agree that the healthcare services are unrestricted to gender. However, 63 junior staff, 57 senior staff and nine senior members indicated that they fairly agree that the healthcare services are unrestricted to gender. Similarly, 54 junior staff, 92 senior staff and 20 senior members indicated that they agree that the healthcare services are unrestricted to gender. However, 15 junior staff, 24 senior staff and five senior members indicated that they strongly agree that the healthcare services are unrestricted to gender. Accordingly, the Pearson's Chi-Square and the asymptotic significance were 11.204 and .041, which indicated that staff category associates significantly with the staff's level of agreement that the healthcare services are unrestricted to gender.

Also, on restriction of services, Table 8 shows that 35 junior staff, 26 senior staff and 5 senior members indicated that they poorly agree that the healthcare services are unrestricted to rank. Also, 53 junior staff, 77 senior staff and 11 senior members indicated that they fairly agree that the healthcare services are unrestricted to rank. Similarly, 43 junior staff, 77 senior staff and 13 senior members indicated that they agree that the healthcare services are unrestricted to rank. However, only a few, 8 junior staff, 8 senior staff and 6 senior members indicated that they strongly agree that the healthcare services are unrestricted to rank. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 16.993 and .009 respectively indicated that staff

category associates significantly with the staff's level of agreement that healthcare services are unrestricted to rank.

Still on restriction of services, Table 8 shows that seven junior staff, 23 senior staff and three senior members indicated that they poorly agree that the healthcare services are unrestricted to disability status. Also, 45 junior staff, 62 senior staff and nine senior members indicated that they fairly agree that the healthcare services are unrestricted to disability status. Similarly, 63 junior staff, 92 senior staff and 16 senior members indicated that they agree that the healthcare services are unrestricted to disability status. Again, 24 junior staff, 11 senior staff and seven senior members indicated that they strongly agree that the healthcare services are unrestricted to disability status. Again, the Pearson's Chi-Square and the asymptotic significance of 16.618 and .011 respectively indicated that staff category associates significantly with the staff's level of agreement that the healthcare services are unrestricted to disability status.

On waiting time, Table 8 shows that 22 junior staff, 52 senior staff and nine senior members indicated that they poorly agree that the waiting time at the hospital to access healthcare services or treatment is ideal. But 58 junior staff, 72 senior staff and 10 senior members indicated that they fairly agree that the waiting time at the hospital to access healthcare services or treatment is ideal. Similarly, 55 junior staff, 56 senior staff and 12 senior members indicated that they agree that the waiting time at the hospital to access healthcare services or treatment is ideal. However, only a few, 4 junior staff, 8 senior staff and 4 senior members indicated that they strongly agree that the waiting time at the hospital to access healthcare services or treatment is ideal. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 13.177 and .040

respectively indicated that staff category associates significantly with the staff's level of agreement that waiting time at the hospital to access healthcare services/ treatment is ideal.

Finally on operations and treatment, Table 8 shows that nine junior staff, 16 senior staff and one senior member indicated that they poorly agree that the nurses' and doctors` general performance in their line of duty is commendable. However, 52 junior staff, 57 senior staff and 10 senior members indicated that they fairly agree that the nurses' and doctors` general performance in their line of duty is commendable. Similarly, 68 junior staff, 100 senior staff and 18 senior members indicated that they agree that the nurses' and doctors` general performance in their line of duty is commendable. However, only a few, 10 junior staff, 15 senior staff and six senior members indicated that they strongly agree that the nurses' and doctors` general performance in their line of duty is commendable. The Pearson's Chi-Square and the asymptotic significance of 6.582 and .034 respectively indicated that staff category associates significantly with the staff's level of agreement that nurses' and doctors` general performance in their line of duty is commendable.

The last part of the service quality looks at management quality. From Table 9, 22 junior staff, 39 senior staff and three senior members indicated that they poorly agree that the management of the hospital addresses grievances and concerns of patients at the hospital in a commendable manner. Also, 64 junior staff, 67 senior staff and 14 senior members indicated that they fairly agree that the management of the hospital addresses grievances and concerns of patients at the hospital in a commendable manner.

Table 9: Staff Category by Management Quality as a Measure of Service Quality

Management Quality as a measure of service quality							
Management addresses grievances and concerns of patients at the hospital in a commendable manner.	Poorly agree	22	39	3	64	7.182[a]	.036
	Fairly agree	64	67	14	145		
	Agree	48	72	15	135		
	Much agree	5	10	3	18		
Total Observations		**139**	**188**	**35**	**362**		
Management addresses conflicts of patients at the hospital in the most professional manner.	Poorly agree	19	31	2	52	16.430[a]	.012
	Fairly agree	71	69	17	157		
	Agree	37	79	11	127		
	Much agree	12	9	5	26		
Total Observations		**139**	**188**	**35**	**362**		
The general quality of services provided at the hospital is ideal.	Poorly agree	8	25	2	35	18.189[a]	.006
	Fairly agree	67	63	14	144		
	Agree	53	93	14	160		
	Much agree	11	7	5	23		
Total Observations		**139**	**188**	**35**	**362**		
Management's feedback collection efforts are plausible.	Poorly agree	6	33	5	44	19.958[a]	.003
	Fairly agree	86	78	17	181		
	Agree	40	65	12	117		
	Much agree	7	12	1	20		

Table 9 continued

Total Observations		**139**	**188**	**35**	**362**		
Management's feedback usage is well satisfying.	Poorly agree	6	25	5	36	10.909[a]	.011
	Fairly agree	80	94	17	191		
	Agree	50	59	11	120		
	Much agree	3	10	2	15		
Total Observations		**139**	**188**	**35**	**362**		
Management's transparency efforts to ensure there are no hidden charges to customers is commendable.	Poorly agree	8	24	5	37	15.095[a]	.020
	Fairly agree	77	79	9	165		
	Agree	50	74	18	142		
	Much agree	4	11	3	18		
Total Observations		**139**	**188**	**35**	**362**		

Source: Fieldwork, (2020)

Similarly, 48 junior staff, 72 senior staff and 15 senior members indicated that they agree that the management of the hospital addresses grievances and concerns of patients at the hospital in a commendable manner. However, 5 junior staff, 10 senior staff and 3 senior members indicated that they strongly agree that the management of the hospital addresses grievances and concerns of patients at the hospital in a commendable manner. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 7.182 and .036 respectively indicated that staff category associates significantly with the staff's level of agreement that management addresses grievances and concerns of patients at the hospital in a commendable manner.

Table 9 also shows that 19 junior staff, 31 senior staff and two senior members indicated that they poorly agree that the management of the hospital addresses conflicts of patients at the hospital in the most professional manner. But a huge 71 junior staff, 69 senior staff and 17 senior members indicated that they fairly agree that the management of the hospital addresses conflicts of patients at the hospital in the most professional manner. Similarly, 37 junior staff, 79 senior staff and 11 senior members indicated that they agree that the management of the hospital addresses conflicts of patients at the hospital in the most professional manner. However, 12 junior staff, 9 senior staff and 5 senior members indicated that they strongly agree that the management of the hospital addresses conflicts of patients at the hospital in the most professional manner. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 16.430 and 0.012 respectively indicated that staff category associates significantly with the staff's level of agreement that management addresses conflicts of patients at the hospital in the most professional manner.

Table 9 also shows that eight junior staff, 25 senior staff and two senior members indicated that they poorly agree that the general quality of services provided at the hospital is ideal. However, 67 junior staff, 63 senior staff and 14 senior members indicated that they fairly agree that the general quality of services provided at the hospital is ideal. Similarly, 53 junior staff, 93 senior staff and 14 senior members indicated that they agree that the general quality of services provided at the hospital is ideal. However, 11 junior staff, 7 senior staff and five senior members indicated that they strongly agree that the general quality of services provided at the hospital is ideal. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 18.189 and 0.006 respectively indicated that staff category associates significantly with the staff's level of agreement that the general quality of services provided at the hospital is ideal.

Regarding feedback, Table 9 shows that six junior staff, 33 senior staff and five senior members indicated that they poorly agree that management's feedback collection efforts are plausible. However, a huge 86 junior staff, 78 senior staff and 17 senior members indicated that they fairly agree that management's feedback collection efforts are plausible. Similarly, 40 junior staff, 65 senior staff and 12 senior members indicated that they agree that management's feedback collection efforts are plausible. However, only a few, 7 junior staff, 12 senior staff and one senior member indicated that they strongly agree that management's feedback collection efforts are plausible. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 19.958 and .003 respectively indicated that staff category associates significantly with the staff's level of agreement that management's feedback collection efforts are plausible.

For feedback usage, Table 9 shows that six junior staff, 25 senior staff

and five senior members indicated that they poorly agree that management's feedback usage is well satisfying. However, 80 junior staff, 94 senior staff and 17 senior members indicated that they fairly agree that management's feedback usage is well satisfying. Similarly, 50 junior staff, 59 senior staff and 11 senior members indicated that they agree that management's feedback usage is well satisfying. However, only a few, three junior staff, 10 senior staff and two senior members indicated that they strongly agree that management's feedback usage is well satisfying. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 10.909 and .011 respectively indicated that staff category associates significantly with the staff's level of agreement that management's feedback usage is well satisfying.

Finally, the last construct looks at transparency. The result in Table 9 indicated that eight junior staff, 24 senior staff and five senior members indicated that they poorly agree that management's transparency efforts to ensure there are no hidden charges to customers is commendable. However, 77 junior staff, 79 senior staff and nine senior members indicated that they fairly agree that management's transparency efforts to ensure there are no hidden charges to customers is commendable. Similarly, 50 junior staff, 74 senior staff and 18 senior members indicated that they agree that management's transparency efforts to ensure there are no hidden charges to customers is commendable. However, only a few, four junior staff, 11 senior staff and three senior members indicated that they strongly agree that management's transparency efforts to ensure there are no hidden charges to customers is commendable. Accordingly, the Pearson's Chi-Square and the asymptotic significance of 15.095 and .020, respectively, indicated that staff category

associates significantly with the staff's level of agreement that management's transparency efforts to ensure there are no hidden charges to customers is commendable.

The analysis indicated that junior staff and senior members have rated communication approximately three-fourths on a scale of one to four, while the senior staff rated it two-fourth on the same scale. This means that the hospital's communication quality is perceived positively above average by the junior staff and senior members, while the senior staff gives it an average score. However, all three staff categories rated the physical environment quality positively above average, scoring it three-fourths on a four-point scale.

Regarding operations and treatment quality, junior staff and senior members have rated it approximately three-fourths on a scale of one to four, while the senior staff rated it two-fourths on the same scale. Finally, management quality has received the lowest rating across all three categories of staff. Management quality was rated two-fourths by all the staff on a scale of one to four. From the analysis so far, management quality has shown to be the weakest dimension of quality at the university hospital. This was followed by operations and treatment, communication, and physical environment.

In summarising the analysis based on staff category, showed that junior staff and senior members perceived communication, physical environment, and operations and treatment quality of the services as positive, while senior staff are only positive about the physical environment of the hospital. Again, the majority of the staff are not satisified with the management quality of the hospital. In all, the healthcare service quality is perceived positively by the junior staff. They agreed (3/4) that the university hospital's overall quality of

services is compensating. The analysis also shows that the overall university hospital's service quality is perceived as quite poor by the senior staff. They fairly agreed (2/4) that the university hospital's overall quality of services is compensating. Finally, the results show that the university hospital's service quality is perceived positively by the senior members. They agreed (3/4) that the university hospital's overall quality of services is compensating.

The main finding for discussion is that staff category associates significantly with all the indicators or dimensions of service quality, which revealed that there is a significant association between staff category and the quality of the health services received from the hospital. Accordingly, more of the junior staff and senior members are more satisfied with the service quality of the university hospital than the senior staff. Mosadeghrad (2014) also had similar report that leaders of organisation received better healthcare service quality compared to other employees in Irran. As explained by the Reciprocity theory, benevolent actions or good deeds get rewarded so it could be that senior members once thaught the healthcare providers, which the healthcare providers reciprocate by giving them better healthcare services.

Moreveover, as noted by Gouldner (1960), reciprocity addresses the processes leading social interaction among individuals, the pattern of exchange through which the mutual dependence of people, brought about by the division of labour, is realised. In this respect, as the junior staff are also academic and non-acdemic service providers to the university, the junior staff might have been in more close contacts with the healthcare providers who might have reciprocated rewards. On the other hand, the senior staff could have limited contacts, which might have related into low healthcare service quality.

Reciprocity theory underpines this result with the idea that one party's action obliges the other party to reciprocate that action as a compensating movement. Thus, such shared prospects put the parties in a relationship of sure rewards that set the tone not only for current behaviour but also indicate future possibilities (Hadi, Aslam & Gulzar, 2019).

However, the analysis above is in dissonance with the views of some sectional heads at the hospital interviewed to help deepen the explanations of the quantitative analysis. For instance, Sectional head 'A' reported that their major area of quality that is lacking is the physical environment. She mentioned an increase in the hospital's clients' population as the first challenge hindering the quality of the physical environment. However, she rated the other three dimensions, four on four, on a scale of one to four. Another sectional head, 'B,' also noted that management quality, operations and treatment are best and were rated four on four. She mentioned that they even have some extra hands in terms of personnel. With communication, she said that the staff no longer provide them feedback though they have the means available to them; hence they are having challenges assessing their communication's effectiveness.

The rest of the sectional heads have all rated management quality, operations and treatment, and communication, four on four, on the scale of one to four, while given physical environment an average of two on four on the same scale. It is interesting to mention here that no seller or vendor will ever speak ill about their product or services. To the staff, quality healthcare is one, which meets their needs, and is delivered courteously and on time (Brown et al., 1990). In sum, the staff wants services that effectively relieve symptoms and prevent

illness. This is because satisfied clients are more likely to comply with treatment and continue using health services.

Effect of the Quality of Healthcare Services on the Utilisation of the Hospital

This section used regression to determine the effect of the quality of healthcare services on the utilisation of the hospital by the staff as required by the third specific objective. The aggregate service quality, the composite of the four service quality dimensions, was entered into the model together with the individual service quality dimensions. The data were analysed using linear multiple regression analysis. A diagnostic test was first conducted to determine whether the independent variables were contaminated by multicollinearity. This was done to investigate the possibility of an undesirable situation occurring when the correlations between the independent variables are high. The SPSS version 26.0 assesses the Variance Inflation Factor (VIF), a measure of multicollinearity in the regression model. Larger VIFs inflate the standard errors misleadingly, making some variables statistically insignificant when they should be otherwise significant.

The VIF was used to determine how much the variance of the estimated coefficients increases when the independent variables are uncorrelated. From the results in Table 7, none of the VIFs exceeded five (5), indicating no collinearity between the variables. Additionally, VIF values were inversely proportional to Tolerance values (VIF = 1/Tolerance). According to Best and Kahn (2012), high VIF values (a typical threshold is 10.0, corresponding to a tolerance of 0.10) indicate a high degree of collinearity or multicollinearity among the independent variables. Overall, the independent variables' influence on the dependent variable was largely unrelated to their strong association.

Table 10: Effect of the Quality of Healthcare Services on the Utilisation of the Hospital by the Staff

	Unstandardised Coefficients		Standardised Coefficients			Collinearity Statistics	
	B	Std. Error	Beta	t	Sig.	Tolerance	VIF
Service Quality	.207	.030	.250	6.977	.000***	.993	1.007
Communication	.253	.047	.253	5.412	.000***	.581	1.720
Physical Environment of the Hospital	.088	.047	.085	1.865	.063*	.621	1.611
Operation and Treatment (Professionalism)	-.002	.056	-.002	-.036	.971	.383	2.609
Management Quality	.398	.042	.494	9.382	.000***	.459	2.180
Constant	-2.002						
R	0.747						
R-Square	0.558						
Adjusted R-Square	0.551						

Note: Dependent variable is Hospital Utilisation, and the total number of observations is 362.

Source: Fieldwork, (2020)

As shown in Table 10, with the exception of operation and treatment in terms of rofessionalism, which did not significantly contribute to the utilization of healthcare services at the hospital, all the other three independent variables entered were statistically significant contributors to Hospital Utilisation. The three individual dimensions of service quality and the aggregate service quality variable all played a significant role in the University hospital's utilisation. Thus, the aggregate service quality pulled a standardised coefficient of 0.250 with a standard error of 0.030 and a p-value of 0.000. The results implied that a unit increase in the aggregate healthcare service quality, increased the utilisation of the University of Cape Coast hospital by 0.25 units, all other things being equall.

Communication service quality had a standardised coefficient of 0.253 with a standard error of 0.047 and p-value of 0.000 (Table 10). This meant that a unit oncrease in communication service quality, increased the utilisation of the University of Cape Coast hospital by 0.253 units, all other things being equall. Similarly, management quality had a standardised coefficient of 0.494 with a standard error of 0.042 and a p-value of 0.000, which suggested that a unit oncrease in management quality, increased the utilisation of the University of Cape Coast hospital by 0.494 units, all other things being equall. Again, quality associated with the physical environment of the hospital had a standadrdised coefficient of 0.085 with a standard error of 0.047 and p-value of 0.063. This indicated that at 10 percent significant level, a unit oncrease in the physical environment quality of the hospital, increased the utilisation of the University of Cape Coast hospital by 0.085 units, all other things being equall.

Comparing the magnitude of the standardised coefficients management quality of the hospital contributes most to staff utilisation of the hospital. The independent variables contributed 0.747 of the variances in the dependent variable, with an adjusted R^2 of 0.558. This meant that when service quality and its dimensions are viewed positively, they contribute to the improvement of hospital utilisation. Thus, service quality and its dimensions account for approximately 55.8 percent of the variance in hospital utilisation. Thus, a unit increase in service quality and its dimension jiontly account for approximately a 55.8 per cent increase in hospital utilisation, ceteris paribus. Therefore, healthcare service quality has a statistically significant positive effect on the utilisation of the University hospital.

The main finding for discussion is that healthcare service quality had a positive and significant effect on the university hospital's utilization, which hinted that increasing healthcare service quality in the hospital will increase the hospital's utilization by the University of Cape Coast staff. Theoretically, this finding supports the attribution theory, which holds that when clients form perceptions about services or products, it will go a long way to affect their choice of using that facility. As reviewed in chapter two, the attribution theory holds that when there is a positive perception of the university hospital's healthcare services, the staff will patronise it. On the other hand, if there is a negative perception, they will seek healthcare needs elsewhere, which may affect their productivity concerning time, money, and general motivation to give off their best to help meet their departments' goals and the university.

It also supports the theory of reciprocity, which posits that customers are committed and loyal to a vendor's product and services when their desired quality or perceived quality standards from service are met. It implies that the higher the quality of services, the higher the service's utilization or patronage. Hence, when the university hospital's services are of superior quality, the staff will highly utilize the hospital. Schneider et al. (1998) posit that customers' perceptions of service quality and the global climate for service pointed to a strong reciprocity in the mutual relationship of sustainable service quality and customer loyalty. Gulzar et al. (2019) also applied the reciprocity theory and concluded that shared prospects put the parties in a relationship of sure rewards that set the tone not only for current behaviour but also provide the indication for future possibilities.

Empirically, the findings support the results of studies like (Gill & White, 2009; Tucker & Adams, 2001), which found service quality to influence customers' behavioural intentions positively. This implies that staff who perceived high healthcare service quality would become loyal customers of the hospital, patronize the hospital's services in the future, and most likely draw other customers through recommendations and positive word of mouth (Elleuch, 2008). Bannerman, Offei, Acquah, and Tweneboa (2002) also found that in an era of competitiveness among healthcare service providers, this would go a long way to improve their competitive position and, consequently, their revenue generation.

The findings also corroborate with that of Baker and Crompton (2000), who used a structural equation to model to hypothesize and confirm that perceived quality would have a stronger effect on utilisation in healthcare service delivery.

Studies by Cristobal, Flavián, and Guinalíu (2007); Mohsan and Nawaz (2011); and Sanayei and Jokar (2013) also established that service quality directly influences utilization and positive word of mouth or recommendations.

Furthermore, this study's findings were in line with that of Ravichandran (2015), who found service quality to have a positive effect on utilization. He posits that irrespective of the hospital management category, hospitals can learn that investing in novel performance to improve service quality is the right thing to do at the right time as it is directly linked to patients` commitment and loyalty. Finally, this study's finding agrees with the results of Agyapong et al. (2018), who also found service quality to be a significant predictor of service utilization. As Service Quality Gap theory explains, the clients (staff) expect to get service quality as a compensation for the time and money resource used to attend to healthcare needs. Thus, unless the expected healthcare service quality is derived, the staff would not continure to utilize the hospital.

Culminating, the qualitative data obtained from the hospital sectional heads' interviews support the position of the results as discussed above. In the interview, one sectional head of the hospital noted that "there is provision for all staff when it comes to accessing healthcare services from us, and though we need not discriminate, we give some priorities to the staff. We don't treat them the same way we treat the general public." Another head remarks that "we give them the best when it comes to service, and as such, we expect that these priorities give them reasons to continue using our services." These explain why service quality has a

statistically significant effect on utilisation, and the total variance explained is less than 30 per cent.

Effect of Background Characteristics of the University Staff on the Utilisation of the Hospital

This study's fourth and last specific objective examined the effect of the university staff's background characteristics on the university hospital's utilisation. Since the independent variables are measured on a categorical scale, the study employed logistics regression to analyse this objective. Moreover, the dependent variable (utilisation) is dichotomous or was also measured on a binary scale like yes or no. Thus, binary logistics regression was computed. As shown in Table 11, the model is statistically significant at 1 percent, indicating that the logistic regression model was significant, and the Pseudo R^2 of 0.718 indicates that the independent variables used are good predictors of the dependent variable. The Log likelihood of 232.887 with P-value of 0.000 coupled with Cox and Snell R-Square of 0.148 and Nagelkerke R-Square of 0.267, buttressed the fitness of the model.

The findings suggest that only two of the university staff's background characteristics used as independent variables had a significant positive effect on the staff's likelihood of using the healthcare service at the University of Cape Coast hospital. Notably, the odds coupled with the sig value of the independent variables representing the various groups as gender, marital status, staff category, age, dependents, and income did not contribute to the utilisation of the hospital, while disability status and medical needs status play singficant roles in staff's likelihood of using the healthcare service at the University of Cape Coast hospital (Table 11).

Table 11: Effect of Background Characteristics of the University Staff on the Utilisation of the Hospital

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Sex	.255	.377	.458	1	.499	1.291	.616	2.703
Single	-.522	.547	.911	1	.340	.593	.203	1.734
Divorced	.170	.546	.097	1	.755	1.185	.406	3.457
Junior Staff	.032	1.315	.001	1	.981	1.032	.078	13.578
Senior Staff	-.420	1.330	.099	1	.752	.657	.048	8.913
People with Disabilities	1.147	.539	4.535	1	.033*	3.148	1.096	9.046
People with special medical needs	1.605	.424	14.355	1	.000*	4.979	2.170	11.424
Ages less than 26	.247	.942	.069	1	.793	1.280	.202	8.110
Ages between 26-30	-1.617	1.225	1.743	1	.187	.198	.018	2.189
Ages between 31-35	-.208	.711	.086	1	.770	.812	.202	3.273
Ages between 36-40	-.245	.704	.121	1	.728	.783	.197	3.111
Ages between 41-45	-.302	.768	.155	1	.694	.739	.164	3.330
Ages between 46-50	-.700	.872	.644	1	.422	.497	.090	2.745
Ages between 51-55	.744	.751	.983	1	.322	2.105	.483	9.172
Dependent	.285	.621	.210	1	.647	1.329	.394	4.489
Incomebelow GH₵1,000	1.756	1.694	1.074	1	.300	5.789	.209	160.208
Income between GH₵1000-2000	1.734	1.654	1.100	1	.294	5.665	.221	144.864
Income between GH₵2000-3000	1.941	1.682	1.330	1	.249	6.963	.257	188.298
Income between GH₵3000-4000	.498	1.817	.075	1	.784	1.646	.047	57.978
Income between GH₵4000-5000	1.520	1.358	1.253	1	.263	4.573	.319	65.455
Constant	-4.061	1.503	7.305	1	.007	.017		
Diagnostics								

Chi-square wald = 144.72 Log likelihood = 232.887
P-value = 0.000 Cox & Snell R Square = 0.148 Nagelkerke R Square = 0.267

Note: Symbols * represent significant levels at 5%.
Source: Fieldwork, (2020)

With respect to disability status, there was a direct association between the disability status of the staff and their ustilisation of the healthcare at the University of Cape Coast hospital (B = 1.147; p-value =0.033). This meant that being disabled increased the utilisation of the Hospital by a maginal factor of 1.147, cetris paribus. The Odds Exp(B) of disability status serving as a contributor to the utilisation of the Hospital was 3.148, which suggested that the staff who had disabilities were 3.148 times more likely to utilise the healthcare services at the University of Cape Coast hospital than their counterpart staff who had no form of disability. This further implies that the hospital is disability friendly.

Similarly, there was a direct association between the special medical needs status of the staff and their ustilisation of the healthcare at the University of Cape Coast hospital (B = 1.605; p-value = 0.000). This suggested that having special medical needs increased the utilisation of the Hospital by a maginal factor of 1.147, cetris paribus. The Odds Exp(B) of special medical needs status serving as a contributor to the utilisation of the Hospital was 4.979, which indicated that the staff who had special medical needs were 4.979 times more likely to utilise the healthcare services at the University of Cape Coast hospital than their counterpart staff who had no special medical needs. This further means that the hospital gives priority to people with special medical needs, which enable them to patronise the services of the hospital more than those without special medical needs.

Combining the two key findings suggested that the staff's utilisation of the hospital was affected by their general health status. With respect to the discussion, even though Fotaki et al. (2008) found that patients' utilisation of a healthcare

service facility was influenced positively by general state of health, they also reported that family income equaly did so, while and age, and gender negatively affects the utilisation of a particular healthcare facility. The bases for the differences may be found in the nature of the respondents used in their study and the ones used in the current study. The previous researchers studied patients in general, while this current research was about staff who had similar healthcare policy.

For instance, in an interview with some sectional heads of the hospital, one mentioned that "I can say that the hospital usage is increasing, and it is so because all the staff is required to visit the hospital first before any other when they need any healthcare service." This implies that all staff must use the university hospital irrespective of their background. This explains why the proportion of variations in utilization accounted for by the background characteristics is very minimal. Besides, there is also a policy of refund of costs or expenses incurred in accessing healthcare services by the staff. Thus, this policy eluded the roles of income, marital status, sex, staff category, and age inutilising healthcare service the hospital.

Chapter Summary

The chapter introduces and presents a descriptive analysis of the respondents` background or demographic characteristics. The descriptive analysis revealed that most of the respondents were males, and most of the respondents were junior staff. The respondents' knowledge of their rights to quality healthcare and their perceived quality level of services were assessed. After the descriptive analysis of the background characteristics, the chapter presents a diagnostic test of

the data to ensure the data meets all the quality, validity, and `reliability conditions necessary to analyse the rest of the specific objectives.

The results revealed that senior mebers had more knowledge on their rights to healthcare services than the junior staff and the senior staff who had similar level of knowledge on their rights to healthcare services. It was also shown that junior staff and senior members perceived the hospital's service quality as higher on the scale than the senior staff. The chapter presented that with the exception of operation and treatment (professionalism), which did not significantly contribute to the utilization of healthcare services at the hospital, aggregate service quality and its dimensions such as communication, physical environment and management quality significantly contributed to Hospital Utilisation. The results also showed that disability status and special medical needs statsus were the only background characteristics had a statistically significant positive effect on utilisation.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

Service quality is essential for improving and differentiating healthcare service delivery in healthcare institutions. As such, the clients use service quality to determine their healthcare service providers. The World Health Organization (2013) reports a growing cry in many developing countries in Sub-Sahara Africa to improve citizens' healthcare areas. A poor-quality healthcare service may result in loss of quality labour through death and prolonged sickness. This forces many institutions to own healthcare units to be responsible for the healthcare needs of their staff. However, the question remains, "what is the level of quality of services provided by these units, and how does that quality perception affect the utilisation of these units?"

This study assessed the university hospital's service quality and how it affects its utilisation by the university's staff. Specifically, the study looks at the staff's knowledge of their right to quality healthcare services, the perceived quality of healthcare services by the staff, and the effect of service quality and background characteristics on the hospital's utilization.

Summary of the Research

This study's general objective was to assess the quality of healthcare delivery by the University of Cape Coast Hospital to the Staff of the University of Cape Coast and its effect on the utilisation of the hospital by the staff. The literature review provided supporting theories, conceptual grounding, and empirical

justification for the university hospital's service quality and its effect on utilisation. The attribution theory and the theory of reciprocity underpin this study of their premise on healthcare service quality and its effect on patronage or utilisation. From the empirical review, it was clear that there is limited evidence of service quality's role in utilising services. The literature review also shows inconclusiveness of findings on the healthcare service quality, knowledge of patients on their rights to quality healthcare services, and the effect of background characteristics and service quality on utilisation.

The discrepancies in the findings result from the fact that many past studies ignored the patients' knowledge of their right to quality services, concentrated on the satisfaction-quality nexus, and neglected the service quality-utilisation relationship. They also failed to use appropriate measures and apply suitable statistical tools to measure service quality and its effect on utilisation. However, from ServQual model, this study used communication, physical environment, operations and treatment, and management quality as the four dimensions of service quality. The study also integrated the role of background characteristics on service utilisation.

The study employed a mixed research approach and used a descriptive research design to estimate its models. Furthermore, the study used 362 respondents, representing 98 per cent of the sample size calculated. The study employed linear and logistic regression to estimate the models to check the effect of the background characteristics and service quality on utilisation. Intermitently,

the qualitative data were transcribed and analysed thematically, which either supported or contradicted the results from the quantitative analysis.

Summary of Findings

The emerging issues from objective one were that:

1. Sex category did not associate significantly with the staff's knowledge of their rights to quality healthcare services, but staff category associates significantly with the staff's awareness on their rights as client of the University Hospital, and that their rights go with responsibilities.
2. Staff category associated significantly with the staff's awareness that the hospital makes the patients` rights and responsibility available at vantage points and that the hospital and its professionals comply by the codes of conduct.
3. Staff category associated significantly with staff's knowledge on their rights to quality healthcare services such that senior members had more knowledge on their rights to quality healthcare services than junior and senior staff who had similar level of knowledge.

The key findings from quality of healthcare service received from the university of Cape Coast hospital were that:

1. Staff category associated significantly with healthcare communication service quality, and the physical environment quality of the University of Cape Coast hospital.
2. Staff category associated significantly with the professionalism service quality, and the management quality of the university of Cape Coast hospital.

3. Service quality perceptions differed among the staff categories such that the junior staff and the senior members were more satisfied with the quality of services of the university hospital than the senior staff.

In relation to the effects of service quality on the utilization of the hospital, the findings were that:

1. Communication service quality, and physical environment quality had a positive and significant effect on the utilisation of the hospital
2. Management quality had a positive and significant effect on the utilisation of the hospital, but professionalism did not significantly predict the hospital utilisation.
3. Aggregate service quality had a positive and significant effect on the utilisation of the hospital

With the effect of background characteristics of the university staff on the utilisation of the hospital, the findings were that:

1. The staff who had disabilities were more likely to utilise the healthcare services at the University of Cape Coast hospital than their counterpart staff who had no form of disability.
2. Staff who had special medical needs were more likely to utilise the healthcare services at the University of Cape Coast hospital than their counterpart staff who had no special medical needs.
3. Despite the refund policies and a regulatory directive that made the university hospital the first point of call when the need arises, disability status and special medical needs determined the choice and use of healthcare service providers.

Conclusions

Both male and female staff had similar level of knowledge on their rights to quality healthcare services. Staff category associated with awareness on their rights as client of the University Hospital, and that those rights go with responsibilities. Similarly, awareness varied among the staff on the assumption that the hospital makes the patients` rights and responsibility available at vantage points and that the hospital and its professionals comply with the codes of conduct. The junior and the senior staff had insufficient knowledge of their rights to quality healthcare, while the senior members had appreciable knowledge on their rights to quality healthcare.

Regarding the quality of services, staff had varied perceptions concerning the communication service quality, and the physical environment quality of the University of Cape Coast hospital. This observation was true for professionalism service quality, and management quality of the university of Cape Coast hospital. Moreover, there was consensus among the junior staff and senior members that the service quality is satisfactory. However, the senior staff perceived the service quality to be low or insufficient. On the quality dimensions, this study concludes that the management quality of the hospital was relatively low.

Also, the study concluded that the staff that had high perception about the communication service quality as well as the physical environment quality and the management quality were more likely to utilise the healthcare services of the University hospital, while professionalism did not influence the hospital utilisation. Yet, aggregate service quality was a positive significant predictor of the hospital utilisation such that an increase in aggregate service quality led to an increase in

the utilisation of the hospital. Thus, performance of the hospital is primarily linked to the quality of its service, because service quality has become the yardstick for measuring the performance of service providers.

Finally, the study concludes that the Staff's disability status and special medical needs were the only background characteristics that served as predictors of the hospital utilisation, while gender, marital status, staff category, age, number of dependents, and income did not contribute to the utilisation of the hospital. Specifically, the disabled staff and those with special medical needs were more likely to utilise healthcare services at the University of Cape Coast hospital than their counterpart staff who had no disability or special medical needs.

Recommendations

Based on the conclusions, this study made some recommendations that would help strengthen the university hospital's service quality and make it more efficient and effective in delivering its services geared towards achieving its stated objectives and mandates and meeting stakeholder expectations. The following were the recommendations.

The hospital needs to take steps to educate the staff on their rights to quality healthcare services. Specifically, the hospital needs to educate senior staff on their rights to quality healthcare services and exercise these rights when needed. Since the discussion shows a misconception between the hospital and the staff on their rights to quality healthcare service, the education may put things right and let both the staff and the hospital management on the same grounds as far as patients' rights are concerned. For instance, a sectional head at the hospital pointed out that the

senior staff does not know their rights and hence ends up abusing privileges given to them as staff of the university when accessing services at the hospital.

In order to increase staff knowledge of their rights to quality services, the hospital authority needs to design leaflets containing clients' rights, responsibilities, violations of those rights, procedures for seeking redress and give copies to staff on a visit to the hospital or at the point of discharge. These leaflets should be designed in local languages for the attention of all and broader coverage. The digital version of this leaflet can also be shown digitally at the OPD and the pharmacy areas. A billboard should also be erected at the hospital's entrance, enumerating patients' basic rights while seeking healthcare.

It is recommended that the hospital improve services' efficiency to increase the general service quality level. Specifically, the hospital's management needs to strengthen its efforts in coordinating the hospital's activities. They need to develop innovative means to obtain and use feedback from clients of the hospital. This will help them improve their performance and service quality from the client's perspective. The hospital needs to create a complaints unit, advertise it if it exists, and make it operational to handle complaints and suggestions for improved services. The complaints unit should initiate a yearly survey where clients can assess the hospital's performance in communication, physical environment, operations and treatment, and management quality for improved healthcare service delivery.

Finally, the study recommends that the hospital strengthen its overall service delivery to execute its functions effectively. This will increase the

utilisation of the hospital by the staff of the university. This is necessary because service quality is a significant predictor of utilisation, and pursuing it could result in maximising utilisation of the hospital. It was also discovered that the university had put some measures in place to ensure equity of service to the staff; these measures must be improved and properly monitored to ensure their effectiveness in serving their intended purposes.

Suggestions for Further Research

The study suggested the following related areas for further research to add to the knowledge of what this study has achieved. First, there is a need to increase the scope to include students for extensive evaluation of service quality perceptions among the University of Cape Coast students and the staffs. This will give a comprehensive report on the hospital's service quality since the students formed the hospital's largest primary clients.

It is also imperative to conduct a study to examine the effect of clients` knowledge of their rights to healthcare services on their perceptions healthcare service quality. This will also explain why quality perceptions may differ among different categories of people.

Future research is also encouraged to examine the effectiveness of the university's priority measures for staff accessing their healthcare service needs from the hospital. This will tell whether the policies, such as cost refund and priority services, are serving their intended purposes.

Lastly, further research is encouraged to replicate this study on similar healthcare service facilities or hospitals so that the hospital authorities can have

firmer bases to make decisions concerning healthcare service quality and utilisation of the hospital.

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APPENDICES

QUESTIONNAIRE

University of Cape Coast
College of Humanities & Legal Studies
School of Development Studies
Department of Integrated Development

Quality of Healthcare Delivery and Utilisation of Hospital Services at the University of Cape Coast Hospital

Hello Respondent,

This questionnaire seeks to gather information on the ***Quality of Healthcare Delivery and Utilisation of Hospital Services at the University of Cape Coast Hospital.*** The researcher would like to collect information about you and the subject under study. You are kindly requested to respond to all questions applicable to you and provide responses reflecting the situation on the ground with utmost good faith. The information required here is purely for academic purposes and will be used as such. Hence, the ultimate privacy and confidentiality of the information provided as a respondent are highly assured and respected.

Thank you for your participation.

SECTION A

Demographic Information. Please tick the most suitable section.

1. What is your gender?

   o Male

   o Female

2. Kindly Indicate your age bracket

   - o Below 26
   - o 26-30
   - o 31-35
   - o 36-40

- 41-45
- 46-50
- 51-55
- 56-60

3. What is your highest rank in the University?
   - Junior staff
   - Senior staff
   - Senior member
4. Do you have any disabilities?
   - Yes
   - No
5. Do you have any special condition that demands frequent medical attention?
   - Yes
   - No
6. Kindly select the number of dependents you have.
   - None
   - 1
   - 2
   - 3
   - 4
   - 5
   - above 5
7. Kindly indicate your monthly income bracket
   - Below 1000
   - 1000 – 2000
   - 2001 – 3000
   - 3001 – 4000
   - 4001 – 5000
   - Above 5000

8. Kindly indicate your marital status
    - Married
    - Divorced
    - Single

SECTION B

Medical Care and Hospital Utilisation

This section seeks to gather responses on your hospital attendance or utilisation of the UCC hospital. Please provide your answer to the questions in the table by using the binary **scale** provided by ticking the most appropriate response to you.

No.	Constructs	Yes	No
1	I only go the University Hospital on referral or transfer		
2	I usually go to the UCC Hospital for medical care or service		
3	I last went to the University Hospital a week/month ago		
4	The University Hospital is always my first point of contact when I need medical services		
5	Quality is a significant factor that influences me to use the UCC hospital		

SECTION C

Quality of Healthcare Delivery at the University Hospital

This section seeks to gather your views on the quality of healthcare services provided at the University Hospital. Please provide your answer to the questions in the table by using the four-point **scale** (1-Least satisfactory, 2-Somehow satisfactory, 3-satisfactory, and 4- very satisfactory) provided by ticking the most applicable answer to you.

Dimensions and Variables	1	2	3	4
Communication				
Nurses exhibit good human relations in their line of duty.				
Nurses explain things to me in an excellent manner				
The doctors exhibit good human relations in their line of duty.				
Doctors give detailed explanations of issues during a consultation.				
Pharmacists give detailed explanations on prescription, dosage, and side effects of drugs.				
The hospital generally respond to an emergency in a professional manner				
The general customer relationship management of the hospital is outstanding				
Physical Environment of the Hospital				
The physical appearance of the facility is excellent.				
The physical appearance of the amenities is ideal.				
The general cleanliness of the hospital is welcoming.				
The physical environment offers a high level of comfort.				
There is very little or no degree of risk of injury at the hospital.				
The hospital has ultra-modern equipment.				
The capacity of the hospital is adequate.				
The hospital is disability-friendly.				
There are directional signs at vantage points.				
The general layout of the facility is outstanding.				

The dressing and physical appearance of the staff of the hospital is very appealing.				
Operation and Treatment (Professionalism)				
The hospital respects the confidentiality and privacy of clients.				
The hospital exhibits a high level of trustworthiness.				
The hospital acts to reduce or eliminate infections or other harmful side effects of treatments.				
Results (outcomes) of care received through diagnosis and treatment are of high quality.				
The ratio of services' outputs to the associated costs of receiving those services (considering monetary and time resources) is high.				
The tasks carried out by health workers and facilities meet expectations of technical quality.				
Healthcare services are unrestricted to gender.				
Healthcare services are unrestricted to rank.				
Healthcare services are unrestricted to disability status.				
Waiting time at the hospital to access healthcare services or treatment is ideal.				
The nurses' and doctors` general performance in their line of duty is commendable.				
Management Quality				
Management addresses grievances and concerns of patients at the hospital in a commendable manner.				
Management addresses conflicts of patients at the hospital in the most professional manner.				
The general quality of services provided at the hospital is ideal.				

Management's feedback collection efforts is plausible				
Management's feedback usage is well satisfying.				
Management's transparency efforts to ensure there are no hidden charges to customers is commendable				

SECTION D

Level of Awareness or Knowledge of Patients' Rights to Health Care

This section seeks to gather respondents' views on their rights and responsibilities in accessing healthcare services from the hospital. Please provide your answer to the questions in the table by using the 4 **Likert scale** (1-Unaware, 2-Somehow aware, 3-Aware, and 4- strongly aware) provided by ticking the most applicable answer to you.

No	**Statements**	**1**	2	3	4
1	I am aware of my rights as a client of the University Hospital				
2	I am aware of my responsibilities as a client of the University Hospital				
3	The hospital makes the patients` rights and responsibility as contained in the Patients` Charter available at vantage points at the hospital				
4	The hospital and its professionals act per the rights always as per my knowledge of the code of conduct				
5	I am aware of the patients` charter and its availability at the hospital				

End of Survey

Thank you

A. INTERVIEW GUIDE

University of Cape Coast
College of Humanities & Legal Studies
School of Development Studies
Department of Integrated Development

Quality of Healthcare Delivery and Utilisation of Hospital Services at the University of Cape Coast Hospital

Hello Respondent,

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Thank you for your participation.

1. On a scale of 1-4, how would you (as a health worker) rate the usage of the University Hospital by University Staff?
2. Do you think the patronage of the hospital by the staff increasing or decreasing?
3. What is your perception about the quality perceptions by the staff of the University of the medical services provided by the University Hospital?
4. As a health worker, assess and rank the quality of services provided by the University Hospital on four dimensions as;

Communication

Physical environment

Operations and treatment, and

Management quality, on a scale of 1 to 4.

5. As a health worker of the hospital, how would you rate the knowledge of rights and responsibilities of clients in accessing healthcare service?
6. Is there any special arrangement or priority for the University's staff in accessing healthcare services from the university hospital?
7. If yes, what are they?

End of Interview Section

Thank you