THE INFLUENCE OF SERVICE QUALITY PERCEPTIONS AND CUSTOMER SATISFACTION ON PATIENTS' BEHAVIOURAL INTENTIONS IN THE HEALTHCARE INDUSTRY

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DECLARATION

I declare that this dissertation hereby submitted is my own independent work and has not previously been submitted by myself for a degree at any other university.

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ABSTRACT

Healthcare today has become a competitive industry, not only locally, but on a global level as well. In the South African economy the healthcare sector presently offers healthcare seekers two options to satisfy their healthcare needs – either through private business enterprises in the private sector or public enterprises in the public sector. Likewise, in the healthcare sector's hospital environment, patients can receive treatment from either private or public hospitals.

As private business enterprises offering a relatively 'pure', but generally unsought-after service, private hospitals compete aggressively to attract patients. Patients are a hospital's lifeblood and they rightfully expect a high standard of customer service throughout the stay. With today's consumers being better informed, more sophisticated and more demanding than in the past, experts agree that the key to survival in the service industry today, almost without exception, is the quality of the service. The cornerstone of the service industry is without doubt the ability to deliver superior service quality that results in customer satisfaction. And the healthcare industry is no exception.

Most consumers will experience a need for healthcare services at some time in their lives, but in South Africa, escalating medical costs in general and private hospitals in particular, have made private healthcare increasingly more expensive for the majority of the country's healthcare seekers. This situation raises the question of customer service in the private hospital industry and how patients' perceive service quality and evaluate customer satisfaction after a hospital stay.

There is a growing body of empirical evidence from United States studies to show that service quality and customer (patient) satisfaction positively influence patients' behavioural intentions to reuse the hospital or recommend it to others (word-of-mouth endorsements). However, in South Africa, empirical studies to investigate these relationships have not been adequately addressed. This study was therefore an attempt to address the

lack of scientific evidence and debate in the area of patient satisfaction.

Against this background, the primary objective of this study was to measure patients' perceptions of service quality and customer satisfaction with a private hospital experience and to estimate the effect that each of these constructs will have on future behavioural intentions. More specifically, the present study was an attempt to assess empirically the most important dimensions of service quality and transaction-specific customer satisfaction dimensions that drive both patient loyalty and 'overall' or cumulative satisfaction in the South African private hospital industry.

For the purpose of this study, buying intentions was used as a surrogate measure of loyalty as measured by willingness to reuse the hospital and/or willingness to recommend it to others (word-of-mouth endorsements).

Initial exploratory research was conducted with the aim of assessing the views of three private hospital stakeholder groups, namely former patients, doctors and management about what the quality of service and customer satisfaction meant to each individual interviewed. A service enterprise that specialises in patient satisfaction surveys in the US provided particularly useful information during this phase of the study. Several case studies of patient satisfaction programmes, mostly at US hospitals, provided additional insights in this area.

The study was conducted nationally at private hospitals owned by one of South Africa's three major hospital groups. Five private hospitals in four major centres were selected on a non-probability convenience basis to participate in the study. The hospital group's senior management and the management at each selected hospital gave their full commitment to ensure that the survey was successfully conducted in their hospital wards.

Data were collected by means of a quantitative study using a self-administered, structured questionnaire. Patients had to meet certain qualifying criteria which included being of adult age, in the hospital for an operation and at least one overnight stay. A total of 3 800 questionnaires was distributed to patients on a random basis in selected wards at the five

hospitals by senior hospital staff designated for this task. From this distribution, 425 questionnaires were returned of which a final sample of 323 could be statistically analysed.

To confirm the internal reliability of the measuring instrument, Cronbach alpha coefficients were calculated for each of the factors identified by the exploratory factor analysis. In order to assess the discriminant validity of the measuring instrument used to measure both service quality and customer satisfaction, the items were subjected to an exploratory factor analysis. The factors that emerged after the exploratory factor analysis were then used as independent variables in the four subsequent multiple regression analyses to assess the study's four hypothesised relationships.

The findings revealed that the service quality dimensions that impact positively on both loyalty and cumulative satisfaction are Empathy of nursing staff and Assurance. The customer satisfaction dimensions to impact positively on both loyalty and cumulative satisfaction are Satisfaction with the nursing staff, Satisfaction with meals, and Satisfaction with fees charged.

The findings reveal that the service quality and customer satisfaction dimensions to influence loyalty are as follows:

- Service quality dimensions to impact positively on loyalty:
  - Empathy of nursing staff
  - Assurance
  - Tangibles
  - Security

It should be noted, however, that the security dimension revealed that too conspicuous a presence of security measures both inside and outside the hospital had a negative impact on loyalty:

- Service quality dimensions to impact positively on ‘overall’ cumulative satisfaction:
  - Empathy of nursing staff
  - Assurance

- Customer satisfaction dimensions to impact positively on loyalty:
  - Satisfaction with meals
  - Satisfaction with the nursing staff
  - Satisfaction with fees charged
  - Satisfaction with the television service in wards
- Customer satisfaction dimensions to impact positively on 'overall' cumulative satisfaction:
  - Satisfaction with the nursing staff
  - Satisfaction with fees charged
  - Satisfaction with meals

The study revealed that, without a doubt, a private hospital's nursing staff remains high on the agenda as far as patients are concerned. From a clinical perspective, patients expect nurses to have a caring, empathetic attitude and possess the appropriate nursing skills. Additionally, the study found that patients expect the hospital to convey 'peace of mind' assurance to its patients that they will be in safe hands for the duration of their stay. Other elements of the hospital experience expected to satisfy patients include a physically appealing exterior and interior, quality meals, reasonable fees and a functioning television service.

It is hoped that future research in this area will focus on the service quality/patient satisfaction relationships in the private hospital environment with the view to improving levels of customer service.

KEYWORDS: Service quality
Customer satisfaction
'Overall' cumulative satisfaction
Loyalty
Buying intentions
Behavioural intentions
Reuse / repurchase
Recommend / word-of-mouth endorsements
Private hospitals

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CHAPTER 1

INTRODUCTION, PROBLEM STATEMENT AND SCOPE OF THE STUDY

"As hierdie navorsing gedoen word, kan tariewe dalk goedkoper wees en meer pasiënte gebruik maak van _____ Hospitaal."

Respondent in present study, a former patient commenting on service delivery following a hospital stay.

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

The cost of private healthcare, and private hospital care, in particular, has become increasingly more expensive for healthcare consumers (Hanson 2005; Laschinger 2004:29; Luiz & Wessels 2004:1,2,8; Road Accident Fund 2002:887; Shevel 2003b; Strunk & Ginsburg 2004:1-2; The Summit Healthcare 2004:10A; Wessels 2002).

The increasing cost of private healthcare, with specific reference to private hospitals, raises an important question concerning those healthcare seekers who prefer to use private hospitals over public (state) hospitals. Are healthcare consumers, from the perspective of private hospital patients, not increasingly exercising their rights as customers to demand that the service delivery process of a hospital visit is aimed at providing superior or excellent quality service, a fundamental component necessary for attracting and keeping customers?

It could be argued that delivering superior service quality which results in customer satisfaction is the cornerstone of the services industry and the healthcare industry should therefore be no exception. Most consumers, whether occasionally or frequently, have a need for healthcare, an essential service. More importantly, the likelihood that they will need to utilise the services of a hospital at some time in their lives for whatever reason, is an almost definite event.

If the preferred choice from which to receive this service is a private hospital, how these patients, as customers, respond to or evaluate the

hospital experience will have important consequences for the hospital, as a service provider.

Healthcare needs to be viewed within the context of the service industry which falls in the domain of services marketing. The demand for services, such as private healthcare, increased considerably during the latter half of the last century as a result, inter alia, of changing trends in societies' demographics and psychographics (Daniels 1993:12-23; Grönroos 1990:9). It is predicted that the growth in demand for services is expected to continue in future (Lamb, Hair, McDaniel, Boshoff & Terblanche 2004:439).

Today the key to survival, almost without exception, is effective service delivery to meet customers' needs and expectations. Grönroos (2000:2,10) makes two observations in this regard. Firstly, all goods manufacturers offer a number of services to their customers and secondly, service functions form the core area of service firms, healthcare providers included, but with the involvement of physical goods components as well.

Therefore, the service offering is the core solution in business today, in part because firms compete more with services, than with physical products (Grönroos 2000:vii). Evidence to justify the importance of services to the economic sector is provided by Grönroos (2000:10) who offers at least three reasons for the need to focus on services, namely the customer, competition and technology.

More specifically, with the increasing number of markets, Grönroos (2000:10) argues that customers are no longer satisfied with a mere technical solution to a problem, whether that solution is provided by a service firm or a goods manufacturer. Today's customers have become more sophisticated, more informed and consequently, more demanding. Furthermore, Grönroos (2000:10) links increasing customer demand to increasing competition, which has become not only more fierce, but increasingly global as well.

Technological developments, especially in the area of information technology, have enabled firms to create new and improved services more

easily (Grönroos 2000:11; Bove 2003:321). New information technology has allowed relationships with customers to become not only easier, but to be expanded in other ways so that the entire firm now shares responsibility for the customer (Grönroos 2000:11). The emphasis therefore in services is on managing relationships with customers (Grönroos 2000:7-8).

In a service-driven economy, it would be up to individual firms to use information and knowledge in such a manner as to develop more customer-oriented relationships and value-enhancing services for their customers, which are aimed at creating total service offerings whether physical products or services (Grönroos 2000:11).

The argument presented above should provide a compelling enough justification not to ignore the importance of services in the economy today.

Taking this argument a step further, the significance of services, in contrast to goods, is reflected in many world economies today. For instance, on a global level, services make up the bulk of today's economy, not only in industrialised nations, but in many developing nations as well (Lovelock 2001:5).

In South Africa, the services sector of the economy is large and growing rapidly (Boshoff 2003:17). Evidence of this can be seen in the country's gross domestic product (GDP) where the latest statistics show that services accounted for 66.1% of South Africa's GDP in 2005 compared with 50.1% in 1982, with an average annual growth in the same year of 4.9%, up from 1.9% in the period 1982-1992 (World Bank 2003, 2006). In 2000, South Africa spent 8.4% of GDP on healthcare alone (UK Trade & Investment 2003).

Most industries today operate in increasingly competitive environments (Gitman & McDaniel 2005:28,38,459; Schermerhorn 2002:14) and healthcare is no exception (Jabnoun & Chaker 2003:290; Luiz & Wessels 2004:10; Reidenbach & Sandifer-Smallwood 1990:47; Taylor 1994:222).

In a competitive environment, and especially in the service industry, there can be little doubt that the main determinants of any service enterprise's

ongoing success are its customers. A central theme of success today is the ability of a service enterprise to satisfy its customers with quality and value of its service offering (Gitman & McDaniel 2005:89,97; Grönroos 2000:66; Schermerhorn 2002:14). Such is the strength of this conviction that Schermerhorn (2002:14) warns that customer demand for quality products and services has become not only unrelenting, but that the forces driving modern day consumers have, to some extent, created a 'revolution' for quality and therefore, failure to listen to customers by meeting these demands will render many firms unable to compete in any already highly competitive environment.

In the service industry, a key solution to this so-called 'customer revolution' is to establish a sustainable competitive advantage. While there are several ways for a service enterprise to achieve a competitive advantage (Lamb et al. 2004:19-23; Schermerhorn 2002:38), the overriding emphasis is clearly on customer service as a means to building successful long-term relationships (Grönroos 2000:66; McColl-Kennedy 2003:14; Schermerhorn 2002:42-43). It is logical to assume therefore that a service enterprise like a private hospital will need to rely heavily on a strategy of customer service over and above its levels of clinical excellence.

Faced with fierce competition and rising costs on the one hand and ever more demanding consumers on the other, the body of literature (both scientific and anecdotal evidence) is filled with proclamations calling for firms to differentiate themselves on the basis of service excellence to the customer as the main source of competitive advantage. This virtually guarantees repeat business and long-term profitability. Emanating from this argument, as further evidence will later show, is that such proclamations form the basis that *satisfied customers will become loyal customers*.

Furthermore, although this phenomenon is not new, growing evidence exists to support the theory that service excellence, reflected in the delivery of quality service and as an important determinant of customer satisfaction, will have a favourable impact on future behavioural intentions of customers,

and in turn, on profitability (Anderson, Fornell & Lehman 1994:53; Zeithaml, Berry & Parasuraman 1996:31; Grönroos 2000:129-130).

Several empirical studies across a variety of service industries including healthcare have investigated the relationships between service quality, customer satisfaction and the impact on future customer behaviour. However, in the South African healthcare environment, specifically the private hospital sector, such studies have only received limited attention. Service quality, which has its origins in the product quality literature (Grönroos 1983b:9; Parasuraman, Zeithaml & Berry 1985:41), has been shown to be an important driver of customer satisfaction from both a theoretical point of view (Heskett, Sasser & Schlesinger 1997) and empirically substantiated in a number of service industries (Anderson et al. 1994:53; Anderson & Sullivan 1993:125; Churchill & Surprenant 1982:491; Green & Boshoff 2002:4).

These empirical findings suggest that customer satisfaction from period to period should be based on long run quality improvement programmes in order to improve future profitability (Johnson, Anderson & Fornell 1995:705).

Empirical studies in the healthcare industry, with specific reference to private hospitals, concur with these findings and have been shown to positively influence the patient's behavioural intentions to reuse the hospital in the future (John 1991:58; Woodside, Frey & Daly 1989:15). Other studies have shown that patient satisfaction and loyalty are fundamental to hospital stability and growth, that is, repeat usage and positive word-of-mouth endorsements (Fisk, Brown, Cannizzaro & Naftal 1990:5,14). Overall perceptions of service quality and patient satisfaction were found to positively influence a patient's willingness to recommend a hospital to others (Reidenbach & Sandifer-Smallwood 1990:53).

No empirical studies to investigate the relationships between service quality, customer satisfaction and reuse or recommendation behaviour of patients in the South African private hospital sector, have, however, been

conducted (see section 1.6).

In this chapter, the general overview of the study is presented, commencing with the statement of the research problem and purpose of the study. The objectives, hypotheses of the study and research design and methodology are discussed in the sections that follow the reason for undertaking the study. This is followed by the contribution to the body of knowledge which the study will attempt to make, the scope or limitations of the study and a list of definitions of some of the key terms to be used. The structure of the dissertation will conclude the chapter.

1.2 STATEMENT OF THE PROBLEM

Healthcare today is a highly competitive global industry (Jabnoun & Chaker 2003:290; Laschinger 2004:29) in which private hospitals can and must compete aggressively to attract patients.

In the South African healthcare environment, private hospitals compete for patients from the pool of healthcare consumers who belong to a medical scheme or who can afford, and are willing to pay the fees for, private hospital care (Luiz & Wessels 2004:2; Road Accident Fund 2002:885;897; Soderlund, Schierhout & Van den Heever 1998:142:148).

Studies have shown that private healthcare is the preferred choice of most South African consumers, irrespective of race, and even if it is unaffordable (Haveman & Van der Berg 2003:1,12-13,20; Palmer 1999:95; Road Accident Fund 2002:904; Soderlund et al. 1998:145).

Whether it is the medical schemes or the private patients themselves who pay the fees for their private hospital care, the assumption is justly made that such patients would expect the quality of customer service delivered to be of a high standard during their stay and leaves them feeling like satisfied customers after their discharge. Likewise, the assumption is also made that as private business enterprises, private hospitals have an in-depth understanding of their customers needs and position themselves to offer a

customer service strategy which they ensure is consistently delivered.

However, a hospital can only gauge its level of customer service if it asks its customers their expectations, perceptions and needs. Then, having listened to the feedback of its customers, a hospital can make the necessary adjustments and improvements to its level of customer service.

At least two trends are emerging in South Africa's private healthcare sector today.

Firstly, the increasingly competitive nature of the private hospital industry and the unequal competition between the private players and their main opposition – state hospitals, has seen the private hospital industry outperform the rest of the market (Council for Medical Schemes 2004:13; Jones 2001:8; 2002:16-17; Laschinger 2004:29; Road Accident Fund 2002:891-892). In spite of this performance, the private healthcare sector at present caters for only 18-20% (seven million) of the population (Council for Medical Schemes 2004:11; De Bruin 2004:54; Doherty & McLeod 2002:41; Road Accident Fund 2002:882,886; Soderlund et al. 1998:142,155). Secondly, increasing criticism is being levelled at private hospitals over the high rate of medical inflation which is resulting in private hospitals become unaffordable for ordinary consumers (Clayton 2003; Council for Medical Schemes 2003/4:13; Everyone must do his share 2002:55; Harvey 2004; Jones 2001:8-9, 2002:16-17; Larsen 2005:84; Luiz & Wessels 2004:1; Road Accident Fund 2002:887-888; Shevel 2003b; Van Reenen & Van der Merwe 2002:248-250; Wessels 2002). In fact, Duncan (2004) makes the claim that in its annual report of 2003/4, the Council for Medical Schemes alluded to the issue of the 'super-profits' earned by the country's three private hospital groups, thus implying that private hospitals are largely responsible for the high rate of medical inflation.

Additionally, according to the Department of Health (2002:86), the private healthcare sector is accused of systemic cost increases in excess of general inflation and economic growth, with the largest increases attributed to private hospitals (560.3 per cent from 1974-1999).

Mentioned here are important publications on matters related to the private healthcare industry and yet, while these publications all discuss the problems of competition and medical inflation, none of them address the subject of customer service – neither quality nor satisfaction, in the private healthcare industry. Does this then mean that a lack of attention to such fundamental marketing principles as service quality and customer satisfaction, suggest that relationships between health providers and their patients, or more appropriately their customers, are shrouded in mystery?

A competitive private hospital industry allegedly plagued by high costs raises a valid question concerning the importance of customer service in the private hospital sector. In particular, what are private patients' perceptions of service quality and customer satisfaction and what influence would these perceptions have on future behavioural intentions following a stay in a private hospital?

The patient is more than just a sick person lying in a hospital bed, but a valuable customer who has the right, just like any other customer, to expect, if not demand, consistent quality service and professional care from all caregivers throughout the hospital stay. Patients are a hospital's lifeblood and they rightfully expect a high standard of customer service during their stay. While the need to go into hospital is normally not a sought-after service, patients no longer need to merely passively receive medical treatment and care, but as customers, can actively demand quality service and expect to be more than satisfied during their stay.

In a competitive environment such as the private healthcare industry, a hospital's management needs to evaluate patients' perceptions of service quality and customer satisfaction, two important marketing considerations, on a continuous basis. Because consumer preferences and expectations (hospital patients included) change continuously, it is crucial for managers to keep abreast, not only with what consumers want at present, but also to anticipate what their needs in the future might be. The hospital's very survival will depend on it.

As a result, a private hospital can no longer afford to rely on its reputation for clinical excellence alone. Being known for practising a high standard of medical care or only employing the services of the most highly skilled medical professionals, is merely one half of the hospital experience. Besides medical care (Jabnoun & Chaker 2003:291), patients also want customer service. The anecdotal literature has gone one step further and declared a 'healthcare customer service revolution' (Zimmerman, Zimmerman & Lund 1996:33): not unlike the view expressed by Schermerhorn (2002:14) which was discussed in the previous section.

Moreover, Zimmerman et al. (1996:33) claim that the customer service revolution in healthcare is just warming up. As Zimmerman et al. (1996:32) correctly point out, the two components of clinical quality and service quality go hand-in-hand with patient satisfaction because the quality of one component impacts on the quality of the other component.

It is the private hospital that can successfully compete through high levels of quality service and the patients who demand to be satisfied by the delivery of such service, that formed the basis of this study.

The production and consumption process of a service such as healthcare is a complex process due to the very high personal involvement and essential interaction of the role players with each consumer. It is therefore necessary that healthcare managers not only understand how consumers evaluate the quality of the healthcare service they receive, but also listen to the needs of their patients. Bowers et al. (1994:55) have recognised that healthcare providers, and specifically hospitals, who satisfy patients' quality perceptions, will secure an important competitive advantage. Adopting such a strategy is the underlying principle of marketing management theory – excellent service quality that results in customer satisfaction – and is endorsed in most marketing textbooks.

Against this background, it is clear that in the healthcare industry, and in private healthcare particularly, the satisfaction of patients cannot be taken lightly. It must however be acknowledged that private hospitals today are

concerned about and do measure patient satisfaction. On the other hand, what is not exactly clear is the extent to which research of this nature is conducted in a scientific manner.

As John (1991:59) observes, 'it is the satisfied patients who are more likely to return or recommend to others the same hospital rather than those who are dissatisfied'. Against this background, this study attempts to identify the most important service quality and customer satisfaction dimensions influencing patients' loyalty (or intentions to repurchase) towards a private hospital.

1.3 PURPOSE OF THE STUDY

Several well-known US studies in the healthcare industry that investigate the relationships between service quality, customer satisfaction and their outcomes have been undertaken (Bowers et al. 1994; Cronin & Taylor 1992, 1994; Fisk et al. 1990; John 1991, 1992; Kleinsorge & Koenig 1991; Reidenbach & Sandifer-Smallwood 1990; Taylor & Cronin 1994; Woodside et al. 1989).

However, in the South African healthcare environment, that is, private hospitals, empirical studies have largely ignored these relationships.

As in other service industries, the provider/customer relationship in healthcare is an important one, particularly those interactions resulting from this relationship. The customer is the lifeblood of the service provider – so the patient is the hospital's lifeblood – and the relationship between the two is likely to be a dynamic one.

There is a need for service firms to get to know their customers much better than was normally done in the past, partly because customers now take a much more active role in the service offering than they did previously (Grönroos 2000:31,32).

On the basis of this assumption, healthcare should warrant inclusion in such an investigation. Therefore, it has become necessary to investigate

how private patients judge their experiences with a private hospital and identify the variables that influence this judgement. Furthermore, it is also necessary to determine whether a patient would be willing to return to the same hospital again or even recommend it to others, as a consequence of such an experience, good or bad.

Due to the lack of empirical evidence on the customer service aspect of the hospital/patient relationship in the South African context, this study will attempt to address this issue.

1.4 OBJECTIVES OF THE STUDY

The question that arose from the research problem outlined in the above section was whether a private hospital could differentiate itself from the competition by means of superior service quality and superior transaction-specific customer satisfaction, and thus be able to enhance customer loyalty?

The primary objective of this study is therefore to measure patients' perceptions of service quality and customer satisfaction with a private hospital experience and estimate the effect that each of these constructs will have on future behavioural intentions. More specifically, the objectives are, to assess empirically which dimensions of service quality and transaction-specific customer satisfaction (the two sets of independent variables) exerted the strongest influence on the study's two dependent variables, namely loyalty (measured by willingness to reuse the hospital and/or recommend it to others) and customer satisfaction (measured by 'overall' or cumulative satisfaction) (Johnson, Anderson & Fornell 1995:695,705).

The following secondary objectives are linked to the main aim of the study:

- Which individual service quality dimensions would be the strongest predictors of loyalty as measured by patients' willingness to reuse and willingness to recommend the hospital to others (positive word-of-mouth

endorsements)?

- Which individual dimensions of customer satisfaction would be the strongest predictors of loyalty as measured by patients' willingness to reuse and willingness to recommend the hospital to others (positive word-of-mouth endorsements)?
- Whether a positive relationship exists between service quality perceptions and 'overall' or cumulative customer satisfaction;
- Whether a positive relationship exists between individual dimensions of customer satisfaction and 'overall' or cumulative customer satisfaction.

In short, the study aims to determine whether a positive relationship exists between the two constructs and the future behavioural intentions of the customers (i.e. the patients) of private hospitals. The study also aims to measure the strength of these relationships and rank the service quality and customer satisfaction dimensions (factors) in order of importance.

Finally, an attempt will be made to propose recommendations emanating from the results of the study that could possibly assist hospital management in the strategic planning for patient satisfaction.

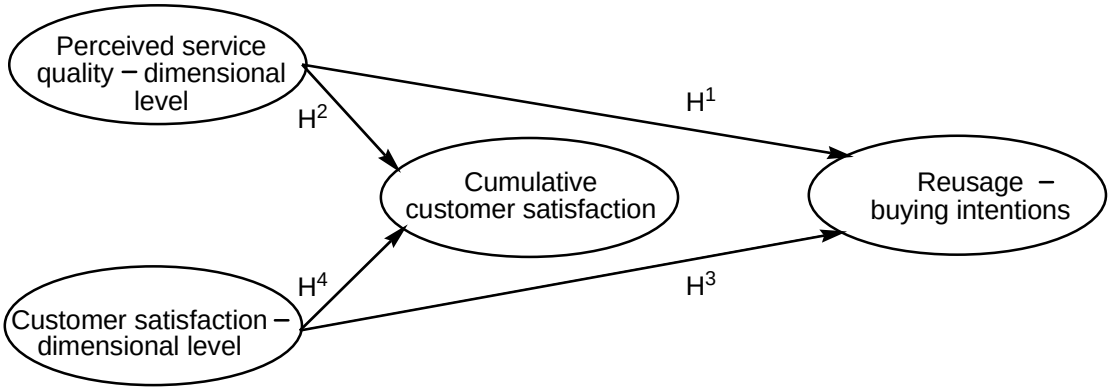
1.5 HYPOTHESES

In line with the objectives of the study to assess the impact of several service-related dimensions, or variables, on the behaviour of a select category of customer, namely the private hospital patient, and to explore how that patient's buying decision might be influenced in the future, a theoretical model was constructed. The model was based on the service quality and customer satisfaction dimensions identified during the exploratory research phase that preceded the study.

Hypotheses have been formulated to test the relationships depicted in the theoretical model illustrated in Figure 1.1. The hypothesised relationships in Figure 1.1 suggest that meeting consumer needs at the attribute level will

enhance cumulative customer satisfaction, which will in turn enhance loyalty and, by implication, profitability, the outcome predicted by the satisfaction-profit chain (Anderson & Mittal 2000:107-120).

Figure 1.1: Model of hypothesised relationships of dimensions that influence behaviour of private hospital patients



The following hypotheses will be tested to assess the theoretical model depicted in Figure 1.1:

H^1: There is a positive relationship between perceived service quality at the dimensional level and loyalty, as measured by patients' willingness to reuse the same hospital in the future or recommend it to others (buying intentions).

H^2: There is a positive relationship between perceived service quality at the dimensional level and cumulative customer satisfaction.

H^3: There is a positive relationship between customer satisfaction at the dimensional level and loyalty, as measured by patients' willingness to reuse the same hospital in the future or recommend it to others (buying intentions).

H^4: There is a positive relationship between customer satisfaction at the dimensional level and cumulative customer satisfaction.

The theoretical model and its respective hypotheses will be tested by collecting quantitative data, obtained from respondents who at the time of

participation, were patients in a private hospital, one of several belonging to a large hospital group in South Africa.

1.6 RESEARCH DESIGN AND METHODOLOGY

A study of this nature is comprised of two components, namely primary data and secondary data, the collection of which are undertaken in order to adequately address the research objectives. Primary data are original data collected specifically for the purpose of solving the current research problem (Hair, Babin, Money & Samouel 2003:72; Van Wyk 1996:99). Secondary data, on the other hand, are existing data that have already been collected for previous research purposes, but may be used to help solve the research problem at hand (Hair et al. 2003:72; Van Wyk 1996:99).

In order to realise the objectives of the study and test empirically the hypotheses that had been formulated for this purpose (refer to sections 1.4 and 1.5 respectively), the primary and secondary research will form the two main sources of data. A detailed exposition of the actual research design and methodology to be undertaken is presented in Chapter 7.

1.6.1 Secondary sources of data

A comprehensive literature search was undertaken to collect sufficient information on the influence of the two constructs, namely service quality and customer satisfaction and their influence on future behavioural intentions in the same service industry. The search was initially widened to include generic topics in the general service literature, but subsequently narrowed to the healthcare industry and as far as possible, to patients in private, or at least for-profit hospitals.

An overlap with other healthcare providers or public hospitals was unavoidable during the literature search and the information generated was not included in the study unless mentioning it was absolutely necessary.

The search comprised related subject disciplines, library data searches

(from where the majority of the data were sourced) including inter-library loan requests, the Internet and unpublished literature produced by some of the participating hospitals.

Subject disciplines that were consulted included Services Marketing (main source), Marketing, Business Management, Management, Consumer Behaviour and Economics. A search of the Quality Management, Service Quality and Customer Satisfaction literature was also necessary. From the Business and Marketing Research literature, research design and methodology publications, including those containing multivariate statistical techniques, were also sourced. Publications covering academic report writing were consulted as well. Anecdotal literature such as the domain of customer service, customer relationships, branding, selected stories of successful business leaders and managing for the future were also consulted.

The library searches were all undertaken at the then University of Port Elizabeth's Albertus Delport Library. Aside from a standard search of the library's shelves for information, national and international searches included EBSCO, SABINET, NEXUS – Database of current and completed research in South Africa (National Research Foundation), Index to South African Periodicals (ISAP) and SACat .

The library's inter-library loans (ILL) facilities were used extensively during the study to obtain material from several other South African libraries, mainly university libraries. Due to the exorbitant costs of international ILL services, no international publications were sourced if copies could not be obtained locally or from the Internet. Most of the journal articles that were requested were available online (PDF was the preferred format selected). In some instances, material requested via ILL was simply not available at all.

As far as could be ascertained, no similar research study relating to service quality, customer satisfaction and the influence on patients' future behavioural intentions had been undertaken previously in the South African

context. The national data searches undertaken by the library to determine the existence of similar Master's dissertations or doctoral theses previously undertaken (or currently being undertaken) revealed that no such research has taken place.

Some Master of Business Administration (MBA) studies on service quality or patient satisfaction were undertaken, but for the purpose of this study, MBA studies are excluded. The apparent lack of empirical research in this field suggests also an absence of quantitative studies which would have the advantage of large sample sizes for collecting the required data.

From this search, it would appear that this is the first such empirical study of its kind to be undertaken in the South African private hospital environment. The following groupings of patient surveys most closely representing the present study were identified in this search:

Service quality studies

- Quality assurance for patient satisfaction in a private cardio-thoracic nursing unit (Muller 1986).
- Service quality indicators in determining patient satisfaction in the primary healthcare sector – a pilot qualitative study (Davies 1998-current).
- Service quality measurement in primary healthcare (Davies 2002; Davies 1998).
- Perceptions of public hospital service quality of HIV positive patients (Madhi 2002).

Patient satisfaction studies

- Patient satisfaction with South African military medical health services (Van Niekerk 2002).
- Designing measuring instruments to measure patient satisfaction of healthcare services (Steyn 1999; Van Niekerk 2002).

- Continuity of care, patient satisfaction and blood sugar control among type II diabetic patients in a rural hospital (Manda 2000).
- Lessons in patient satisfaction for South African rural healthcare services from the Australian perspective (Marinus 1999).
- Patient satisfaction at South African hospitals (Bruwer 1992).
- Patient satisfaction at South African hospitals (Ndjeka 2001-current).

1.6.2 Primary sources of data

Preceding the empirical study to test the theoretical model, information was solicited from three groups of stakeholders primarily to gauge the feelings of different role players regarding their perceptions and opinions of the patient as a customer and their understanding of the concepts quality service and customer satisfaction. Two of the groups were hospital management and medical practitioners and some of these individuals also evaluated the preliminary questionnaire. Feedback offered by these individuals was incorporated into finalising the research problem and questionnaire design.

In addition to the informal discussions with all three stakeholder groups, pre-testing of the questionnaire was carried out on the third group, a small number of former, but recent, private hospital patients to determine whether any difficulties existed in understanding the wording of the questionnaire, or in the design itself. No major difficulties were found. The pre-test also estimated that the length of time required to complete the questionnaire took approximately 10-15 minutes.

Once the recommendations and minor adjustments from the pre-test had been made, the questionnaire was ready for the next phase of the primary research process, namely finalisation and translation into Afrikaans.

1.6.3 The sample

One of South Africa's three major private hospital groups, Afrox Healthcare Limited, granted permission for the survey to be conducted in its hospitals. However, Afrox prohibited the use of its hospitals' database of patient admissions as a mailing list on account of the confidentiality clause that exists between each of its hospitals and their respective patients.

Five hospitals were selected on a non-probability convenience basis to participate in the study. With Afrox's support, each of the five hospital managers served as the main contact person together with the assurance that designated senior staff would take responsibility for the distribution of questionnaires in the relevant wards. Each hospital manager provided suitable dates when the hospitals could be visited to brief staff. Also, it was important that the survey did not lose momentum, as questionnaire distribution had to be spread over several weeks. Weekly telephone calls to monitor progress and offer encouragement were made to each contact person who had been nominated to handle the distribution in the wards.

Respondents first had to meet certain qualifying criteria, after which questionnaires were distributed to patients on a random basis in selected wards at the participating hospitals. This was done just prior to discharge. Once the self-administered questionnaire had been completed, it had to be mailed back to the addressee. The package included an outer envelope, covering letter (including incentive-to-respond details), A5 questionnaire booklet and reply-paid envelope. An Afrikaans version was available on request.

From a total distribution of 3800 questionnaires, 425 were returned of which 323 could be statistically analysed. Because anonymity of respondents was guaranteed, it was not possible to carry out any telephonic follow-ups to obtain missing data.

1.6.4 The measuring instrument

The measuring instrument consisted of an eight page self-administered, structured questionnaire divided into three sections which totalled 117, statements in all, including biographical data. It was printed as an A5 booklet. Ten dimensions of service quality related to the patient's hospital visit were measured using 54 items (statements). For the purpose of this study, the original ten dimensions of service quality conceptualised by Parasuraman, Zeithaml and Berry (1985) rather than its subsequent reduction to five dimensions (Parasuraman et al. 1988) were utilised on account of their being a stronger predictor of customer satisfaction (Green & Boshoff 2002:4).

On the other hand, the 48 items (statements) used to measure customer satisfaction were based on a thorough literature review (Bowers et al. 1994; Fisk et al. 1990; John 1991, 1992; Jun, Peterson & Zsidisin 1998; Reidenbach & Sandifer-Smallwood 1990; Taylor & Cronin 1994; Woodside et al. 1989; Zimmerman et al. 1996). The exploratory research that was mentioned in section 1.6.2 and in-depth interviews conducted with some individuals who had been recent private hospital patients at the time of questionnaire design were also included.

Because of the dilemma of not being able to refer to customer loyalty in the private hospital industry in the same manner as, for instance, in the retail industry like the grocery store or the bank, future behavioural intentions of patients, namely buying intentions were used as a surrogate measure for loyalty (Shaw-Ching, Furrer & Sudharshan 2001). Five items (statements) were used to measure loyalty, that is willingness to reuse the hospital or recommend it to others.

The 102 items used to measure service quality and customer satisfaction were linked to a 7-point Likert scale, ranging from strongly agree (7) to strongly disagree (1). Overall cumulative satisfaction was measured using three semantic differential-scaled items (statements) containing bipolar 'satisfaction' adjectives to describe the hospital experience.

The survey was only partly a mail survey on account of the questionnaires being distributed by hand to qualifying patients in various wards. Using the reply-paid envelope, respondents were then required to mail back the completed questionnaires.

The data were subjected to an exploratory factor analysis in order to identify the underlying relationships and create a clear factor structure. Cronbach alpha coefficients for each set of factors were calculated to confirm the reliability of the measuring instrument. This was followed by regression analysis to measure the strength of the relationships between the service quality and customer satisfaction dimensions (the independent variables) and 'overall' cumulative satisfaction and loyalty (the two dependent variables).

1.7 CONTRIBUTION OF THE STUDY

The study will endeavour to contribute to the body of knowledge on customer service in the healthcare industry with a particular focus on two service-oriented constructs, namely service quality and customer satisfaction, but from the perspective of the private hospital patient, the customer in this instance. Moreover, it will attempt to predict the future behavioural intentions of patients, that is, their willingness to reuse the same hospital or recommend it to others after experiencing a stay in a private hospital.

By identifying the specific dimensions of service quality and customer satisfaction which would most likely influence patients' future buying intentions, the study also aims to improve current understanding of the patient as a customer and thereby increase awareness of the value of a returning patient who might then do so more readily should the need arise again in the future.

The understanding so gained is also intended to provide further insight on how these relationships impact on the patient's overall judgement or evaluation of the hospital experience (or experiences) over the passing of time.

Finally, it is also intended that the study could provide a basis from which to develop a more sophisticated measuring instrument that could be used in future research undertakings, even by private hospitals themselves.

1.8 SCOPE OF THE STUDY

Traditionally, the South African healthcare sector has consisted of two distinct industries, namely public and private healthcare and in the case of hospitals, public and private hospitals (Road Accident Fund 2002:888-889). A more recent development in this arena is the emergence of public/private partnerships entered into with some of the country's hospitals (Wilson 2002:90).

Three main groups, namely Netcare, Afrox Healthcare Limited and Medi-Clinic currently dominate the private hospital industry with a smaller grouping of independent players also operating in this industry (Bhoola 2002:55). Collectively, these groupings constitute about 178 private hospitals in South Africa (Health Annals 2002:2).

The study was limited to the private hospital environment only and confined to one hospital group, namely Afrox Healthcare Limited. Afrox, while not an official participant in the study, granted approval for certain of its hospitals to participate and determined the extent of its involvement in ensuring each hospital's cooperation. The empirical research was conducted at five Afrox hospitals situated in four major centres across the country. The hospitals were selected on a non-probability convenience basis.

Afrox Healthcare Limited, as the group was known at the time of participation in the study, underwent a name change in 2005 to become Life Health Care (Pty) Ltd. Since the five hospitals participated under the auspices of Afrox at the time, for the purposes of this study, the company name Afrox will be referred to.

The presumption was made that for a patient, the group of factors that comprise the hospital experience can be both complex (not always easy to

understand) and comprehensive (wide in scope), leading to the conclusion that the entire experience could be somewhat difficult to define in specific terms. For this reason, in part, the study will concentrate on one aspect of the provider/customer relationship only, namely, whether service quality and transaction-specific customer satisfaction could influence future behavioural intentions by enhancing patient loyalty (willingness to reuse, offer word-of-mouth endorsements).

1.9 DEFINITION OF CONCEPTS

Since the focus of the research is on the influence of service quality perceptions and customer satisfaction on patients' behavioural intentions in the healthcare industry, it is necessary to provide clear definitions of some of the key terms used in the present study.

1.9.1 Private healthcare

In section 1.8, it was mentioned that South Africa's healthcare sector consists of two distinct industries, namely public and private healthcare. As the names imply, public healthcare is primarily state-funded while private healthcare is owned by private enterprise (Road Accident Fund 2002:882,884). It is only very recently, and still on a limited scale, that a third initiative, the public/private partnership, has entered the country's healthcare environment.

Currently, public healthcare provision has been the responsibility of the state, serving mostly those healthcare seekers who, due mainly to socio-economic reasons, are virtually excluded from medical aid coverage (Luiz & Wessels 2004:1; Road Accident Fund 2002:882). Public healthcare is often criticised for being of poor quality and in a state of decline (Road Accident Fund 2002:898,900).

In contrast, private healthcare has traditionally served healthcare seekers who enjoy the benefit of being contracted to medical aids which then pay health service providers on a fee for service basis (Luiz & Wessels 2004:2).

Private healthcare in South Africa is recognised for its extremely high standard, comparable with the best in the world, and consists of many leading medical professionals working in private practice.

In the hands of private enterprise, the market for private healthcare exists not only in an increasingly competitive environment, but in an increasingly more expensive one too as the cost of medical procedures continues to rise.

For the purpose of this study, private healthcare is predominantly an intangible service marketed to those healthcare seekers who have a strong preference for private healthcare. The assumption is therefore made that private healthcare consumers are willing and able to satisfy their healthcare needs because they are able to afford the services of private healthcare, either through some form of medical cover or else from personal funding. Furthermore, by virtue of the high standard of care expected of private industry, it is deemed to be the preferred choice.

1.9.2 Private hospitals

The three large groups and smaller independent groups who own and manage South Africa's private hospitals are classified as private sector enterprises. In South Africa, there are some 178 private hospitals accounting for 24 042 hospital beds (Health Annals 2002:2). In sum, these groups and their assortment of hospitals constitute the country's private hospital industry – many business enterprises independently owned and managed. More than 40 000 employees are employed in the private hospital industry (Joseph 2002:37). It should be noted that all employees in this industry are trained to deliver quality patient care and that customer satisfaction levels are measured at regular intervals (Joseph 2002:38).

As individual business enterprises competing for a share in the market in the private hospital industry, the achievement of the three financial goals of profitability, profit maximisation and shareholder wealth maximisation is crucial to survival (Marx, Van Rooyen, Bosch & Reynders 1998:592). But

as in any other competitive environment, these hospitals have to also satisfy consumer needs through the achievement of marketing's most fundamental goal, that of customer satisfaction.

Private hospitals will compete aggressively to attract patients, but having done so must ensure that their patients leave satisfied after a hospital visit to ensure their willingness to return. In this way, the hospital's long-term survival and growth are properly ensured.

The ability to achieve these twin goals (financial returns, on the one hand, and the marketing concept on the other) must apply to all contemporary business enterprises regardless of the form of business ownership a firm takes.

In this study, a private hospital is considered to operate as a business enterprise in accordance with recognised business principles, while at the same time being a member of a larger hospital group within the country's private hospital industry. As such, it pursues, and is actively engaged in, the attainment of the goals highlighted above.

1.9.3 Private patients

Different types of patients occur in the wider market for healthcare. The focal point in this study is on one type only, the hospital patient. More specifically, the focus is on the patient who has sought to have his or her healthcare needs satisfied in the private healthcare industry. Thus, the private hospital patient in this study is an adult who has been admitted to a private hospital in order to undergo medical treatment which had to include surgery and at least one overnight stay in a hospital ward.

For the purpose of this study, the patient is a person whose current state of health or physical condition necessitates hospitalisation for medical treatment that includes an operation, and that patient in turn becomes the hospital's customer, at least for the duration from admission to discharge.

Being a private hospital patient means that the benefit of some kind of

medical cover exists or otherwise personal funding is available to pay the costs of the hospital visit in full. By implication, the private patient is also a paying customer entitled to the normal rights of any other customer. It is also important to note that the actual hospital utilised might not have been the patient's choice, but rather, for varying reasons, the referring doctor's choice. However, this should not affect the provider/customer relationship in any way.

1.9.4 Service quality

Service quality arose out of the need for a concept which described how customers perceived the quality of a service, with particular reference to the service industry. It was believed that once the service provider knew how customers evaluated the quality of its service, it would be in a better position to not only influence these evaluations in a desired direction, but also to relate the service to customer benefits.

In this study, the concept of service quality is based on the early work of Parasuraman et al. (1985, 1988), and refers to the customer's judgement of the overall excellence or superiority of the service. It is distinct from customer satisfaction in that service quality is a global judgement, formed over a period of time, but nonetheless related to satisfaction since the outcome of incidents of satisfaction over time give rise to service quality perceptions.

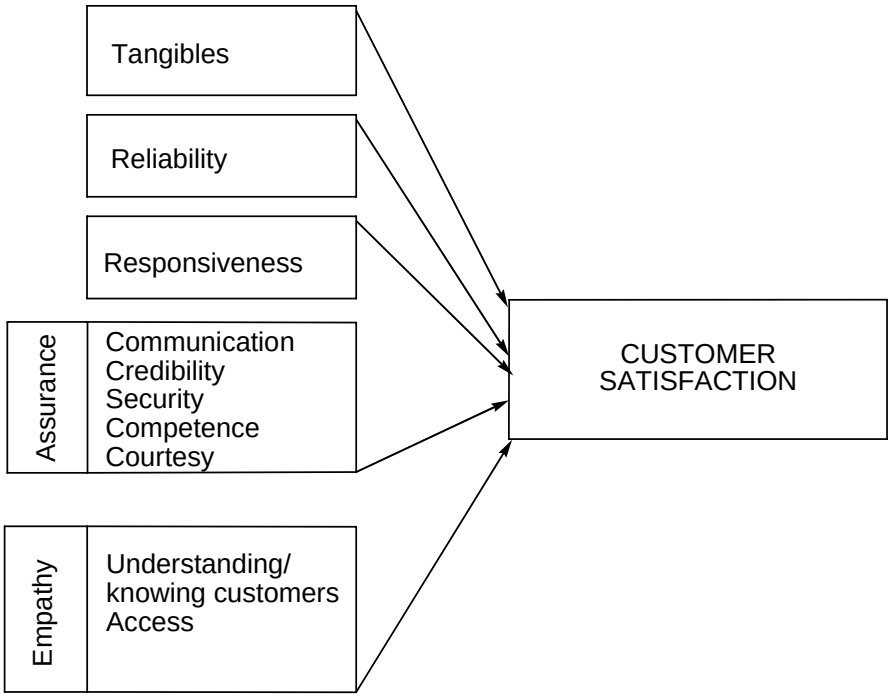
The perception of service quality by consumers refers to a comparison of customer expectations of a particular service provider with customer perceptions of its actual performance. Furthermore, that only the customer can be the judge of service quality, irrespective of the service provider.

Previous research found that customers used the same general criteria to arrive at an evaluative judgement about service quality, regardless of the type of service. The multiple-item scale to measure consumer perceptions of service quality, SERVQUAL, was the result of initial research that reduced the dimensions of service quality to just five dimensions. The ten

original dimensions first proposed by Parasuraman et al. (1985) were named tangibles, reliability, responsiveness, communication, credibility, security, competence, courtesy, understanding/knowing the customer and access.

The five dimensions that remained after the reduction were similarly named tangibles, reliability, responsiveness, assurance and empathy (Parasuraman et al. 1985, 1988). Figure 1.2 depicts the service quality dimensions to be empirically tested in this study.

Figure 1.2: Service quality dimensions



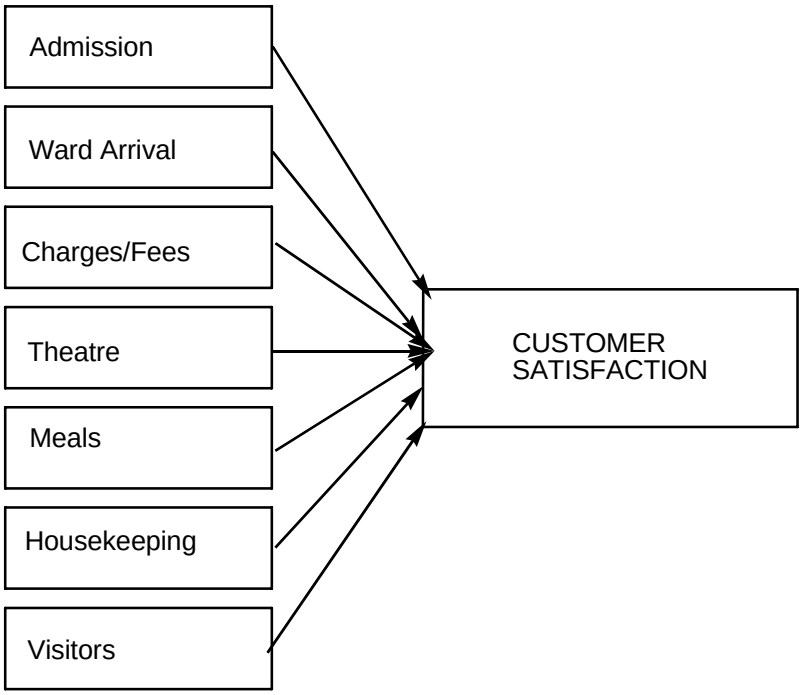
Source: Adapted from Oliver (1997:48) and Parasuraman et al. (1988:21-22).

However, several problems and criticisms of SERVQUAL experienced in later studies determined that the original version of SERVQUAL, which measures the ten dimensions of service quality outlined above, would be used in the present study. A further reason not to use the reduced five dimensions was that the original ten dimensions of service quality are a stronger predictor of customer satisfaction.

1.9.5 Customer satisfaction

Unlike the global judgement of service quality arrived at over a period of time, customer satisfaction is transaction-specific, that is, it is the outcome resulting from a particular consumption experience, such as a hospital visit. In addition, customer satisfaction is viewed as uniquely personal, in other words, satisfaction stems from the interaction of perceptual interpretations of the service and customer expectations of that service. This will result in different consumers having varying levels of satisfaction for an experience, which is essentially the same in delivery. The transaction-specific dimensions of customer satisfaction to be empirically tested in this study are shown in Figure 1.3.

Figure 1.3: Customer satisfaction dimensions



Source: Researcher's own construction.

The dynamics that combine to create the service experience – perceptual, evaluative and psychological processes and the unique characteristics of services – suggest that customer satisfaction of a service encounter is more complex than satisfaction after consumption of a physical product. Multiple encounters with the same service provider will result in multiple

experiences for the customer, which over time, will lead to an overall level of satisfaction.

In the present study, both transaction-specific customer satisfaction at the attribute level and 'overall' cumulative customer satisfaction of the hospital stay will be measured.

1.9.6 Loyalty

Two aspects related to the private hospital/patient relationship need to be considered when attempting to predict patient loyalty. Firstly, since it is often the referring doctor who makes the choice of hospital, or at least strongly influences the choice, loyalty to a particular hospital in the private healthcare environment was considered more difficult to measure than the alternative of willingness to reuse the same hospital again in the future or recommend it to others. And secondly, to have to go into hospital is not normally a sought-after service and in many cases, may not occur too frequently. Nonetheless, even a single encounter with a service provider includes elements by which a loyal relationship can be built (Grönroos 2000:7).

Keeping customers loyal is not an easy task (Grönroos 2000:34), yet many hospitals today are increasingly finding profitable opportunities to establish and build loyal relationships with their patients (Schiffman & Kanuk 1994:591-597). In fact, relationships with customers are central to loyalty and loyal customers are normally, but not always, profitable customers (Grönroos 2000:7,131).

Thus, the importance of customer loyalty, and in this case, patient loyalty, can hardly be overstated. Consumer loyalty has even been described as the marketplace currency for the 21st Century (Singh & Sirdeshmukh 2000:150).

Definitions of customer loyalty point to probability of repurchase to proportion of purchase (Sivadas & Baker-Prewitt 2000:79). Customer

loyalty is typically viewed as having a positive propensity toward a certain store or brand on the one hand (East, Hammond, Harris & Lomax 2000:308), and both a cognitive construct (attitude) and shopping behaviour on the other (Dick & Basu 1994); Mellens, Dekimpe & Steenkamp 1996).

Because customer loyalty to a particular hospital is likely to differ from other service providers or even brand or store loyalty in a retail context, future behavioural (buying) intentions were used to measure loyalty in this study. In particular, willingness to reuse the same hospital in the future or recommend it to others was taken into account.

Thus, for the purpose of this study, customer loyalty will refer to two specific repeat purchase behaviours, a private hospital patient's willingness to reuse the same hospital again in the future (should the need arise), or recommend it to others (positive word-of-mouth endorsements).

Regardless of the service industry in question, studies have shown that customer loyalty increases profitability (Heskett, Sasser & Schlesinger 1997; Reichheld 1996); it serves as a barrier to entry for competitors (Aaker 1991) and is a key determinant in predicting market share (Baldinger & Rubinson 1997; Jacoby & Chestnut 1978).

1.10 STRUCTURE OF THE DISSERTATION

The dissertation is divided into 9 chapters structured as follows:

Chapter 1 provides the introduction and background to the study, an explanation of the problem area to be investigated and the purpose for undertaking this particular study. The objectives of the study and equivalent hypotheses of the research are specified, followed by a brief overview of the study's research design and methodology. The contribution the study will endeavour to make and its limitations; also, definitions of the most important terms used are presented. An overview of the structure of the dissertation concludes the chapter.

Chapter 2 denotes the importance of business management and the place

of services marketing in the marketing function, one of the eight business functions which need to be managed in a coordinated manner within an enterprise. The purpose for including this chapter is to contextualise the study within the field of study of business management.

Chapter 3 provides a brief overview of the South African healthcare sector with particular reference to the private hospital industry as a component of the service sector in which the present study was undertaken.

In Chapter 4, services marketing is discussed. The growth in service industries and the increasing importance of services marketing to the economy today start off the discussion. The major contributors that laid the groundwork for services marketing's development are also mentioned.

It is necessary to understand the exact nature of a service in contrast to physical goods. This concept is explored as well as the contrasting views that services marketing is not a separate discipline from marketing.

The services marketing mix is discussed taking into consideration the private hospital environment. Services consist of a number of unique characteristics. These are examined on a generic basis first and then an attempt is made to contextualise them to a private hospital setting.

Chapter 5 addresses the development of service quality and its role in services marketing research. Its application as a marketing strategy in the healthcare industry and more specifically, the private hospital, is also offered. This is followed by a discussion of the original ten dimensions of service quality, its subsequent reduction to five dimensions and some of the well-known models of service quality. The importance of service quality to the South African private healthcare industry, namely private hospitals, is also proposed.

Chapter 6 examines the concept of customer satisfaction and attempts to put a meaning on what constitutes a customer. The importance of customer satisfaction in the services industry, with particular reference to the private hospital is discussed. Selected models of customer satisfaction

are examined.

In Chapter 7, the research design and methodology are presented. This chapter examines the nature and importance of scientific research and distinguishes between research design (the plan or blueprint of the research) and research methodology – the actual process used in the research. The research design deemed appropriate for the present study is motivated. The chapter further elaborates on the sample used in the study and the measuring instrument developed to collect the data. An overview of the statistical analyses to be performed is also provided.

In Chapter 8, the data preparation of editing, coding and capturing are discussed. The empirical results of the validity and reliability assessments of the questionnaire are reported, followed by the empirical results of the measuring instrument used in the present study to gather service quality and customer satisfaction perceptions.

Finally, in Chapter 9 the summary, conclusions and recommendations for future studies are presented. The contributions and limitations of the study are also highlighted. A final word on the benefits of positively perceived service quality and customer satisfaction to a private hospital is offered in conclusion.

CHAPTER 2

THE NATURE AND SCOPE OF BUSINESS MANAGEMENT

> *"xyz Hospital is a business to make profit for its shareholders. It's* [sic] *promises were not conveyed to me as a patient."*
>
> Respondent in present study, a former patient commenting on service delivery following a hospital stay.

2.1 INTRODUCTION

The two constructs which formed the basis of this study, namely, service quality and customer satisfaction in the marketing of services, do not exist in isolation and therefore need to be contextualised within the field of study of business management. Business management itself is a sub-section of the economic sciences whose major focus is on maximum need satisfaction of mankind (Marx, Van Rooyen, Bosch & Reynders 1998:8,23). The study of business management entails, inter alia, comprehensive and ongoing scientific research by testing theories to evaluate their practical applicability, examining and overcoming management problems and the continuous scanning of environmental variables (Cronjé, Du Toit, Marais & Motlatla 2004:25; Marx et al. 1998:21).

The aim of this chapter is to examine the nature and purpose of business management and demonstrate how the research problem of the present study fits into the field of study of business management. The reason why the role of business in society is examined and how the satisfaction of needs is achieved by means of goods and services produced by a country's economy, will become apparent in this chapter.

The services marketing discipline forms the focal point of this study. Services marketing and the functional area of marketing management comprise a specific group of tasks that are performed in a business enterprise. Services marketing's connection to the field of study of business management and the business functions are also explored in this chapter.

2.2 THE LINK BETWEEN SOCIETY AND ITS ECONOMY

All societies are faced with the common economic problem of striving to achieve the best possible satisfaction of their inhabitants' needs for goods and services by using the factors of production to create and then dispense them. These goods and services are produced by the economy of a country. An economy therefore is the mechanism that provides the solution to this ubiquitous problem. Simply put, an economy comprises a set of scarce resources capable of producing a limited quantity of goods and services for a population with unlimited needs and wants (Parkin & King 1995:11), and is thus the system by which need satisfaction is achieved (Cronjé et al. 2004:13).

Different economic systems offer different solutions to a country's need satisfaction problems and it is the choice of system taken by a country that will determine what goods and services are actually produced.

2.2.1 The main economic systems in the world today

Societies around the world are faced with the dilemma of satisfying a wide and almost unlimited array of needs with the scarce and limited resources at their disposal. Almost without exception, an organised and ongoing process is required by society to accomplish this task, providing this process is a role undertaken by government, via the economy. The organisation of the economic processes of a country is referred to as an economic system (Marx et al. 1998:10).

Economic systems found in the world today include the free market system or market economy, the command economy or communism (also known as centrally-directed economic system), socialism or socialist system and the mixed economic system or mixed economy (Cronjé et al. 2004:15-18; Gitman & McDaniel 2005:34-36; Marx et al. 1998:11-15). A country's choice of economic system will directly determine how the needs of its people are satisfied. It is necessary to briefly examine each system to understand the role of need satisfying organisations in society.

2.2.1.1 The free market system

Under a free market system or market economy, privately owned business enterprises in a society are allowed to supply its members, for a profit, need-satisfying solutions to meet their demands (Cronjé et al. 2004:15; Marx et al. 1998:11). The private enterprise system is based on competition in the marketplace and private ownership of the factors of production (Gitman & McDaniel 2005:34). Individuals themselves have the freedom to decide, generally without government interference, which goods and services to provide (Marx et al. 1998:11; Cronjé et al. 2004:4).

As the system with the most economic freedom, several assumptions relevant to the free market economy have been highlighted (Cronjé et al. 2004:15; Gitman & McDaniel 2005:34; Marx et al. 1998:11-12). These assumptions include:

- **The right to own assets and earn an income from them**. The fact that individuals have the right to own property is fundamental to the free market economy. The right to pursue the profit motive and the right to compete freely with minimal interference from the state stimulates entrepreneurship and job creation. Privately-owned assets and capital must be applied as productively as possible to the factors of production.

- **Distribution of resources through free markets**. Private business enterprises decide which goods and services to produce and how they will be distributed. The owners of the capital determine which manufacturing processes to adopt.

- **Freedom of choice.** Private enterprises are free to choose which markets they can profitably serve and with which goods and services. Likewise, individuals – the consumers of these goods and services – are free to choose whether or not to purchase them. Competition takes place as a result of the degree of freedom that exists in a free market economy and stimulates ways for improving need satisfaction. Workers are also free to decide on a choice of career. Thus, individual consumers and the business enterprises who intend to

serve them influence the decision concerning which goods and services to offer.

- **Minimum state interference**. It is generally accepted that the state should only maintain the economic system, however, it can, and does, impose certain restrictions on private enterprise.

  Even though the free market economy guarantees certain economic rights (Gitman & McDaniel 2005:34), the system is not entirely "free" because the state does "restrict" certain freedoms through legislation (Marx et al. 1998:11). Private enterprise has to survive in a dynamic business environment characterised by risk and uncertainty.

2.2.1.2 The command economy

In a command economy (or centrally-directed economic system), the state owns and controls a country's resources or factors of production (Cronjé et al. 2004:17). It is therefore the state that makes all the decisions about which products and services to produce, how distribution will take place and where individuals should work. Freedom of choice is thus severely restricted. The state owns all the property and the profit motive does not exist. Consequently, competition is absent as the state owns all the enterprises. Because the state assumes full responsibility for the ownership of enterprises, individual ownership of property does not exist. The environment is the state so survival is virtually guaranteed due to the absence of risk. Consumers have to accept whatever is offered regardless of the quality (Marx et al. 1998:14-15).

This system used to be known as communism and today exists only in a few remaining countries in the world.

2.2.1.3 Socialism

Socialism or the socialist system appears to offer something of both the aforementioned systems. Under this system, the basic industries are

owned by the state or by the private sector under strong government control (Gitman & McDaniel 2005:35). Thus, some free market economy does prevail (Cronjé et al. 2004:17). The basic premise of socialism is that strategic and basic resources should belong to every individual of the economy which leaves private enterprise to operate in the free market of that economy (Cronjé et al. 2004:17; Marx et al. 1998:12). Competition is restricted as a result of state controlled enterprises (Cronjé et al. 2004:20; Marx et al. 1998:14), but outside of this control, consumers do have freedom of choice.

2.2.1.4 Mixed economic system

In addition to the three main economic systems above, Gitman and McDaniel (2005:36) describe a fourth system, namely the mixed economic system or mixed economy. This system combines several economic systems. Under a mixed economic system for instance, the government is sometimes fundamentally socialist and owns the basic industries in the economy. The main difference according to Gitman and McDaniel (2005:36) lies in government involvement in the economic system – taxing, spending and welfare activities and the striving to achieve many goals that otherwise might not be attempted in a purely free market system, such as, income redistribution and social security. As in a free market system, private enterprises carry out most other activities (Gitman & McDaniel 2005:36).

It would be unrealistic to assume that any of these systems are found in a pure form today. Instead, several mixed forms are found (Cronjé et al. 2004:4,23; Marx et al. 1998:11) and the economic system followed by a government should aim at encouraging growth and stability (Cronje et al. 2004:19). It should, however, be noted that a government may even change an economic system if it so wishes (Marx et al. 1998:71), but that this should be done only with the approval of its inhabitants (Cronjé et al. 2004:19).

While a more detailed discussion of each economic system and its merits and shortcomings falls outside the scope of this study, it is necessary to understand that an economic system is required if production and distribution of need-satisfying goods and services are to reach the members of a society. Taking a brief look at each system as done here, also helps to contextualise the origin and role of business enterprises in society (Cronjé et al. 2004:14). The economic systems used by some of the main regions in the world, including South Africa, are highlighted in the next section.

2.2.2 The main economic systems in the world today

Accurate statistics on the exact number of countries in the world seems unclear, but estimates list this figure as 194 countries (Cateora 1996:76). While a review of these countries' economic systems is not relevant to this study, the sheer numbers of inhabitants that 194 countries translates into on a global scale, implies that economies today are under pressure to satisfy needs. The issue of need satisfaction will be addressed in a later section; however, knowledge of a country's economic system, and South Africa's in particular, will provide an understanding of how the satisfaction of needs for goods and services in an economy, is achieved.

Additionally, from an economic perspective, cognisance must be taken of countries' changing economic systems as globalisation spreads across the world. As Cateora (1996:29) and Gitman and McDaniel (2005:122) correctly point out, the emerging global economy brings about worldwide competition with significant benefits for both business enterprises and consumers alike. However, globalisation has also been criticised for destroying jobs, especially in developing countries (Cronjé et al. 2004:585).

Global competition and the greater freedom of choice it brings, has enabled business enterprises to expand beyond the 'home' economy and into other economies. Increasingly, one country's production is exchanged for the production of other countries as the world evolves into what Parkin and

King (1995:17) view as a closely integrated economic machine that links the economies of individual nations.

The impact of globalisation on national economies is that business enterprises will increasingly have to compete internationally, whereas previously they had to compete with local rivals only (Cronjé 2004:585). The increase in international competition brought about by the emerging global economy raises the question as to the future relevance of the four economic systems examined in the previous section. However, as the world economy continues to evolve, and given that economic systems no longer exist in pure form today, some of the main regions in the world where one system is still historically most prevalent in a country, are the following examples (Gitman & McDaniel 2005:34-36; Cronjé et al. 2004:15-18; Marx et al. 1998:11-13):

- Free market economy: Countries include the USA, Japan, Singapore, South Africa and most western countries.
- Command economy: Still prevalent in China, Vietnam, Cuba and some African states.
- Socialism: Countries include Great Britain and some Western European countries like Denmark, Germany and Sweden, and Israel.
- Mixed economy: Gitman and McDaniel (2005:35) hold the view that countries like Canada, Great Britain and Sweden use more than one system.

Gitman and McDaniel (2005:37) predict that over the long term, only the free market economy will continue to show steady growth while the mixed economic system will continue to grow, but at a slower rate. Socialism will grow only slightly while the command economy will show no growth at all and possibly even disappear. The collapse of communism in the former

Soviet Union and other East European countries in the early 1990s is proof that the command economy has failed to create wealth (Cronjé et al. 2004:17).

2.2.2.1 The economic system in South Africa

In order to address the issue of need satisfaction in an economy, it is necessary to understand the economic system in which a country operates. Cronjé et al. (2004:20) define the South African economic system as a market-oriented economy with a high degree of government participation and control. This definition implies that the same assumptions highlighted in the discussion on the free market economy will apply under the South African market-driven economy. In fact, South African consumers enjoy a high degree of freedom (Cronjé et al. 2004:21) in exercising their consumption needs. However, it must be pointed out that the South African economy is also a 'more or less' free market system (Cronjé et al. 2004:21) because of government intervention, as mentioned above. Marx et al. (1998:11) term a 'more or less free market system' as one where the characteristics of one system are to a lesser or greater degree also prevalent in other systems.

In a free market economy, as in South Africa, it is the business world (Cronjé et al. 2004:21) and its network of business enterprises that accomplish the task of need satisfaction. Under this system, freedom of choice in pursuit of need-satisfying solutions can best be achieved through private enterprise. A free market economy implies a complex system based on the satisfaction of needs on the one hand and profit seeking on the other. The next section will examine the role of business enterprises in a free market economy, and within the field of study of business management.

2.3 THE ROLE OF BUSINESS ENTERPRISES IN THE FREE MARKET ECONOMY

The business world in a free market economy comprises of private business enterprises (Cronjé 2004:21) which are established and managed

with the primary goal of making a profit through the satisfaction of multiple human needs (Marx et al. 1998:5). Business enterprises are established by entrepreneurs – people with vision, drive and creativity who are willing to take the risk of starting and managing an enterprise to make a profit (Gitman & McDaniel 2005:183). It is the entrepreneur who achieves need satisfaction solutions that ultimately result in a profit.

Entrepreneurs are the link between the business enterprise and the individuals, or other enterprises, it intends to serve. More specifically, the business enterprise serves two kinds of consuming entities. Schiffman and Kanuk (1994:8) describe these consuming entities as personal consumers, or end users, and organisational consumers or other enterprises – business, government or non-profit seeking. Entrepreneurs serve as the link because they are the ones who establish business enterprises, or grow existing enterprises, and take all the risks associated with providing products and services to consumers (Cronjé et al. 2004:37).

2.3.1 Human needs are wide-ranging

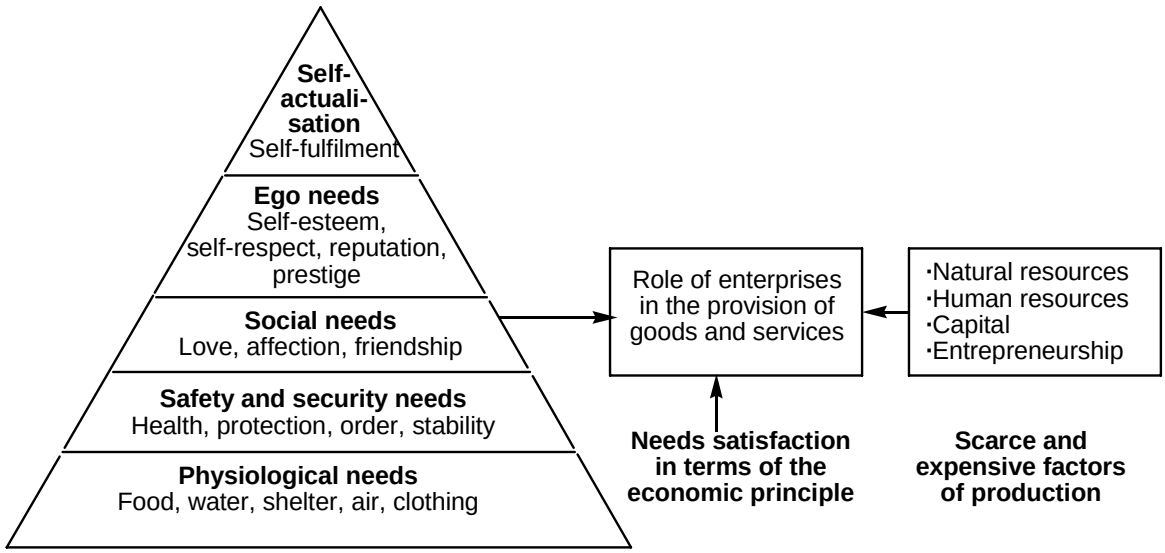
Humans depend on the ongoing satisfaction of their needs for survival. It was well-known clinical psychologist Abraham H Maslow who explained humans' wide range of virtually unlimited needs by means of a pyramid or hierarchy of needs (Schiffman & Kanuk 1994:109-113).

Maslow's hierarchy of human needs theory postulated that five basic levels of human needs exist, ranked in order of importance from lower-level needs to higher-level needs (Schiffman & Kanuk 1994:109). Figure 2.1 shows how Maslow's hierarchy of needs are satisfied with the effective use of the factors of production. The first and most basic level of needs to be satisfied is physiological and is required for the purpose of survival. The satisfaction of hunger, thirst and the need for air, clothing and shelter are examples of physiological needs. The next level of needs in the hierarchy is safety and security needs such as health, protection, order, stability and control over one's environment. Social needs represent the third level of the needs

hierarchy and include the need for love, affection, friendship and belonging. Moving towards the top of the hierarchy, the fourth level is concerned with esteem needs and refers to ego needs such as self-acceptance, self-esteem, prestige and reputation. Right at the top of the hierarchy the self-actualisation needs can be found. This need refers to the striving to fulfil one's potential, that is, to become everything that one is capable of becoming.

Maslow held the view that humans attempt to first satisfy the lower-level needs before higher-level needs emerge, but conceded that needs can also overlap, as no level is ever completely satisfied (Schiffman & Kanuk 1994:109). The hierarchy of needs theory was not without its critics, however. According to Schiffman and Kanuk (1994:113), the main criticism is that the theory cannot be tested empirically as it is not possible to measure precisely how satisfied one need must be before the next higher need becomes operative.

Figure 2.1: Maslow's hierarchy of human needs



Source: Adapted from Marx et al. (1998:6); Schiffman & Kanuk (1994:109).

Despite the criticisms, Maslow's work has received widespread attention in social sciences textbooks and does give some idea of the motivation behind human need satisfaction. The hierarchy theory is a useful tool for

understanding human needs for goods and services and the motivations for satisfying different levels of needs (Schiffman & Kanuk 1994:113). In a more or less free market economy, business enterprises are established and managed with a view to satisfying the multitude of different needs in the communities they serve, with a variety of goods and services.

2.3.2 How human needs are satisfied

According to Marx et al. (1998:6), the urge to satisfy needs by means of goods and services is referred to as the economic motive and is not only the driving force behind all economic activities, but also one of the most powerful incentives for material progress. Motives themselves are difficult to identify and measure because they are hypothetical constructs, in other words, motives cannot be seen, touched, handled, smelled or tangibly observed (Schiffman & Kanuk 1994:118). Consumer behaviourists believe that motives drive an individual to satisfy particular needs (Schiffman & Kanuk 1994:97). Business enterprises therefore need to identify, understand and satisfy unfulfilled needs by producing goods and services in the economy, to meet those needs (Cronjé et al. 2004:4; Schiffman & Kanuk 1994:93).

In the previous section, it was mentioned that humans have a multitude of virtually unlimited needs. Need satisfaction is achieved through processing a society's factors of production, or limited resources (Cronjé et al. 2004:11; Marx et al. 1998:6). Business enterprises use the factors of production to satisfy needs. They are however scarce, expensive and have alternative uses and applications (Marx et al. 1998:7). The production-processes created by business enterprises combine and transform the factors of production into end products and services (Marx et al. 1998:24). Briefly, the four existing factors of production (Gitman & McDaniel 2005:25-27; Cronjé et al. 2004:11-12,586; Marx et al. 1998:6-7,24-26) and an emerging fifth factor, are as follows:

- **Natural resources** include all natural sources such as minerals and

metals, forests, water, the riches of the sea and crude oil. Also known as land, this includes agricultural land, industrial sites and residential stands. It is important to note that the supply of natural resources cannot simply be increased. Additionally, human effort is usually required to process these resources into need-satisfying products.

- **Human resources** are also known as labour and refer to the mental and physical efforts and human skills expended by employed individuals to create goods and services. Training and development of this resource is an ongoing activity if the required output is to be achieved.

- **Capital** includes the buildings, machinery, equipment and other means of production which are used not in final consumption, but in the production process to create final goods and services. Capital comes from two main sources, the funding provided by investors in which case the owners or suppliers of capital earn an income in the form of interest or rent, and profits retained by the enterprise.

- **Entrepreneurship** refers to those individuals who accept the risks associated with establishing and managing a business enterprise in order to provide need-satisfying goods and services for communities. Entrepreneurs are said to be the driving force in the free market system since they influence how goods and services are produced and also determine the various combinations of the three other factors of production.

- **Knowledge** is increasingly being recognised as a fifth factor of production. It includes the combined talents and skills of the workforce. The emerging ‘knowledge economy’ requires that enterprises need to manage knowledge as a valuable resource in order to survive. An increasingly competitive environment, rapid change and uncertainty and the way enterprises are managed today are some of the reasons given for the value placed on knowledge-sharing and continued learning in order to remain successful.

The economic problem facing enterprises is how to achieve the highest possible need satisfaction with the limited resources available. Marx et al. (1998:7) refer to this as the economic principle, that is, how scarce factors of production (inputs) can be used to ensure maximum satisfaction of needs (outputs). Business enterprises not only have to apply the factors of production as economically as possible, they also have to remunerate at the highest levels possible the factors of production utilised in the production process (Marx et al. 1998:7,17). This remuneration refers to rewards of profit for entrepreneurship, rate of return for capital, salaries and wages paid to human resources and market prices for natural resources (Marx et al. 1998:17).

Rewarding the factors of production is made possible if the business enterprise earns a profit. The economic principle can therefore also be expressed in terms of profit maximisation (Marx et al. 1998:22). In other words, business enterprises are required to earn the highest possible sales income on the market with the lowest possible expenditure on the factors of production (Marx et al. 1998:22).

2.3.3 Types of enterprises found in the free market system

The conversion process of the factors of production into need-satisfying goods and services in the 'more or less' free market system is undertaken by enterprises and their operating units. Three main categories of enterprises constitute the network of institutions which form the modern business world (Cronjé et al. 2004:21; Marx et al. 1998:18). These are private business enterprises, government enterprises or public corporations and non-profit enterprises. A brief discussion of three types of business enterprises follows.

2.3.3.1 Private business enterprises

Found in a free market system, private business enterprises accept the risk of loss, but more importantly, actively seek to make a profit from the

communities they serve through the effective utilisation of the factors of production (Cronjé et al. 2004:21; Marx et al. 1998:16). An enterprise is an independent economic entity, but is dependent on its owners for establishment, survival and growth (Marx et al. 1998:16). Collectively, these enterprises constitute the private sector of the economic activities of South Africa according to Marx et al. (1998:92).

The production of goods and the provision of services are offered by private enterprises in targeted markets to the consuming entity known as consumers. Solomon (1994:8) describes a consumer as someone who identifies a need or desire, makes a purchase and eventually disposes of that purchase during the different phases of the consumption process. Consumer needs and wants for products and services therefore translate into expected demand, which business enterprises are then free to decide how to satisfy.

Private hospitals such as St George's or Greenacres are examples of private business enterprises found in the services sector of the South African economy. Other examples of private enterprises include major retailers like Pick 'n Pay and Woolworths, financial institutions Standard Bank and Absa and many others, ranging in size from small businesses to large corporations, local and multinational players, all competing in the business world for the attention of the consumer.

2.3.3.2 Government enterprises

In the earlier discussion on economic systems, it was pointed out that no economic system exists in a pure form today, but that several mixed forms are found such as in the case of South Africa – a market-oriented economy with a high degree of government intervention. The government therefore owns and controls several need-satisfying institutions referred to as state-owned enterprises, parastatals or public corporations, which in many cases are profit seeking and sometimes even in competition with other private enterprises (Cronje et al. 2004:23).

The state can create products and services if it believes they are of strategic, economic or political importance to the community such as transport, energy, military equipment and armaments (Cronjé 2004:23). Production and distribution then takes place through the state-owned enterprises. Likewise, a need which cannot be ignored is the wellbeing of the community and the state can assume responsibility for another important offering, namely healthcare.

Government enterprises form part of the public sector (Marx et al. 1998:91) and include the country's state hospitals, national airline carrier South African Airways, Eskom (electricity) and Telkom (communication).

2.3.3.3 Non-profit seeking enterprises

As the name implies, this category of enterprises satisfies needs for goods and services not provided by private business or government enterprises. The main difference here is that need-satisfying services are provided by enterprises without seeking a profit (Cronjé et al. 2004:24). However, non-profit enterprises still need to be managed by the individuals who operate them, not unlike a private business enterprise, and therefore must aim to achieve a surplus of income over expenditure (Marx et al. 1998:24). Their continued existence is often dependent on community members' scarce volunteer time and public donations (Gitman & McDaniel 2005:25).

Non-profit seeking enterprises contribute only a small share to the economy (Cronjé et al. 2004:24), but they do provide a valuable service to society in a wide variety of activities, such as professional bodies, sport and recreation, feeding the poor, prevention of drunk driving, environmental issues and animal welfare groups, to name but a few.

Examples include the South African Chamber of Business (SACOB), Cancer Association of South Africa (CANSA), and the Society for Prevention of Cruelty to Animals (SPCA). Sports clubs, cultural associations and welfare organisations are also part of this category (Cronjé et al. 2005:24).

From the above discussion, it should be clear that the long-term survival of business enterprises is dependent on their ability to satisfy the needs of their consumers in the market(s) they serve if the reward of profit is to be achieved. Thus, private business enterprises and their ownership and management form the main subject of study of business management and offer many opportunities for scientific research (Cronjé et al. 2004:23; Marx et al. 1998:8,21). According to Cronjé et al. (2004:23,24), profit seeking government enterprises and non-profit seeking enterprises need to be included in the field of study of business management because on the one hand, government enterprises employ profit seeking motives and on the other, non-profit enterprises employ management principles.

It is against the background of the various economic systems discussed above and the role of business enterprises in a more or less free market economy, that the nature and task of business management and its scientific framework can be examined more closely.

2.3.4 The nature and task of business management

It should be clear from the above discussion that in a more or less free market economy like South Africa, it is private business enterprises which are the main area of focus. Furthermore, that the production and distribution of need-satisfying goods and services should result in the achievement of a business enterprise's primary objective – to make a profit.

Pitt and Bromfield (1994:90) use the well-known profit formula or simple business model to encapsulate the multitude of events, principles, methods and tasks that need to transpire in a business enterprise before a profit can be realised. The profit formula is depicted as follows:

Profit = Sales Income – Total Costs

The right-hand side of the profit model suggests that every action or transaction by the enterprise will have an impact on the left-hand side of the model. Consequently, the enterprise's performance in converting the

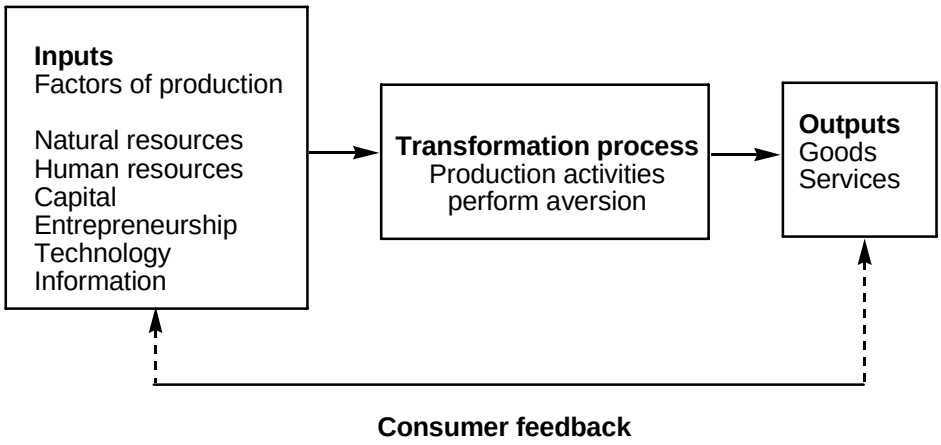
economic principle into need satisfaction will determine its reward of profit. Service quality and customer satisfaction are linked to need satisfaction. This raises the question whether service quality and customer satisfaction are relevant to the profit model. The findings of several empirical studies (Anderson et al. 1994) indicate a positive relationship between service quality and/or customer satisfaction and profitability. In the context of this study, service quality and customer satisfaction are deemed to be relevant to the profit model as these two constructs would therefore be encapsulated in the model. In Chapter 1 it was pointed out that a discussion of the profitability aspect falls outside the scope of this study.

The discipline of business management studies these events, principles, methods and tasks, or more specifically, the managerial activities performed by business enterprises. Marx et al. (1998:8) define business management as the science which is concerned with the study of what a business enterprise is and how it can best be established and managed in a more or less free market system. Although Cronjé et al. (2004:24) concur with this definition, to their definition of business management, the component, need satisfaction of the community, is added, to more clearly reflect that enterprises serve their communities.

All enterprises of all sizes and types, whether private, government or non-profit enterprises, have a common purpose, which has already been stated as providing goods and services so that each enterprise renders value to society and satisfies customers' needs in order to justify their continued existence (Schermerhorn 2002:12).

To achieve this common purpose, inputs such as raw materials or factors of production (natural resources, human resources and capital) are transformed by the enterprise into outputs, that is, goods and services, on a continuous basis, as shown in Figure 2.2.

Figure 2.2: The transformation process



Source: Adapted from Schermerhorn (2002:12) and Marx et al. (1998:20).

Marx et al. (1998:3-4) however, caution that while enterprises are responsible for the conversion process of inputs into outputs, and require purposefully managed activities in order to do so, without the addition of the managerial dimension the entire process will fail. Schermerhorn (2002:13) emphasizes that feedback from an enterprise's customers, will indicate how well it is doing and only through their willingness to use its outputs can success over the long run be determined.

Thus, the conversion process must be linked not only to profitable outputs, but more importantly to the goal of continuous customer satisfaction, which in turn is closely linked to quality (Gitman & McDaniel 2005:368-369). Additionally, customer satisfaction and quality are the foundation of all business principles because satisfied customers who experience quality products and services, tend to become loyal customers (Gitman & McDaniel 2005:xiv-xv).

Against this background, Marx et al. (1998:8) hold the view that the field of study of business management focuses on four main areas:

- science
- free market system and profit motive
- what an enterprise is

- how an enterprise is established and managed

The achievement of a business enterprise's main objective of making a profit would not be possible without the performance of several management functions, discussed in the following section.

2.3.4.1 The functional areas of management

Several schools of thought or approaches to management evolved during the last century. By the start of the 21st century, the theories of management had been classified into two main schools of thought, namely the classical approaches (±1900-1950s) and the contemporary management approaches (±1960-present). Each of these theories has made a substantial contribution to the theoretical body of knowledge on management (Cronjé et al. 2004:134; Schermerhorn 2002:92).

One such school of thought, the classical management process school, postulated by French industrialist, Henri Fayol, identified the most important functions in a business enterprise (Cronjé et al. 2004:135). Fayol's original six business functions became known as the functional approach and were subsequently expanded into eight business functions (Cronjé et al. 2004:32,135; Marx et al. 1998:29), which are still relevant today. According to Cronjé et al. (2004:135), these functions, also known as functional areas of management, comprise all aspects of a specific group of activities.

A study of this nature, that is, an investigation into two kinds of customer-experienced perceptions of service received from private business enterprises operating in the service industry, would be incomplete without first demonstrating the most important business function into which the study fits. This, and the main task of each of the eight business functions, is discussed in the following section. Cronjé et al. (2004:32) note that the business functions form a synergistic whole to direct the business enterprise toward its goal and objectives.

2.3.4.1.1 General and strategic management

Also referred to as the function of general and strategic leadership, general management integrates all the other functions of a business enterprise and therefore incorporates the fundamental tasks of management, namely planning, organising, leading and control. These tasks are also present in each business function (Marx et al. 1998:353-354). What makes general management the overriding function in an enterprise today is that it controls the management process and the general principles of top management, including that of the other functional managers as well (Cronjé et al. 2004:128).

Strategic management, on the other hand, focuses on the "bigger picture" of a business enterprise. This process requires ongoing environmental scanning over time to identify potential external opportunities and threats in the business environment and to evaluate the enterprise's internal strengths and weaknesses (Cronjé et al. 2004:136; Marx et al. 1998:42,351).

All managers in an enterprise should know and understand the general principles of management and how to perform the tasks of the management process if they are to manage their own functional areas more efficiently and effectively. On the one hand, to be efficient in a functional area, managers need to ensure that the right activities are performed in a productive manner with minimal wastage of resources. Functional area effectiveness, on the other hand, requires managers to strive for results, that is, performance is measured in terms of the functional area's output or goal achievement (Schermerhorn 2002:13,14; Jain 1997:59,60). Profitability as a percentage of sales income is a measure of efficiency and a percentage increase in market share (perhaps due to improved customer satisfaction) is a measure of effectiveness. A time frame would be necessary to accomplish these performance measures.

Cronjé et al. (2004:136) would therefore be correct in their assumption that managers in an enterprise today are required to think and act strategically because all levels of management in enterprises today are involved in

some form of strategic management.

2.3.4.1.2 Purchasing management

The purchasing function is concerned with the acquisition of all products and raw materials including components, tools and equipment, as well as services, that must be purchased in order to ensure an effective production process (Cronjé et al. 2004:34; Marx et al. 1998:398). Today, purchasing costs are considered an enterprise's biggest expense, up to 90% of each rand spent on purchases in the case of retailing enterprises and up to 40% in services enterprises (Cronjé et al. 2004:527-528). This kind of spending suggests that if purchasing costs constitute a major portion of an enterprise's total costs, it can therefore be deduced from the profit model discussed in section 2.3.4 that purchasing costs can significantly influence an enterprise's profit. Moreover, that each rand saved on purchasing costs can lead to an increase in profit (Marx et al. 1998:407).

Efficient purchasing and profitability is reinforced by Marx et al. (1998:407). Although the percentage share of purchasing costs differs from enterprise to enterprise, the profit-leverage effect assumes that even a modest reduction in purchasing costs can lead to a relatively larger increase in the enterprise's return on investment (Marx et al. 1998:405). This process is known as the profit-leverage effect of effective purchasing and needs to be practised by each business function in order that the enterprise as a whole can meet its profitability objective (Marx et al. 1998:119,406,408).

2.3.4.1.3 Production and operations management

The production and operations function is responsible for the ongoing transformation of resources, the inputs, into products and services; the enterprise's outputs (Gitman & McDaniel 2005:368; Marx et al. 1998:438). The transformation process, which is managed by this function, was discussed earlier in section 2.3.4.

For the production and operations function to be effective today, it is

increasingly required to link quality to the goal of customer satisfaction while simultaneously ensuring the enterprise produces its products and services profitably (Gitman & McDaniel 2005:368, 369).

2.3.4.1.4 Financial management

The financial function is concerned mainly with the production factor capital and involves the flow of capital (the funds lent to the enterprise) to and from the enterprise (Cronjé et al. 2004:394; Marx et al. 1998:583). The financial function also involves two crucial responsibilities, viz., the acquisition of funds, known as financing and the application of funds for the acquisition of assets, known as investment (Cronjé et al. 2004:394). Financial administration and reporting on financial matters are other important aspects of this function (Marx et al. 1998:584).

2.3.4.1.5 Human resource management

The human resources function involves the employment and retention of the right quantity and quality of employees to achieve the enterprise's objectives (Gitman & McDaniel 2005:272; Marx et al. 1998:30). Because it is the 'people element' that allows an enterprise to either prosper or not, human resources can also limit or enhance the strengths and weaknesses of the enterprise (Cronjé et al. 2004:221). Thus, human resources influence all the business functions in the enterprise. Cronjé et al. (2004:221) are correct in viewing human resources as the key element to the enterprise's effectiveness.

Marx et al. (1998:474) divide the human resource function into two dimensions, namely human resource provision and human resource maintenance. The former involves a consecutive process of human resource planning, job analysis, recruitment, selection, placement and incorporation, while the latter concentrates on training and development of human resources, their remuneration, benefits, motivation, job re-design, labour relations and other aspects of human resources administration.

2.3.4.1.6 Public relations management

The main purpose of the public relations function is to foster a favourable and objective image of the enterprise among its many stakeholder groups through the process of two-way communication between itself and its stakeholders (Marx et al. 1998:560). Others hold the view that public relations is also required to promote goodwill between the enterprise and its stakeholders (Gitman & McDaniel 2005:519; Shimp 2003:569).

Cronjé et al. (2004:353) note that business ethics is increasingly playing a role in the public relations function of South African enterprises. Moreover, Cronjé et al. (2004:388) advise enterprises to draw up a code of conduct for their employees specifying rules on what is regarded as ethical or unethical business behaviour. This practice has become necessary because many enterprises in South Africa employ people from diverse ethnic and cultural backgrounds and therefore, divergent views on ethical and unethical conduct are held (Cronjé et al. 2004:387-388).

2.3.4.1.7 Information management

Although recognized as a separate business function, it is important to note that some authors such as Marx et al. (1998:31) view information as spread throughout the entire enterprise. This implies that all the functional areas in an enterprise are responsible for information. The purpose of the information function is to provide the enterprise with sound information for decision-making purposes, in good time, in the correct form and at an acceptable cost (Marx et al. 1998:661).

Information today is at the heart of all enterprises (Gitman & McDaniel 2005:538), both internally and externally, which therefore requires that enterprises have an efficient information system in place to store and provide information whenever it is needed (Marx et al. 1998:665). For instance, information on the various functional areas of the enterprise is required for decision-making purposes not only across each area, but for the enterprise as a whole as well. Information to external institutions and

enterprises must be furnished by the enterprise on an ongoing basis, so the relevant information must be available at the time when it is needed (Marx et al. 1998:665-666).

2.3.4.1.8 Marketing management

The marketing function is responsible for the income of the enterprise, which in turn influences the achievement of the enterprise's objectives (Marx et al. 1998:30). This is accomplished by combining several activities in order to transfer a product or service from the enterprise to a consumer, through a process of exchange that leads to the satisfaction of a need (Cronjé et al. 2004:283-284).

Contemporary marketing thought views marketing as an integrating function that focuses all the enterprise's resources and decisions on meeting the needs of the consumer (Marx et al. 1998:521). Thus, the fundamental goal of marketing is customer satisfaction – the customer's feeling that a product or service has met or exceeded expectations (Lamb et al. 2004:5). Similarly, but more in the provision of services than physical products, through its marketing efforts, an enterprise needs to understand how the service quality perceptions of its customers influence their future behaviour (Parasuraman et al. 1985:47; Parasuraman et al. 1988:23).

In the case of the present study, the standard of customer service provided by a private hospital to its patients can greatly influence their perceptions of service quality and levels of customer satisfaction resulting from a hospital stay. This study attempts to identify service quality and customer satisfaction dimensions that influence patient behaviour.

This section has attempted to highlight each of the different business functions which influence the business enterprise as a whole. Managers of these functional areas, across all levels of management, are required to perform the management tasks of planning, leading, organising and control. Marx et al. (1998:355) view all the management tasks as having equal importance and part of a total management process. The next section

addresses the position of the present study in the field of business management.

2.4 POSITION OF THE PRESENT STUDY IN BUSINESS MANAGEMENT

The phenomena surrounding the relationships to be researched in the present study can be studied because South Africa follows a more or less free market economic system. In a free market economy, it is private business enterprises that are the main area of study (Cronjé et al. 2004:24) and therefore provide favourable opportunities for researchers to explore. Without these opportunities, researchers would not be able to add their contributions to the body of knowledge of business management.

Thus, in a more or less free market economy, the present study will be undertaken in the services sector, as opposed to the goods sector, of the South African economy, namely, the healthcare sector. Today, in many westernised countries, need satisfaction is increasingly being achieved by service economies, which means that the production of services is exceeding the production of physical goods – a trend that continues to grow worldwide (Parkin 2003:3), including South Africa (World Bank 2003). The increasing importance of services to the economy is discussed in Chapter 4.

According to Marx et al. (1998:84), the field of business refers to the position occupied by an enterprise as an economic entity in the economic activities of a country and is influenced by service variables. For the purpose of this study, health is the field of business, or position in the community occupied by the enterprises that are to participate in the study. Health is also the umbrella term for the production branch on account of the broadly similar production processes used. Enterprises from similar industries can be grouped together if their production processes are broadly similar (Marx et al. 1998:89). The branch of industry within which these enterprises operate, is the healthcare industry, further sub-divided into two categories of enterprises based on the various economic sector classifications (Marx et al. 1998:90-92).

Owing to South Africa's more or less free market system, the country's healthcare industry is presently served by two categories of enterprises, namely public healthcare providers (state run enterprises) and private healthcare providers (private business enterprises). The majority of these providers fall into the two main industries constituting South Africa's healthcare industry – public (or state) hospitals and private hospitals. A third dimension, and a potentially major development in the hospital environment, has been the recent emergence of a limited number of public/private partnership hospitals (Wilson 2002:90).

Every business enterprise in a specific branch of industry competes to increase its share of the market (Marx et al. 1998:89) and the private hospital industry is no exception. The healthcare industry as a whole also forms part of South Africa's formal sector of economic activities, but the private hospital industry additionally falls into the private sector on account of its private ownership of hospitals. Healthcare services, and thus private hospitals, are deemed to be part of the tertiary sector which includes end user consumers, who in this case would be healthcare consumers and more specifically, private patients. The private hospital industry is where the study will be conducted.

Private hospitals are therefore also private business enterprises and through their ownership, seek to make a profit from the communities they serve. As a privately-owned enterprise, the hospital becomes an independent economic entity dependent on its owners for its continued existence.

Though private hospitals may serve several categories of customer, for example, medical practitioners, it is the hospital patient who is their most important customer. If applied to Maslow's hierarchy of human needs theory discussed in section 2.3.1, the satisfaction of consumers' healthcare needs are taken care of by the second level – safety and security needs. As private enterprises competing for customers, private hospitals owe their long-term survival partly on their ability to satisfy the healthcare needs of their patients – their paying customers.

The transformation process or production of services in a private hospital environment is dealt with in Chapters 3, 4 and 5. For the purpose of this study, the assumption is made that all eight business functions are present in some or other format in a private hospital and that the tasks of the management process are performed by its managers as a normal part of their working day.

The question arises as to the placement of the present study into one of the different functional areas of management within the field of study of business management. The response to this is that the business function into which the study falls is marketing management and more specifically, services marketing.

Since customer satisfaction is the fundamental goal of marketing activity, the two important measures of customer satisfaction to be scientifically investigated in the present study can be explained according to business management's scientific framework, as depicted in Table 2.1, as follows:

Table 2.1: The scientific framework of the present study

Business management The marketing function (marketing management) Services marketing Healthcare industry Private hospital industry	
Empirical object/object of study	**Problem statement/angle of investigation**
Private hospital enterprises	The influence of service quality and customer satisfaction on patients' behavioural intentions in the healthcare industry

Source: Adapted from Marx et al. (1998:22).

2.5 SUMMARY

The main purpose of this chapter was to demonstrate how the present study is contextualised in the field of study of business management. In

particular, to clarify the position of a services marketing study in business management, a sub-section of the economic sciences. This clarification entailed first examining a somewhat broad view of the economy before narrowing down the topic to a specific position in the business management discipline.

In this chapter, the nature and scope of business management was examined. The importance of an economic system in society, and in particular, the free market system, for the satisfaction of unlimited human needs with limited resources was emphasized. Need satisfaction in a free market system is best achieved by entrepreneurs who establish business enterprises for profitable gain. To illustrate the wide range of virtually unlimited human needs, this chapter also highlighted the well-known hierarchy of human needs theory. It was also explained that to achieve a profit, the limited resources must be applied as economically as possible in business enterprises. Three types of enterprises were identified.

The profit formula, also known as the simple business model, was included in this chapter to explain how every action or transaction taken by the business enterprise has an impact on its primary objective, namely to make a profit. However, it was pointed out that profits must be linked to the goal of continuous customer satisfaction, which is in turn linked to quality products and services, and ultimately customer loyalty.

To facilitate understanding of the link between profit and customer, as described in the chapter, the eight business functions and their role in the business enterprise were discussed. Each business function has its respective purpose, which collectively, forms a synergistic whole to meet the overall goal of the enterprise. However, it was pointed out that it is the marketing function which must ensure that the goal of customer satisfaction is achieved. Furthermore, that in the marketing of services, such as in the case of healthcare, how the hospital patient perceives the quality of service received will influence their levels of customer satisfaction.

The discipline of marketing management, with specific reference to services

marketing, is the business function in which the present study is placed. The services marketing constructs which form the focal point of this study were first introduced in Chapter 1 as service quality and customer satisfaction. Their influence on the behavioural intentions of private hospital patients following a hospital visit is the problem area to be investigated.

Following the above discussion, it is now possible to present a brief overview of the South African healthcare industry with particular relevance to the private hospital industry. Chapter 3 deals briefly with the South African healthcare industry.

CHAPTER 3

THE SOUTH AFRICAN HEALTHCARE INDUSTRY: A BRIEF OVERVIEW

"I would venture to say if I had to find TV sets in an open ward should I perhaps need to enter hospital again I would seriously look at other hospitals. TV sets do not belong in hospitals' public wards."

Respondent in present study, a former patient commenting on service delivery following a hospital stay.

3.1 INTRODUCTION

A traditional service industry such as the healthcare industry can be quite varied, particularly with the inclusion of its many ancillary health services. Added to the complexity, is the Department of Health's (DoH) vision of a caring and humane society in which all South Africans have access to affordable, good quality healthcare (DoH 2005). In order to achieve the promised equity in healthcare, the government is said to be working in partnership with other stakeholders (presumably private enterprise) to improve the quality of care in all levels of the health system, including improvements to the overall efficiency of healthcare delivery (DoH 2005; Shevel 2003a:1).

Historically, however, the delivery of hospital services in the South African healthcare environment has been differentiated by two sectors, namely, private hospitals and public hospitals. More recently, a major development in the hospital environment heralded a new dawn for South African public healthcare (Wilson 2002:90), thereby effectively offering healthcare consumers what is expected to become a third choice in hospital services. This choice refers to a public private partnership (ppp) initiative, which is intended to introduce a new model of healthcare to consumers (DoH 2005; Krige 2004).

According to Wilson (2002:90), South Africa's first public private partnership hospital, labelled as the country's new healthcare flagship, opened in KwaZulu Natal in 2002. An 850-bed facility, the new public private hospital

is presently the largest of its kind in Africa. Furthermore, for the industry in general, it is also the biggest multi-service facilities management contract ever to be awarded in South Africa, the first fully privatised contract entered into with a government hospital and the largest and most extensive outsourcing facilities management contract in Africa. While the concept is still in the early phases of development, some public hospitals in the country have also begun to offer private hospital services in designated wards.

While the present study focuses on the private hospital industry only, an analysis of the private and public hospital sectors, and emerging public private partnership hospitals, therefore, falls outside the scope of this study. The purpose of this short chapter is to present a brief overview of the South African healthcare industry, with particular emphasis on the private hospital sector. Additionally, to contextualise private hospitals within the healthcare industry in general.

This chapter commences with selected statistics pertaining to hospital bed distribution in the South African hospital environment. An examination of the private hospital industry follows.

3.2 HOSPITAL BED DISTRIBUTION IN SOUTH AFRICA

Steyn (2002:57) points to the absence of a single, reliable source of health-related information, and as a result, many different data sources must be consulted. However, in spite of a variation in the quality of the data, more reliable local sources are becoming available (Steyn 2002:57). Public and private hospital representation in South Africa, based on the Department of Health and the Hospital Association of South Africa (HASA) statistics, is illustrated in Table 3.1 (Steyn 2002:57). It is clear from Table 3.1 that public hospitals constitute by far the larger sector. In contrast, private hospitals, the majority of which are Hospital Association of South Africa (HASA) members, make up approximately one third of the hospital environment. As public/private partnerships develop further, data for this sector will, no doubt, also begin to emerge.

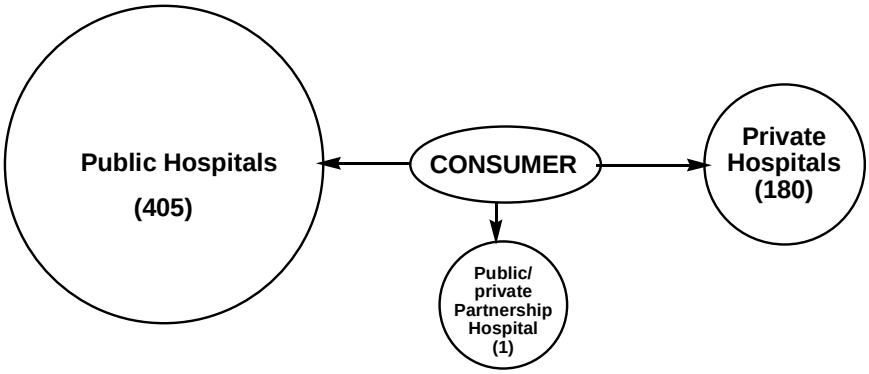
Table 3.1: Hospital bed distribution by province

PROVINCE	Private Hospitals		Public Hospitals		Public/Private Partnerships	
	Number of HASA hospitals/beds per national province June 2002		Number of hospitals/beds in public hospitals per province December 2001		Number of hospitals/beds June 2002	
	Beds	**Hospitals**	**Beds**	**Hospitals**	**Beds**	**Hospitals**
Eastern Cape	1 283	14	19 453	91		
Free State	1 647	9	7 075	34		
Gauteng	11 631	75	16 845	30		
KwaZulu-Natal	3 471	27	27 795	73	850	1
Limpopo	186	1	11 582	44		
Mpumalanga	785	6	4 826	29		
Northern Cape	386	6	6 522	22		
North West	883	10	1 608	26		
Western Cape	3 770	30	10 857	56		
RSA TOTAL	**24 042**	**178**	**106 563**	**405**	**850**	**1**
Namibia	72	1				
Swaziland	40	1				
SOUTHERN AFRICA TOTAL	**24 154**	**180**	**106 563**	**405**	**850**	**1**

Source: Adapted from Steyn (2002:59) and Wilson (2002:90).

The arrival of public/private partnership hospitals adds another dimension to the hospital environment by offering consumers a third choice of what can only be speculated as a much improved quality option than a present state hospital, but nevertheless a cheaper option than a private hospital. The size of the circles depicted in Figure 3.1 indicates, by industry representation, the three industry choices to healthcare consumers.

Figure 3.1: Consumers choice of the hospital industry



Source: Researcher's own construction.

Padayachee (2003/4:3) argues that private healthcare in South Africa is a complex environment in which to operate as a medial aid funder, or healthcare provider or even to receive care as a patient, and consequently, is also a challenge to regulate. The remainder of this chapter deals with South Africa's private hospital industry, which is, no doubt, part of this complex environment.

3.3 THE PRIVATE HOSPITAL INDUSTRY

Slabbert (2002:49) chronicles the 'birth' of South Africa's private hospital industry from the early 20th century when it consisted of mostly maternity homes and general surgical units through various representative bodies for private hospitals, until the present day, when finally, one association representing the interests all South African private hospitals, was formed. According to Health Annals (2002:2), the collective interests of some 178 private hospitals, or 97% of South Africa's private hospitals, (180 private hospitals with the inclusion of Namibia and Swaziland) are today represented by an official body, the Hospital Association of South Africa (HASA).

According to Slabbert (2002:53), HASA was established in 1996, and is still growing. Furthermore, having achieved status and credibility, it currently boasts two major strengths, namely recognition as the mouthpiece of the industry, and being seen by Government as the official representative body

for the private hospital industry. Such achievements are notable considering the efforts of HASA's predecessor, the National Association of Private Hospitals that existed by the end of the 1980s (Slabbert 2002:54).

HASA's members comprise individual hospitals that pay annual membership levies based on bed numbers – member hospitals are distributed throughout South Africa, but are found mainly in Gauteng, KwaZulu-Natal and the Western Cape (Steyn 2002:57,59).

3.3.1.1 The main hospital groups

At the time the study was undertaken, three groups, namely Netcare, Afrox Healthcare Limited and Medi-Clinic dominated South Africa's private hospital industry (Health Annals 2002; Bhoola 2002:55). The independents and smaller groups comprise of Clinix, Community Health, Curamed, Joint Medical Holdings, Melomed and Protector Group (Health Annals 2002:2). The three major players collectively own 80% of hospital beds in the private sector according to Bhoola (2002:55). From this information, it can be deduced that the aforementioned independent hospitals account for the remaining 20% share of the market.

Shevel (2003b:1) however, suggests a slightly different perspective in that the same three listed companies, Netcare, Afrox Healthcare and Medi-Clinic, dominate as providers of hospital services, but that collectively the three groups actually account for approximately 90% of all private hospital beds in South Africa. Depending on the accuracy of Shevel's information, this suggests a much smaller slice of the pie attributed to independent hospitals, at only 10%. Bhoola (2002:55) classifies independent hospitals as not belonging to one of the three major groups mentioned above.

In spite of Afrox Healthcare's recent renaming to Life Health Care (mentioned in Chapter 1), the three groups – Life Health Care, Netcare and Medi-Clinic – still dominate the industry. Duncan (2005) argues that this domination has enabled the three groups to reap the benefits of an oligopoly situation in the form of favourable margins and regional

monopolies. However, the government (DoH 2005) is aiming for a much more regulated private sector component in the future, but has shifted away from its original stated objective (*circa* 1994) to close down completely the private healthcare sector.

Although broad healthcare trends have had an impact on the three groups, Duncan (2005) remains upbeat and predicts a more competitive industry in the future, but with the ability to provide low-cost care becoming ever more important. Shevel (in Duncan 2005) insists that the hospital business is a volume business – it relies on 'bodies in beds'. Moreover, that the more people covered by the private healthcare industry, the better the impact for the hospitals' volumes.

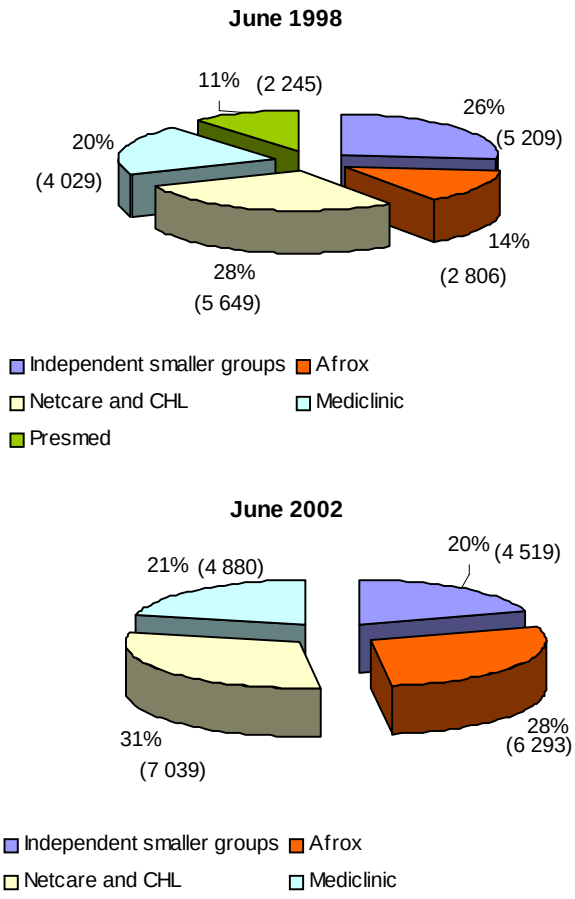
At present, while changes to both the private and public healthcare sectors appear to be on the cards, at least as far as the government is concerned, until a clear-cut policy with measurable deadlines becomes available, the healthcare environment should be closely monitored.

3.3.2 HASA private hospital membership

The Hospital Association of South Africa (HASA) is a non-profit enterprise representing the collective interests of private hospitals in Southern Africa, and has some 180 hospitals under the HASA umbrella (refer to Table 3.1). This figure comprises approximately 97% of Southern Africa's private hospital industry, representing a total of 24 154 beds (HASA 2002:2). Included in this figure is Namibia and Swaziland with one hospital each (Steyn 2002:59). Bhoola (2002:55) puts the total number of hospital beds in South Africa at approximately 132 000 of which 24 154 beds fall under the private sector (refer to Table 3.1). Of the 24 154 private sector beds, 80% belong to the aforementioned three major groups (Bhoola 2002:55).

According to Bhoola (2002:55) there has been a steady decline in the number of beds owned by the independent hospitals over the four year period to June 2002, from 37% in 1998 to 20% in 2002, as shown in Figure 3.2.

Figure 3.2: Private bed distribution by hospital group

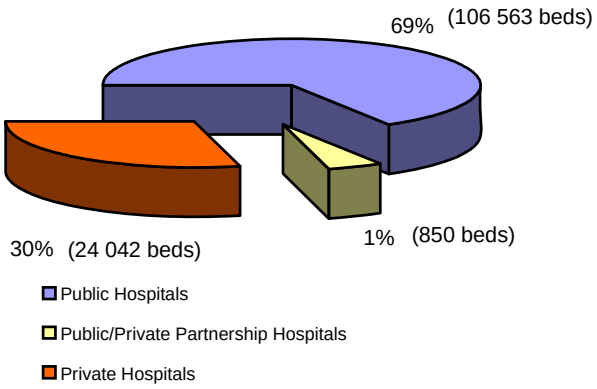


Source: Adapted from Bhoola (2002:55).

Bhoola (2002:55) ascribes change of ownership of hospitals as the major reason for the decline in private bed distribution, but more specifically, the dramatic fall was due mainly to 'cherry picking' of the profitable hospitals by the three major groups, as well as those hospitals with the greatest potential for growth, profitability and expansion.

The pie chart in Figure 3.3 shows South Africa's public and private hospital bed representation, incorporating the country's first fully-fledged public private hospital with an estimated 1% share of the market.

Figure 3.3: Private bed distribution by hospital group



Source: Adapted from Steyn (2002:59) and Wilson (2002:90).

The recent publication of the Competition Commission's investigation into possible price fixing by associations representing private hospitals, doctors and medical aid schemes (Shevel 2003b:1) raises the question as to whether this developing oligopolistic situation is not perhaps a case of the group hospitals, gaining ever larger slices of the pie, attempting to squeeze out the independents as they continue to fight for survival in an increasingly competitive environment. By all accounts, private hospitals compete aggressively to attract patients (Jabnoun & Chaker 2003:290; Laschinger 2004:29; Luiz & Wessels 2004:2; Shevel (in Duncan 2005)) and those with the necessary financial muscle such as the three major groups will obviously be in a stronger position to retain their market shares.

Bhoola (2002:56) discusses several reasons to suggest why independent hospitals are finding it difficult to survive or remain independent. Additionally, some tough challenges lie ahead for independent hospitals as the slice of the pie (bed ownership) becomes ever smaller, as a result of the takeovers by the three major groups (Bhoola 2002:56).

3.3.3 The caregivers – private hospitals human resources

The private hospital industry employs more than 40 000 employees, described as high calibre individuals who are attracted, motivated and

retained to serve its doctor and patient client base (Joseph 2002:37).

According to Joseph (2002:37), education and training in the workplace by private hospital employers is acknowledged as both important and necessary in order to meet the sector's needs. This training is extensive and varied. Insofar as improvements to the quality of patient care is concerned, Joseph (2002:38) explains that all employees in the industry have been trained to deliver quality patient care and to achieve the principles laid down in the Patients' Rights Charter and the Government's Batho Pele campaign. Moreover, Joseph (2002:38) reports that companies have laid down sets of values and codes of ethics to which employees are required to subscribe. More importantly, that customer satisfaction levels, that is, for both patients and doctors, are measured at regular intervals to ensure compliance, and to implement timeous corrective action if necessary (Joseph 2002:38).

To promote the affordability of private healthcare, structures are in place at all private hospitals according to Joseph (2002:38-39) that focus on improving productivity to support and sustain the culture of performance, critical for the survival and success of the private sector (Joseph 2002:39).

While Joseph (2002:39) lauds several notable achievements in the private hospital industry's human resources procurement, all of which should benefit quality patient care in the long run, one particular aspect of the employer/employee relationship is worth mentioning because it could potentially threaten the caregiver/patient relationship. It refers to the fact that the private hospital sector has not been declared an essential service, which by implication, entitles employees, who are in compliance with the labour relations laws, to engage in industrial action. Should such industrial action ever occur, for whatever reason, nursing staff for instance could potentially engage in strike action. Any such action would be detrimental to the nurse/patient relationship.

However, on a positive note, Joseph (2002:39) attributes the development of sound and positive employer/employee relationships in the industry to

the absence of any such industrial action over the past few years.

Given the competitive nature of the private hospital industry discussed in Chapter 1, as with business enterprises in other industries of the private sector, there is general agreement that the hospital/customer relationship has significant value (Fisk et al. 1990; John 1991, 1992; Taylor & Cronin 1994). In other words, a hospital's relationship with its patients must be built on a commitment to delivering quality service aimed at achieving patient satisfaction, which studies have shown will lead to the accrual of positive benefits to the hospital (Fisk et al. 1990; John 1991, 1992; Reidenbach & Sandifer-Smallwood 1990; Taylor 1994; Taylor & Cronin 1994).

Of particular importance is patient loyalty in this relationship, which is dealt with in the present study. Patient loyalty translates into buying intentions, which over the longer term for the hospital, this means willingness to reuse (or repeat usage) and positive word-of-mouth recommendations to others (Fisk et al. 1990; Reidenbach & Sandifer-Smallwood 1990; Taylor 1994; Woodside et al. 1989). Studies have also shown the significant influence that a hospital's nursing staff have over patients assigned to their care (Atkins & Marshall 1997; Why patients recommend hospitals 1997). In a study of more than one million patients in 545 hospitals, patients reported that the more empathetic nursing staff were toward their present state of health, the more likely they were to recommend the hospital to others (Why patients recommend hospitals 1997).

Nurses are viewed as goodwill ambassadors of a hospital (Atkins & Marshall 1996:14). Findings have also shown that patients are willing to return in the future or recommend the hospital to others in the case where a strong relationship exists between nurse satisfaction and patients (Atkins & Marshall 1996:14).

3.4 SUMMARY

The main purpose of this chapter was to contextualise the private hospital industry within the South African healthcare environment in general. Given that the present study was undertaken in several hospitals belonging to one of the country's largest private hospital groups, it was necessary to highlight certain hospital related statistics and provide a background, albeit a brief one, to the private hospital environment. While there is some evidence of a changing healthcare landscape, the status quo, that is, a separate private and public sector, remains intact for the time being. The healthcare environment should, however, be closely monitored for any further announcements in this regard.

In Chapter 4, an overview of services marketing, a specialised field of the marketing function, is addressed.

CHAPTER 4

SERVICES MARKETING: A BROAD OVERVIEW

"Please after reading this about the food – will you try to get something done. If it wasn't for the food this would be the best hospital in Gauteng – but because of the food it is not just a mediocre Hospital which is not fair for Doctors or nursing staff [sic]*."*

Respondent in present study, a former patient commenting on service delivery following a hospital stay.

4.1 INTRODUCTION

The arrival of the 21st Century for the business environment signified a new era of change at an unprecedented pace. As the economy becomes increasingly globalised, society must adapt faster to an ever-changing and more competitive business environment. Technology and innovation drive an ever-wider choice of consumer goods and services today. Business enterprises must transform to serve new customer expectations (Shermerhorn 2002:4) and compete for more demanding and better-informed consumers in an environment of rapid change and uncertainty.

As Cronje et al. (2004:82) and Grönroos (2000:12) correctly point out, the latter half of the last century was characterized by environmental forces that brought about rapid change. Parallel to these changing events, a growing body of evidence confirmed the increasing importance of services to the economy, an in particular, the substantial growth in services during the last 20-30 years (Baron & Harris 2003:23; Berry & Parasuraman 1993:17; Grönroos 1990:8, 2003:11; Langeard, Bateson, Lovelock and Eiglier 1981:1,8; Levitt 1972:41; Quinn, Baruch & Paquette 1987:24). Well into the first decade of the 21st Century, the growth in services, shows no sign of slowing down.

In this context, service providers today must increasingly concern themselves with two consumer-owned judgements about the service experience:

- Consumers overall perceptions about the superiority of the service, or service quality (Parasuraman et al. 1988:16);

- Consumers levels of satisfaction with the entire experience (Oliver 1997:12).

It is in this dynamic environment that business enterprises must compete. More importantly, the modern enterprise must develop *global* assessments of the environment in which it operates (Guiltinan, Paul & Madden 1997:25) if it is to compete successfully in the new global economy (Cronje et al 2004:83).

For service industries, growth has been something of a transformation (Daniels 1993:2) resulting from the marked increase in the production, consumption and trade in services (McColl-Kennedy 2003:6; Ochel & Wegner 1987:142). In the words of Riddle (1986:2), "no economy can survive without a service sector". This view remains true till today (Grönroos 2000:10). Riddle (1986:28) also believes that services are the glue that holds any economy together, the industries that facilitate all economic transactions and the driving force that stimulates the production of goods, and no doubt, more services.

As Berry et al. (1983:1) stated more than two decades ago, "The *service economy* is no longer a thing of the future; the service economy is here." Similarly, Eiglier (in Barry & Parasuraman 1993:53) agrees that, "services are the tomorrow world." It is clear then, that as far as the Western world is concerned, the service economy will continue to grow.

Against this background, the focus of this chapter is on the marketing of services, in particular, the healthcare industry pertaining to private hospitals. The present study is based on the assumption that the ongoing, phenomenal growth in services in the second half of the 20th Century (Berry, Shostack & Upah 1983:1; Daniels 1993:7; McConnell-Kennedy 2003:5; Parasuraman et al. 1985:41; Regan 1963:57; Verma 2000:8), will also increase the need for healthcare (Daniels 1993:16; Grönroos 1990:9; Stanton & Futrell 1987:498), including private healthcare (Havemann & Van

den Berg 2003:1; Soderlund, Schierhout & Van den Heever 1998:141) in the future.

The emergence of the services marketing field into a *separate sub-discipline* over the last five decades evolved from the field of marketing (Fisk, Brown & Bitner 1993:62), itself a developing discipline at first (Perreault & McCarthy 1996:35-36) and which focused traditionally on the marketing of physical goods (Fisk, et al. 1993:66; Rathmell 1974:vii; Shostack 1977a:73). It is noteworthy that during the earlier phases of this development, while services were growing at a rapid rate in industrialised countries with the United States as world leader (Berry & Parasuraman 1993:17; Berry, Shostack & Upah 1983:2; Grönroos 1990:1; Kotler 1994:464; Parasuraman et al. 1985:41; Zeithaml & Bitner 1996:6), very little attention was being paid to the development of services (Fisk, et al. 1993:66; Grönroos 1983a:6,16). The study of services marketing is therefore a relatively recent phenomenon in the marketing literature (Berry 1980:24; Boshoff 2003:173, Palmer 1998:1).

This chapter provides an overview of several key areas of contemporary services marketing. It commences with a discussion of the importance of services marketing to the economy followed by an examination of the three stages of the evolution of services marketing. In this section, the historical advances of the major contributors who laid the groundwork to the field of services marketing over a period spanning approximately 50 years, is presented. The nature of services and the two schools of thought, namely that ‘services marketing should not be viewed as a separate discipline from marketing’, versus ‘services are distinct from physical goods’, is examined. Particular emphasis on the five characteristics common to services and how each characteristic relates to the private hospital environment is then contextualised. Finally, the services marketing mix applied generically to a private hospital is given consideration.

4.2 THE IMPORTANCE OF SERVICES TO THE ECONOMY

Feigenbaum (1983:31) observes that service industries, as they came to be known in the early eighties, represent one of the fastest growing sectors of national economies. The growth in services is well documented in the services literature and the significant impact they have made and continue to make on a country's economy will be illustrated here.

From a global perspective, services make up the bulk of today's economy according to Lovelock (2001:4), not only in the developed industrialised nations of the world, but in many developing nations as well (Lovelock 2001:5-6). Today, services account for a substantial share of industrialised countries Gross Domestic Product (GDP), generally well over 60% of the GDP (Baron & Harris 2003:22; Evans & Berman 1994:380; Grönroos 2000:1). As far as development is concerned, service industries account for more than two-thirds of total employment in developed economies (Daniels 1993:2) and in some countries, this figure exceeds 80% (Baron & Harris 2003:22; McColl-Kennedy 2003:5). Feigenbaum (1983:31) suggests that services can account for almost two-thirds of the private, non-governmental work force.

It is well acknowledged that the services sector provides employment for an increasing number of people around the globe, as the statistics offered by several authors, including those mentioned above, have shown (Berry & Parasuraman 1993:17; Kotler 1994:464; Lovelock 2001:4; Palmer 1998:3; Zeithaml & Bitner 1996:7). The same group of authors offer evidence to suggest that by the last decade of the 20th century, services accounted for over 70% of the GDP and over 80% of total employment in the US alone.

With respect to developing nations however, Daniels (1993:2) suggests that services make a less significant contribution to economies of developing nations. In this regard, Lovelock (2001:6) cautions that while services account for more than 50% of GNP in many developing countries, the large informal sector operating within these economies means that significant statistics, and in particular for services, is not captured in official data gathering exercises.

Several reasons for the phenomenal growth in services in the last two decades are cited (Albrecht and Zemke 1985:11-12; Baron and Harris 2003:23; Daniels 1993:13-23; Grönroos 1990:8-9, 2000:10-11). Although a detailed discussion falls outside the scope of this study, some of the main reasons for this growth include the following:

- Increased affluence brought about by rising disposable incomes has increased the demand for such services as leisure pursuits, tourism, healthcare, domestic cleaning, event planning, etc.
- Changing demographics, for example, an increase in the number of working women has resulted in an increase of specific services like childcare to cater for their needs.
- The availability of information and digital technology has enabled consumers to make online service purchases from the comfort of their homes, thus resulting in an increasing number of service opportunities on the Internet.

In spite of an increase in the demand for services, Daniels (1993:16) is careful to point out that services are income elastic, meaning they are affected by changes in tastes and priorities and by changes in price.

For South Africa, still a relatively young democracy, the position is no different. Classified a developing nation (Park 2003), Boshoff (2003:173) indicates that the services sector of the South African economy is large and growing rapidly. The impressive growth in the services sector in the country also accounted for the creation of a significant number of jobs in this sector (South Africa – Employment and Labour 2004).

The country has witnessed an increasing trend towards services sector employment, while employment in the primary and manufacturing sector has declined (Increasing Demand for Labour in South Africa 1996). Services accounted for 66.1% of South Africa's GDP (www.WorldBank.2006) during 2005. Table 4.1 illustrates the contribution made by services to the South African economy including the annual

growth rate, since 1982.

Table 4.1: Services as a percentage of South Africa's GDP since 1982

Year	1982	1992	2001	2002	2004	2005
%	50.1	59.8	65.0	64.2	66.1	66.1
Average Annual Growth Rate	1.9	3.2	3.4	3.1	4.7	4.9

Source: World Bank (2003, 2006).

It was mentioned in Chapter 2 that the present study will be undertaken in the services sector of the country's economy, specifically the healthcare sector and will be conducted amongst private patients in the private hospital industry. The healthcare environment, including private hospitals, has been characterised by change in recent years (Bisseker 2001:34-36; Krige 2004; Luiz & Wessels 2004:1; Padayachee 2003/4:3; Qoza 2003; Wessels 2002). A changing environment provides an attractive opportunity to study, as in the case of the present study. Private hospitals nowadays compete for patients. As customers, patients expect to receive a quality service and leave feeling like satisfied customers.

From the discussion above, there is sufficient evidence to show that many national economies of the world today are now dominated by services (McColl-Kennedy 2003:5; Palmer 1998:3; Shostack 1977a:73; Zeithaml & Bitner 1996:xv).

The change towards service economies has been described as revolutionary. It was in the early sixties that Regan (1963:57) first declared a service revolution, a term later used by Grönroos (1983a:6, 1984:11, 1990:6) to describe the ongoing change in the economic pattern, which was characterised by the growth of service consumption. Grönroos (1983a:6; 1990:6) later maintained that the service revolution was still prevalent as more and more countries became service economies. Fuchs (1968:2) and others concurred with the notion of a 'service revolution'. The author predicted that the shift from an industrial to a service economy had implications for society and for economic analysis, of 'revolutionary proportions'.

As far as the healthcare industry is concerned, Zimmerman et al. (1996:85) is convinced that the service revolution is only just getting underway as hospitals and clinics develop innovative ways to 'connect' with their customers. Moreover, that if a hospital fails to listen to what the patient is saying, or does not meet the patient's needs, then a competitor will.

The increasing importance of services in today's global economy means that services cannot be ignored. More importantly, research in this area must not only continue, but opportunities to research new or undiscovered areas pertaining to services, must also be initiated and explored.

This study supports the school of thought that the marketing of services, while sharing many similarities with the marketing of physical goods, is in fact different and that a separate discipline is therefore warranted. This viewpoint is discussed in section 4.4 under the nature of services.

4.3 THE EVOLUTION OF SERVICES MARKETING

Two landmark articles (Berry & Parasuraman 1993; Fisk, et al. 1993) document the field of services marketing from its 'infancy' to 'adulthood' and into an independent, academic sub-discipline of the broader marketing discipline. Both works, published coincidentally in the same issue of the same publication, offer different historical accounts of the development of services marketing.

In the first approach, Berry and Parasuraman (1993) analysed the forces that combined to create a new field of study, that is, the growth of services marketing as an academic field, as opposed to examining the stages through which the services marketing literature developed, the subject matter of the second approach. Berry and Parasuraman (1993) concentrated on the period between 1970-1990 when an interest in the marketing of services in general began to take effect. According to Berry and Parasuraman (1993:14), prior to the 1970s the sub-discipline of services marketing did not yet exist. The field was still largely unexplored and required research to develop theories and create an understanding of

the area of services marketing (Grönroos 1983b:15,16).

In the second approach, contemporaries, Fisk et al. (1993) reviewed more than 1000 English language, general services marketing publications, spanning four decades of literature from 1953-1993, and identified three distinct stages in the development of services marketing. To track the historical debate reflected in the scholarly services marketing literature, the authors dubbed the period the 'evolution of services marketing' (Fisk et al. 1993:62). The three stages were aptly named as follows:

- The 'Crawling Out' stage (pre-1980);
- The 'Scurrying About' stage (1980-1985);
- The 'Walking Erect' stage (1986-1993).

Each of these stages (Fisk et al. 1993) is briefly examined in the sub-sections that follow, as is the companion analysis of Berry and Parasuraman (1993).

4.3.1 Crawling out stage (pre-1980)

The 'Crawling Out' stage marked the longest period of services marketing's development, at 27 years, commencing around 1953. During the initial phase of Crawling Out, recognition of the need to establish a separate services marketing literature base emerged. Even though the US economy had been dominated by services by the mid-1940s, the marketing of physical goods literature still overshadowed the marketing of services literature.

The debate later focused on whether the marketing of services was different to the marketing of physical goods. Much of the early literature on services was limited to conceptual assessments and lacked empirical research. A basic services research model was still in its infancy. Prior to 1980, only 120 publications on services marketing, most of which were published in the 1970s, were recorded (Fisk et al. 1993:66).

Berry and Parasuraman (1993:14) based their work on the period when the

marketing of *services*, rather than specific service industries, began to gather momentum. Prior to the 1970s, little interest amongst scholars towards an integrative approach to services marketing and the sub-discipline of services marketing did not yet exist (Berry & Parasuraman 1993:14). Documenting this period led to the development of a three component model categorising the forces that contributed to the development of the services marketing field (Berry & Parasuraman 1993:15-16).

While a detailed discussion of this model falls outside the scope of this study, Berry and Parasuraman (1993:46) and Fisk et al. (1993:67) were in agreement on two issues. Firstly, publication of services marketing material was hindered and secondly, a need for a separate field for services marketing did not yet exist.

The most critical feature of the Crawling Out period, emerging only towards the 1970s, was the intense debate between services pioneers and marketing traditionalists over whether services marketing was different from goods marketing. The fundamental challenge facing scholars of the services debate was the right of services marketing to exist as a separate discipline (Fisk et al. 1993:69; Berry & Parasuraman 1993:14.).

The majority of services marketing scholars argued that services marketing was indeed different, but they faced criticism through a reluctance to accept their work for publication. Because the early scholars took a defensive stand against the criticism that services marketing is different to goods marketing debate, Fisk et al. (1993:69) warn present day observers of this period against retrospectively assuming that the debate was largely one-sided.

It was not until the publication of a landmark article by Shostack (1977a) which, ‘altered the evolution of the services marketing field’ (Fisk et al. 1993:69) and ‘accelerated the development of services marketing’ to become a separate discipline (Berry & Parasuraman 1993:42). Kotler (in Grönroos 1990:xiii) commented that Shostack’s article, ‘was to alter the course of our thinking about services marketing, if not general marketing

itself'. Shostack (1977a:73) criticised the goods marketing establishment by arguing that marketing itself had become 'myopic' in having failed to create new paradigms relevant for the services sector. Shostack's contribution to the field of services marketing is discussed in section 4.4.

Some of the early services marketing pioneers and scholars, many of whom still feature prominently today, who emerged during the crawling out stage include Bateson (1979); Berry (1975, 1980); Blois (1974); Donnelly 1976; Eiglier, Langeard, Lovelock, Bateson and Young (1977); Grönroos (1978); Judd 1964; Lovelock (1979); Rathmell 1966, 1974; Regan 1963); Shostack (1977a, 1977b).

The major outcome of the goods marketing versus service marketing debate was described as the literature's delineation of services characteristics (Fisk et al. 1993:68). Corroboration was reached that four unique features characterise services as different from physical goods – intangibility, inseparability, heterogeneity and perishability. The characteristics of services are the subject matter of section 4.5.

4.3.2 Scurrying about stage (1980-1985)

A much shorter – spanning only 5 years – and no less significant period, the Scurrying About stage represented several important developments in services marketing that occurred at a much faster rate than those of the preceding Crawling Out stage. Moreover, the goods marketing versus services marketing debate had begun to subside. (Fisk et al. 1993:70.)

The main observations that characterised this phase concerned environmental changes that favoured service industries and a significant increase in the body of services marketing literature.

The deregulation of service industries at the beginning of the 1980s created new opportunities in the business environment, particularly for service industries. Fisk et al. (1993:71) reported that services firms realised that the marketing function was key to their survival, which in turn accelerated

the development of services marketing. Acceptance that services marketing was indeed different from goods marketing gathered momentum. For the first time, there was a need for business practitioners and academics to come together to share not only marketing knowledge, but services marketing insights as well.

The body of knowledge that was becoming services marketing increased considerably, spurred partly by the survival needs of services firms. Much of the literature from this period resulted from a series of marketing and services marketing conferences which were held in Europe and North America. These conferences brought members of the business community and academics together on one platform to promote and stimulate greater interaction and dialogue.

The volume of written publications grew and several topics emerged that were particularly relevant to the marketing of services. For instance, the conceptualisation of service quality (Parasuraman et al. 1985, 1988) spearheaded much further research and debate by other contributors.

Some of the main contributors during the 'Scurrying About' stage included Bateson (1979), Berry (1980), Berry et al. (1983), Booms and Bitner (1981), Grönroos (1980, 1981, 1983a, 1983b, 1984), Gummesson (1981), Langeard, Bateson, Lovelock and Eiglier (1981), Levitt (1981), Lovelock (1984), Parasuraman et al. (1985, 1988) and Solomon, Surprenant, Czepial and Gutman (1985).

Towards the end of this short phase, services were still viewed as fundamentally different from physical goods, but new issues in the field of services marketing were already being investigated. Fisk et al. (1993:74) marked this new area of inquiry as the third stage in the evolution of services marketing.

4.3.3 Walking erect stage (1986-1993)

The third and last documented stage of services marketing's development

was its so-called progress toward becoming an established field within the marketing discipline. The period covers seven years commencing around 1986 until 1993 (Fisk et al. 1993:63).

The Walking Erect stage experienced an explosive growth in the number of services marketing publications (Fisk et al. 1993:74). A boom in empirical publications occurred and the literature focused on specific marketing problems in service firms. The early debate of the Scurrying About stage – whether services are different from goods – gave way to a more mature body of services theory. The field of services marketing had advanced to become increasingly cross-disciplinary and international in nature. This was because the field of services marketing had become substantive enough to adopt a multi-disciplinary approach for solving services related problems.

There was greater acceptance of the differences between goods and services which enabled researchers to focus their efforts more on realistic business problems caused by these basic service differences (Fisk et al. 1993:77).

This stage gained further impetus when global interaction and collaboration between services marketing academics and business practitioners from different countries increased as a result of a series of specialist conferences that took place (Fisk et al. 1993:75). Academic expansion benefited from the erection of new institutes devoted exclusively to the services marketing field, established at universities in Sweden and the US.

A growing body of researchers, both established and upcoming, contributed to the boom in journal publications, conference proceedings, dissertations and services marketing textbooks. It was not only the services marketing literature that rapidly increased during this phase, but also the number of publications on topics closely related to services marketing, such as service quality, customer satisfaction, customer service and relationship management.

A number of prominent researchers representative of this period, and some of their work, includes Bateson (1989), Berry (1991), Bitner (1990), Bitner, Booms and Tetreault (1990), Brown and Swartz (1989), Grönroos (1990), Gummesson (1993), Lovelock (1991), Oliver (1993), Parasuraman et al.

(1988), Solomon et al. (1985), Zeithaml, Parasuraman and Berry (1990).

It was not until the Walking Erect stage that a cohesive core of specialist services related topics was addressed. These topics continue to receive attention today. Fisk et al. (1993:77-82) examine at least five specialist services related topics. A discussion of each topic falls outside the scope of this study, however, with the exception of service quality, and customer satisfaction, which form the basis of the present study. Service quality is discussed in Chapter 5 and customer satisfaction in Chapter 6. The specialist topics examined by Fisk et al. (1993:77-82) include the following:

- Service quality
- Customer satisfaction
- Service encounters/experiences
- Service design
- Customer retention and relationship marketing
- Internal marketing

Table 4.2 shows a summary tally of the services marketing literature spanning the three evolutionary stages.

Table 4.2: General services marketing literature
(As at November 1992)

Stage	Journal Articles	Books	Proceedings Papers and Book Chapters	Dissertations	Total
Crawling Out* (pre-1980)	59	10	32	19	120
Scurrying About (1980-85)	104	26	141	16	287
Walking Erect (1986-1992)	361	50	272	37	720
Total	524	86	445	72	1127

*The first services publication included in the data base is dated 1953. Thus, the Crawling Out stage represents a 27 year time period.

Source: Adapted from Fisk et al. (1993:65).

From the above discussion, it is clear that services marketing has grown over the past five decades into a separate sub-discipline worthy of academic research and vigorous debate. Moreover, that the potential for future growth in contemporary services marketing still exists today.

The answer to the question as to why services marketing grew so rapidly as it did into an academic field of its own when other potential subdisciplines did not, can be found in Berry and Parasuraman (1993:50). The authors argued that services marketing developed academically because it filled a need in the world of marketing practice, that is, the development of services marketing was 'market-driven'. However, to achieve this growth and flourish as a new field required a strong demand for new knowledge on the one hand and producers able and willing to take the risk to meet the demand, on the other hand (Berry & Parasuraman 1993:50).

4.4 THE NATURE OF SERVICES

The view that services are produced not only by service enterprises, but are also integral to the offerings of many manufactured goods producers, is shared by most authors (Boshoff 2003:174; Grönroos 1978:590, 1990:3,

2000:2; Levitt 1972:42; Lovelock 2001:9,11; McColl-Kennedy 2003:7; Palmer 1998:16; Rathmell 1966:33; Regan 1963:57; Shostack 1977:77,78; Wilson 1972:7; and Zeithaml & Bitner 1996:5). In spite of this acceptance however, the literature suggests two schools of thought (Palmer 1998:2) as to whether or not services warrant a distinctive area of study in marketing.

On the one hand, proponents of the school of thought that holds that services marketing should not be viewed as a separate discipline from marketing, include Levitt (1972:41-42; 1974:51; 1981:94) and to a lesser extent Stanton and Futrell (1987:496). It should be noted that this early viewpoint fell into the 'Crawling Out' stage documented by Fisk et al. (1993) and discussed in the previous section. At that point in the history of services marketing's development, support for the school of thought that the marketing of services was no different to the marketing of goods, could be attributed to the lack of documented knowledge about the nature of services that prevailed at the time.

On the other hand, the more favoured view holds that services are in fact different because they are distinct from physical goods. Proponents include Baron and Harris (2003:19); Berry (1980:29); Grönroos (1978:590, 1983b:12, 2000:47); Lovelock (2001:19); Palmer (1998:3); Rathmell (1966:36, 1974:9); Shostack (1977a:75); Zeithaml and Bitner (1996:7).

The argument is further exacerbated because there is no universally accepted definition of what constitutes a service (Boshoff 2003:174; Grönroos 1990:28, 2000:46; Palmer 1998:2). Several authors (Palmer 1998:16; Rathmell 1966:33; Shostack 1977a:74; Zeithaml & Bitner 1996:5-6), observe that there are very few, if any, 'pure' products or services that exist in the market place today.

In support of the view that marketing of services is no different from the marketing of physical goods, Levitt (1972:41-42, 1974:51) argues, "there are no such things as service industries. There are only industries whose service components are greater or less than those of other industries. Everybody is in service."

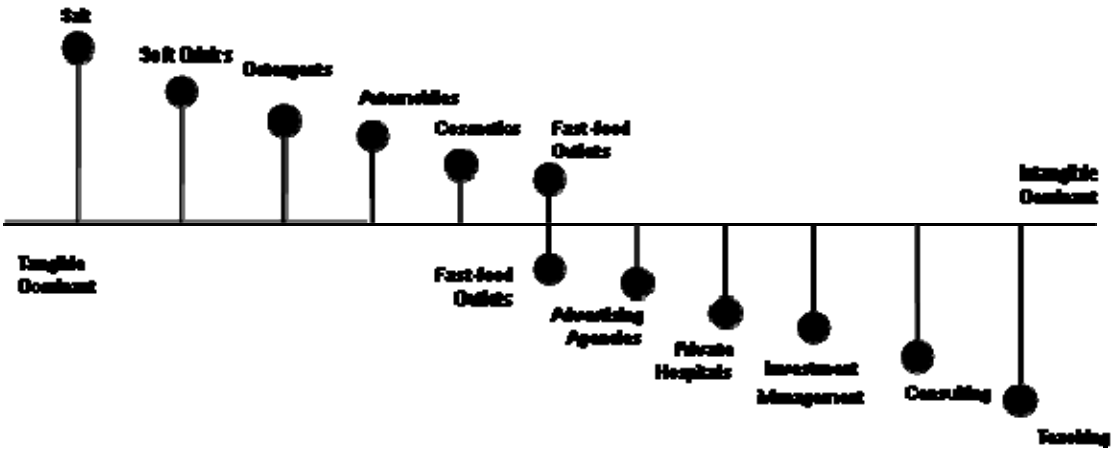
According to the traditionalists, existing marketing theories can and should be applied to service enterprises (Grönroos 1983b:11). This is due in part to the belief that it is not generic goods and services that consumers buy, but rather customer-satisfying benefits (Levitt 1974:8,9) which stems from Levitt's (1981:94) notion that everybody sells intangibles in the marketplace, no matter what is produced in the factory.

In the groundbreaking article, Shostack (1977a) shares some agreement with Levitts's (1960:51) view that tangible and intangible elements exist in both products and services. However, Shostack (1977a:74-75) argued that although similarities between physical products and services indeed exist, the two were still different because of the *level* of tangible and intangible elements present in each. Furthermore, that if services are dominated by intangible elements and physical products by tangible elements, it follows that the approach to marketing each entity must also be different. In this regard, Wilson (1972:8) points out that the more intangible the service, the greater will be the difference in the marketing characteristics of the service.

Shostack (1977a:75) therefore contends that the greater the weight of intangible elements present in a service, the greater will be the divergence from a product marketing approach.

To illustrate this phenomenon, Shostack (1977a:77) proposed a continuum along which market entities, namely, goods and services, are arranged according to the degree of tangible or intangible elements present within them. The goods-services continuum is presented in Figure 4.1. For the purpose of the present study, private hospitals, a service aimed at satisfying consumers healthcare needs, has replaced airlines, a service aimed at satisfying transportation needs and which featured in Shostack's original continuum.

Figure 4.1: Goods – services continuum



Source: Adapted from Shostack (1977a:77).

Shostack (1977a) compared the differences between services and products and argued that services marketing requires a mirror-opposite view of 'conventional' product marketing. In this seminal work, Shostack (1977a:74-75) postulated that while there might be similarities between a service and a product, the two entities are not the same. Elements of one entity are present in the other and vice versa, but the whole is distinguished by its dominant elements.

For the purpose of this study, the focus is on service enterprises only, namely, the healthcare industry and more specifically, private hospitals, which play an increasingly important part in the private sector of the South African economy. According to the Nordic School (Grönroos 1983b:11), it is not necessary to consider various service industries as unique and different from one another. Grönroos (1983b:11) argued that a variety of service industries such as banking, airlines, travel agencies and insurance all have common features that can be generalised into service marketing theory. The healthcare industry therefore is perceived to be no different.

It can be said that services differ from physical goods in several significant ways (Berry 1980; Grönroos 1990; Lovelock 2001; Palmer 1998; Rathmell 1974; Zeithaml & Bitner 1996). The section on characteristics of services will examine this distinction in more detail.

Few would disagree with Grönroos' (2000:45) view that a service is a complicated phenomenon. One reason for this is the many meanings which can be attached to the word 'service' (Baron & Harris 2003:18; Grönroos 2000:45). In order to understand the meaning of services, it is necessary to examine some definitions of services. Over the past four decades, several authors have attempted to define services (American Marketing Association (AMA) 1960:21; Converse, Huegy & Mitchell 1965:397; Daniels 1993:3-5; Grönroos 1983a:8, 1990:26-27, 2000:46; Kotler 1994:464; Lovelock 2001; Palmer 1998:2; Quinn, Baruch & Paquette 1987:24; Rathmell 1966:33, 1974:25; Stanton & Futrell 1987:496; Zeithaml & Bitner 1996:5), however, consensus on a general definition of a service has not yet been reached (Grönroos 1983a:2,7, 2000:46; Lovelock 2001:3).

A review of a selection of these definitions, ranging from fairly loose to more detailed descriptions, implies that within the services landscape several salient features are evident. Four definitions of services, from four decades, are presented below. A list of salient features implicit within the definition framework, proposed by the researcher then follows.

The American Marketing Association (1960:21) defines services as, '*activities, benefits or satisfactions which are offered for sale, or are provided in connection with the sale of goods'.* A shortcoming of this definition is that it places the greater emphasis on physical goods rather than on the intangible element, namely services.

Quinn, Baruch and Paquette (1987:24) define services as to '*include all economic activities whose output is not a physical product or construction, is generally consumed at the time it is produced, and provides added value in forms such as convenience, amusement, timeliness, comfort, or health that are essentially intangible concerns of its first producer'*. This definition excludes the physical element of service delivery altogether.

Kotler (1994:464) defines a service as, *'any act or performance that one party can offer to another that is essentially intangible and does not result in the ownership of anything. Its production may or may not be tied to a*

physical product'.

Finally, Lovelock (2001:3) offers two approaches to defining services. In the first approach, the author suggests a service '*is an act or performance offered by one party to another. Although the process may be tied to a physical product, the performance is essentially intangible and does not normally result in ownership of any of the factors of production'*. The second approach describes services as *'economic activities that create value and provide benefits for customers at specific times and places as a result of bringing about a desired change in – or on behalf of – the recipient of the service'*.

The salient features implicit within the definition framework are proposed as follows:

- The primary mode of delivery is a human activity, or performance from one party to another (AMA 1960:21; Converse et al. 1965:397; Grönroos 1983a:8, 1990:27; Kotler 1994:464; Lovelock 2001:3; Palmer 1998:2; Quinn et al. 1987:24; Rathmell 1966:33, 1974:25; Stanton & Futrell 1987:498; Zeithaml & Bitner 1996:5);

- Production and consumption are simultaneous (Grönroos 1990:27; Kotler 1994:464; Lovelock 2001:3; Palmer 1998:2; Quinn et al. 1987:24; Rathmell 1974:25; Stanton & Futrell 1987:496);

- Ownership does not change hands (Grönroos 1990:27; Kotler 1994:464; Lovelock 2001:3; Palmer 1998:2; Quinn et al. 1987:24; Rathmell 1974:25; Stanton & Futrell 1987:496);

- A service is experienced, used or consumed (Daniels 1993:3; Grönroos 1990:27; Lovelock 2001:3; Quinn et al. 1987:24);

- Services provide added value or want satisfaction for the consumer (Grönroos 1990:27; Lovelock 2001:3; Palmer 1998:2; Quinn et al. 1987:24; Stanton & Futrell 1987:496);

- Services are essentially intangible in nature, although services are also linked to physical products (Grönroos 1990:27; Kotler 1994:464; Lovelock

2001:3; Palmer 1998:2; Quinn et al. 1987:24; Rathmell 1974:25; Stanton & Futrell 1987:496);

- Services have a significant place in the economy (Lovelock 2001:3; Quinn et al. 1987:24).

The features summarised above are contained in what has traditionally become known as the characteristics of services, first addressed by Converse as early as the 1930s (Vargo & Morgan 2005:48), and their implications for marketing (Berry 1980:31-36; Zeithaml, Parasuraman & Berry 1985:35).

4.5 THE CHARACTERISTICS OF SERVICES

Zeithaml, et al. (1985:33) identified three basic assumptions that pervaded the growing body of literature on services marketing. These assumptions are presented as follows:

- A number of unique characteristics – notably intangibility, inseparability of production and consumption, heterogeneity (or variability), and perishability – separate services from tangible goods;
- These characteristics pose vexing problems for services marketers that are not faced by goods marketers;
- Services marketing problems require services marketing solutions and that strategies developed from experience in goods marketing are often insufficient to deal with services.

The four characteristics that distinguish services from physical goods are well documented in the literature (Baron & Harris 2003:19-22; Grönroos 1978:591, 1990:29-30; Kotler 1994:466-468; McConnell-Kennedy 2003:6-10); Palmer 1998:11-15; Zeithaml & Bitner 1996:19-21).

A fifth distinction was also later recognised and refers to the lack of ownership in a service transaction (Grönroos 1983b:9,1990:30, 2000:47,49; Lovelock 2001:9-10; McColl-Kennedy 2003:6-9; Palmer 1998:15-16).

Of the five characteristics of services, intangibility emerges as the common element cited universally by services marketing authors (Bateson 1977:8; Berry 1980:30; Levitt 1981:96; Lovelock 1983:115; Rathmell 1966:35, 1974:6; Shostack 1977a:74) and according to Bateson (1979:138), is *the* critical goods – services distinction from which all other differences emerge.

Although Lovelock (1983:115) agrees with this viewpoint to a certain extent, the author cautions that the four characteristics of services are an over-simplification of the real world environment and do not apply to all services (Lovelock 1996:16, 2001:9).

According to Zeithaml et al. (1985:33), it was the four characteristics of services and their consistent citing in the literature that led to the rationale for a separate treatment of services marketing. A selection of services marketing researchers who documented the unique characteristics of services, from the 1960s to the present day, is presented in Table 4.3.

Table 4.3: References listing unique characteristics of services*

Characteristic Cited	Baron and Harris (2003[e])	Bateson (1977, 1979)	Bell (1981)	Berry (1975, 1980, 1983)	Bessom and Jackson (1975)	Booms and Bitner (1981, 1982)	Boshoff (2003)	Carmen and Langeard (1980)	Davidson (1978)	Davis, Guiltinan and Jones (1979)	Donnelly (1976, 1980)	Eiglier and Langeard (1975, 1976), Eiglier et al. (1977)	Fisk (1981)	George and Barksdale (1974), George (1977)	Grönroos (1977, 1978, 1979, 1983, 1990[a], 2000[d])	Johnson (1969, 1981)	Judd (1968)	Knisely (1979a, 1979b, 1979c)	Kotler (1994)	Langeard et al. (1981)	Levitt (1981)	Lovelock (1981b, 1983, 1991, 1996, 2001[b]), Lovelock et al. (1981)	McColl-Kennedy (2003[f])	Palmer (1998)	Rathmell (1966, 1974[c])	Regan (1963)	Sasser (1976), Sasser and Arbeit (1978)	Schlissel (1977)	Shostack (1977a, 1977b)	Stanton & Futrell (1987)	Thomas (1978)	Uhl and Upah (1980), Upah (1980), Upah and Uhl (1981)	Wilson (1972)	Zeithaml (1981), Zeithaml & Bitner (1996)
Intangibility	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Heterogeneity (Variability/ Non-standardization)	✓		✓	✓	✓		✓	✓	✓			✓			✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inseparability of Production and Consumption	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Perishability (Cannot be inventoried)	✓	✓	✓	✓			✓				✓				✓			✓	✓			✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Ownership															✓							✓	✓	✓	✓								

*Several authors have disputed the need for a separate treatment of services in marketing. These authors include Bonoma and Mills (1979), Enis and Roering (1981) and Wyckham, Fitzroy and Mandry (1975).

**Only publications indicated by [a, b, c, d, e or f] discussed the characteristic, ownership.

Source: Adapted from Zeithaml et al. (1985:34) plus researcher's own construction, based on additional sources as indicated.

In this section, each characteristic of a service will be discussed first and then related to the private hospital setting. Thereafter, some strategic marketing implications for hospital management are presented.

Several authors (refer to Table 4.4) highlight a number of marketing implications common to each of the five characteristics of services. The associated implications for the private hospital environment are presented after the discussion of each service characteristic.

Zeithaml et al. (1985:33,34) imply that each of the four characteristics of services (the authors do not address ownership) present specific problems for services marketers and require services marketing strategies to overcome them. A summary of the problems which the literature suggests frequently arise from each of these characteristics (Zeithaml et al. 1985:35), is presented in Table 4.4. This summary is followed by a list, shown in Table 4.5, of the marketing strategies identified in the literature to overcome these problems (Zeithaml et al. 1985:35). The problems and marketing strategies for the fifth characteristic mentioned earlier have been added to both tables. Specific problems relevant to the healthcare industry, in this case, private hospitals, and particular marketing strategies to overcome them, are also indicated in Table 4.4 and Table 4.5, which are shown at the end of this section.

4.5.1 Intangibility

The most distinguishing feature of intangibility is the fact that services, unlike physical products, cannot be seen, felt, tasted or touched before they are bought (Baron & Harris 2003:19; Boshoff 2003:176; Grönroos 1978:591, 1990:29, Kotler 1994:466; Levitt 1981:96; Palmer 1998:11; Shostack 1977a:73,75; Zeithaml & Bitner 1996:19). For this reason, a theatrical metaphor is often used to liken services to performances or actions rather than objects (Zeithaml & Bitner 1996:19; Zeithaml et al. 1985:33).

According to Berry (1980:24) it is the service performance itself which is basically intangible. Berry (1980:24) contrasts goods and services as

follows: “A good is an object, a device, a thing; a service is a deed, a performance, an effort”.

Early on Rathmell (1966:3) observed that in each transaction a consumer has ‘nothing’ to show for the purchase and comes away ‘empty-handed’ (Rathmell 1974:25). Translated, the customer has purchased an intangible product – a service. Shostack (1977a:73) however, took this notion one step further, viewing services as being more than just products which are intangible. Exploring the issue of intangibility in more depth, Shostack (1977a:73) argues that, “… it is wrong to imply that services are just like products except for intangibility. By such logic, apples are just like oranges, except for their ‘appleness’.”

Shostack (1977a:74) recognised that although the service itself is intangible, within the total entity can be found certain tangibles which can dramatically affect the ‘reality’ of the service in the consumer’s mind.

Applied to the healthcare industry, in the private hospital environment the patient will typically experience many performances during a hospital stay, such as, treatment administered by nursing staff, surgery ranging from minor to major operations, diagnosis of a condition, physical examination, X-rays and the consumption of meals. While these services cannot actually be seen, felt, tasted or touched by the patient before purchase, certain tangible components will be evident. For example, the hospital bed in which the patient lies for the duration of the stay, the physical surroundings of the buildings, appearance of the wards, general cleanliness, the state of the equipment used to administer treatment and the presentation of the evening meal. Palmer (1998:11) is correct in stating tangible evidence is important, as it may be the only basis on which a patient is able to evaluate one hospital against another.

Palmer (1998:11) further suggests that the level of tangibility present in services is based on three main elements:

- Tangible goods which are included in the service and consumed by the user. Such as the use of breathing apparatus to which a patient might need to be attached.

- The physical environment in which the service production/consumption takes place, such as the condition of the hospital building, cleanliness of the wards and appearance of the nursing staff.

- Tangible evidence of service performance, such as a brochure given to a patient before surgery explaining the before and after procedures that will take place.

Some services might even be difficult for the patient to fully comprehend (Zeithaml & Bitner 1996:19), particularly in the case of post-operative care or the patient's state of health after discharge. For a patient about to undergo major, life-saving surgery, while the life-saving surgery itself might be necessary, a surgeon cannot offer an absolute guarantee that the patient will wake up from the anaesthetic, or even recover fully from the surgery.

Although the lack of physical evidence implied by intangibility increases the level of uncertainty which a customer faces when choosing between competing services (Palmer 1998:12), might not necessarily hold true for the private hospital patient. The reason for this possible lack of uncertainty is that the patient's doctor very often decides which hospital the patient is referred to. The patient may then be resigned to the fact that a particular hospital will be used, in spite of the customer's (albeit restricted) choice and the competitive nature of private hospitals today.

These and other problems of intangibility which face marketers are summarised in Table 4.4. Only pricing, because it is such a complex issue in healthcare (Padayachee 2003/4:3) will be addressed briefly in this section. Zeithaml and Bitner (1996:20) argue that the actual costs of a 'unit of service' are hard to determine and the price/quality relationship is complex. The price/quality relationship is particularly relevant to the private hospital environment, where in many cases, patients do not know beforehand exactly what a hospital visit is going to cost and often only see the 'price', if at all, after discharge.

To illustrate the intangible nature of the price/service relationship, Zeithaml and Bitner (1996:486,487) cite two of several reasons for this complexity.

Two of these reasons have a bearing on the hospital visit. The first reason according to the authors, is that many service providers are unable or unwilling to estimate prices in advance. As far as the patient is concerned, only once the patient has been fully examined, undergone all the relevant tests or had the operation will the exact price become known. The second reason is that customers sometimes feel overwhelmed with the information they need to gather beforehand. A patient about to undergo an operation would need to obtain prices from all the service providers who will be involved in the process, and then add them up to get the final price. The problem is further complicated by the fact that the main recipients of the hospital bills (including auxiliary services) are, often the private patients' medical aids or hospital insurance plans and consequently the patient may or may not get to see some, or even all of the prices.

An analysis of the price/service relationship, although relevant (if not somewhat controversial) in a service offering like a private hospital, falls outside the scope of this study and will not be discussed further.

Marketing implications for private hospitals. Intangibility presents several implications and opportunities for services marketing, in particular, associating the service with appropriate tangible cues (Berry 1980:28; Kotler 1994:466; Lovelock 2001:10; Palmer 1998:12; Shostack 1977a:77-79; Zeithaml & Bitner 1996:19).

Shostack (1977a:74) argues that although the service itself is intangible, there exists very real 'things', namely, tangibles that belong in any description of the total entity. Moreover, these tangibles can dramatically affect the 'reality' of the service in the consumer's mind. However, Shostack (1977a:74) cautions that there is also no accurate, one-word description into which these tangibles can be grouped.

Thus, it is clear that the healthcare service provider must offer tangible elements, that is, physical evidence to assist consumers to evaluate the quality of the service. Physical evidence includes, *inter alia*, the general appearance of the buildings, grounds, interior décor, nurses' uniforms, levels of cleanliness, provision of audio-visual entertainment and the serving of

meals. Palmer (1998:37) stresses the importance of the service provider's corporate image or branding, as another tangible element. In this way, private hospitals are usually differentiated on the basis of corporate name and reputation. By adding tangible cues to services, such as these and other strategies listed in Table 4.5 above, the aim should be to reduce customer uncertainty when choosing between competing services (Palmer 1998:12).

Furthermore, tangible evidence allows service providers to reinforce their continued presence and performance in the minds of the customers (Levitt 1981:101). Shostack (1977a:77) observed that when a consumer attempts to judge a service, particularly before using or purchasing it, that service is 'known' to a consumer by its tangible cues, i.e., the tangible evidence that surrounds it. Likewise, the visual basis on which consumers judge quality, comes from the presence of tangible components (Palmer 1998:11).

Some of the changes taking place in South Africa's healthcare industry were reported in Chapter 1. The very nature of private hospitals, coupled with the high costs of private healthcare, implies that only the highest standards of facilities are offered to patients. In order to remain competitive, the country's three hospital groups need to spend millions of rand upgrading their facilities. Evidence of construction, refurbishment and expansion at several hospitals belonging to all three hospital groups was clearly evident during the undertaking of the present study and confirmed by hospital management as part of an ongoing upgrading programme. For example, improvements and extensions to buildings, refurbishment of wards and interior surroundings, upgraded cafeterias/ coffee shops and increased parking facilities. Nurses' uniforms have been updated, having gone from the traditional, stark white uniforms to matching outfits in the hospital group's corporate colours.

4.5.2 Inseparability

There is general agreement in the literature that services are, in most cases, produced and consumed at the same time (Baron & Harris 2003:20; Grönroos 1990:29; Kotler 1994:467; Palmer 1998:12-14; Zeithaml & Bitner

1996:20;). To be more precise, most physical goods are produced first, then sold and later consumed, unlike most services, which are sold first and then produced and consumed simultaneously (Palmer 1998:13; Rathmell 1974:6; Zeithaml & Bitner 1996:20). Inseparability, according to Palmer (1998:12), means that producer and consumer must interact in order for the benefits of the service to be realised and in the extreme case of personal care services, the customer must be present during the entire production process. In that case, a surgeon cannot perform an operation (production of the service) without the involvement of a patient.

For the patient therefore, the hospital stay and all it entails is produced and consumed at the same time. In the private hospital environment there is a strong human element present due to the many different role players with whom the patient must come into contact, for example, the administrative staff upon arrival and discharge, the nursing staff who look after patients in the ward, doctors, specialists and surgeons, theatre staff, catering staff and other auxiliary service providers. Collectively, these role players, as producers of a series of services, must actively participate with the patient during several production processes in order for the full benefit of the complete service to be realised. Active participation in a service is described by Palmer (1998:13) as being as important as defining the end benefit. In the opinion of Zimmerman et al. (1996:13), the end benefit is *whether the patient is satisfied with the care he or she receives.*

Marketing implications for private hospitals. According to Zeithaml and Bitner (1996:21), because services are often produced and consumed at the same time, mass production is difficult if not impossible. Moreover, the authors believe that the quality of service and customer satisfaction will be highly dependent on what happens in 'real time'. This must be true for the private hospital environment. While surgical procedures for carrying out certain operations might be similar (caesarean section, hernia or heart by-pass), no two patients are alike in their conditions for which they sought diagnosis, treatment and in due course, a return to good health, in the first place. This outcome will result from the production process between

service provider (private hospital) and customer (patient).

In the view of Grönroos (1990:29) it is the visible part of the production activities of the service that matters in the mind of the customer and it is these visible activities that are experienced and evaluated *in every detail*. For the patient in the hospital, the visible aspect of the service production is particularly relevant. For example, how would the post-surgical removal of tubes, apparatus, sutures, dressings and the like, matter to the patient? The patient is normally awake for these necessary, but sometimes unpleasant, procedures if done by rough hands and which are both felt and evaluated by the patient.

4.5.3 Heterogeneity (variability)

Because services are performances frequently performed by humans, no two service performances will be exactly alike (Zeithaml & Bitner 1996:20). Consequently, heterogeneity means the potential for high variability in the performance of services (Berry 1980:25; Zeithaml et al. 1985:34). That makes heterogeneity applicable to both the deliverer of the service as well as the recipient of the service, namely service employees on the one hand and customers on the other. Employees, being human, may differ in their performance from day to day or even hour-to-hour (Zeithaml & Bitner 1996:20). Likewise, no two customers are exactly alike either. Zeithaml and Bitner (1996:20) believe that each customer will have unique demands or will experience the service in a unique way.

To illustrate, nursing staff typically work long hours, often in twelve-hour shifts. A nurse might be feeling tired and less energetic toward the end of a long day compared to feeling fresh and bright during the early morning part of the shift. A depletion of energy could impact on the nurse's service performance and interaction with patients. Likewise, the attitude of a patient who is particularly difficult and demanding and blames the nursing staff or hospital, or otherwise an 'easy' patient whose attitude is just the opposite. Thus, the behaviour of the patient could also influence the

interactions between provider and recipient.

Palmer (1998:14) offers two dimensions of variability:

- The extent to which production standards vary from a norm;
- The extent to which a service can be deliberately varied to meet individual customer's specific needs.

For the first dimension of variability, Palmer (1998:14) argues that variability in production standards is particularly relevant where customers are highly involved in the production process, such as in healthcare. This is because of the difficulty in being able to monitor one-to-one service production.

The second dimension is easier to achieve than for manufactured goods. Palmer (1998:14) reasons that because services are created as they are being consumed, and consumers are often part of the production process, the potential exists for customisation of the service. However, customisation is dependent on production methods used and may not always allow for individual customers' needs to be met. A surgeon could, for example, discuss the exact placement of an operation cut and suturing procedure with a patient beforehand, to meet the specific needs of that particular patient.

Marketing implications for private hospitals. Because of the heterogeneous nature of services described above, ensuring consistent service quality in the production of services is a major challenge for most service providers (Berry 1980:25, 1981:272; Chase 1978:137; Zeithaml & Bitner 1996:20).

In a high-contact (Chase 1978:137), people-based (Thomas 1978:161) service like a private hospital, some quality aspects might be more difficult to control than others. For instance, medical practitioners are not employees of the hospitals where they prefer to send their patients to, but nonetheless are an essential part of the overall service offering. Likewise, if the catering function is outsourced and something goes wrong with the delivery of meals, the patient will blame the hospital.

To deal with the quality of service performed by the human element, Berry (1980:25-26,1981:271) proposed a strategy to improve the service provider's capability for satisfying its customers and which can be applied to the heterogeneous nature of the private hospital environment. The author argues that the same marketing tools used to attract customers can also serve to attract and retain the best employees, that is, internal customers, within a particular service enterprise. This strategy implies that a private hospital could attract and retain the best medical practitioners to practice from its premises, or accept only those tenders it feels confident will be able to deliver 'good quality food'.

4.5.4 Perishability

Services cannot be stored (Grönroos 1990:30; Kotler 1994:468; Lovelock 2001:13; Palmer 1998:15; Rathmell 1966:34, 1974:7; Zeithaml & Bitner 1996:21) and used at some future time when demand occurs (Morgan 1991:10). In most service industries what is not taken up by the customer (such as a seat on a plane, a hair appointment or restaurant meal) cannot be reclaimed, stored or re-sold at a later time Grönroos 1990:30; Palmer 1998:15; Zeithaml & Bitner 1996:21). The perishability of services is not a problem when demand is steady (Kotler 1994:468) because advance planning can be carried out on a more or less constant basis. However, Palmer (1998:15) argues that very few services face a constant pattern of demand through time, but rather show considerable variation of demand. For services in general, this variation could be daily (the staff canteen at lunchtime), weekly (the Saturday morning peak in demand for shopping centre parking space), seasonal (hotel or coastal resort accommodation), cyclical (the building industry) or even unpredictable (emergency repair services following heavy storms) (Palmer 1998:15).

Private hospitals in South Africa generally enjoy a steady demand for services throughout the year, but are known to reduce bed occupancy, wherever this is possible, for instance over weekends and holiday periods. Specific wards might also experience quieter times, for instance,

when specialists take their annual leave.

Marketing implications for private hospitals. Quieter times allow for a reduction in staff capacity or temporary interruption of certain facilities such as the closure of a non-emergency ward during a school holiday. As mentioned earlier, Palmer's (1998:15) argument that very few services maintain a constant pattern of demand through time implies that perishability results in greater attention having to be paid to the management of demand, namely by smoothing out peaks and troughs in demand and in scheduling service production to follow this pattern as far as possible (Lovelock 1980:481, 1991:8; Palmer 1998:15).

For a customer, the perishability aspect of a bed not taken up in a private hospital is not necessarily the same as a missed seat on a plane. A passenger who does not turn up at the airport for a booked flight is likely to have had more choice in the decision not to do so than a patient whose doctor has advised admission into hospital for a necessary operation. It is less likely that a patient, facing imminent surgery, will not turn up at the hospital on the scheduled date than a passenger who fails to turn up at the airport for a scheduled flight.

It is assumed therefore, that demand for bed occupancy is not created by the customer as is in the case with an airline, but rather by the referring doctor. This raises the question whether the strategies to deal with management of demand for a hospital service should not be different for a private hospital? A discussion thereof, however, falls outside the scope of this study.

4.5.5 Lack of ownership

Only a handful of authors have addressed ownership, namely that services do not result in ownership of anything (Grönroos 1978:591, 1990:30, 2000:47; Lovelock 2001:9,10; McColl-Kennedy 2003:9; Palmer 1998:15; Rathmell 1974:6). After the service has been purchased, the customer does not come to own anything. Lovelock (2001:9) argues that lack of ownership is perhaps the key distinction between goods and services, which Palmer

(1998:15) relates to the characteristics of intangibility and perishability.

In purchasing a physical product, customers acquire title to tangible elements (Lovelock 2001:9; Palmer 1998:15) and upon transfer of possession, the customer's control over the use of the product is absolute (Rathmell 1974:6). On the other hand, customers usually only derive value from services without actually obtaining ownership of any tangible elements – no ownership is transferred because the customer is merely buying the right to a service process (Lovelock 2001:9; Palmer 1998:16). But the service will certainly be remembered, because the customer is left with memories of the service after its consumption (McColl-Kennedy 2003:9).

Thus, a patient, upon discharge from the hospital, which brings to an end the service process, does not acquire ownership of any part of the hospital visit, but the memories of that visit which remain. Exceptions include organ donation/transplants, insertion of devices such as pacemakers or steel plates and artificial insemination. Notwithstanding any follow-up visits to the doctors concerned, the patient is then left to continue with recuperation at home.

Marketing implications for private hospitals. The lack of ownership has implications for the design of distribution channels (Palmer 1998:16). The author notes that direct distribution methods are more common and where intermediaries are used, they generally act as co-producer with the service provider. In practice, for example, it will be the doctors who act as co-producer with the private hospital. For the patient, however, it will be one and the same service.

Each of the five characteristics of services discussed above has been related to the private hospital environment. These characteristics present special challenges to the service provider (Berry 1980:29) that need to be strategically managed. For the private hospital, the strategies adopted to deal with these differences must be relevant to its particular situation and the needs of its patients. Hospital management must understand how each characteristic impacts on the provider/customer relationship and more importantly, the influence they have on the quality of the service, as perceived by the customer.

Table 4.4: Unique Service Characteristics and Resulting Marketing Problems for the Healthcare Industry

Unique Service Characteristics	Resulting Marketing Problems	Specific to Private Hospitals	Selected References Citing Problems
Intangibility	1. Services cannot be experienced by the physical senses (seen, felt, tasted or touched) before purchase.	Results of surgery e.g. facelift, a diagnosis, or X-ray e.g. MRI scan, cannot be seen beforehand.	Baron and Harris (2003), Berry (1980), Boshoff (2003), Grönroos (1978), Kotler (1994), Langeard et al. (1981), Levitt (1981), Lovelock (1981, 1983, 1996, 2001), Palmer (1998), Shostack (1977), Stanton and Futrell (1987), Zeithaml and Bitner (1996)
	2. Cannot protect services through patents.	New service concepts such as 'guest excellence' programmes in hospitals can easily be copied.	Eiglier and Langeard (1975, 1976), Judd (1968), Zeithaml and Bitner (1996)
	3. Cannot readily display or communicate services.	Ethical code of conduct in medical profession restricts doctors from advertising their services.	Boshoff (2003), Rathmell (1974), Zeithaml and Bitner (1996)
	4. Prices are difficult to set.	Exact costs of an operation or consumables used for duration of hospital stay are difficult to specify up front.	Dearden (1978), Lovelock (1981, 2001), Rathmell (1996), Thomas (1978), Zeithaml and Bitner (1996)
Inseparability	1. Consumer involved in production.	Childbirth, heart surgery, blood transfusion, physical examination.	Baron & Harris (2003), Booms and Nyquist (1981), Boshoff (2003), Kotler (1994), Levitt (1981), Lovelock (1981, 1983, 1996, 2001), Palmer (1998), Rathmell (1974), Stanton and Futrell (1987), Zeithaml and Bitner (1996)
	2. Other consumers involved in production.	Donors, such as bone marrow or organ donation, other patients in the ward.	Bateson (1977), George (1977), Grönroos (1978), Lovelock (1981, 1996, 2001), Zeithaml and Bitner (1996)
	3. Centralised mass production of services difficult.	Similar surgical procedures, but no two patients are alike.	Lovelock (1996, 2001), Rathmell (1966), Sasser et al. (1978), Upah (1980), Zeithaml and Bitner (1996)
Heterogeneity (Variability)	1. Standardisation and quality control difficult to achieve.	Quality and essence of a medical examination, service performance from a nurse at end of a 12-hour shift.	Baron and Harris (2003), Berry (1980), Booms and Bitner (1981), Levitt (1981), Lovelock (1983, 1996, 2001), Rathmell (1974), Zeithaml (1981)
Perishability	1. Services cannot be stored or inventoried.	Demand for hospital services fluctuates, empty beds cannot be stored.	Baron and Harris (2003), Bateson (1977, 1979), Levitt (1981), Lovelock (1981, 1983, 1996, 2001), Rathmell (1966, 1974), Sasser (1976), Wilson (1972), Zeithaml and Bitner (1996)
Ownership	1. No transfer of ownership in the service transaction.	Patient is dependent on the private hospital and relevant role players until after the service has been carried out.	Grönroos (1978, 1990), Lovelock (2001), McColl-Kennedy (2003), Palmer (1998), Rathmell (1974)

Source: Adapted from Zeithaml et al. (1985:35) plus researcher's own construction, based on additional sources as indicated.

Table 4.5: Suggested Marketing Strategies for Problems Stemming from Unique Service Characteristics Applied to the Healthcare Industry

Unique Service Characteristics	Marketing Strategies to Solve Problems	Specific to Private Hospitals	References Citing Strategies
Intangibility	1. Stress tangible cues.	Hospital's physical surroundings, such as buildings, ward décor and nurses' uniforms, inclusion of television sets in the wards and presentation of meals.	Baron and Harris (2003), Berry (1980), Booms and Bitner (1982), George and Berry (1981), Kotler (1994), Palmer (1998), Shostack (1977a), Zeithaml & Bitner (1996)
	2. Use personal sources more than nonpersonal sources.	In compliance with medical profession's code of conduct, a doctor to give endorsement of a particular hospital, or let a former patient endorse it.	Donnelly (1980), Johnson (1969)
	3. Simulate or stimulate word-of-mouth communications.	Using former, satisfied patients to recommend the services of a particular hospital (testimonials).	Baron and Harris (2003), Davis, Guiltinan and Jones (1979), George and Berry (1981)
	4. Create strong organisational image.	Visual symbols should reflect the image the hospital wants to convey.	Judd (1968), Knisely (1979a), Palmer (1998), Schiffman and Kanuk (1994), Shostack (1977), Thomas (1978), Uhl and Upah (1980)
	5. Use cost accounting to help set prices.	Unravel the "price mystery" of the total hospital service.	Beard and Hoyle (1976), Dearden (1978), Zeithaml and Bitner (1996)
	6. Engage in post-purchase communications.	Conduct regular surveys with patients to establish levels of service quality and patient satisfaction.	Bessom and Jackson (1975), Fisk (1981), Zeithaml (1981)
Inseparability	1. Emphasise selection and training of public contact personnel.	All patient/contact personnel should undergo customer care training programmes. Incentivise with built-in reward systems.	Berry (1981), Davidson (1978), George (1977), Grönroos (1978), Kotler (1994), Zimmerman et al. (1996)
	2. Manage consumers.	Instructions to patients on what is/is not permissible after surgery, are expected to be followed, but must also be clear.	Lovelock (1981)
	3. Use multisite locations.	Parent company must ensure a uniform quality of services at all its hospitals, promote its member hospitals as part of a large group while still retaining the personal touch of an individual hospital.	Carman and Langeard (1980), Langeard et al. (1981), Upah (1980)

Unique Service Characteristics	Marketing Strategies to Solve Problems	Specific to Private Hospitals	References Citing Strategies
Heterogeneity (Variability)	1. Industrialise service*	Adopt a production line approach in the hospital environment, where possible.	Levitt (1972, 1976)
	2. Customise service.	Some aspects of the hospital visit can be tailor-made to meet specific needs.	Bell (1981), Berry (1980), Johnson (1981), Regan (1963), Sasser and Arbeit (1978), Schoeman (2000)
Perishability	1. Use strategies to cope with fluctuating demand.	Offer various combinations of services. Complete the pre-admission procedure before scheduled arrival date.	Baron and Harris (2003), Lovelock (1981), Schiffman and Kanuk (1994)
	2. Make simultaneous adjustments in demand and capacity to achieve a closer match between the two.	During quieter periods, reschedule non-urgent surgery and other medical procedures, conduct staff training such as customer care programmes or allow staff much needed time off. Reassign staff to other wards during busy periods. Sharing capacity of expensive medical equipment between hospitals.	Baron and Harris (2003), Sasser (1976)
Ownership	1. Provide ownership of some tangible components of the visit.	Offer patients informative literature in printed or electronic format, e.g. DVD, on their condition and treatment.	Grönroos (1990, 2000), Lovelock (2001), Palmer (1998), Rathmell (1974)

*Levitt suggests specific techniques to substitute organised preplanned systems for individual service operations (e.g. a travel agency could offer pre-packaged vacation tours to obviate the need for the selling, tailoring and haggling involved in customisation). This strategy is the opposite of customisation.

Source: Adapted from Zeithaml et al. (1985:35) plus researcher's own construction, based on additional sources as indicated.

4.6 THE SERVICES MARKETING MIX

The traditional marketing mix conceptualised by McCarthy (1964:38-40) consists of the four elements product, price, place and promotion, known as the 4Ps. Its restriction to physical goods was noticed by Booms and Bitner (1981) who expanded the marketing mix to include services by adding three new elements; physical evidence, people and process.

All 4Ps are essential to the marketing mix (McCarthy 1964:40; Perreault & McCarthy 1996:53) and are interrelated and dependent on each other to some extent (Zeithaml & Bitner 1996:23). Furthermore, the marketing mix philosophy implies that there is an optimal mix of the four variables for a given market segment at a given point in time. Central to, but not part of, the marketing mix is the customer. Early on McCarthy (1964:40) recognised that the focal point of all marketing efforts, is the customer.

Today, the 4Ps apply as much to the management of physical goods as they do to services. The traditional marketing mix is well documented in the literature. The expanded marketing mix for services (Zeithaml & Bitner 1996:24-26) is explained as follows:

Physical evidence: Refers to the physical surroundings in which the service is delivered and where the firm and customer interact. It includes all tangible cues that facilitate performance or communication of the service. For instance logos, letterheads, business cards, brochures, customer accounts, etc. The actual physical facility, where the service is offered, is also relevant in some cases.

People: Consists of all the human actors who play a part in service delivery and in so doing, influence the buyer's perceptions. These are the service enterprise's personnel, the customer and other customers in the service environment. The cues include the way the actors are dressed, their personal appearance and their attitudes and behaviours. These influence the customer's perceptions of the service.

Process: Includes the actual procedures, mechanisms and flow of activities by which the service is delivered. All provide customers with evidence on which to judge the service.

Zeithaml and Bitner (1996:27) are careful to point out that the three new marketing mix elements are included separately, for the following reasons:

- The three elements are within the control of the service provider;
- Any or all three of the elements may influence the customer's initial decision to purchase a service;
- The three elements may influence the customer's level of satisfaction and repurchase decisions.

The expanded marketing mix for services thus consists of seven elements, or 7Ps. Table 4.6 represents a services marketing mix for a private hospital. The traditional 4Ps are shown in the first four columns and the 3Ps of a typical services marketing mix in the last three columns. The list is by no means exhaustive.

Table 4.6: Expanded marketing mix for a private hospital

Product	Price	Place	Promotion	Physical evidence	People	Process
Service environment - Physical evidence • Hospital buildings, e.g. exterior, interior, gardens • Other facilities, e.g. cafeteria, ward décor, bed comfort, cleanliness, television/radio, parking, security, admission forms • Appearance of personnel, e.g. nurses' uniforms, administrative staff outfits • Machinery and equipment, e.g. age and condition • Meals, e.g. menu choice, presentation, taste, temperature Quality level - Set measurable standards Patient instruction - Before, during and after procedure Product lines - Facilities offered by hospital Packaging - Hospital visit Branding - Group identity - Hospital identity - Corporate colours	Objectives - Pricing flexibility that patients understand Fee structure - Single daily rate - Itemised daily billing - Medical aid vs private - Cost saving options linked to quality and value	Objectives - Number of beds - Geographic space requirement - Expansion possibilities Physical location - City centre or suburban - Proximity to patient's home - Proximity to accommodation for out of town family members Channels - Intermediaries • Facilitators, e.g. doctors, radiologists, physiotherapists • Health delivery systems, e.g. complete medical care, or limited facilities Service levels - Waiting time - Service offerings	Objectives - Communication to patients, e.g. inform, persuade, remind patients about hospital Combination of promotional activities - Advertise benefits of hospital group - Advertise benefits of each hospital - Information brochures	Hospital exterior Garden layout Parking facilities Signage Reception area Staff dress code Ward appearance Ablution facilities Meals served	Nursing staff Medical practitioners Administrative staff Auxiliary services Other patients Performances - Recruitment - Training - Motivation - Rewards - Teamwork - Professionalism - Caring - Empathy - Helpfulness - Friendliness	Admission procedure Ward admittance Preparation for surgery Operating theatre Post-operative care Discharge procedure Account queries

Source: Adapted from Zeithaml and Bitner (1996:25), plus researcher's own construction.

4.7 SUMMARY

In this chapter, the historical advances and key contemporary areas of services marketing were provided. The importance of services to many national economies, as well as the global economy, created a need for academics to improve the understanding of the marketing of services. In this regard, an evaluation of the seminal work of a group of leading academics who documented their understanding of services marketing's development, was presented.

The complex nature of services was discussed, with the view that the marketing of services is indeed distinct from the marketing of physical goods. The five unique characteristics – intangibility, inseparability, heterogeneity, perishability and lack of ownership – were examined with particular reference to the choice of service provider in which the present study was undertaken, namely the private hospital industry within South Africa's healthcare sector.

The next two chapters, namely Chapters 5 and 6 deal with the constructs of service quality and customer satisfaction. These two constructs lie at the heart of services marketing and are considered to be desirable outcomes of any customer service strategy.

CHAPTER 5

SERVICE QUALITY AS A COMPETITIVE STRATEGY IN THE HEALTHCARE INDUSTRY

"My overall impression was the nursing staff are overworked, underpaid and tied up with a lot of administrative red tape."

Respondent in present study, a former patient commenting on service delivery following a hospital stay.

5.1 INTRODUCTION

When consumer demand for product quality appeared to be reaching its peak (Deming 1986:167; Feigenbaum 1991:31,825; Parasuraman et al. 1985:41; Steenkamp 1990:310; Takeuchi & Quelch 1983:141), a need to explore quality in services was becoming apparent (Deming 1986:183; Feigenbaum 1991:31; Grönroos 2000:62; Parasuraman et al. 1985:41). While quality is considered by some to be the ultimate goal of product or service provision (Horovitz & Jurgens-Panak 1992:29; Oliver 1997:162), it is the consumer who ultimately decides which product or service to buy (Deming 1986:169,174; Garvin 1983:68; Grönroos 2000:1; Steenkamp 1990:310.

Traditionally, quality was related to product performance (Garvin 1983:65; Takeuchi & Quelch 1983:140) and technological excellence in manufacturing (Grönroos 2000:61; Oliver 1997:162), whereas service quality, a more contemporary phenomenon in services marketing (Parasuraman et al. 1985), is judged by the consumer (Berry, Zeithaml & Parasuraman 1990:29; Grönroos 2000:63; Parasuraman, Zeithaml & Berry 1988:16; Zeithaml, Parasuraman & Berry 1990:16). One view that has consistently maintained that quality is a consumer-generated comparative judgement (Oliver 1997:163), has its origins in the 'perceived quality' approach (Garvin 1984:27,28,33, 1987:107; Grönroos 2000:62). According to this approach, quality judgements are dependent on the perceptions, needs and goals of the consumer (Steenkamp 1990:310).

It was previously stated in Chapter 4 that the most important focus of all

marketing activities is the customer, and customer satisfaction is the fundamental goal of marketing (Lamb et al. 2004:5,12). Customer satisfaction, on the one hand, is a dominant concern in the period immediately following the purchase of a product or service (Taylor & Cronin 1994:34), being a short-term reaction to a specific transaction (Oliver 1997:174). On the other hand however, service quality is viewed as an attitude (Bitner 1990:70; Bitner & Hubbert 1994:75,77; Parasuraman et al. 1988:16) in response to multiple transactions (Bitner & Hubbert 1994:76), making it a longer-term global judgement of the product or service experience (Oliver 1997:174).

This chapter will examine service quality and how the consumer evaluates it, while Chapter 5 will examine customer satisfaction and the comparison or link between the two constructs. More specifically, this chapter will commence with a brief overview of the concept of quality, considered to be an influencing variable in the conceptualisation of service quality. The development of the service quality construct and the ten original dimensions of service quality, later reduced to five dimensions, are addressed. An evaluation of the much-publicised SERVQUAL measuring instrument is presented. Thereafter, two of the well-known earlier models and a more recent model of service quality are examined. Lastly, in conclusion, this chapter will address the importance of service quality to the South African private healthcare industry.

5.2 THE IMPORTANCE OF QUALITY IN SERVICE DELIVERY

'Customers want quality', is a mantra frequently carried in the anecdotal literature (Cheales 2000:15; Lascelles & Dale 1992:2; Peters 1987:64; Pring 1992:100). Empirical studies have shown that consumers evaluate dimensions of quality and satisfaction (Bowers, et al. 1994:54; Burns & Beach 1994:28; Lascelles & Dale 1992:2). When a service provider's offerings are difficult to judge, especially a hospital, most patients will look for evidence of quality dimensions first (Berry & Bendapudi 2003:100; Zimmerman et al. 1996:18). Thus, searching for evidence demonstrates that quality is always in the eye of the beholder (Peters & Austen 1985:112).

The present view in the service quality literature is that the quality of a particular product or service is *whatever the customer perceives it to be* (Grönroos 2000:63; Jun, Peterson, Zsidisin 1998:81). If enterprises strive to understand quality in the same way that their customers do, the result will be positive word-of-mouth and customer loyalty (Berry & Bendapudi 2003:100; Grönroos 2000:63,128,131).

Schermerhorn (2002:14) describes the forces that drive modern-day consumers as a 'sort of revolution' in that consumers have become unrelenting in their demand for quality products and services. Moreover, failure to listen to customers and failure to deliver quality goods and services will leave enterprises struggling in a highly competitive environment.

In the delivery of healthcare, Bowers et al. (1994:49) view quality as being increasingly important and consumer perceptions of quality will be a significant determinant of a hospital's survival and success. Additionally, an understanding of what dimensions consumers use to judge healthcare quality will result in higher levels of perceived quality and satisfaction on the part of the consumer.

In spite of several attempts over the years to define quality, it remains a difficult concept to define in specific terms, possibly because quality can be seen as being abstract in nature (Grönroos 2000:63; Oliver 1997:166). Oliver (1997:165) argues that while quality appears to be elusive as a universal concept, several 'cues' are available which may be used for inferring quality. Because a service is a complicated phenomenon (Grönroos 2000:45,62), several authors agree that, similarly, the quality of a service is also complicated and not easy for a consumer to judge (Deming 1986:185; Grönroos 2000:63; Tekeuchi & Quelch 1983:139,141). Satisfaction measures of quality for customers have shown a range of distributions, from extreme dissatisfaction to highly pleased or even elated (Deming 1986:185). These measures are also because 'quality of service' is largely a subjective matter (Albrecht & Zemke 1985:37; Bitner & Hubbert 1994:76; Grönroos 2000:63; Oliver 1997:164; Parasuraman et al. 1985:41).

For the healthcare industry, quality of healthcare is difficult to define because of the many different angles from which healthcare can be approached, for example, the comfort of patients and facilities for tests and X-rays (Deming 1986:171). A further example is, if the rate at which patients are discharged is high, it could mean that the care received was excellent, or vice versa (Deming 1986:172). Jun et al. (1998:82) note that identifying quality attributes in healthcare is not without its problems and argue that a comprehensive understanding of what constitutes quality in healthcare services is required if higher levels of perceived quality and satisfaction are to be achieved.

According to Grönroos (1990:35, 1993:17), quality came to the service literature at the beginning of the 1980s and was hailed as the most important trend of that decade (Parasuraman et al. 1985:41). Until then, as mentioned above, quality was a concept confined largely to physical goods. The early researchers of service quality (Grönroos 1983b:9; Parasuraman et al. 1985:41-42) looked to the quality 'gurus' for definition and construct development (Godfrey & Kammerer 1993:3; Grönroos 1993:17; Parasuraman et al. 1985:41-42).

To put service quality into perspective therefore it is necessary to first examine quality. A brief overview of the construct quality is introduced due to its concomitant role in the origin of service quality development. Substantial research to develop service quality emerged only decades after the growth in services became a rising trend (Parasuraman et al. 1985:41; Zeithaml & Bitner 1996:6-10).

Therefore, a study on customer satisfaction in the services industry, in this case, private hospitals, would be incomplete without first understanding 'quality' from the perspective of the customer and its importance in the conceptualisation of the service quality construct. In this section the concept quality and how it is related to service quality, taking into account the effect of the quality movement, which gained momentum in the post World War II era, will be examined.

When the pioneering research of Parasuraman et al. (1985) began in the 1980s it was discovered that even though services had grown significantly in

contrast to manufactured goods (Parasuraman et al. 1985:41; Zeithaml & Bitner 1996:7), very little research had been undertaken to develop the construct service quality. Much had been written about product quality in terms of technical performance (Crosby 1979, 1984; Deming 1986; Garvin 1983, 1984, 1987; Feigenbaum 1991; Ishikawa 1990; Juran, Gryna & Bingham 1951; Juran 1989), however the existing literature on service quality was limited (Grönroos 1983a; Lewis & Booms 1983; Sasser, Olsen & Wyckoff 1978).

5.2.1 Quality becomes consumer focused

Garvin (1987:103) held the view that high quality means not only pleasing consumers, or simply protecting them from annoyance, but also that it is only the consumer who will be the judge of quality.

For the purpose of this study, the presumption is made that the eight critical dimensions of quality that were proposed by Garvin (1987:104-108) to encourage managers to view quality from the vantage point of the customer, can also be related to the ten dimensions of service quality proposed by Parasuraman et al. (1985, 1988 and discussed in section 5.4).

By breaking down the word quality into manageable parts, or dimensions, only then can managers define the quality niches in which to compete (Garvin 1987:104). These dimensions are illustrated in Table 5.1 and have been applied generically to a private hospital setting. Garvin's (1987:104) dimensions attempt to encompass both physical products and services. In contrast to Garvin's dimensions, Parasuraman et al. (1985:46) proposed ten dimensions of service quality that could be applied across any type of service and based on the consumer's view of service quality.

Garvin (1987:108) points out that since it is seldom possible for an enterprise to compete on all eight dimensions simultaneously, unless unreasonably high prices are charged, a selective quality niche can be pursued as an alternative strategy instead. Thus, as a forerunner to service quality, a private hospital can choose to compete on selected dimensions of quality and tailor its organisation and operations to meet these specific needs (Garvin 1984:33).

Table 5.1: Garvin's eight critical dimensions of quality for a private hospital setting

Quality Dimension	Meaning and Position in a Hospital Setting	Measurability of the Dimension	Objective vs Subjective
Performance	Refers to a hospital's primary operating characteristics. The private hospital should provide a service that promotes caring, healing and recovery. Performance can be measured objectively, therefore individual aspects of performance based on the function of a hospital should be established. The patient will judge the quality of performance depending on circumstantial preferences based on functional requirements.	Yes	More objective than subjective
Features	Refers to the secondary characteristics, or "bells and whistles", that supplement the basic functioning of a private hospital. It is crucial that features involve objective and measurable attributes which can be judged by individual patients' needs. Patients often view choice as quality. Providing a selection of daily newspapers and for every bed, radios and television sets with different channel offerings, allows patients a wide range of 'entertainment' options.	Yes	More objective than subjective
Reliability	Refers to the probability of malfunctioning or failing within a specified time period, however, more so in the case of durable goods than to products or services that are consumed instantly. In the hospital setting, reliability is reflected in its machinery and equipment, or in the case of a patient who is last in the queue of a surgeon performing a string of operations at the end of a busy day.	Yes	More objective than subjective
Conformance	Refers to pre-determined standards built into a product's design and operating characteristics. Specifications are found in most products or services. In service enterprises, measures of conformance normally focus on accuracy and timeliness, such as counts of processing errors and unanticipated delays. For the private hospital, such errors could be detected in its billing process or the time it take for nursing staff to respond to a patient's request.	Yes	More objective than subjective
Durability	Applies more to physical products than to services and is a measure of product life cycle. Two dimensions, economic – breakdown, repair or replacement, and technical – deterioration then replacement, are related to durability. The patient will come into contact with the many physical facilities of the hospital environment. The extent to which the hospital undertakes refurbishment or replacement for the benefit of patients – the customers.	Yes	More objective than subjective
Serviceability	Refers to the speed, courtesy and competence with which customer complaints are handled. A hospital's complaint handling procedures are likely to affect customers' ultimate evaluations of its product and service quality. How complaints are handled is important to a hospital's reputation for quality and service as profitability could be affected if customers remain dissatisfied.	Yes	More objective than subjective
Aesthetics	Refers to elements of physical properties – look, feel, sound, taste and smell – and because they relate to personal tastes and preferences, it is a subjective dimension. In a hospital setting aesthetics are depicted in the physical surroundings which implies that aesthetic choices are not nearly universal, i.e., it is not always possible to please everyone on this dimension of quality. However, a hospital can still position itself somewhere along the aesthetics dimension.	More difficult to measure	More subjective than objective
Perceived Quality	Refers to how consumers, in the absence of complete information about a product or service's attributes, usually have to make inferences about quality from various tangible and intangible aspects of the product or service. Examples include image, advertising and brand names. A time factor, such as reputation, is the primary element of perceived quality. Quality is built on reputation. The power of perceived quality comes from the analogy that quality today is similar to the quality of yesterday in the case of a product or service. A hospital can emphasize its reputation if it has built a credible one over time.	More difficult to measure	More subjective than objective

Source: Adapted from Garvin (1984:29; 1987:104-108) plus researcher's own construction.

5.3 CONCEPTUALISATION OF SERVICE QUALITY

Efforts to conceptualise service quality as a separate construct arose on account of the limited availability of literature on service quality (Grönroos 1983a:23-34; Lewis & Booms 1983:99-100; Sasser, Olsen & Wyckoff 1978) at a time when the service sector was growing. These early efforts became the foundation of the perceived service quality model conceptualised by Grönroos (1983b:9, 1990:35) of the Nordic School of Services Marketing.

Interest in service quality first emerged in the late 1970s according to Grönroos (2000:61,62), when the need arose to understand how services are perceived and evaluated by consumers during service encounters as well as with ongoing relationships. Since then, service quality has received much attention from researchers and practitioners alike (Berry & Parasuraman 1992; Berry, Zeithaml & Parasuraman 1990; Boshoff, Mels & Nel 1997; Buttle 1995; Carman 1990; Cronin & Taylor 1992, 1994; Dedeke 2003; Grönroos 1983a, 1983b, 1990; Lake & Hickey 2002:151-153; Parasuraman & Grewal 2000; Parasuraman, Zeithaml & Berry 1985, 1988, 1990, 1993, 1994a, 1994b; Scheuing & Christopher 1993; Sureshchandar, Rajendran & Anantharaman 2002).

In one of the few works on service quality that existed at the time, Grönroos (1983a:23) first proposed the need for a concept of service quality to help managers and researchers understand what constitutes a service in the minds of customers. Moreover, that once the service provider knows how consumers evaluate the quality of its service, it will be in a better position to influence these evaluations in a desired direction and to relate a service idea to customer benefits. The cornerstone of service quality development is based on the notion that it is what customers perceive as quality that is important (Grönroos 1993:10).

Early research on service quality explored these and other related themes (Grönroos 1983a, 1983b, 1993; Lewis & Booms 1983; Parasuraman et al. 1985). Two models of service quality that developed from the early

exploratory research (Grönroos 1993:19; Parasuraman et al. 1985, 1988; Zeithmal et al. 1990:18-20) are discussed in section 5.4.

From this early work on service quality, Lewis and Booms (1983:99) and Parasuraman et al. (1985:42) identified three underlying themes:

- Service quality is more difficult for the consumer to evaluate than goods quality;
- Service quality perceptions result from a comparison of consumer expectations with actual service performance;
- Quality evaluations are not made solely on the outcome of a service, they also involve evaluations of the *process* of service delivery.

Service quality is undoubtedly the single most researched area in services marketing to date (Fisk et al. 1993:77; Grönroos 2000:62; Lovelock 2001:364; McKoll-Kennedy 2003:90). However, the best-known pioneers in the field of service quality research were the trio of Parasuraman, Zeithaml and Berry (1985, 1988).

The lack of literature on service quality set in motion exploratory research by Parasuraman et al. (1985:43) to investigate the concept of service quality. From initial focus group research conducted in four large service firms, a conceptual model of service quality was developed. Parasuraman et al. (1985:46,47) also identified ten criteria used by consumers in evaluating service quality. The results of Parasuraman et al.'s (1985) pioneering study, formed the basis of their definition of service quality (Parasuraman et al. 1988:17). The meaning of service quality as it was conceptualised through this groundbreaking research is discussed in the following paragraphs.

5.3.1 The meaning of service quality

Parasurman et al. (1985:47, 1988:17) observed that *perceived service quality* is the result of the consumer's comparison of *expected service* with *perceived service*. These findings are consistent with similar research undertaken by Grönroos (1983a:24-25) and others (Parasuraman et al.

1988:16). Reviewing the work of consumer behaviourists, Grönroos (1983a:24) found that *perceived quality* of a service will be the result of consumer comparisons of their *expectations* with the service against their *perceptions* of what the service would be, in other words, consumers compare *perceived service* against *expected service*.

As noted previously in section 5.2, a great deal of documented evidence on quality of physical goods existed from which the quality of a service, or more specifically, the conceptualisation of service quality, could benefit. However, while such retrospection might have had its advantages, because of the unique characteristics of services (discussed in Chapter 4), Grönroos (2000:62) is correct in arguing that physical goods quality is not necessarily transferable to the service environment.

Pertaining to the quality versus service quality paradigm, Parasuraman et al. (1985:17) examined three basic concepts which were borrowed from the consumer behaviour discipline, namely attitude, perception and expectations which, according to the authors, influence the consumer's evaluative judgement about service quality. Each one of these concepts is built into the service quality construct and therefore requires further clarification.

(a) From the quality paradigm, with regard to attitude, Parasuraman et al. (1988:15) agreed that perceived quality is a form of attitude, related, but not equivalent to satisfaction and results from a comparison of expectations with perceptions of performance. In addition, emanating from the results of their 1985 exploratory research, Parasuraman et al. (1988:15) maintained that service quality is an overall evaluation similar to a person's attitude.

Although attitudes are discussed in the consumer behaviour literature, an understanding of 'attitude' is helpful to an understanding of how consumers form perceptions of service quality. Peter and Olson's (1987:191) definition that, 'an attitude is a person's overall evaluation of a concept' seems to correlate with the idea that service quality is similar to an attitude. However, Fishbein and Ajzen's (1975:10) well-known definition of attitude, 'a learned predisposition to respond in a consistently favourable or

unfavourable manner with respect to a given object' was adapted by Solomon (1994:148) to include behaviour. Solomon (1994:148) believes that anything toward which one has an attitude, whether it refers to tangible or intangible concepts, is called an attitude object. This clarification is helpful because it applies to the notion that an attitude is lasting, as it tends to endure over time (Solomon 1994:148).

(b) A comparison between expectations on the one hand and perceptions on the other will determine the strength of a consumer's judgement about service quality.

In the context of service quality, expectations are viewed as desires or wants of consumers, according to Parasuraman et al. (1988:17), and more specifically, what consumers feel a service provider *should* offer rather than *would* offer. On the other hand, perception is a consumer behavioural concept. According to Schiffman and Kanuk (1994:162), perception is the process by which an individual selects, organises and interprets stimuli into a meaningful and coherent picture of the world. The definition implies that no two people will perceive stimuli in exactly the same way. Thus, Grönroos' (2000:63) view that service quality is 'whatever the customer perceives it to be' holds true.

In the private hospital environment there are several stimuli that could influence a consumer's perception, for example, the hospital name itself, the bedside manner of the attending doctor, attitude of the nursing staff, presence of television set in the wards, meals, ward décor and so on.

Grönroos (1983a:23-24) also examined the discipline of consumer behaviour, in particular, expectations and perceptions, to gain a better understanding of how customers evaluated expected service and perceived service in the service quality construct. Grönroos (1983a:23) noted that according to consumer behaviour theories, consumers form expectations concerning the future performance of a product when purchasing it. According to Swan and Combs (1976:25), consumers compare the quality to their prior expectations as they consume the product.

Grönroos (1983a:24) emphasised that to compare expectations with perceptions of the service, consumers put the perceived service against the expected service, as indicated in Figure 5.1.

Figure 5.1: Perceived service quality

Source: Adapted from Grönroos (1983a:24).

5.3.2 Service quality is different to customer satisfaction

Service quality has been closely linked to customer satisfaction (Bitner & Hubbert 1994; Bowers et al. 1994; Spreng & McKoy 1996; Taylor & Baker 1994; Taylor & Cronin 1994). For the purpose of the present study, while the similarities between the two constructs are acknowledged, service quality and customer satisfaction will be treated as two separate constructs and distinguished as such.

Largely due to its comparison in nature to an attitude, service quality has not been easy to define. Furthermore, it has been argued that service quality is an elusive and abstract construct (Bitner & Hubbert 1994:77; Parasuraman et al. 1988:13). Grönroos (1983a:25) first attempted to define service quality by distinguishing between technical quality (what is done) and functional quality (how it is done).

The pioneering work of Parasuraman et al. (1985:42) established that while knowledge of product quality was useful, it was not enough to understand service quality. Parasuraman (1985:42) believed that to fully understand service quality, three well-documented characteristics – intangibility, heterogeneity and inseparability – had to be accepted. Thus, acceptance of the service characteristics helped to re-affirm the notion that service quality was different from product quality.

Parasuraman et al. (1988:16) defined service quality as a consumer's

global judgement or attitude relating to the overall excellence or superiority of the service. Moreover, that service quality originates from a comparison of consumer expectations of the service enterprise's offering with consumer perceptions of its performance (Parasurman et al. 1985:42; 1988:16).

Bitner and Hubbert (1994:77), on the other hand, associate service quality with the consumer's overall impression of the relative inferiority/superiority of the enterprise and its services.

Dagger and Lawley (2003:74) are therefore correct in assuming that a consumer can have a perception about the quality of a service enterprise (based on expectations) without necessarily having experienced the service itself. Likewise, a prospective patient will possibly have a perception about the quality of the private hospital the patient has been referred to, without ever having been a patient there before.

In contrast to consumer expectations and perceptions concerning whether or not the service has been experienced, customer satisfaction is transaction specific (Parasuraman 1988:16). To date, the evidence suggests the existence of two schools of thought concerning customer satisfaction, namely whether customer satisfaction is an outcome or a process. On the one hand, Churchill and Surprenant (1982:493) and Oliver (1997:55-56) view customer satisfaction as an outcome resulting from the consumption experience. Hunt (1977:459), on the other hand, argues that satisfaction is not the pleasure of the experience, it is the evaluation rendered that the experience was at least as good as it was supposed to be. This debate will be further explored in Chapter 6 on customer satisfaction.

A recent refinement of the service quality definition is proposed by Zeithaml and Bitner (1996:17) as the delivery of excellent or superior service relative to customer expectations.

5.4 THE DETERMINANTS OF SERVICE QUALITY

The early exploratory research undertaken by Parasuraman et al. (1985:46-49) produced ten key categories based on the finding that consumers used relatively similar criteria in evaluating service quality. These categories are referred to as 'service quality determinants', or dimensions (Parasuraman et al. 1985:47; Zeithaml et al. 1990:21-22) and are depicted in Table 5.2, with each dimension related to an example in a private hospital setting.

Table 5.2: The ten dimensions of service quality for a private hospital

Dimension and Definition	Examples of Specific Questions Raised by Customers
Tangibles Includes the physical evidence of the service: - physical facilities; - appearance of personnel; - tools or equipment used to provide the service; - physical representations of the service; - other customers in the service facility.	- Are the hospital's physical facilities attractive? - Are the doctors appropriately dressed when doing ward visits? - Does the hospital use modern equipment and machinery? - Are the admission forms easy to understand? - Are doctor's rooms conveniently located in the hospital's premises?
Reliability Involves consistency of performance and dependability: - ability to perform the service right the first time; - ability to honour promises.	- Will the diagnosis prove to be accurate? - Does the hospital perform its services by the promised times?
Responsiveness Concerns the willingness or readiness of employees to provide service: - timeliness of service.	- Was the admission procedure prompt? - Do the nurses respond quickly to a patient's needs?
Competence Possession of the required skills and knowledge to perform the service: - knowledge and skill of contact personnel and operational support personnel; - research capability of the firm.	- How skilled are the doctors in their respective fields? - Does the hospital employ highly skilled nursing staff? - Does the hospital keep abreast with current medical research?

Dimension and Definition	Examples of Specific Questions Raised by Customers
Access Involves approachability and ease of contact: - service is easily accessible by telephone; - waiting time to receive service is not extensive; - convenient hours of operation and location of service facility.	- Will the hospital provide information about my condition if my family should phone? - Does the hospital have long queues? - How far is the hospital from my home?
Courtesy Involves politeness, respect, consideration and friendliness of contact personnel: - Consideration for the consumer's property; - Clean and neat appearance of public contact personnel.	- Are patients treated with respect by nursing staff? - Is hospital staff friendly and helpful?
Communication Keeping customers informed in language they can understand and listening to them, as well as adjusting language for different consumers: - Explaining the service itself; - Explaining how much the service will cost; - Explaining the trade-offs between service and cost; - Assuring the consumer that a problem will be handled.	- Does hospital staff thoroughly explain treatment procedures? - Will the hospital provide an accurate assessment of the cost of the stay? - Will this expensive procedure lead to a cure? - Does the hospital provide adequate information about a patient's treatment procedure?
Credibility Involves trustworthiness, believability, honesty and having the customer's best interests at heart: - Company name and reputation; - Personal characteristics of the contact personnel; - Selling tactics.	- Does the hospital have a good name/reputation? - How does the hospital's staff treat its patients? - Will my doctor insist on which hospital I should go to (or will I have a choice)?
Security Involves freedom from danger, risk or doubt: - Physical safety; - Financial security; - Confidentiality	- Will my personal belongings be safe in the hospital ward? - Can patients feel safe in the hands of the hospital? - Are the patient's dealings with the hospital treated as confidential?

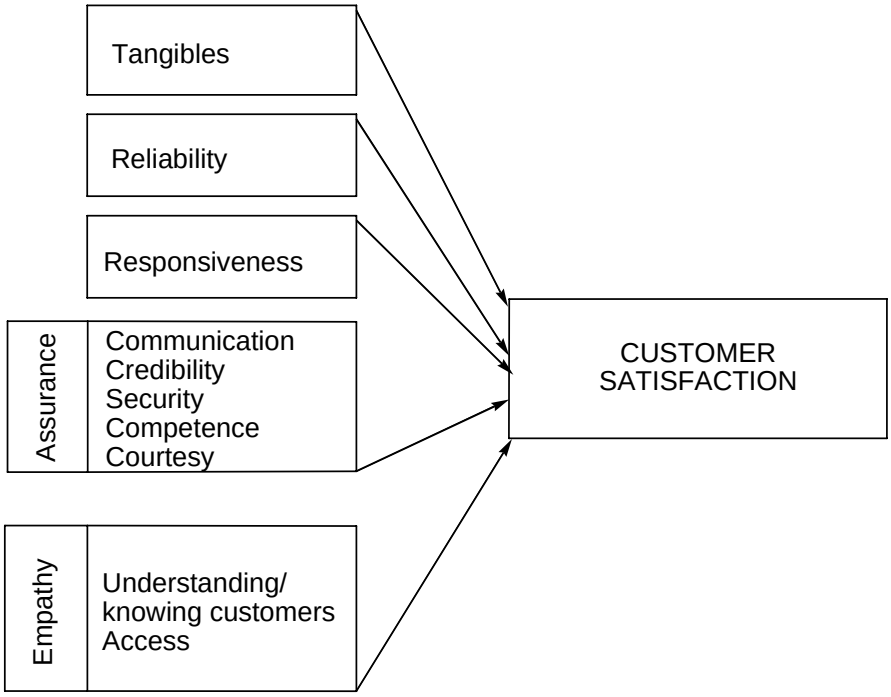
Dimension and Definition	Examples of Specific Questions Raised by Customers
Understanding/Knowing the customer Involves making the effort to understand the customer's needs: - learning the customer's specific requirements; - providing individualized attention; - recognizing the regular customer.	- Do nursing staff treat patients in a caring manner? - Are patients given individual attention? - Will I be recognized from my previous visit?

Source: Adapted from Parasuraman et al. (1985:47); Zeithaml et al. (1990:21-22).

Subsequent research (Parasuraman et al. 1988) produced a refinement of the original ten dimensions into a factor analysed, 22-item scale (called SERVQUAL) that reduced to five similar, but distinct dimensions, as shown in Figure 5.2.

Although SERVQUAL was used for assessing customer perceptions of service quality in service (and retailing) enterprises (Parasuraman et al. 1988:12), the early model of service quality (Parasuraman et al. 1985) served as the foundation framework linking service quality, customer satisfaction and behavioural intention (Woodside, Frey & Daly 1989:6). As mentioned in Chapter 1, for the purpose of the present study, Parasuraman et al.'s (1985:47) original ten dimensions from their exploratory research were used to measure patients' perceptions of service quality.

Figure 5.2: The service quality dimensions



Source: Adapted from Oliver (1997:48) and Parasuraman et al. (1988:21-22).

Several reasons for using the original ten dimensions can be given. Cronin and Taylor (1992:55) found the five dimension SERVQUAL to be somewhat inadequate as little, if any, theoretical or empirical evidence supports the relevance of the expectations-performance gap (the model is discussed in section 5.5.2) as the basis for measuring service quality (Carman 1990:47). The main criticism expressed by Cronin and Taylor (1992:64) suggest that SERVQUAL is based on a satisfaction paradigm rather than an attitude model. In the Cronin and Taylor (1992) study, SERVQUAL could only be confirmed in two out of four industries.

In a replica study of SERVQUAL, Carman (1990:37,40) found that some of the items used did not load on the same component when compared across four different service providers, thus suggesting possible validity problems.

Dagger and Lawley (2003:87) argue that SERVQUAL's applicability to industries other than that for which it was developed, may also be questionable. This criticism was based on several research findings which

differed from the dimensions of Parasuraman et al.'s (1988) model. However, it must be pointed out that Parasuraman et al. (1988:24,28) clearly indicate the SERVQUAL model's generic applicability across a variety of service firms. Furthermore, that researchers might need to make two adjustments to the model, namely:

- Adaptation of the instrument in the case of single service investigations;
- Rewording or adding additional items to each of the five dimensions to increase their relevance to the subject matter under investigation.

In the case of a high involvement service like healthcare, Cronin and Taylor (1992:65) propose that service quality definitions might be different to low involvement services such as fast food or dry-cleaning and therefore consideration must be given to the individual dimensions of service quality when making cross-sectional comparisons.

In spite of its criticisms, there is currently no other credible alternative to SERVQUAL to measure service quality. Parasuraman et al.'s (1985) original ten dimensions of service quality are a more effective predictor of customer satisfaction (Green & Boshoff 2002:4) than SERVQUAL's five dimensions and were therefore considered the more appropriate option for the present study.

5.5 SELECTED MODELS OF SERVICE QUALITY

Nearly three decades after an interest in service quality first emerged, several researchers of this consumer-owned judgement have developed models of service quality.

Three traditional approaches to service quality have been identified (Parasuraman et al. 1985:42-43) and a fourth, more recent approach to understanding how consumers evaluate service quality, has been postulated.

In this section, the well-known Nordic School (Grönroos 1983a, 1990, 1993, 2000) and Gaps models (Parasuraman et al. 1985, 1988) are presented,

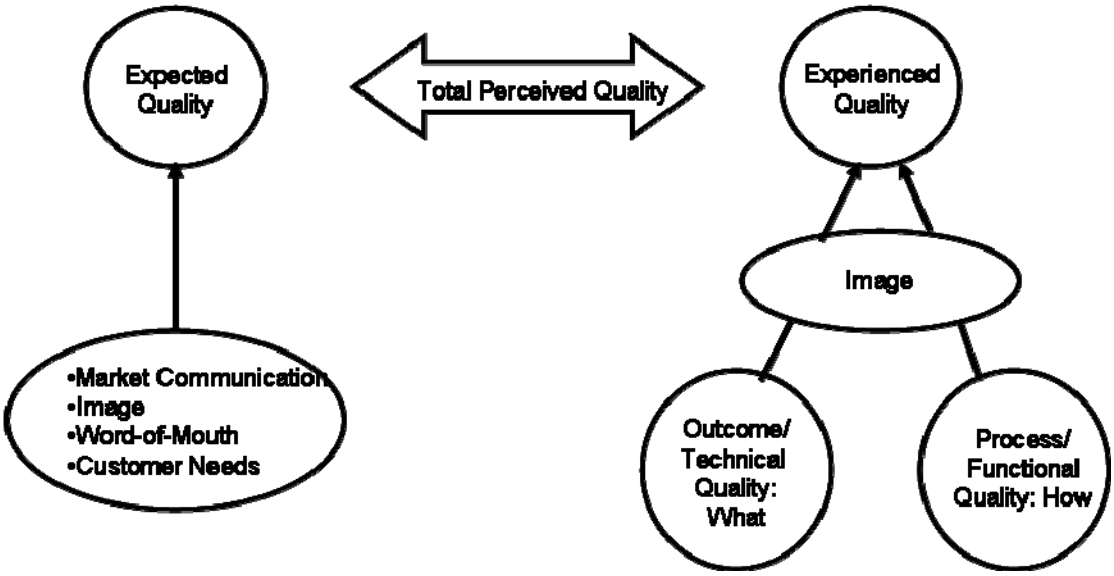
followed by the recent integrated model of service quality (Brady & Cronin 2001).

5.5.1 The perceived service quality model

The first attempt to conceptualise service quality was the disconfirmation of expectations paradigm proposed by Grönroos, of the Nordic School of service marketing in 1982 (Grönroos 1983a:iii). It was first introduced as the perceived service quality model (Grönroos 1993:20). This model examines service quality from two perspectives, namely the customer's comparison of actual versus expected service (or pre- and post-service evaluation) and the objective versus subjective dimensions of the buyer-seller interactions.

In the actual – versus – expected component of the Grönroos model of service quality, Grönroos (1993:20) notes that the quality of a service, as perceived by the customer, is the result of a comparison between the expectations of the customer and the customer's real life experiences. According to Grönroos (1993:20), if the customer's experiences exceed the expectations, the perceived quality is positive, however, if the experiences do not reach the level of expectations, the perceived quality is low. In an earlier work in this regard, Grönroos (1983a:24) explains that the *perceived quality* of a given service will be the outcome of an evaluation process where consumers compare their expectations with the service they perceive they have got, that is, consumers compare the *perceived service* against the *expected service*. The perceived service quality model is shown in Figure 5.3.

Figure 5.3: The Grönroos perceived service quality model



Source**:** Grönroos (1990:41).

As indicated on the left-hand side of the diagram, expected quality is influenced by the variables market communication, word-of-mouth communication, corporate/local image and customer needs (Grönroos 1990:41, 1993:21, 2000:67).

As mentioned previously, the second component of the model examines two dimensions that occur in what Grönroos (1983a:25) refers to as buyer-seller interactions or service encounters (1990:37). According to Grönroos (1990:37) two dimensions, namely a technical or outcome dimension and a functional or process-related dimension are inherent in these buyer-seller interactions. The right-hand side of Figure 5.3 illustrates the two service quality dimensions as perceived by consumers. An explanation of the difference between the technical and functional quality dimensions follows.

The technical quality (or outcome) dimension refers to *what* the customers receive in their interactions with the service firm which are important to their evaluation of the quality of service (Grönroos 1983a:25, 1990:37). Often it can be measured by the consumer in a rather objective manner. Moreover, consumers will also be influenced by the way in which technical quality is

transferred to them (Grönroos 1983a:25). For example, in a private hospital environment several service encounters will influence the customer's views of the service, such as the response time of a nurse, whether the patient's doctor is available, the delivery of meals, the presentation of food, and so on.

In a later version of the model, Grönroos (1990:37) implies that technical quality is what the customer is left with, when the production process of the service and buyer-seller interactions are over. Grönroos (1993:27) later described it as a technical solution to a customer's problem as a result of service production and delivery process.

The functional quality (or process) dimension refers to *how* the customers receive a service and how the simultaneous production and consumption process is experienced (Grönroos 1983a:25, 1990:38). Thus, Grönroos (1990:38) views the two quality dimensions as quite different – technical quality, on the one hand, answers the question of *what* the customer receives, while functional quality on the other hand, answers the question *how* the customer receives it. Functional quality is therefore the more subjective dimension of the two, according to Grönroos (1990:38).

Later research (Parasuraman et al. 1985, 1988) confirmed Grönroos' (1993:22) conclusion that as long as the outcome, or technical quality is acceptable, the process dimension, or functional quality, may often be more critical to the customer's overall quality perception. This view has not changed. Grönroos (2000:66) believes that by developing the functional quality dimension, substantial value is added for customers and the necessary competitive edge is created.

5.5.2 The 'Gaps' model of service quality

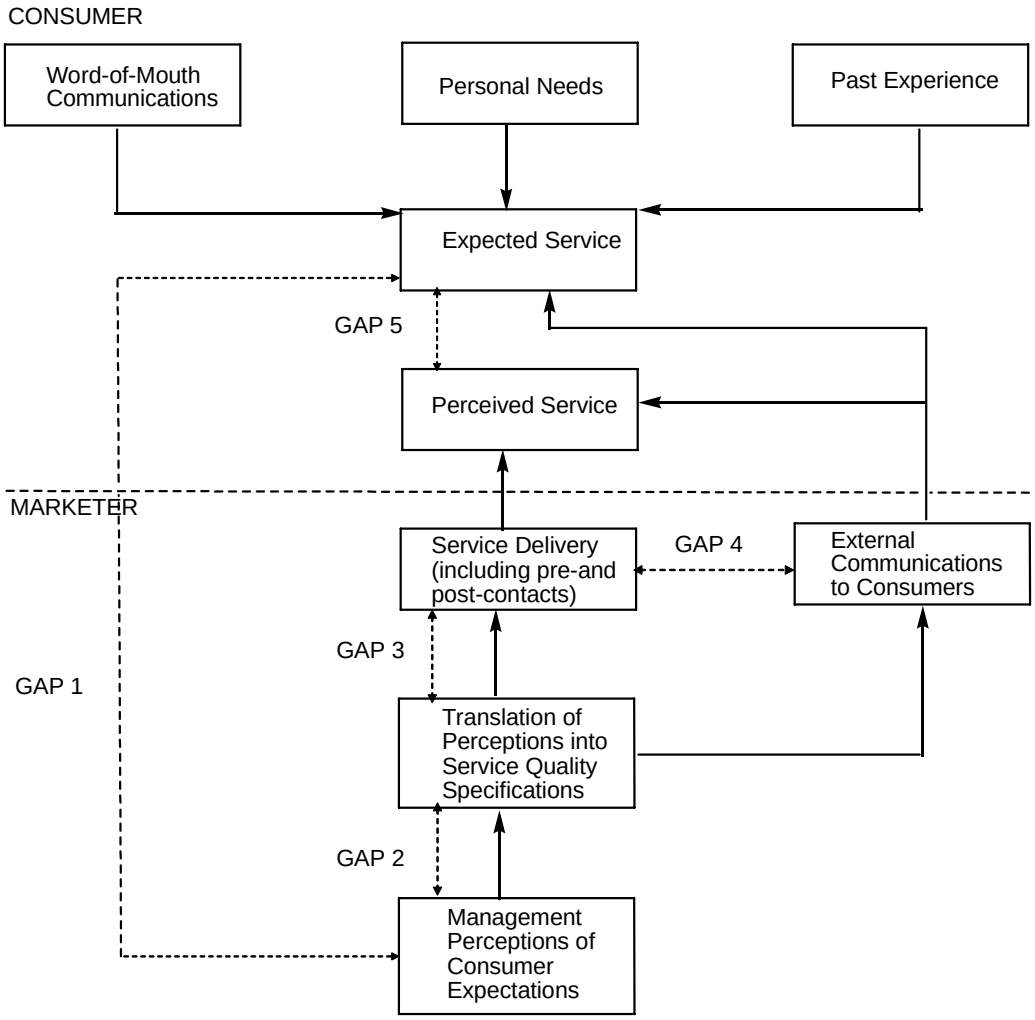
Arguably, the best known method of operationalising service quality and probably the most widely written about model of service quality, the Gaps model proposed by Parasuraman et al. (1985) is based on pioneering research conducted on executive managers from four different service

industries and a sample of consumer focus groups (Parasuraman et al. 1985:43-49). The overall conclusion resulting from these interviews is that a set of key discrepancies or gaps exist between what management perceives service quality is and what consumers perceive it is (Parasuraman et al. 1985:44). According to the authors, the existence of gaps can impede service delivery, particularly a service which consumers would perceive as being of high quality (Parasuraman et al. 1985:44).

The original Gaps model of service quality is based on the 'expectancy disconfirmation' paradigm and views service quality as the gap between the expected level of service and consumers perceptions of the actual service received (Parasuraman et al. 1985:46). The Gaps model is shown in Figure 5.4. In more recent versions of the model, the somewhat restrictive terms, marketer (see Figure 5.4) and provider from the original research (Zeithaml et al. 1990:46) have been replaced by the term company (Zeithaml & Bitner 1996:39,48) to encompass anyone in the service enterprise who is involved in or empowered to effect changes in service policies, procedures and standards. Such empowerment is particularly significant in the private hospital environment today, as the authority to create, change or influence any aspect of the delivery of service to patients is carried out by many different groups of service providers and their employees (doctors orders regarding their patients not withstanding).

The Gaps model of service quality depicted in Figure 5.4 proposed four service provider, or company 'gaps', that is, discrepancies within the enterprise that impede the delivery of quality service (Parasuraman et al. 1985:44-46; Zeithaml et al. 1990:36; Zeithaml & Bitner 1996:38-47). The first four gaps identify possible service failure resulting from the service provider and provide management with a means to understanding why failure has occurred. The fifth gap relates to the consumer and suggests that the difference between expected and perceived levels of service form consumers' overall perception of service quality (Dagger & Lawley 2003:82). The five gaps are discussed as follows:

Figure 5.4: **The 'Gaps' model of service quality**



Source: Parasuraman et al. 1985:44.

Gap 1: Not knowing what consumers expect. This is the gap between consumers' expectations of a service and the service enterprise's understanding of those expectations. It is implied that management may not fully understand what consumers expect in a service.

Gap 2: Service quality specifications that do not reflect consumer's expectations. This gap occurs when service enterprises find themselves unable to match or exceed consumer expectations, either as a result of not being able to perceive consumers service quality expectations, or the absence of total management commitment to service quality.

Gap 3: Service delivery does not meet the service quality specifications.

This gap refers to a service enterprise's difficulty in being able to adhere to the service quality specifications of its service programmes. The importance of the contact personnel and the influence they have on the service quality perceptions of consumers cannot be underestimated in the service delivery process.

Gap 4: Service performance and promises fail to match up. If the external communications of a service enterprise promise more than it can actually deliver, the enterprise may raise expectations initially, but perceptions of service quality will be lowered when promises are not fulfilled.

Gap 5: Expectations of service quality and perceptions of the actual performance differ. Evaluations of service quality depend on how consumers perceive the actual service performance based on their prior expectations.

Parasuraman et al. (1985:46) found that a consumer's perception of service quality depends on the size and direction of gap 5, which in turn will depend on the size and direction of gaps 1, 2, 3 and 4, as expressed by the following equation:

Gap 5 – f(Gap 1, Gap 2, Gap 3, Gap 4)

It is the fifth gap that forms the main focus of SERVQUAL. It is also the gap measured by SERVQUAL. This is the so-called customer gap and identifies service performance problems, but not their causes. Therefore, service enterprises need to close the gap between customer expectations and perceptions of the actual service received if these enterprises wish to satisfy their customers and build long-term relationships (Dagger & Lawley 2003:82).

5.5.3 An integrated model of service quality

Brady and Cronin (2001) proposed a new approach to service quality based on an in-depth analysis of service quality, from its origins in the product quality and customer satisfaction literature (Grönroos 1983a, 1984; Churchill & Surprenant 1982; Parasuraman et al. 1985, 1988 and others),

to the present day. The authors took the view that a new and integrated conceptualisation of service quality was required to ensure that the service quality debate continued in the future. In particular, because a unifying theory of service quality still appears to be lacking in this area (Brady and Cronin 2001:34). After almost two decades of measuring service quality perceptions, Brady and Cronin (2001:34) realised that there was still no consensus amongst researchers on how to reflect the complex process of service quality evaluations, or more importantly, the hierarchical nature of the service quality construct. The results of Brady and Cronin's (2001) efforts can thus be seen as a virtual 'makeover for service quality' for the 21st Century.

In developing an alternative conceptualisation of service quality, Brady and Cronin (2001:36) agreed with the notion that overall perception of service quality is based on the customer's evaluation of three dimensions of the service encounter:

- customer-employee interaction (refers to functional quality as postulated by Grönroos 1983a, 1984);
- the service environment (Bitner 1992);
- outcome (refers to technical quality as postulated by Grönroos (1983a, 1984).

The view that customers tend to break service quality dimensions into various sub-dimensions and that service quality perceptions are multilevel and multidimensional (Carman 1990) was a further consideration in developing a hierarchical approach to service quality.

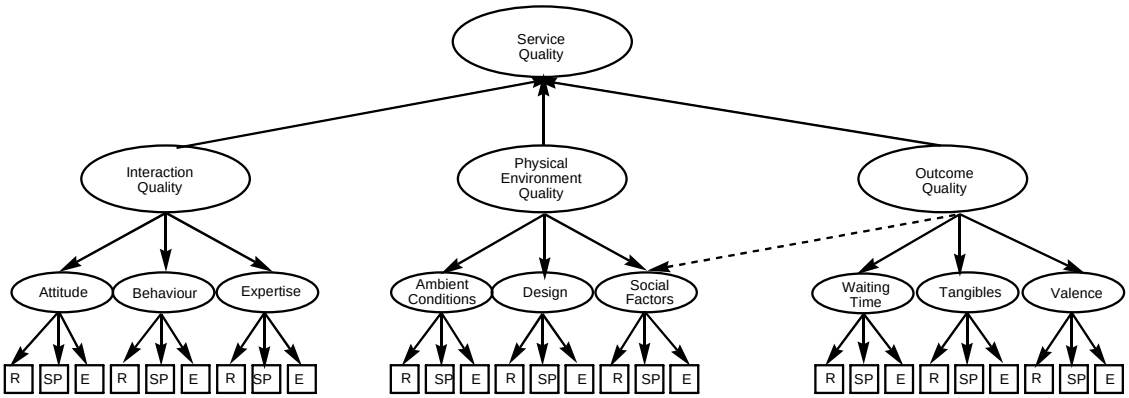
Thus, as a departure from the perceived service quality (Grönroos 1983a) and 'Gaps' models (Parasuraman et al. 1985, 1988), Brady and Cronin (2001:37) propose a hierarchical model of service quality that integrates many dimensions of previously researched models of service quality.

In this model, Brady and Cronin (2001:37) depict three different tiers, or levels of service quality dimensions (Dagger & Lawley 2003:90):

- Tier one: reflects the customers' overall perceptions of service quality.
- Tier two: reflects the primary dimensions that consumers use to evaluate service quality.
- Tier three: identifies the subdimensions and individual items that make up the primary dimensions in the model.

According to Brady and Cronin (2001:37), the three primary dimensions of service quality, namely interaction, environment and outcome are further sub-divided into nine subdimensions, as shown in Figure 5.5. Customers then evaluate these nine subdimensions to form a perception of service quality based on the three primary dimensions. Thus, the authors are of the opinion that customer service quality perceptions are formed on the basis of multilevel performance evaluations. In due course, customers form an overall perception of service quality based on a combination of these evaluations.

Figure 5.5: A hierarchical approach to service quality



Note: R=a reliability item, SP=a responsive item, E=an empathy item. The dotted line indicates that the path was added as part of model respecification.

Source**:** Brady and Cronin (2001:37).

Brady and Cronin (2001:44) argue that firstly, the new approach provides a single, multidimensional model of service quality based on a strong theoretical foundation and secondly, it gives a fresh direction to the current body of service quality research.

The three service quality models presented in this section each serve as a

framework for understanding consumer perceptions of service quality. While each model can provide useful guidelines for improving service levels in order that consumer perceptions of service quality might improve, the assumption in the present study is that the Gaps model and the ten dimensions of service quality provide a more detailed and comprehensive approach to understanding service quality.

5.6 OVERVIEW OF SERVICE QUALITY PARADIGMS

The foundation of service quality theory is based on two early paradigms borrowed from the product quality and customer satisfaction literature. The service quality construct has been developed in the body of knowledge of services marketing over a period of approximately two decades. The disconfirmation paradigm encapsulates the pioneering work of Grönroos (2001:62) and Parasuraman et al. (1985, 1988). This view suggests a comparison between expectations and performance, that is, consumers compare the service they expect with perceptions of the service received (Grönroos 1983a:23; Parasuraman et al. 1985:142).

In the customer satisfaction literature, disconfirmation was related to performance judgement and referred to gratifications received and gratifications sought (Oliver 1997:99). The disconfirmation school of thought is still strongly represented in the service quality literature today.

In an attempt to improve on the disconfirmation paradigm of measuring the service quality construct, Cronin and Taylor (1992:55) proposed a performance-based measure of service quality, in particular, as an alternative to SERVQUAL (Parasuraman et al. 1988). The performance-based paradigm (SERVPERF) suggests that service quality should be measured as an attitude and furthermore, that service quality is related to consumer satisfaction and purchase intentions (Cronin & Taylor 1992:65).

At least one current paradigm in the literature, namely an integrated approach based on two decades of service quality research, links service quality perceptions to a multilevel, multidimensional set of dimensions

(Brady & Cronin 2001:37). This view attempts to shift the service quality paradigm into a unifying theory that reflects the complexity and hierarchical nature of the construct (Brady & Cronin 2001:34,38). In this latest research, nine subdimensions have been identified that define three direct dimensions of service quality. Customers evaluate the quality of the service based on these dimensions (Brady & Cronin 2001:38).

5.7 THE IMPORTANCE OF SERVICE QUALITY TO HEALTHCARE

The ability of service enterprises to deliver quality service is of increasing importance for success and survival in today's competitive environment (Brady & Cronin 2001:44; Zeithaml et al. 1996:31). Increasing competition in the healthcare environment, and hospitals in particular, has highlighted the importance of hospitals delivering higher levels of quality service if they wish to ensure that their patients are willing to return to the same hospital again in the future (John 1991:58; Reidenbach & Sandifer-Smallwood 1990:47). Returning patients are the key to a hospital's (private hospital in the South African context) long-term survival and growth.

It has already been mentioned in this chapter, as well as in Chapter 1, that empirical studies in the healthcare industry, including hospitals, are increasingly receiving attention. These studies have shown that several key benefits associated with a hospital's survival can be achieved by improving not only patients' perceptions of service quality, but customer satisfaction as well. This section will examine some of the benefits associated with service quality while the benefits associated with customer satisfaction will be examined in Chapter 6.

- Encouraging repeat purchase intentions. Studies have shown that higher perceptions of service quality are associated with intentions to reuse the service again. Specifically, it has been found that hospitals who focus more on the human dimensions of service quality and not their technical competence will gain the competitive advantage (Bowers, et al. 1994:54,55). This study found that patients define service quality in

terms of empathy, reliability, responsiveness, communication and caring (Bowers et al. 1994:54). In their study, which included the healthcare industry, Taylor and Baker (1994:173) found that purchase intentions are influenced by both service quality perceptions and customer satisfaction judgements. Thus, hospitals should be equally concerned with service quality as with customer satisfaction (Taylor & Baker 1994:173; Woodside et al. 1989:15).

Perceptions of service quality, specifically patient confidence, in a hospital study by Reidenbach and Sandifer-Smallwood (1990:50) were influenced by the length of stay. When patients perceive a higher level of service quality with the care received, they are more likely to be willing to return to the same hospital again in the future (John 1991:58). Likewise, the influence of prior impressions of a hospital's service quality will impact on intentions to return to the same hospital (John 1992:60). In order to pre-empt patient expectations of service quality, John (1992:61) recommends that the hospital's external marketing communications programme could be used for two purposes. Firstly, to manage patient expectations of a hospital experience, and secondly, to manage potentially unrealistic patient expectations through patient education.

- Willingness to recommend and/or positive word-of-mouth endorsements. Patient recommendations of a particular hospital to other potential patients are an exceptionally strong form of advertising (Reidenbach & Sandifer-Smallwood 1990:51). It was found that patient confidence and business competence affect a patient's willingness to recommend a hospital to others. Prior impressions of a hospital's service quality will also impact on willingness to recommend the hospital to family and friends (John 1992:60).

- Sustainable competitive advantage. Studies have shown that hospitals who understand the service quality dimensions patients deem to be most important, who can better manage patient expectations and successfully communicate the desired functional dimensions of service quality to all role players, will attain the competitive advantage (Jun, Peterson &

Zsidisin 1998:94; Lytle & Mokwa 1992:12).

From the above discussion, it is clear that overwhelming evidence exists to suggest that hospital management, and private hospitals in particular, should be concerned about their patients' perceptions of service quality, not merely in the short-term, but over the long run as well. Furthermore, that service quality research can be tailor-made for a healthcare, and even a hospital, setting.

Taylor and Cronin (1994:42) emphasise the increasing need for further research in healthcare, in particular, to measure the relationship between service quality and customer satisfaction because of the high involvement and high-risk nature of healthcare services and the general lack of expertise that healthcare consumers are likely to have about healthcare. The importance of customer satisfaction to healthcare will be examined in the following chapter.

5.8 SUMMARY

The foundation for service quality was laid through an examination of the so-called quality movement which focused largely on product quality and the contributions during the latter half of the 20th Century of several renowned quality 'gurus'. The pioneering work of the early service quality practitioners became the cornerstone of service quality research since it was first conceptualised during the late 1970s and early 1980s.

This chapter briefly examined quality and its importance in quality service delivery due to the fact that the customer is the judge of quality. The customer as the central focus is widely accepted in service quality circles and this school of thought is encapsulated in the three service quality models that were evaluated in this chapter. Over the course of the last two decades, at least three service quality paradigms have emerged in the literature, most notably the disconfirmation paradigm on which service quality is based and which today remains a strongly held view. A synopsis of these paradigms was also presented in this chapter.

As discussed, studies have shown the increasing importance that service quality has for the healthcare industry. This chapter examined empirical evidence of various hospital studies which suggest that several benefits accrue to hospitals that recognise that service quality perceptions of their patients have become key to their survival.

In Chapter 6, the nature of customer satisfaction and its link to service quality is discussed.

CHAPTER 6

CUSTOMER SATISFACTION: AN EVALUATION

"Satisfied with my stay but disappointed as I contracted gastroenteritis on the last morning of my stay – but can't actually blame the hospital as it is a breeding ground."

Respondent in present study, a former patient commenting on the nursing in general.

6.1 INTRODUCTION

The essential focus of the present study is whether the customer, in this case the private hospital patient, is satisfied with the care he or she received during the hospital stay. Customer satisfaction is important to marketers of service enterprises because, like service quality, it is generally accepted to be a significant determinant of consumers' future behavioural intentions. Specifically, customer satisfaction is a significant determinant of repeat sales, positive word-of-mouth and consumer loyalty (Bearden & Teel 1983:1). By their very nature, services are inherently relationship-oriented which means that relationships between service providers and consumers normally continue over time (Grönroos 2000:127). With every encounter between a consumer and the service provider exists an opportunity for the service enterprise to reinforce its commitment to customer satisfaction and service quality (Bitner & Hubbert 1994:74).

High levels of customer satisfaction are also generally associated with increased loyalty as a result of repeat future purchases (Anderson, Fornell & Lehman 1994:55) made by returning customers. Studies have shown that customer satisfaction is the key to profitability (Anderson et al. 1994:55; Oliver 1997:10) because repeat purchases from loyal customers have a cumulative value to the service enterprise (Anderson et al. 1994:55).

Customer satisfaction has long been the fundamental goal of marketing, hence it is assumed that marketers today understand that every service encounter can enhance or destroy the relationship. Oliver (1997:10)

argues that customer satisfaction, from the consumer's perspective, is a desirable goal to be attained from the consumption of products and the patronisation of services. Grönroos (2000:21) therefore correctly points out that the way the relationship is managed will have an impact on the purchasing behaviour of consumers. Moreover, today's customers are more sophisticated and demanding than in the past, so if they perceive the service to be of lower quality, less value or worse than what a competitor seems to be able to offer, there is no reason for them to stay (Grönroos 2000:23). Thus, customers have the freedom of choice to take their patronage elsewhere if they are not satisfied.

In the healthcare industry, customer satisfaction, or more appropriately, patient satisfaction must be viewed in the same context as any other service enterprise/customer relationship. Several studies have shown customer satisfaction to be positively associated with the hospital experience and purchase intentions (Bowers et al. 1994:49; Fisk et al. 1990:5; John 1991:58; Jun et al. 1998:83,84; Reidenbach & Sandifer-Smallwood 1990:47; Woodside et al. 1989:5).

Studies have also examined the relationship between service quality, customer satisfaction and purchase intentions (Bowers et al. 1994:49; Jun et al. 1998:81; Reidenbach & Sandifer-Smallwood 1990; Woodside et al. 1989; Taylor & Baker 1994; Taylor & Cronin 1994). Research has also focused on customer satisfaction at a more general, or service enterprise level (Bitner & Hubbert 1994; John 1992; Johnson, Anderson & Fornell 1995).

The purpose of this chapter is to examine the nature and importance of customer satisfaction, with particular reference to the healthcare industry. This chapter will commence with a discussion of the formation of the customer satisfaction construct based on cognitive dissonance theory. Buying intentions as a surrogate for loyalty in a hospital setting and the view concerning 'overall' cumulative satisfaction is examined. The distinction or similarity between service quality and customer satisfaction is addressed in this chapter. Clarity is also provided on the customer/patient

concept in relation to the present study. The chapter concludes with the dimensions of customer satisfaction deemed appropriate for a hospital visit.

6.2 THE FORMATION OF CONSUMER SATISFACTION

According to Oliver (1997:100), the first behavioural work in consumer satisfaction dates back to the early 1970s when views of consumer satisfaction were based on the cognitive dissonance theory of Festinger (1957). Cognitive dissonance focused on the relations between cognitive elements, namely a person's knowledge about himself, his behaviour or his surroundings (Festinger 1957:9). In principle, dissonance refers to situations where two of these cognitive elements are inconsistent with one another (Solomon 1994:156) and result in a psychologically uncomfortable tension state (Oliver 1997:247). This process is distinguished from disconfirmation, discussed later in this chapter, and other comparative processes where the purchase outcomes are known (Oliver 1997:247). Research has shown that a common response to dissonance is a psychological effort on the part of the consumer to reduce that dissonance (Oliver 1997:247).

The early belief about consumer satisfaction using dissonance theory was that 'shopping' effort would cause consumers to become committed to their expectations for products (Oliver 1997:100), and by implication, for services too. Oliver (1997:100) points out that the argument presented by the early researchers was that shopping effort generates knowledge for the consumer and a sense of confidence in that knowledge.

However, the early research of dissonance in customer satisfaction failed to examine the causes of dissonance and what marketers and consumers can do to reduce it (Oliver 1997:250). In spite of its use in the early consumer satisfaction research studies, it was also found to be an elusive construct to measure (Oliver 1997:260).

A need to find alternative interpretations of how consumers evaluate purchase outcomes prompted a departure away from the expectations focus of dissonance theory (Oliver 1997:100). More importantly, the

proliferation of research findings on customer satisfaction produced mixed findings about the antecedents and outcomes of the consumer/customer satisfaction construct, resulting in the need to integrate the diverse results (Szymanski & Henard 2001; Yi 1990).

Several contributions have been added to the consumer satisfaction debate over the decades. The early research on consumer, also referred to as customer, satisfaction focused on physical goods and argued that product performance that exceeds standards leads to satisfaction, while performance falling below standards leads to dissatisfaction (Yi 1990:87).

According to Yi (1990:87), this argument is consistent with findings in areas of work, life and services, notably patient satisfaction, in that satisfaction is a function of certain standards and the perceived discrepancy from those standards. While Yi (1990:87) finds agreement with this paradigm to a certain extent, the author points out that many consumer satisfaction studies differ in the choice of standards. One such theory emanating from this belief is the expectation disconfirmation paradigm.

6.2.1 Outcome versus process

One debate which is of particular importance to service enterprises, is whether customer satisfaction is an outcome or a process (Yi 1990:69). To date there seems to be two schools of thought. On the one hand, customer satisfaction is an *outcome* resulting from the consumption experience (Churchill & Surprenant 1982:493; Lytle & Mokwa 1992:4; Oliver 1997:55-56), which Yi (1990:69) suggests could be attributed to:

- the consumer's cognitive state of being adequately or inadequately rewarded for sacrifice's undergone;
- an emotional response to the experiences provided not only by products or services purchased, but also by other aspects of the consumption experience;
- the summary psychological state resulting from the consumer's

emotional state.

On the other hand, the *process* school of thought suggests that customer satisfaction is not the pleasure of the experience, it is the evaluation rendered that the experience was at least as good as it was supposed to be (Hunt 1977:12). The process school of thought stresses that satisfaction or dissatisfaction is not inherent in the product, but instead is the individual's perceptions of that product's attributes as they relate to that individual.

Thus, customer satisfaction is idiosyncratic and as a construct, is formed by the interaction of perceptual interpretations of the service and consumer expectations of that service. Consequently, different consumers will have varying levels of satisfaction for an experience which is essentially the same.

Although both schools of thought, that is, satisfaction as an outcome and as a process, have been widely recognised in the literature, the process-oriented approach seems more appropriate in the service environment. As Yi (1990:70) points out, this approach spans the entire consumption experience and consists of collective perceptual, evaluative and psychological processes that combine to generate consumer satisfaction.

6.2.2 The expectancy disconfirmation model of satisfaction

The vast majority of customer satisfaction research is based on the expectancy disconfirmation paradigm (Churchill & Surprenant 1982:491; Hill 2003:106; Oliver 1997:99; Szymanski & Henard 2001). The expectation-disconfirmation model proposes that consumers' judge satisfaction based on a comparison of their expectations to actual performance (Oliver 1997:120; Yi 1990:87), where disconfirmation is related to the consumer's initial expectations (Churchill & Surprenant 1982:491).

Oliver (1997:104) suggests that consumers' expectations are zero disconfirmed, or simply confirmed when performance is equal to standards

or expectations; negatively disconfirmed when performance is below standard and positively disconfirmed when performance is above standard. The disconfirmation theory is therefore expected to affect customer satisfaction (Yi 1990:87).

According to Churchill and Surprenant (1982:492), the full disconfirmation paradigm contains four constructs:

- Expectations. Consumers may use different 'types' of expectations to anticipate performance, such as ideal, expected, minimum tolerable and desirable. For example, a patient about to undergo a major operation might have an expectation about post-operative pain.

- Performance. Serves as a standard of comparison by which to assess disconfirmation. For example, the patient could praise the surgeon as 'highly skilled'.

- Disconfirmation. Considered to be the crucial intervening variable and arises from discrepancies between prior expectations and actual performance. For example, a patient could describe the hospital stay as "better than expected".

- Satisfaction. Viewed as an outcome of the purchase and use resulting from a comparison of the rewards and cost of the purchase. For example, a patient who undergoes major heart surgery might anticipate a longer life.

The expectancy disconfirmation model has been favourably received as a reliable means of evaluating performance (Yi 1990:78). The positive review suggests that further improvements to the expectancy disconfirmation model still exist, which future research could address (Yi 1990:78).

Similarly, Hill (2003:109) concurred with Yi (1990:78) by also noting that a lack of research testing the dynamics of the disconfirmation paradigm means that a need for more customer satisfaction research to fill in the picture of the specific dynamics at play, still exists. An examination of the many studies that have explored the expectancy disconfirmation model

suggests that consumer satisfaction may be influenced by any one, or more, of the model's components (Churchill & Surprenant 1982:493; Hill 2003:109; Szymanski & Henard 2001; Yi 1990:78,88).

6.2.3 The nature of cumulative satisfaction

The unique nature of services as performances (intangibility) rather than tangible objects and the peculiarities of marketing the interactions of services (inseparability) necessitate a distinction between satisfaction with a specific service encounter (discrete) and cumulative or 'overall' satisfaction. This is an important distinction in service encounter transactions but is often ignored (Bitner & Hubbert 1994:74).

How the service enterprise interacts with the customer will affect the customer's perceptions of the service and ultimately, how satisfied the customer is, overall, with the service. The very nature of a hospital visit requires a patient to interact with several role players such as doctors, nurses and administrators on different occasions during the stay. As service providers, they cannot be separated from the work they need to perform on or for the patient.

Service encounters between service enterprises and their customers vary. From an encounter-specific perspective, that is, a once-off interaction, customer satisfaction is viewed as a post-choice evaluative judgement of a specific purchase occasion, sometimes called encounter- or transaction-specific satisfaction (Anderson et al. 1994:54; Bitner & Hubbert 1994:76; Oliver 1997:15). Most behavioural research to predict consumer responses to customer satisfaction can be interpreted as focusing on the transaction-specific conceptualisation (Yi 1990:100-105).

However, Bitner and Hubbert (1994:74) point out that this perspective is insufficient to explain customer satisfaction because the evaluation of each encounter will not necessarily correlate with the customer's overall satisfaction with the service enterprise or perceptions of the enterprise's quality. Furthermore, over time, it is likely that multiple service encounters

will lead to an overall level of satisfaction.

Alternatively, therefore, the service encounter may be a series of inter-related events (White 2003:33), or many occurrences of the same experience (Oliver 1997:15). More recently, research has focused on satisfaction at a more general or enterprise level, namely, measuring global satisfaction with the enterprise's services (Bitner & Hubbert 1994:74).

From this enterprise- or brand-specific perspective, overall or cumulative satisfaction is an overall evaluation based on many transient experiences (the total purchase and consumption experience) with a good or service over time and, as such, satisfaction can also be thought of as an ongoing evaluation of a service enterprise's ability to deliver the benefits a customer is seeking (Anderson et al. 1994:54; Bittner & Hubbert 1994:77).

Bittner and Hubbert (1994:77) further point out that overall satisfaction is likely to be multidimensional and based on all encounters and experiences with that particular service enterprise. Moreover, these multiple encounters may include several interactions with one person, as well as experiences with multiple contact persons in the same enterprise (Oliva, Oliver & MacMillan 1992:91).

Thus, transactional satisfaction can be considered a contributor and subsequent modifier to a less dynamic attitude of satisfaction at a service enterprise level, while overall or cumulative satisfaction can be considered as the customer's global evaluation of the product or service offering.

Whereas the transaction-specific customer satisfaction perspective may provide specific diagnostic information about a particular product or service encounter, Anderson et al. (1994:54) argue that this information will be insufficient over the long-term. Economically, those service enterprises who take cognisance of the long-term, or what Oliver (1997:16) views as summary satisfaction, will benefit across two fronts.

Firstly, it is cumulative customer satisfaction that motivates a service enterprise's investment in customer satisfaction, which is related to

profitability and return on investments (ROI). Thus, a service enterprise that strives to increase customer satisfaction will, over the long-term, increase the value of its customer assets and future profitability (Anderson et al. 1994:54,55).

Secondly, the cumulative experiences of consumers in a given industry or sector are fundamental not only to the profits of the enterprises within them, or the well-being of the individual consumers who patronise these enterprises, but also to a society's well-being and survivability as a whole (Oliver 1997:9,11,16).

No matter how customer satisfaction is perceived, there can be no doubt that it is a key to long-term profitability (Oliver 1997:10), an economic benefit which applies also to private hospitals (Raju & Lonial 2001:140).

6.3 CONSEQUENCES OF CUSTOMER SATISFACTION

There is no shortage of literature on the subject of satisfying customers and the value to service enterprises of customer satisfaction (Yi 1990:68). Although absolute consensus on the meaning of satisfaction does not exist in the literature (Oliver 1997:13; Yi 1990:70), there is substantial evidence to support the argument that customer satisfaction yields economic benefits to service enterprises (Anderson et al. 1994:53; Bearden & Teel 1983:21; Szymanski & Henard 2001; Yi 1990:103; Zeithaml et al. 1996:31).

Satisfaction has not been an easy concept to define, but Oliver (1997:13) offers a definition that is consistent with recent theoretical and empirical evidence:

> *"Satisfaction is the consumer's fulfilment response. It is a judgement that a product or service feature, or the product or service itself, provided (or is providing) a pleasurable level of consumption-related fulfilment, including levels of under- or over fulfilment."*

From the above definition, it is important to note that only the customer is able to make the judgement about the service encounter. Therefore, it is the customer who is but one determinant of an enterprise's success.

Several studies have been linked to customer satisfaction and its consequences, most notably loyalty, as measured by purchase intentions, that is, willingness to reuse the service again and recommend it to others, or word-of-mouth endorsements (Cronin & Taylor 1992; Fisk et al. 1990; John 1991, 1992; Taylor & Baker 1994; Zeithaml et al. 1996).

6.3.1 Customer loyalty

Not all satisfied customers will become repeat users or exhibit any form of loyalty to the service provider, but there can be no doubt that repeat patronage is just one benefit associated with establishing a loyal customer base (Sparks & Tideswell 2003:406).

Anderson et al. (1994:55) argue that the more loyal customers become, the longer they are likely to continue to purchase from the same supplier. By implication then, regular patronage has a cumulative value for the service enterprise, because the loyal customer's repeat purchases, made over a period of time, contribute significantly to its revenue. However, since a hospital visit is not generally a sought after need, a hospital patient is unlikely to develop the same kind of 'loyal' relationship with a particular hospital, like a customer of a retail store would, unless the patient is going to require more than one visit to the hospital over time.

Whereas the hospitality industry (for example, hotels, restaurants, airlines, theme parks) places a great deal of emphasis on exceeding customer expectations and ensuring satisfaction levels are maintained, the relationship between customer satisfaction and loyalty may well be different for hospitals, partly because the expectations of patients relate more to the clinical quality issue than say, the entertainment value of theme parks (Fisk et al. 1990:6; Sparks & Tideswell 2003:406).

Kotler (1988:192-193,202-203) found that customer loyalty tends to be lowest for products or services, such as healthcare, that are perceived to be major decisions for consumers and which are used relatively infrequently. Moreover, Fisk et al. (1990:7-8) infer from this finding that

extremely high levels of service satisfaction must be achieved in order to minimise the extent of subsequent erosion of customer loyalty. Kotler 1988:202-203) suggests that in the case of healthcare, patient satisfaction must be measured both during the service encounter and again some time later.

In a five-year study, Fisk et al. (1990:14) found that patients who reported having participated actively in the choice of hospital, rather than just following the physician's recommendation, appeared more likely to remain loyal. Woodside et al. (1989:8,12) found that overall customer satisfaction with a hospital stay, in this study the entire service encounter experience, is associated strongly with behavioural intentions to reuse the same hospital. Another factor to influence behavioural intentions to return to the same hospital are the effects of previous hospital experiences on patient satisfaction with subsequent hospital experiences (John 1992:59-60).

Patient satisfaction studies with an individual dimension of satisfaction, namely nursing staff, have consistently had the highest correlation with overall satisfaction and is considered a major determinant of overall patient satisfaction (Atkins & Marshall 1996). In a similar study, Atkins and Marshall (1996) found a strong positive relationship between nurse satisfaction and patients' intention to re-use the hospital in future or recommend it to others (word-of-mouth endorsements).

The Fisk et al. (1990:14) study observed that patients who had expressed their satisfaction by recommending a service to others seemed more loyal than those who merely reported a willingness to recommend. Yi (1990:103) points to the impact that recommendation, or word-of-mouth, seems to have on consumer response behaviour. Word-of-mouth is a form of communication – a face-to-face communication of a consumer's experience which can be vividly told. It is a credible source of information, but potentially could also be damaging since it is communicated to many other consumers. Thus, Yi (1990:103) believes that word-of-mouth could have a substantially greater impact on recipients than, for example, mass communication.

Customer loyalty has been defined in various ways, but to date no universal definition has emerged (Oliver 1997:389). Early definitions of loyalty (in the 1970s) viewed it as a pattern of repeat purchasing and later, researchers turned to behavioural explanations for brand specific purchase patterns (Oliver 1997:389). More recently, a critical review of the many definitions of loyalty suggests that loyalty is both a cognitive construct (attitude) and a shopping behaviour (Dick & Basu 1994; Mellens, Dekimpe & Steenkamp 1996; Olsen 2002:241).

Whilst loyalty in a healthcare environment, and in particular, a hospital setting, differs from brand or store loyalty (it was mentioned in Chapter 1 that it is often the physician who makes the choice, or strongly influences the choice of hospital) there can be no doubt that the same benefits of loyalty accrue to a hospital as would a retailer or bank, for instance.

Fisk et al. (1990:14) report that patient loyalty is vital to stability and growth and should be pursued as a managerial goal. Additionally, patient loyalty programmes must be pursued as an integrated system by hospital management.

Despite the claims that satisfaction is linked to loyalty as measured by purchase intentions and willingness to recommend, Olsen (2002:241) argues that few empirical studies exist that relate satisfaction to self-reported or actual repurchase behaviour. Szymanski and Henard (2001) report also that few empirical studies have tested the entire relationship between quality, satisfaction and loyalty.

No matter what the industry under discussion, loyal customers are a competitive asset to any business enterprise (Dekimpe, Steenkamp, Mellens & Vanden Abeele 1997) as customer loyalty serves as a barrier to competitive entry (Aaker 1991).

6.4 THE RELATIONSHIP BETWEEN SERVICE QUALITY AND CUSTOMER SATISFACTION

It was mentioned in Chapter 5 that interest in service quality emerged in the late 1970s (Grönroos 2000:62), making the construct a fairly recent development in services' history. Service quality has its origins in services marketing (Grönroos 1983a; 1983b; Parasuraman et al. 1985, 1988) and its widely used SERQVUAL instrument consisting of five key dimensions, reduced from an original list of ten, to measure customers' perceptions of service quality.

Customer satisfaction, on the other hand, first emerged in the early 1970s (Oliver 1997:100) and is based on the early cognitive dissonance theory of Festinger (1957). The early work on customer satisfaction focused initially on physical goods, and its application to services is also relatively recent (Hill 2003:103). It is, however, the older of the two constructs. Satisfaction is strongly linked to the expectancy disconfirmation paradigm (Oliver 1997:104), which was discussed in section 6.2.2.

A debate which has prevailed is that consumers' perceptions of service quality, on the one hand, conform to the disconfirmation paradigm (Bitner 1990:70; Bolton & Drew 1991:1), while on the other, service quality and customer satisfaction are related but distinct constructs (Bitner 1990:70; Bitner & Hubbert 1994:73; Cronin & Taylor 1992:55, 1994:35; Parasuraman et al. 1998:16).

Current evidence at present supports the view that service quality and customer satisfaction are related, but nevertheless distinct constructs (Cronin & Taylor 1992:56; Hill 2003:103; Oliver 1997:178; Taylor & Baker 1994:165). Oliver (1997:174) draws a distinction between the concept of quality, such as service quality, and satisfaction.

This argument is based on transaction-specific reactions versus global judgements. Oliver (1997:174) holds the view that satisfaction is a consumer's reaction to a short-term, transaction-specific encounter, or judgement, rendered during or immediately following a particular service

provision or product consumption episode. The consumer's reaction is based on that particular experience only. Whereas, overall or global judgements, according to Oliver (1997:174), are based on the consumer's memories of past experiences, and are interpreted by a summary judgement, or in the absence of personal experience with the product or service, then external information or vicarious experience is sourced.

To further distinguish the quality from satisfaction argument, Oliver (1997:177) proposes several differences, as shown in Table 6.1.

Table 6.1: Conceptual differences between quality and satisfaction

Comparison Dimension	Quality	Satisfaction
Experience dependency	None required; can be externally or vicariously mediated	Required
Attributes/dimensions	Specific to characteristics defining quality for product or service (e.g., five star hotel)	Potentially all attributes or dimensions of product or service (e.g., accommo-dation in hotel
Expectation/standard	Ideals, excellence	Predictions, norms, needs, etc.
Cognitive/affective	Primarily cognitive	Cognitive *and* affective
Conceptual antecedents	External cues (e.g., price, reputation, various communication sources)	Conceptual determinants (e.g., equity, regret, affect, dissonance, attribution)
Temporal focus/short-versus long-term)	Primarily long-term (overall or summary)	Primarily short-term (trans-action or encounter-specific

Source: Adapted from Oliver (1997:177).

According to Cronin and Taylor (1992:56,65), the relationship between service quality and customer satisfaction in the service literature is not yet fully distinct and remains an important area of research. Moreover, bringing clarity to the relationship between service quality and customer satisfaction is important to both managers and researchers alike in order to determine

which construct should take priority, either consumers who are satisfied with a service enterprise's performance, or the delivery of the maximum level of perceived service quality (Cronin & Taylor 1992:56).

Empirical evidence exists to support the premise that service quality and customer satisfaction are unique constructs and should not be treated as equivalents (Taylor & Baker 1994:165). More specifically, this argument refers to the relationship between service quality, customer satisfaction and purchase, or behavioural intentions. Empirical studies which have examined the relationship between service quality, satisfaction and purchase intentions include Cronin and Taylor (1992), Taylor and Baker (1994) and Woodside et al. (1989). Studies on satisfaction, service quality and behavioural intentions include Bitner (1990) and John (1991, 1992).

For instance, in the Woodside et al. (1989) hospital study, empirical results support the causal ordering of the two constructs in the selection of health service providers as service quality → patient satisfaction → purchase intentions (Taylor 1994:223). From the results of a survey of four service industries, Cronin and Taylor (1992:65) suggest that customer satisfaction exerts a stronger influence on purchase intentions than does service quality.

However, in a study of passengers at an international airport, Bitner (1990) proposed an alternate causal ordering of the service quality and satisfaction construct, namely customer satisfaction → service quality → behavioural intentions (Bitner & Hubbert 1994:73).

At present, despite extensive debate over the service quality and customer satisfaction constructs, and their various relationships, there appears to be few empirical studies that have tested their relationship to buying behaviour or repurchase loyalty (Olsen 2002:240). To date, some of this evidence has produced conflicting results (Taylor 1994:222; Taylor & Baker 1994:165; Taylor & Cronin 1994:42). A similar problem exists with empirical results to measure the relationship between service quality, customer satisfaction and purchase intentions. According to Taylor and Baker (1994:166), the empirical evidence remains incompatible until such

time that research can prove otherwise.

Whatever concerns there may be about the relationship between service quality and customer satisfaction and their causal link, there does seem to be a strong case for addressing, through empirical research, unresolved issues concerning the two constructs (Cronin & Taylor 1994:129-130; Parasuraman et al. 1994:120-122).

Taylor and Baker (1994:165) correctly point out that service quality is consistently viewed in the literature as a unique construct from satisfaction. Bitner and Hubbert (1994:77) share this view in that service quality is a higher order construct that relates to the overall quality of the service enterprise and its offerings.

To strengthen the case for developing healthcare marketing strategies, Taylor (1994:222) presents a convincing argument that the two constructs are, indeed, distinct. The author claims that healthcare practitioners and researchers alike need to conceptually and empirically distinguish service quality from satisfaction because it is important to know whether positioning strategies should be based on providing service quality *or* satisfying patients. More specifically, because service quality perceptions are considered long-term consumer attitudes and patient satisfaction short-term, service encounter/ specific consumer judgements, this distinction is necessary (Taylor 1994:222-223; Cronin & Taylor 1992:56).

To overcome some of the problems associated with the service quality/ customer satisfaction distinction, Cronin and Taylor (1992:58) proposed an alternative approach to SERVQUAL, which was based on service performance and termed (SERVPERF). Cronin and Taylor (1992:63) reported three important findings to emanate from this study. Firstly, as an alternative to SERVQUAL, service performance (SERVPERF) might be a more suitable measure to conceptualise service quality. Secondly, in agreement with Parasuraman et al. (1985, 1988), the causal order of the two constructs is, namely service quality leads to satisfaction. And thirdly, that satisfaction has a stronger effect on purchase intentions than service quality.

Cronin & Taylor (1992:64) concluded that service quality definitions might differ from industry to industry. For example, high involvement services such as healthcare may have a different service quality definition than low involvement services.

In a study of former hospital patients, Taylor & Cronin (1994:42) reported a non-recursive relationship between the service quality and customer satisfaction constructs, noting that the finding is not only new to health service literature, but to the general services literature as well. Taylor and Cronin (1994:42) make an important observation in this regard, namely that it could be possible that healthcare consumers are unable to distinguish service quality from customer satisfaction in their minds when they respond to patient satisfaction surveys or service quality surveys. Alternatively, if this is not the case, and healthcare consumers are able to cognitively distinguish between these concepts, Taylor and Cronin (1994:42) caution that the use of direct measures could be seriously questioned by the results of the research. The results of this study seriously question current models used in healthcare research and suggest a thorough examination of the scales used to operationalise the service quality and customer satisfaction constructs (Taylor & Cronin 1994:42).

6.5 THE CUSTOMER/PATIENT CONCEPT

The present study, which will investigate two customer-owned judgements, namely service quality perceptions and customer satisfaction evaluations with a service experience, in this case a patient with a private hospital, prompted the need to also investigate the meaning of a customer, mainly because a patient is not always considered in the same light as the notion of ‘customer’ typically is.

Additionally, because the patient is not only a sick person (and many times also a healthy person) lying in a hospital bed, but also a valuable, paying customer who has the same common law and statutory rights as any other customer. For a customer, this means to expect and even demand

consistent levels of quality service, professional care and excellent service delivery throughout the hospital stay.

While the concept of 'customer' is nothing new (Heller & Spenley 2000:155), the birth of the customer probably occurred at the same moment as pre-historic man first bartered his unwanted and surplus self-made implements with those of his neighbour's, whose equally self-made implements he must have wanted. It was not until the early 1950s and 1960s that customer satisfaction first began to receive attention. The satisfaction of man's very simple needs by exchanging an object of value with his neighbour has evolved through the ages to the present day's sophisticated consumer who has acquired not only a myriad of virtually unlimited needs, but is also exposed to a great deal of choice. Today, many of those needs can now be satisfied in a rapidly growing global market, and the healthcare industry is by no means excluded from this global phenomenon.

Drucker (1955:29) put it succinctly when he argued that there is only one definition of business purpose – to create a customer. Having created customers, the next best step is to satisfy them (Heller & Spenley 2000:155). Concerning the fact that the customer holds all the power, Drucker (1955:30,41) draws two obvious conclusions. Firstly, the customer is the foundation of a business and keeps it in existence and secondly, a business is defined by the want the customer satisfies when buying a product or service. Drucker's observations apply equally across the spectrum of business enterprises – services and physical goods.

Throughout the text of the present study, reference has been made for deliberate reasons, not to one, but to three terms commonly associated with the consuming entities, consumers, customers and patients.

Webster (2000:20) cautions against confusing the terms *consumer* and *customer* for the following reasons. A *consumer* is a person who uses or consumes the product. However, a *customer* is an individual or business entity that buys the product, meaning that they acquire it (legally and probably, but not necessarily, physically).

Parasuraman and Grewal (2000:11) acknowledge the increasing importance of customer service in service enterprises and emphasise that enterprises will find it difficult to compete effectively by merely applying the traditional marketing mix variables. Parasuraman and Grewal (2000:11) further argue that customer service is the solution to serving customers effectively.

The terms *consumers* and *customers* are at times used interchangeably both in scholarly writing and in the popular press (Parasuraman & Grewal 2000:10). Thus, in the present study, an endeavour was made to use the term consumer in the context where services, and particularly healthcare services, are referred to in broader terms and secondly, to use the term customer in a narrower context. In this instance, customer would refer to an individual who has actually used the service enterprise on one or more occasions and may do so again in the future.

The third entity, the patient, or more specifically in this study, the private patient, has purchased either directly or indirectly some type of medical service from a private hospital. According to De Jager and Grundling (2004:44), a patient represents a customer 'on-site' situation and for the patient, the service is an experience occurring in the environment of the hospital facility.

To a certain extent, the terms customer and patient have also been used interchangeably. Ultimately, however, all private patients are customers. It was previously discussed in Chapter 1 that the private patient in this study is an adult over the age of twenty who was admitted to a private hospital in order to undergo medical treatment which included surgery and at least one overnight stay in a hospital ward. Furthermore, that the patient is also a paying customer regardless of the length of stay or whether the physician made the choice of hospital, or whether the account will be settled by the patient directly or indirectly by a medical cover provider.

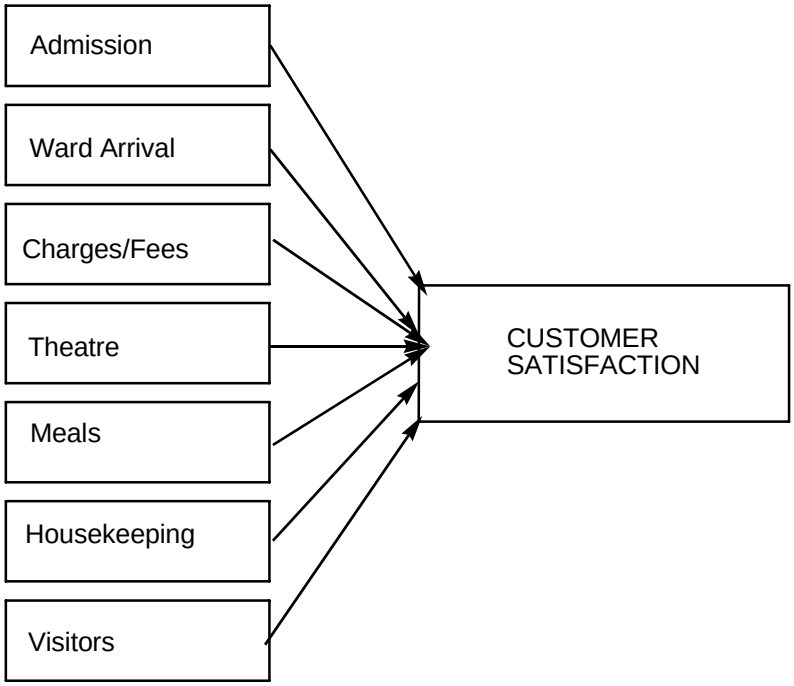
6.6 THE DIMENSIONS OF CUSTOMER SATISFACTION FOR A PRIVATE HOSPITAL

Oliver (1997:17) describes a hospital stay as a complex experience, and as such, consumer reactions to this or other situations can be based on a single unique encounter, on continual ongoing encounters, or on any frequency of contact between these two extremes. Additionally, consumers can base their satisfaction judgements on one event, for example, the hospital stay, or over a longer period, such as repeat hospital stays.

A researcher's goal is to determine the predictors or key drivers of satisfaction/dissatisfaction for a service (or product) under investigation (Oliver 1997:37,41). From these satisfaction drivers it is then possible for the researcher to formulate a list of dimensions on which customer satisfaction will be measured. In satisfaction research, factor analysis is frequently used to reduce the dimensionality (the number of satisfaction drivers) of the particular list under investigation (Oliver 1997:37-44).

The complex nature of healthcare services include a variety of direct relationships, such as medical practitioners, nursing staff, administrative staff, catering, housekeeping and others. Indirect contact with ancillary role players like the in-hospital pharmacy or patient's medical aid are also important members of the entire healthcare team with whom the patient will interact during the hospital stay. For the purpose of this study, these interactions, or the individual dimensions of customer satisfaction with a private hospital that will be measured, are illustrated in Figure 6.1.

Figure 6.1: Customer satisfaction dimensions with a private hospital



Source: Researcher's own construction.

As shown in Figure 6.1 (and discussed in Chapter 1), the seven dimensions are presumed to be appropriate satisfaction drivers of a hospital stay.

The treatment of the service quality dimensions discussed in Chapter 5 and the customer satisfaction dimensions presented in this chapter, by means of exploratory factor analysis to reduce the dimensionality (satisfaction drivers), are addressed in Chapters 7 and 8.

6.7 SUMMARY

There can be no doubt that customer satisfaction is linked to an enterprise's survival and long-term success, as empirical studies have shown. Satisfied customers are a source of repeat purchases through repatronage and positive behavioural intentions, although not every satisfied customer will necessarily become a repeat user. This would be true for hospital patients, not all of whom would necessarily require hospitalisation again in the immediate future.

Customer loyalty is an important outcome of customer satisfaction in services

since it is manifested in a consumer's willingness to reuse the service again or, through word-of-mouth endorsements, recommend it to others.

Some early theories of customer satisfaction in services are still referred to in recent literature, such as the expectancy disconfirmation paradigm which is based on a consumer's comparison of expectations to performance. Customer satisfaction research has also focused on two separate types of satisfaction with services, namely discrete satisfaction which results from a once-off interaction in a single encounter and the more recent, 'overall' cumulative satisfaction resulting from multiple service encounters. However, the effect of cumulative satisfaction has received less attention than encounter specific customer satisfaction in empirical research.

There has been much debate in the literature concerning the relationship between the two constructs of service quality and customer satisfaction, but overwhelming evidence does seem to support the view that while the two constructs may be related, they are in fact distinct. However, consensus has not yet been conclusively reached and so this issue remains an important area of research.

Another well researched topic is the relationship between service quality and customer satisfaction and repurchase or behavioural intentions, not only in service enterprises in general, but also in the healthcare industry specifically. It was pointed out that results from the various studies show that much research is still needed in this very important area.

Within the 'service quality, customer satisfaction and future buying or behavioural intentions' scenario of a private hospital, it is also important to understand that the patient is a paying customer who will interact on several levels with various dimensions of service during the hospital stay. And it is only the customer who can be the judge of these experiences, no matter how long the duration of the hospital stay.

Against the background of this chapter on customer satisfaction and the preceding chapter of service quality, the next chapter presents the research design and methodology proposed to measure private hospital patients'

perceptions of service quality and customer satisfaction with a recent hospital experience, and to estimate their effect on future behavioural intentions.

CHAPTER 7

RESEARCH DESIGN AND METHODOLOGY

"I would go back to St George's because they [sic] other options are not even a consideration for this family at present and I see this questionnaire and St George's own questionnaire as a serious attempt to make improvements".

Respondent in present study, a former patient commenting on the questionnaire used in the present study.

7.1 INTRODUCTION

The primary goal of research is discovery (Leedy 1993:8). Moreover, research is fundamental to learning (Balian 1994:3) and the ongoing quest for knowledge and understanding (Babbie & Mouton 2001:4). There is general agreement that the process of continuous research brings about the discovery of new knowledge and insights (Preece 1994:8; Salkind 1997:3; Smit 1995:3). If the knowledge and information produced is to be used efficiently and effectively (Babbie & Mouton 2001:4), research is not only necessary, but also fundamental to learning the truth about different phenomena.

Scientific research is presumed to produce truthful results. For scientific research to be undertaken, the use of the scientific method, a procedure according to Leedy (1993:110) literally meaning, "the method that searches after knowledge", is required. If research starts with a problem and culminates in a solution if the objectives are achieved, then scientific inquiry is required.

The purpose of this chapter is therefore to explain the research design and methodology that was followed in order to solve the research problem of the present study.

This chapter opens with a discussion of the research design and methodology undertaken to address the objectives of the investigation, which was conducted in accordance with the principles of the scientific

method. The research design deemed appropriate for this study is presented together with a description of the sample and the measuring instrument developed to address the research problem. The chapter concludes with a discussion on the scaling of the data.

7.2 RESEARCH DESIGN AND METHODOLOGY USED

Some researchers differentiate between research design and research methodology (Babbie & Mouton 2001:72; Leedy 1993:113). Babbie and Mouton (2001:74) argue that researchers often confuse research design and research methodology when in fact these procedures present two very different dimensions of research.

On the one hand, a research design is a plan or blueprint for how a researcher intends conducting the research (Mouton 2001:55). The aim of a research design is to plan and structure a given research project in such a manner that the eventual validity of the research findings is maximised (Mouton & Marais 1990:33).

On the other hand, however, research methodology focuses on the research process used (Mouton 2001:56). More specifically, it consists of the various tools and procedures used – the research design, data collection methods, sampling techniques, fieldwork procedures, types of data analysis used and the interpretation of results (Mouton 2001:56; Zikmund 2000:GL11; 2003:741). This chapter intends to follow that distinction and discusses research design and methodology as separate sections.

7.2.1 Research design

In keeping with the principles of scientific research (Babbie & Mouton 2001; Hair et al. 2003; Leedy 1993; Mouton 2001; Mouton & Marais 1990; Smit 1995 and others), the plan considered appropriate for solving the research problem of the present study consists of the following accepted research design components:

- Formulation of the research problem
- Exploratory research
- Secondary data (literature review)
- Primary data (descriptive research)
- Mail survey

While each component can be viewed as a separate activity in scientific research, it is the first three components in particular which need to fit together if the research problem is to be accurately identified and clearly formulated. Martins et al. (1996:83) observe that problem definition provides direction and guidance to the remaining steps in the research process. These five components are discussed in the sections to follow.

7.2.1.1 Formulation of the research problem

The point of departure in research design is the research problem (Babbie & Mouton 2001:73; Leedy 1993:139; Mouton & Marais 1990:37,57; Mouton 2001:56). The translation of the problem into a specific need for inquiry is done by formulating clearly stated research questions and specific hypotheses that can be empirically tested (Zikmund 2003:94).

It was previously pointed out in Chapter 1 that empirical studies in the South African private hospital environment have largely ignored the relationships between service quality, customer satisfaction and their behavioural outcomes. Service firms today, and private hospitals are by no means excluded, need to know their customers much better than they did in the past because customers participate in the service offering more than was done previously. Rising costs have resulted in private healthcare becoming increasingly expensive for healthcare consumers and private hospitals have to contend with fierce competition in the healthcare environment. It was also reported that a growing body of evidence views *service* – the service offering, as the core solution in the business world today.

Against this background, the research problem was stated in section 1.2 of Chapter 1. Briefly, it is to identify the most important service quality and

customer satisfaction dimensions influencing patients' loyalty (or intentions to repurchase) towards a private hospital, or recommend it to others.

The importance of a clearly formulated research problem can therefore not be overestimated since it forms the basis of the logic of scientific inquiry (Babbie & Mouton 2001:72,78). Babbie and Mouton (2001:78) note that a well-formulated research problem contains two elements – a clear indication of the purpose of the research and a clear specification of the object of study (or unit of analysis). As indicated in the problem statement of Chapter 1, private hospital patients formed the unit of analysis in this study.

7.2.1.2 Exploratory research

Early on in the investigation, exploratory research was undertaken to develop what started out as a general research topic into a narrowly focused problem statement.

Zikmund (2000:57) points out that not all studies commence with clearly formulated research problems. In a case where the problem is not immediately clear, the research design should commence with exploratory research during the initial phase of the project. Exploratory research provides an opportunity to narrow the scope of the research topic (Zikmund 2000:57) and thus enable the researcher to formulate a clear definition of the problem under investigation, before making a final decision on the eventual research design. Hence, the use of exploratory research to gain a better understanding of satisfying hospital patients.

The opinions, perceptions and expectations of three different groups of stakeholders – hospital management, doctors and former patients were solicited during the exploratory study. Hospital management and doctors, particularly, were open and cooperative in sharing their insights during one-on-one interviews that lasted for approximately 1-1½ hours with each participant. The information gathered from these three sources helped to finalise the research problem and provide some preliminary questions to be included in the questionnaire design.

Exploratory research is not restricted to questioning small groups or small numbers of individuals. A review of secondary data is one of several other methods which can be used to conduct exploratory research (Holbert & Speece 1993:44,62).

Thus, the exploratory research also took the form of reading case studies in the anecdotal literature on strategies and programmes used by individual hospitals to ensure the delivery of good service. These hospitals were mostly in the USA. The researcher also contacted an established service firm in the USA that specialises in patient satisfaction surveys who then became instrumental in providing valuable information on the subject. Information couriered to the researcher took the form of books written by the firm's owners on patient satisfaction as well as a selection of its questionnaires. The firm also offered whatever other assistance it could with the present study.

7.2.1.3 Secondary data (literature review)

A study to investigate private hospital patients' perceptions of the quality of service experienced during a hospital stay and the levels of customer satisfaction achieved would not be possible unless secondary sources of data are also consulted. As mentioned above, some researchers (Holbert & Speece 1993:62; Martins et al. 1996:100) view secondary data as a form of exploratory research, but in general, it is a task that requires a comprehensive review of the literature relevant to the particular research problem at hand. Secondary data provides the researcher with a good grasp of the situation.

How the literature review was undertaken for this study was discussed extensively in Chapter 1.

7.2.1.4 Primary data (descriptive research)

There is a lack of empirical evidence in the South African environment at present to substantiate the relationships between service quality and customer satisfaction and their influence on future customer behaviour, with specific reference to private hospital patients. Additionally, it is not known

why scientific studies in this field – the private hospital environment, have not received attention in the past.

This study is an attempt to address the lack of scientific knowledge and understanding of patient satisfaction against the background presented in Chapter 1.

Primary data will be collected using descriptive research, suggested by Hair et al. (2003:57) and Babbie and Mouton (2001:205) as the most appropriate research design for learning more about a situation. Since a large sample is planned, this will take the form of quantitative research using the fifth and final component of the study's research design, namely a mail survey.

7.2.1.5 Mail survey

How the present study came to make use of a mail survey was explained in Chapter 1 and will be further discussed in this chapter under the research methodology section. It was necessary to obtain the data from patients *following* a hospital stay, thus respondents could complete the questionnaire after discharge from the hospital in their own time and return it by post.

In the case of the present study, a mail survey was a cost effective technique since it covered a large geographic area of the country, namely South Africa's four major cities. The design of the questionnaire enabled a large volume and variety of service quality and customer satisfaction data to be collected. The questions, or items, were structured to limit respondent subjectivity and maximise reliability.

Hair et al. (2003:57) strongly suggest that the research design chosen by the researcher should meet two objectives, namely:

- to provide relevant information on the research questions, and
- to do the job of carrying out the research project in an efficient manner.

In conclusion, a research design provides the basic directions for carrying

out scientific research (Hair et al. 2003:57). To be effective, scientific research is therefore a systematic procedure that requires a planned, objective and goal-oriented research methodology applied to a clearly defined research problem that can be measured and resolved.

Once the plan for the present study was established, it was then possible to implement the procedure by means of the research methodology.

7.2.2 Research methodology

As the name suggests, research methodology addresses the strategy and method to be used to obtain scientifically valid results (Smit 1995:23). The quality of the research findings is directly dependent on the research methodology followed (Mouton & Marais 1990:192). Leedy (1993:137) argues that *methodology* is merely the study of a particular method, or methods, for reaching a desired result.

A review of the literature reveals that no one best methodology exists or that one specific sequence should be followed to reach the desired result (Babbie & Mouton 2001:75,98,103; Balian 1994:56,76; Leedy 1993:145; Mouton 2001:56; Mouton & Marais 1990:192; Smit 1995:23-24; Zikmund 2000:62). Instead, research methodology is merely an operational framework within which a set of facts are placed so that their meaning may be seen more clearly (Leedy 1993:121).

In order to give a clear statement of the research methodology and its rationale used in the present study, this section will elaborate on the sample selected and the measuring instrument developed to test the hypotheses.

7.2.2.1 The sample and response rate

It was mentioned in Chapter 1 that one of the three hospital groups that currently constitute the major portion of South Africa's private hospital industry, namely Afrox Healthcare Limited (Bhoola 2002:55), allowed certain of its hospitals to participate in the study.

(a) Sample selection

From a total of sixty-one member hospitals in the Afrox group (Health Annals 2002:44), five were selected on a non-probability convenience basis to participate in the study.

Initially, Afrox Healthcare made ten of its hospitals available, but this number was reduced to five on account of budgetary constraints in getting to all ten hospitals, as they are located across the country. Additionally, ten hospitals were deemed unnecessary for a study of this nature. Table 7.1 lists the five participating hospitals and the major centres in the country where each one is situated.

Table 7.1: Afrox Healthcare participating hospitals

Participating Hospital Group: Afrox Healthcare Limited	
Hospital	**Centre**
St George's	Port Elizabeth
Flora Clinic	Johannesburg
Glynnwood	Johannesburg
Entabeni	Durban
Kingsbury	Cape Town

Afrox nominated the hospital manager from each hospital as the contact person with whom to make all the physical arrangements for the survey.

Furthermore, Afrox also assured the full cooperation of designated senior staff from each participating hospital to handle distribution of the questionnaires in the relevant wards and to deal with any queries about the survey itself. One contact person per hospital was nominated for follow-up purposes.

The survey was conducted over a seven-month period to allow time for the researcher to visit each hospital and explain the distribution procedure to designated staff members who would be responsible for distributing questionnaires to qualifying patients. School holidays had to be considered as well, since it was pointed out by some of the participating hospitals that

wards are not normally full during these periods because many of the doctors go on holiday during this time. Empty wards would have reduced the number of potential respondents for the survey. Each hospital visit entailed a presentation to designated staff explaining how the questionnaires were to be distributed in the wards.

The use of the hospitals' database of patient admissions as a mailing list was prohibited on account of the confidentiality clause that exists between each hospital and its patients.

During the distribution period, which lasted for approximately 2-3 weeks per hospital, weekly telephone calls were made by the researcher to each contact person to monitor progress and ensure that the questionnaire distribution was going according to plan. Apart from slow progress at times, no major problems were experienced in this regard.

To qualify to participate in the study, respondents had to meet the following minimum criteria:

- Be adult (private hospital) patients over the age of 20 years;
- Be admitted to undergo an operation (anaesthetic included);
- Have had at least one overnight stay in a hospital ward.

In addition to the convenience sampling of the five participating hospitals and given the above restrictions on access to patient databases for mailing purposes, questionnaires were distributed to patients by designated hospital staff on a random basis inside selected wards at these hospitals. These staff members understood and adhered to the qualifying criteria for participation.

(b) Realised sample

To ensure an adequate realised sample to permit the use of multivariate statistics to analyse the data, a total of 3 800 questionnaires were distributed to private patients at the five participating hospitals listed in Table 7.1. From this distribution, 425 questionnaires were returned (response rate 11.2%).

After eliminating the incorrectly completed questionnaires (n=102) from this figure, the remaining 323 questionnaires (response rate 8.5%) could then be statistically analysed. Anonymity of respondents meant that no telephonic follow-up to obtain missing data could be done. Thus, the final sample yielded (n=323), although lower than anticipated, was considered to be an adequate response rate for a survey of this nature. The response rate per hospital is shown in Table 7.2.

Table 7.2: Realised sample showing responses per hospital

Participating Hospital Group: Afrox Healthcare Limited		**Realised Sample**	
Hospital	**Centre**	**n**	**%**
St George's	Port Elizabeth	180	55.7
Flora Clinic	Johannesburg	27	8.4
Glynnwood	Johannesburg	56	17.3
Entabeni	Durban	28	8.7
Kingsbury	Cape Town	32	9.9
TOTAL		**323**	**100.0**

It is a well-known fact that mail surveys typically yield low response rates and a return of between 5% to 15% is not uncommon (Babbie & Mouton 2001:262; McBurney 2001:245; Wegner 2000:75; Zikmund 2003:215). Although a low response rate could lead to response bias, Babbie and Mouton (2001:261) argue that overall response rate is merely a guide to the representativeness of the sample respondents.

Several mitigating arguments are to be found in the literature in support of accepting, for statistical analysis and interpretation, a sample size that might have arisen as a result of a low response rate. For instance, Hair, Anderson, Tatham and Black (1995:373) advise that the multivariate statistical method, factor analysis, can be used for at least five and preferably ten respondents for every variable or item (10:1 ratio) to be factor analysed. However, the authors add that a sample should contain no fewer than 50 respondents for factor analysis, although the preferred

sample size should be 100 or larger.

Babbie and Mouton (2001:261) hold the view that since response rates for mail surveys vary considerably, a general rule of thumb is that response rates should serve only as rough guides since they have no statistical basis. Furthermore, a demonstrated lack of response bias is far more important than a high response rate.

The demographic characteristics of the realised sample are summarised in Table 7.3. In spite of the 8.5% response rate, the realised sample of n=323 is probably considered to be representative of the population on the grounds that the hospital managers from the participating hospitals judged the sample to be fairly representative, the above argument about response rates notwithstanding.

Table 7.3: Demographic characteristics of the realised sample

Variable	Respondents	
	n	**%**
Gender		
Male	115	35.6
Female	208	64.4
Total	**323**	**100**
Age		
20-29	38	11.8
30-39	59	18.3
40-49	70	21.7
50-59	55	17.0
60-69	66	20.4
70+	35	10.8
Total	**323**	**100**
Language		
English	186	57.6
Afrikaans	129	39.9
Xhosa	4	1.2
Zulu	4	1.2
Other	0	0
Total	**323**	**100**

Variable	Respondents	
	n	%
Household Size		
1 Person	33	10.2
2 Persons	129	39.9
3 Persons	56	17.3
4 Persons	59	18.3
5 Persons	25	7.7
6+ Persons	21	6.5
Total	**323**	**100**
Household Income (Before Tax)		
R0-R2 999	40	12.4
R3 000-R5 999	93	28.8
R6 000-R8 999	79	24.5
R9 000-R11 999	35	10.8
R12 000-R14 999	33	10.2
R15 000+	43	13.3
Total	**323**	**100**
Medical Cover		
Medical Aid	240	74.3
Hospital Plan	17	5.3
Medical Aid + 'gap cover'	25	7.7
No medical cover at all	13	4.0
Other	28	8.7
Total	**323**	**100**

Given the above argument that small samples resulting from low response rates, especially for mail surveys, are not necessarily unacceptable, the final number of respondents (n=323) was deemed large enough for statistical analysis and interpretation in this study.

7.2.2.2 The measuring instrument

Having considered survey research to be the most appropriate form of research design for the present study, it followed that the measuring instrument would be the questionnaire. As Hair et al. (2003:130) correctly point out, a questionnaire is a scientifically developed instrument for measurement of key characteristics of individuals, business enterprises, phenomena or events, and consists of a set of predetermined questions

designed to capture data from respondents in a sample. Logic therefore demands that good survey research requires good questionnaire design and construction to ensure accuracy in the data. Thus, the questionnaire is an accepted measuring instrument used in the field of human sciences for collecting data (Mouton 2001:100), and from the literature search, should be designed to achieve at least four broad goals (Babbie & Mouton 2001:233; Hair et al. 2003:169,184,189,202; Loubser 1996:216; Tull & Hawkins 1993:331; Zikmund 2003:329-330), namely:

- Maximise the relevance, reliability (consistency) and validity (accuracy) of the data collected;
- Optimise the participation and cooperation of the target respondents;
- Facilitate the collection, statistical analysis and interpretation of the data;
- Maximise the response rate and minimise any measurement errors.

This section discusses the development of the present instrument and the operationalisation of the variables to be measured.

(a) Instrument development

The measuring instrument consisted of a structured questionnaire divided into three main sections to be self-administered by respondents either at the point of discharge from the hospital or on arrival back home. Because of the nature of the treatment involved, which could have been anything from a minor to a major procedure, the researcher had to bear in mind how the respondent (now former patient) might have been feeling from a health/wellness point of view at the time of completing the questionnaire.

(i) Questionnaire administration

The questionnaire comprised of items based on previous research studies as well as self-generated questions by the researcher. Sections A and B measured service quality and customer satisfaction respectively, while Section C measured biographical data. The items developed to measure the dimensions of service quality and customer satisfaction were randomly

sequenced under their respective sections.

Service quality and customer satisfaction perceptions of the hospital visit were both measured using a 7-point Likert-type scale ranging from strongly agree (7) to strongly disagree (1), as was the loyalty surrogate, willingness to reuse or recommend the hospital. The semantic differential scaled items to measure 'overall' cumulative satisfaction used 7-point bipolar 'satisfaction' adjectives to describe patients' hospital experiences. In total, the measuring instrument contained 117 items.

The self-administered questionnaire was accompanied by an English/ Afrikaans covering letter introducing the survey (incentive-to-respond details were also included) and a reply-paid envelope placed in an outgoing envelope for protection and distribution purposes. An official letterhead of the Centre for Applied Business Management was used for the covering letter. The questionnaire was printed as an A5 booklet. An Afrikaans version of the questionnaire was available on request. See Annexure A, B and C for a copy of the covering letter and the English and Afrikaans questionnaires. Questionnaires could either be completed in the ward if patients felt up to it and returned before they left the hospital, or otherwise mailed to the addressee once they had returned home. The reply-paid envelope could be used for both options.

Section C of the measuring instrument contained six items to measure the respondents' biographical data. Table 7.3, discussed earlier, contains the results of this section. One additional variable to measure duration of the hospital stay was also included for control purposes.

(ii) The pilot study

Prior to administering the questionnaire, a small pilot study was conducted on a group of individuals who had recently been patients in private hospitals and had all undergone surgery. The purpose was to pre-test the questionnaire on a small sample of similar respondents to ensure that it was clearly understood and could be completed in under 15 minutes. Also, to ensure that there were no problems with the design of the questionnaire.

No major difficulties were encountered and after a few minor adjustments, the questionnaire was ready to be administered.

Leedy (1993:188) refers to this process as the pre-test or pilot study. It provides an opportunity for the questionnaire to be tested first on a small sample of respondents with characteristics similar to the target population (Hair et al. 2003:201; Loubser 1996:232; Zikmund 2003:359). Babbie and Mouton (2001:244) view a group of friends as pre-test subjects also acceptable, but advise that respondents from different cultural backgrounds should be used if the sample is to be drawn from more than one language group.

(b) Operationalisation of the variables

Definitions of the key concepts to be used in the study were provided in Chapter 1 (refer to section 1.9). The service quality, customer satisfaction, 'overall' cumulative satisfaction and loyalty constructs relative to a hospital environment in the case of the present study, were also substantiated.

Babbie and Mouton (2001:113) and Zikmund (2003:294) stress that it is important in survey research, which is a predominantly rigorously structured process, to identify and address the *concepts* relevant to the problem at the beginning of the study. Thereafter, a concept must be *operationalised* in order to be measured (Zikmund 2003:294). In this way, an operational definition gives meaning to a concept by specifying the procedures or operations necessary to measure it (Diamantopoulos & Schlegemilch 2000:22; Zikmund 2003:294).

In survey research especially, Babbie and Mouton (2001:113) argue that operationalisation results in a commitment to a specific set of questionnaire items that are intended to represent the concepts under study. Furthermore, operationalisation can be discussed as part of research design and methodology, that is, prior to data collection, as well as in the presentation of empirical results when the data are analysed (Babbie & Mouton 2001:128). This recommendation has been followed in the present study.

For the purpose of this study then, the two sets of independent variables, namely service quality and customer satisfaction, and the two dependent variables, namely 'overall' cumulative customer satisfaction and loyalty, of the proposed theoretical model, are operationalised below. Operationalisation is further addressed in the presentation of the empirical results in Chapter 8.

(i) Service quality

In the present study, service quality is operationalised as the customer's judgement of the overall excellence or superiority of the service, in this case a hospital visit. Moreover, service quality is viewed as distinct from customer satisfaction since it is a global judgement which the consumer has formed over a period of time. However, it is accepted that service quality is related to customer satisfaction as the outcome of incidents of satisfaction over time give rise to service quality perceptions. Consumer perceptions of service quality refer to a comparison of customer expectations of a particular service provider, such as a private hospital, with customer perceptions of its actual performance. Customers use the same general criteria to arrive at an evaluative judgement about service quality, regardless of the type of service.

Service quality in a hospital environment is therefore based on the initial operationalisation proposed by Parasuraman et al. (1985, 1988) in their groundbreaking research on service quality and the Gaps Model /SERVQUAL approach. A multi-item scale was used to measure consumer perceptions of service quality based on the 'expectancy disconfirmation' paradigm. The scale measures service quality perceptions (as opposed to so-called 'objective' quality) by comparing customer expectations with service performance (Parasuraman et al. 1985, 1988).

Section A of the measuring instrument contained 54 items (statements) to measure service quality. More specifically, the ten dimensions of service quality related to the patient's hospital visit and were measured using an average of 5 items (statements) per dimension.

For the purpose of this study, the original ten dimensions of service quality operationalised by Parasuraman et al. (1985), were used as the first set of

independent variables instead of the subsequent reduction to five dimensions (Parasuraman et al. 1988), on account of service quality being a strong predictor of customer satisfaction (Green & Boshoff 2002:4). Each item was phrased to be applicable to a hospital setting.

The number of items used to measure each of the ten dimensions of service quality is indicated in Table 7.4. The table also shows the later reduction to five dimensions of service quality. At this point, the labelling of two dimensions in the present study requires clarification. Assurance was the label used to measure the dimension competence and empathy was used to measure the dimension access, not for any specific reason, but merely because assurance and empathy were considered more suitable 'labels' for a hospital setting. Parasuraman et al. (1988:28) permit appropriate adaptation of SERVQUAL in the case of a single service investigation.

Table 7.4: Questionnaire items used to measure service quality

Item Code	Service Quality Dimensions				Items per Dimension
TANP1-TANP6	Tangibles*	-physical facilities	6		
TANS1-TANS3		-staff	3		10
TANE1		-equipment	1		
RELI1-RELI6	Reliability*				6
RESP1-RESP6	Responsiveness*				6
COMM1-COMM7	Communication				7
CRED1-CRED4	Credibility				4
SECU1-SECU4	Security			Assurance*	4
ASSU1-ASSU5	Competence				5
COUR1-COUR3	Courtesy				3
UNDE1-UNDE6	Understanding/knowing customers			Empathy*	6
EMPA1-EMPA3	Access				3
TOTAL					**54**

*Denotes the five subsequent service quality dimensions.

The measuring instruments that were used in previous scientific research studies to measure service quality in a hospital setting were scrutinised for

suitability in the present study and augmented with questions formulated by the researcher. Previous studies included Bowers et al. (1994), Carman (2000), Mangold and Babakus (1991), Mowen and Licata (1993), Nelson (1990), Nelson and Rust (1992), Reidenbach and Sandifer-Smallwood (1990) and Taylor and Baker (1994).

(ii) Customer satisfaction

Two aspects of customer satisfaction are to be measured in the present study. Firstly, transaction-specific customer satisfaction, that is, the outcome resulting from a particular consumption experience, such as a hospital visit. Secondly, the multiple experiences which a customer has over time with the same service provider are likely to lead to an overall level of satisfaction, for instance, return visits to the same hospital.

The school of thought deemed appropriate for a study on patient satisfaction in the service environment is the process-oriented approach of satisfaction (Hunt 1977:455). The reason for this approach is because consumption is considered to be an experience and consists of collective perceptual, evaluative and psychological processes that combine to generate consumer satisfaction. Additionally, the nature of services, for example, intangibility and the peculiarities of marketing services, for example, inseparability, makes it necessary to distinguish between 'overall' or cumulative satisfaction and satisfaction with a specific service encounter, that is, transaction-specific satisfaction.

Resulting from a consumption experience, customer satisfaction is therefore operationalised, for the present study, as transaction- or encounter-specific and is a post-choice evaluative judgement of a specific purchase occasion, which could include a hospital visit. Customer satisfaction at the dimensional level was used as the second set of independent variables.

Section B of the measuring instrument contained 53 items (statements) in total to measure customer satisfaction with the hospital visit, that is, transaction-specific customer satisfaction. Of these, five items were

regarded as surrogate measures of loyalty, the second dependent variable, while the other 48 items measured customer satisfaction. An average of 5 items (statements) per dimension was used to measure customer satisfaction.

Customer satisfaction dimensions were based on a thorough literature review of patient satisfaction research and the exploratory research that was undertaken during the research design phase. The personal experiences of certain individuals known to the researcher who themselves were former, but recent private hospital patients, turned out to be something of a catalyst as their experiences precipitated a study of this nature in a private hospital environment, and some of their experiences as private patients were included in the questionnaire design.

Altogether, seven dimensions were used in the measuring instrument to measure customer satisfaction. Table 7.5 shows the number of items used to measure each customer satisfaction dimension, while the loyalty surrogate is addressed in the next section.

Table 7.5: Questionnaire items used to measure customer satisfaction

Item Code	Customer Satisfaction Dimensions	Items per Dimension
ADMI1-ADMI4	Admission	4
WARD1-WARD16	Ward Arrival	16
CHAR1-CHAR4	Charges/Fees	4
THEA1-THEA7	Theatre	7
MEAL1-MEAL11	Meals	11
HOUS1-HOUS4	Housekeeping	4
VISI1-VISI2	Visitors	2
TOTAL		**48**

The measuring instruments that were used in previous scientific research studies to measure patient satisfaction in a hospital setting were scrutinised for suitability in the present study and augmented with questions formulated by the researcher to ensure that at least five items represented each

dimension to measure customer satisfaction in this measuring instrument.

Previous studies consulted included Bowers et al. (1994), Fisk et al. (1990), John (1991,1992), Jun et al. (1998), Reidenbach and Sandifer-Smallwood (1990), Strasser and Schweikhart (1995), Taylor and Cronin (1994), Woodside et al. (1989) and Zimmerman et al. (1996).

(c) Operationalisation of the dependent variables

The two dependent variables used in the present study are discussed below.

(i) Overall cumulative customer satisfaction

The distinction between customer satisfaction as an encounter- or transaction specific evaluative judgement and 'overall' cumulative customer satisfaction resulting from multiple service encounters was addressed in Chapter 6. In the case of 'overall' cumulative satisfaction, Bitner and Hubbert (1994:74) view overall satisfaction as likely to be multidimensional and based on all encounters and experiences with that particular service firm, gained over a period of time. These multiple encounters may include a series of interrelated events (White 2003:33), as well as many occurrences of the same experience (Oliver 1997:15).

In this study, overall cumulative satisfaction is operationalised as a patient's overall evaluation based on many transient experiences (the total purchase and consumption experience) with the private hospital. As such, overall cumulative satisfaction is also considered to be an ongoing evaluation of the private hospital's ability to deliver the benefits a patient would be seeking. Given the fact that a patient will experience multiple encounters with different role-players during a hospital visit, or several visits if the patient's state of health requires, the viewpoint that satisfaction is also a cumulative process (Anderson et al. 1994:54, Bitner & Hubbert 1994:77), is adopted in the present study.

Three semantic differential-scaled items were used to measure 'overall' or cumulative satisfaction, a global assessment, as opposed to a dimensional

assessment as follows:

SEM1	Overall, how satisfied were you with your stay at _____? (satisfied ↔ dissatisfied)
SEM2	How would you rate the overall standard of service at _____? (excellent ↔ poor)
SEM3	Did you comment on any aspect of your hospital stay to any hospital staff member? (praised ↔ complained)

Using 'overall' or cumulative satisfaction as a dependent variable has been shown in previous research to be a better predictor of loyalty (Olsen & Johnson 2003:194). It will therefore be used as a dependent variable in the present study.

(ii) Loyalty

The notion of customer loyalty in a private hospital setting posed something of a dilemma since an individual would not normally have a need for hospital services in the same manner as, say banking services in the retail sector. The buying decision is generally different. This is because it is often the patient's doctor who makes the decision, that is, the actual choice, or strongly influences the choice of hospital. To overcome this problem, future behavioural intentions of patients, that is, buying intentions, were used as a surrogate measure for loyalty.

Buying intentions have been successfully used as a surrogate measure for loyalty in a service environment in previous research (Shaw-Ching et al. 2001). For the purpose of the present study, willingness to reuse the hospital or recommend it to others will refer to buying intentions. Five items were used to measure the 'loyalty' surrogate, namely willingness to reuse the hospital or recommend it to others and was the second dependent variable in the study. The items were as follows:

WILL1	I would not mind returning to ___ again in the future
RECO1	I would recommend this hospital to family and friends

WILL3	In an emergency, this is the hospital I would like to be admitted to
WILL4	I regard myself as a 'loyal' customer of ___
WILL2	I would definitely return to this hospital in the future if necessary

7.3 MEASUREMENT OF EVALUATION CRITERIA

In order to evaluate the relative success or failure of the results of scientific research, two statistical techniques – the tests of reliability and validity – must always be addressed (Babbie & Mouton 2001:119; Hair et al. 2003:169). The aim of these two procedures is to reduce measurement error, that is, when the values obtained in a survey (observed values) are not the same as the true value (Hair et al. 2003:170).

To conclude this chapter, a discussion of the statistical techniques used to evaluate the reliability and validity of the results of the present study, follows.

7.3.1 Reliability

A measuring instrument (the survey questionnaire) is considered reliable if its repeated application yields consistent scores (Babbie & Mouton 2001:119; Hair et al. 2003:170), notwithstanding the degree to which the measures are free from error (Peter 1979:6).

A number of techniques for measuring reliability have been developed (Babbie & Mouton 2001:121). In the case of the present study, it was necessary to determine the internal consistency (Hair et al. 2003:172) of the multiple-item measures of the measuring instrument (Zikmund 2003:301).

Internal consistency was calculated by using Cronbach's alpha, also referred to as the coefficient alpha, a technique which calculates the mean of all possible combinations of split-half coefficients resulting from different

splittings of the measurement instrument (Hair et al. 2003:172; Tull & Hawkins 1993:316). The computer programme SAS (SAS Institute 1990) was used to achieve this. Table 7.4 illustrates the general rules of thumb for interpreting alpha values.

Table 7.6: Interpreting Cronbach's alpha coefficient size

Alpha Coefficient Range	Strength of Association
<.6	Poor
.6-<.7	Moderate
.7-<.8	Good
.8-<.9	Very good
.9	Excellent

Source: Adapted from Hair et al. 2003:172.

It can be implied from the table that a high coefficient, for example .8-.9, indicates that the measure is highly reliable (a strong association), whereas a low coefficient of <.6 would indicate poor reliability (a weak association).

According to Nunnally (1978:245-246) and Peterson (1994:381,382,385), Cronbach alpha coefficients above 0.7 are generally considered to be acceptable as a yardstick, while those of 0.6 and below are deemed questionable. However, Peterson (1994:381) cautions that because of a lack of guidance in the literature on established "acceptable" or "sufficient" reliability for research purposes, the recommendations of various researchers, comprising decades of research, provide a viable alternative.

Thus, reliability is concerned with the consistency of the research findings (Hair et al. 2003:170,172) and scientific research requires acceptable reliability. The same group of authors offer the following guidelines to ensure acceptable reliability:

- The minimum number of items in a scale to measure a particular concept should be at least three;
- The items must be positively correlated;
- Items that are correlated with other items on a scale at a level lower

than .3 should be removed from the scale.

7.3.2 Validity

Scientific research is also concerned with accurate measurement (Zikmund 2003:302). The extent to which a construct (or measuring instrument) measures what it is supposed to measure, is referred to as validity, that is the purpose of measurement (Hair et al. 2003:174; Zikmund 2003:301,302). Several approaches to assess validity are available (Babbie & Mouton 2001:122-123; Hair et al. 2003:174-176; Zikmund 2003:302-304). These approaches include content validity, construct validity and criterion validity.

For the purpose of the present study, it was necessary to assess the construct validity of the measuring instrument used. More specifically, to substantiate whether the measuring instrument to measure service quality and customer satisfaction actually measured what it was supposed to measure. Hair et al. (2003:174) offer two checks to assess construct validity. These checks are convergent validity and discriminant validity.

According to Hair et al. (2003:174) and Zikmund (2003:303), the test for construct validity is used to determine the degree to which a measure confirms a network of related hypotheses generated from the theoretical rationale underlying the measurements obtained from the research. In other words, that the empirical evidence must be consistent with the theoretical concepts reviewed. A measuring instrument is considered to demonstrate construct validity if the scale exhibits both convergent and discriminant validity (Parasuraman 1991:442).

In the case of convergent validity, on the one hand, it is the extent to which the construct(s) is positively correlated with different measures of similar constructs. On the other hand, discriminant validity refers to the extent to which the construct has a low or no correlation with measures of dissimilar constructs (Hair et al. 2003:174; Zikmund 2003:304).

As mentioned in section 7.3 and also Chapter 1, the development of the

measuring instrument was based on associations between the constructs of service quality, customer satisfaction and behavioural intentions reviewed in the literature, as well as the exploratory research conducted by the researcher. For this reason, the discriminant validity of the measuring instrument was assessed. The measuring instrument needed to reflect sufficient discrimination between the service quality and customer satisfaction constructs.

Discriminant validity of the measuring instrument to measure both service quality and customer satisfaction was assessed by conducting an exploratory factor analysis. An exploratory factor analysis is a multivariate statistical technique that summarises the information contained in a large number of variables into a smaller number of variables or factors based on the linear combination of the original variables (Hair et al. 1995:365; Hair et al. 2003:358; Zikmund 2003:586).

Factor analysis is used to define a set of common underlying dimensions known as factors (Hair et al. (1995:367). This allows the researcher to first identify the separate dimensions of the structure of the interrelationships and then determine the extent to which each variable is explained by each dimension (Hair et al. 1995:367).

Secondly, scores for each underlying dimension can be calculated and substituted for the original variables (Hair et al. 1995:367). The main goal of factor analysis therefore is twofold: summarisation and data reduction (Hair et al. 1995:367; Tull & Hawkins 1993:693; Zikmund 2003:587).

According to Hair et al. (1995:373), the general rule for sample size in factor analysis is to have a minimum sample of at least five times as many questionnaire items as those to be analysed, while the more acceptable range would be a ten-to-one ratio. For example, if twenty questionnaire items are to be factor analysed, the minimum suggested sample is one hundred.

To perform the exploratory factor analysis in this study, the computer programme BMDP4M (Frane, Jennrich & Sampson 1990:311-337) was

used to extract the factors and identify the common underlying dimensions. The maximum likelihood estimation method and a direct quartimin oblique rotation of the original factor matrix was also specified (Jennrich & Sampson 1966:313-323). The results of the exploratory factor analysis are presented in Chapter 8.

7.4 REGRESSION ANALYSIS

Arguably the most widely used multivariate statistical technique in scientific research, multiple linear regression analysis (or regression analysis for short), can be used to measure the strength of possible relationships between a set of two or more variables (Hair et al. 2003:290; Wegner 1996:353, 2000:602). Specifically, regression analysis is used to predict the relationship between a single dependent (response/criterion) variable and several independent (predictor) variables simultaneously (Hair et al. 1995:85; Hair et al. 2003:291; Zikmund 2003:576).

These two variables differ from one another, however. The dependent variable (typically represented by the symbol *y*) is assumed to be influenced or determined by the independent variable, hence its alternative name, response variable. The independent variable (typically represented by the symbol *x*) is assumed to influence the outcome of the dependent variable (Wegner 2000:604).

Additionally, values for independent variables are usually known or easily determined, however, for the dependent variable, values are not readily known but can be estimated using values of the independent variable. According to Hair et al. (1995:85-86), the objective of regression analysis therefore is to use the independent variables whose values are known to predict the single dependent value selected by the researcher.

Wegner (1996:353-354) offers the researcher several additional insights provided by regression analysis into the identified relationship(s):

- It identifies the relative importance of the independent variables in

predicting the dependent variable;

- It determines the overall strength of the relationship (from multiple correlation measures) and overall usefulness of the regression model for estimation purposes;
- It establishes whether a linear structure is the most appropriate relationship between the independent variables and dependent variable; and
- It can highlight the omission of potentially useful independent measures.

Two basic conditions for the application of multiple regression analysis must first exist (Hair et al. 1995:86):

(i) The data must be metric or else appropriately transformed using dummy-variable coding or logistic regression.

(ii) The researcher is first required to decide which variable is to be dependent and which remaining variables are to be independent, before deriving the regression equation.

Having met the requirements for regression analysis, the researcher can then decide whether to proceed with the implementation of the steps for multiple regression analysis. Hair et al. (1995:97-129) present a comprehensive framework for discussing the factors that impact the creation, estimation, interpretation and validation of a regression analysis by means of a six-stage model building process. A detailed explanation of these six steps falls outside the scope of this study.

7.5 SUMMARY AND CONCLUSIONS

This chapter has provided a distinction between research design and research methodology and substantiated reasons why some researchers view these procedures as different. The approach adopted in this chapter followed this distinction and was applied to the present study.

The research design deemed appropriate for gathering the data was presented and an exposition of the research methodology followed in this study was also provided. The procedure which yielded the realised sample emanating from five participating private hospitals was explained together with the demographic data of the respondents collected in this study. The composition of the measuring instrument to gather the data in accordance with the research objectives was made clear. A description of the statistical techniques to be applied to ensure the reliability and validity of the research results was presented in conclusion. The results of these techniques and empirical results of the measuring instrument are presented in Chapter 8.

CHAPTER 8

EMPIRICAL RESULTS

"Special thanks to the staff of Highcare for their professional nursing"

Respondent in present study, a former patient commenting on the nursing in general

8.1 INTRODUCTION

In the previous chapter the research design and methodology undertaken to collect the data according to the principles of scientific research were discussed. Construction of the measuring instrument to measure the perceptions of service quality and customer satisfaction of private hospital patients were also dealt with in that chapter. The empirical data collected during this study were subjected to statistical analysis. Firstly, it was necessary to assess the reliability and validity of the measuring instrument and secondly, to assess the empirical results of the four hypothesised relationships (refer to section 1.5 in Chapter 1) in order to convert data to knowledge. Leedy (1993:12) cautions that if there is no discovery of the meaning of the data, there is no research. Consequently, no new knowledge or insights can be gained from the research.

The purpose of this chapter is to present the results of the different phases of data analysis and to assess the hypothesised relationships. However, before the data analysis can commence, the completed questionnaires need to undergo a process of data preparation. The two procedures generally undertaken to process and prepare data are coding and editing, followed by the actual data entry and capturing. The chapter commences with a short discussion of the treatment of the returned questionnaires in the present study and then continues with the data analysis results.

The data analysis section commences with a discussion of the results of the discriminant validity of the measuring instrument, namely the exploratory factor analysis, undertaken in phase one. This is followed by

phase two of the analysis, namely assessing the internal reliability of the measuring instrument by calculating the Cronbach alpha coefficients. The operationalisation of those factors identified by means of the exploratory factor analysis is then presented. The results of phase three, namely regression analysis, conclude the chapter.

8.2 DATA PREPARATION

Data preparation consists of three main tasks, namely editing, coding and data capturing (Hair et al. 2003:227; Martins 1996:295). These measures are necessary because the quality of the analytical results is dependent on the correctness of the raw data (Martins 1995:295).

In the case of the present study, the editing process required that every returned questionnaire was thoroughly scrutinised for completeness and adherence to sample requirements and assigned a number on the front cover according to the hospital in which the respondent was a patient, for example, SG20 for St George's Hospital and questionnaire number 20. Questionnaires with missing information as well as those with inaccuracies such as responding, "strongly agree" throughout, were discarded. Those questionnaires received after the cut-off date, were also discarded.

The coding process was undertaken after the data had been collected, which is referred to as post-coding using a coding frame (Martins 1996:301).

An MS-Excel spreadsheet was created as the initial storage file to capture the data from each of the three sections of the questionnaire.

On completion of the editing, coding and data capturing procedures, the data were then ready to be analysed. The data analysis is presented in the sections that follow.

8.3 DISCRIMINANT VALIDITY OF THE MEASURING INSTRUMENT

The data were analysed in three phases commencing with an assessment of the discriminant validity of the measuring instrument by means of an

exploratory factor analysis. The computer programme BMDP4M was used to conduct the exploratory factor analysis (Frane, Jennrich & Sampson 1990).

The method of factor extraction specified was maximum likelihood and the rotational procedure, direct quartimin oblique rotation of the original factor matrix, was used (Jennrich & Sampson 1966).

As is the researcher's prerogative (Hair et al. 1995:386), several different exploratory factor analysis solutions were considered until the most interpretable factor solution emerged. The entire matrix of responses to the service quality and customer satisfaction statements was subjected to factor analysis, but the results were depicted under the two constructs separately.

In the case of service quality, 54 items were factor analysed for the ten dimensions measured and for customer satisfaction, 48 items were factor analysed for the seven dimensions measured.

The problem with the first factor analysis (although the maximum likelihood estimation had failed because the matrix of approximate second derivatives was not positive definite) occurred because the data were not adequately normally distributed.

The service quality construct was analysed first, although the number of factors to be extracted was not specified. The eigenvalues (eigenvalues larger than 1) and the scree plot suggested that possibly eight different underlying factors were present for measuring service quality in a healthcare environment.

A second factor analysis was then run where the principal factor analysis (PFA) was specified, a technique which is not based on the assumption that the data were normally distributed.

The most interpretable factor structure to emerge from the analysis is depicted in Table 8.1 and Table 8.2. In the case of service quality, shown in Table 8.1, the results of the factor analysis revealed that neither the

original ten dimensions, nor the subsequent five dimensions of service quality proposed by Parasuraman et al. (1985:44,46,47; 1988:20,23) could be replicated. A number of questionnaire items did not demonstrate sufficient discriminant validity by either cross-loading or not loading, and were thus deleted.

Table 8.1 therefore shows that the service quality dimensions utilised from the original ten dimensions proposed by Parasuraman et al. (1985:46,47) loaded on seven distinct factors, namely Communication (measured by three items), Tangibles (measured by six items), Empathy of nursing staff (measured by seven items), Assurance (measured by four items), Responsiveness of administrative staff (measured by four items), Security (measured by two items) and Physicians responsiveness (measured by two items). As indicated in Table 8.1, a total of 54 items were grouped into seven factors and explain a total of 72% of the variance in the data space.

In Table 8.2 the seven factors for customer satisfaction loaded as follows: Satisfaction with meals (measured by six items), Satisfaction with fees charged (measured by four items), Satisfaction with the nursing staff (measured by four items), Satisfaction with the admission process (measured by three items), Satisfaction with the theatre experience (measured by four items), Satisfaction with the television service in wards (measured by two items) and Satisfaction with the ward arrival (measured by two items). As indicated in Table 8.2, a total of 48 items were grouped into seven factors and explain a total of 67% of the variance in the data space.

Table 8.1: A sorted factor matrix for service quality

Item Code	Service Quality Items	Factor 1 Commu-nication	Factor 2 Tangibles	Factor 3 Empathy of Nursing Staff	Factor 4 Assurance	Factor 5 Responsive-ness of Ad-ministrative Staff	Factor 6 Security	Factor 7 Physician Respon-siveness
COMM2	Patients assured of receiving adequate information about their condition	0.945						
COMM3	Patients assured of receiving adequate information about their treatment	0.890						
COMM1	Procedures thoroughly explained to patients by hospital staff	0.745						
COMM4	Discharge care thoroughly explained	0.546						
TANP4	Spotlessly clean wards at ___		0.866					
TANP3	___ is a clean hospital		0.801					
TANP2	___ maintains a neat appearance of buildings		0.602					
TANP5	Tastefully decorated wards		0.552					
TANS2	Nursing staff look professional and neat in their uniforms		0.522					
RELI6	Service at ___ is excellent overall		0.444					
RESP1	Nurses never too busy to respond to patients' needs			0.699				
UNDE5	Nurses show understanding toward patients feelings of discomfort			0.644				
UNDE4	Patients do not feel neglected by nursing staff			0.610				
UNDE2	Patients are given plenty of individual attention			0.607				
ASSU5	Nursing staff efficient at dealing with patients' problems			0.421				
UNDE3	Nurses show understanding when patients feel low			0.490				
UNDE1	Nurses treat patients with a warm and caring attitude			0.493				
CRED4	___ cares about its patients				0.815			
SECU2	Patients feel safe at ___ hospital				0.796			
CRED3	___ has an excellent reputation				0.701			
CRED2	Patients can feel confident in treatment to be received				0.630			
ASSU4	Administrative staff efficient at dealing with patients' queries/problems					0.827		
RESP5	Admission handled quickly and efficiently by administrative staff					0.696		
COMM7	Administrative staff sincerely interested in solving patients' problems					0.637		
RESP4	Administrative staff never too busy to respond to patients' requests					0.630		
SECU3	Adequate security provided inside hospital						0.788	
SECU4	Adequate security provided outside hospital						0.754	
RESP2	Doctors are punctual when conducting ward rounds							0.723
RELI4	Doctors can be counted on to attend to their patients needs							0.540
	7 Factors together explain 72% of the variance in the data space							
	Eigenvalues:	15.45	1.74	1.47	1.33	1.07	0.90	0.89
	Cronbach's alpha:	0.92	0.88	0.95	0.95	0.87	0.82	0.77
	Rotation method: Direct quartimin oblique rotation							

Table 8.2: A sorted factor matrix for customer satisfaction

Item Code	Customer Satisfaction Items	Factor 1 Meals	Factor 2 Fees Charged	Factor 3 Nursing Staff	Factor 4 Admission Process	Factor 5 Theatre Experience	Factor 6 Television Service in Wards	Factor 7 Ward Arrival
MEAL3	Meals were tasty	0.987						
MEAL4	Meals were nutritious	0.903						
MEAL5	Meals were attractively presented	0.899						
MEAL1	Overall, patient enjoyed the food while at ___	0.876						
MEAL2	Meals always served at correct temperature	0.715						
MEAL6	Meals were served in a variety of ways	0.640						
CHAR2	Fees at ___ are reasonable		0.880					
CHAR1	Considering fees charged, stay worth the money		0.779					
CHAR4	A stay at ___ is good value for money		0.773					
CHAR3	___'s fees are not expensive		0.618					
WARD7	Nursing staff were always cheerful			0.888				
WARD6	Nursing staff responded promptly to patient's needs			0.839				
WARD5	Nursing staff kind and caring throughout patient's stay			0.706				
WARD8	Nursing staff were skilled in administering medical procedures			0.583				
ADMI3	Administrative staff courteous and helpful at admissions counter				0.825			
ADMI4	Administrative staff willing to listen to patient's concerns				0.675			
ADMI1	Patient's admittance procedure carried out promptly				0.634			
THEA2	Pre-med (for surgery) was administered at correct time					0.824		
THEA1	Preparation for surgery carried out efficiently					0.569		
THEA4	Nursing staff eased patient's fears about the surgery					0.517		
THEA5	Anaesthetist came to explain his role during surgery					0.403		
WARD12	Television sets functioned properly						0.993	
WARD11	Television set in the ward						0.671	
WARD3	Upon arrival in ward, nursing staff told patient what to do next							0.561
WARD4	After arrival in ward, patient shown ablution/ward facilities							0.471
	7 Factors together explain 67% of the variance in the data space							
	Eigenvalues:	9.76	2.91	1.69	1.44	1.28	1.20	0.84
	Cronbach's alpha:	0.94	0.89	0.91	0.79	0.77	0.80	0.77
	Rotation method: Direct quartimin oblique rotation							

8.4 RELIABILITY OF THE MEASURING INSTRUMENT

The second phase of the data analysis was to assess the reliability of the measuring instrument. A measuring instrument is considered reliable if it consistently produces the same results with repeated applications on future occasions. Because the study consisted of multiple items as opposed to a single item, the internal consistency reliability was assessed.

This method is used to assess a summated scale of a multi-item measure, where several items have been summed to give a total score for a construct (Hair et al. 2003:171). The intercorrelation among the scores of the items is used to estimate the internal consistency reliability. The assumption is that since the individual items have been designed to measure the same construct, they should be highly correlated.

According to Nunnally (1978:230), the Cronbach alpha is the basic formula for determining reliability based on the internal consistency of a multi-item scale. The Cronbach alpha should be obtained first, even if other estimates of reliability need to be made for particular measuring instruments (Nunnally 1978:230).

The Cronbach alpha (also known as coefficient alpha) test was applied to assess the internal consistency reliability of the measuring instrument used to test the four hypotheses of the theoretical model depicted in Figure 1.1 in Chapter 1. The computer programme SAS (SAS Institute 1990) was used to calculate the Cronbach alpha coefficients. It has already been mentioned in Chapter 6 that the rule of thumb generally considered acceptable is an alpha value of not less than 0.7 (Nunnally 1978:245-246; Peterson 1994:381,382,385).

As shown in Table 8.1 and Table 8.2, the Cronbach alpha coefficients were well above the recommended 0.7 threshold recorded for the seven factors for each of service quality and customer satisfaction. Thus, on the basis of this recommendation, it can be concluded that the items used to measure the service quality and customer satisfaction constructs are reliable. The

Cronbach alpha results are discussed in conjunction with the factor loadings and eigenvalues in the next section.

The revised theoretical model depicting only those service quality and customer satisfaction factors identified by means of the exploratory factor analysis on patients' cumulative, or overall satisfaction perceptions, is shown in Figure 8.1, which follows after the regression analysis results in section 8.6. The discussion of the operationalisation of the factors emanating from this model is presented in the next section.

8.5 OPERATIONALISATION OF THE FACTORS

As mentioned under sections 8.3 and 8.4 respectively, the exploratory factor analysis of the data revealed seven factors for service quality and seven factors for customer satisfaction. Cronbach alpha values well in excess of the 0.7 threshold were recorded for each of these factors. A discussion of the operationalisation of each of these factors (dimensions), commencing with service quality, follows.

8.5.1 Dimensions of service quality

Each of the seven factors to emerge from the measuring instrument's ten dimensions of service quality is discussed separately. It should be noted that in the present study, two of the service quality factors, namely empathy and responsiveness changed in composition. Empathy was renamed Empathy of nursing staff because the items which loaded on this factor dealt only with the hospital's nursing staff. Responsiveness split into two separate factors and was renamed Responsiveness of administrative staff and Physician responsiveness for similar reasons. To ease readability, in this discussion, the questionnaire items for each factor plus their respective item codes used during the data preparation stage are repeated in a summarised table per factor. Factor loadings for each item, Cronbach alpha coefficients and eigenvalues for each factor are also included in the respective tables.

8.5.1.1 Communication

The questionnaire consisted of seven items (COMM1-COMM7) to measure the dimension communication. The four items depicted in Table 8.3 emerged as the ones to load on Factor 1. Of the remaining three items, one loaded on Factor 5, while the other two did not load on any of the other factors. No other items loaded on this factor.

The high Cronbach alpha coefficient of 0.92 confirms the reliability of the measuring instrument for the dimension Communication.

Table 8.3: Communication

Factor 1: Communication		
Item Code	**Questionnaire Item**	**Factor Loading**
COMM2	Patients can be sure of receiving adequate information about their condition	**0.945**
COMM3	Patients can be sure of receiving adequate information about their treatment	**0.890**
COMM1	Patients can rely on hospital staff to thoroughly explain procedures	**0.745**
COMM4	Patients can rely on having their discharge care thoroughly explained	**0.546**
Eigenvalue 15.45		**Cronbach Alpha: 0.94**

Based on the items reported in Table 8.3, communication was operationalised, for the purpose of this study, as the adequacy of communication received by patients regarding their medical condition and treatment.

8.5.1.2 Tangibles

The tangibles dimension was sub-divided into three parts. Six items (TANP1-TANP6) were formulated to measure the hospital's physical facilities, three items (TANS1-TANS3) to measure the appearance of staff and one item (TANE1) to measure perceptions of the latest equipment and machinery, thus giving a total of ten items in the questionnaire to measure the tangible, or physical evidence, of the service.

Six items loaded on Factor 2, of which five were from the original ten items formulated to measure tangibles. Four of the six items measured physical facilities and the fifth measured the appearance of staff. One item from the reliability dimension (RELI1-RELI6), also loaded on this factor. No further items loaded on Factor 2.

The high Cronbach alpha coefficient of 0.88 confirms the reliability of the measuring instrument for the dimension Tangibles.

Table 8.4: Tangibles

Factor 2: Tangibles		
Item Code	**Questionnaire Item**	**Factor Loading**
TANP4	The wards at ___ are kept spotlessly clean	**0.866**
TANP3	Generally, ___ is a clean hospital	**0.801**
TANP2	___ maintains a neat appearance of its buildings	**0.602**
TANP5	___ has tastefully decorated wards	**0.552**
TANS2	Nursing staff at ___ look professional and neat in their uniforms	**0.522**
RELI6	Overall, the service at ___ is excellent	**0.444**
Eigenvalue 1.74	**Cronbach Alpha: 0.88**	

Since four of the items all relate to aspects of cleanliness or neatness of the service, based on Table 8.4, tangibles was operationalised for the purpose of this study as physical evidence that the hospital maintains a clean and neat appearance of its facilities, both inside and outside the hospital. In particular, perceptions of the cleanliness of the hospital in general and the wards in particular, the neatness of the buildings, décor in the wards and the appearance of the nursing staff, all count as evidence of overall service delivery.

8.5.1.3 Empathy of nursing staff

Empathy of nursing staff was not one of the ten original service quality dimensions, but emerged as a new factor from a combination of items from three dimensions. These dimensions were responsiveness (RESP1-RESP6),

understanding/knowing the customer (UNDE1-UNDE6) and assurance (ASSU1-ASSU5). In Factor 3, the seven loadings were as follows: one item from responsiveness, five items from understanding/ knowing the customer and one item from assurance. Two other items from the responsiveness dimension loaded on Factor 5 and one loaded on Factor 7.

No other items from understanding/knowing the customer loaded on any other factors while one item from assurance loaded on Factor 5. It should be noted also that items from the original empathy (EMPA1-EMPA3) dimension did not load on any of the seven factors.

The high Cronbach alpha coefficient of 0.95 confirms the reliability of the measuring instrument for the renamed dimension Empathy of nursing staff.

Table 8.5: Empathy of nursing staff

Factor 3: Empathy of Nursing Staff		
Item Code	**Questionnaire Item**	**Factor Loading**
RESP1	The nurses are never too busy to respond to patients' needs	**0.699**
UNDE5	Nursing staff show understanding towards patients' feelings of discomfort	**0.644**
UNDE4	Patients will not feel that their needs are neglected by nursing staff, irrespective of the time of day or night	**0.610**
UNDE2	Patients at ___are given lots of individual attention	**0.607**
ASSU5	Nursing staff are efficient at dealing with patients' queries/problems	**0.421**
UNDE3	Nursing staff show understanding when patients are feeling at a low ebb	**0.490**
UNDE1	Nursing staff treat patients with a warm and caring attitude	**0.493**
Eigenvalue 1.47		**Cronbach Alpha: 0.95**

Factor 3 was appropriately renamed Empathy of nursing staff because all seven items which loaded on this factor measured interaction aspects between nursing staff and their patients. Based on the items reported in

Table 8.5, empathy of nursing staff was then operationalised, for the purpose of this study, as the extent to which nursing staff demonstrate empathy toward their patients. In this instance, empathy is demonstrated through nurses' responsiveness to patients' needs, understanding how patients are likely to be feeling, the adequacy and individualisation of attention given, efficiency and a warm/caring attitude, which will all assist with the recovery process.

8.5.1.4 Assurance

As with the previous factor, the four items that loaded on Factor 4 were originally used to measure other service quality dimensions in the questionnaire. Three items expected to measure the dimension credibility (CRED1-CRED4) and one item expected to measure security (SECU1-SECU4) loaded on Factor 4. The single remaining item from credibility did not load anywhere else. Of the three other items to measure security, two loaded on Factor 6, while the third did not load on any other factor.

The high Cronbach alpha coefficient of 0.95 (the same as Factor 3) confirms the reliability of the measuring instrument for the dimension Assurance.

Table 8.6: Assurance

Factor 4: Assurance		
Item Code	**Questionnaire Item**	**Factor Loading**
CRED4	_____ cares about its patients	**0.815**
SECU2	Patients can feel safe in the hands of _____	**0.796**
CRED3	_____ has an excellent reputation	**0.701**
CRED2	Patients can feel confident in the treatment they will receive	**0.630**
Eigenvalue 1.33	**Cronbach Alpha: 0.95**	

Although none of the five items intended to measure assurance loaded on this factor, the name assurance was retained. Considering that the four

new items refer to the hospital staff itself, it is understandable that patients would want the assurance that they will be looked after. Thus, based on the items reported in Table 8.6, for the purpose of this study, assurance was operationalised as the extent to which the hospital inspires confidence and trust that its patients will be well taken care of for the duration of their stay. Specifically, if the hospital shows that it cares about its patients and makes them feel safe there by means of the reputation it has earned.

8.5.1.5 Responsiveness of administrative staff

Two of the four items that loaded on Factor 5 were used in the questionnaire to measure responsiveness (RESP1-RESP6). The third and fourth items that loaded on this factor were to measure assurance (ASSU1-ASSU5) and communication (COMM1-COMM7) respectively. Two other responsiveness items loaded on Factor 3 and Factor 7.

The high Cronbach alpha coefficient of 0.87 confirms the reliability of the measuring instrument for the renamed dimension Responsiveness of administrative staff.

Table 8.7: Responsiveness of administrative staff

Factor 5: Responsiveness of Administrative Staff		
Item Code	**Questionnaire Item**	**Factor Loading**
ASSU4	Administrative staff are efficient at dealing with patients' queries/problems	**0.827**
RESP5	Admission of patients is handled quickly and efficiently by administrative staff	**0.696**
COMM7	Administrative staff show a sincere interest in solving patients' problems	**0.637**
RESP4	Administrative staff never show that they are too busy to respond to patients' requests	**0.630**
Eigenvalue 1.07		**Cronbach Alpha: 0.87**

The four items which loaded on this factor all refer to the hospital's administrative staff and their dealings with its patients. Factor 5 was then renamed Responsiveness of administrative staff to reflect the administrative

side of the service. It is not unexpected that the two new items, ASSU4 and COMM7, initially formulated to measure the dimensions assurance and communication, loaded on this factor, since both items also measure aspects of the administrative process. For the purpose of this study, based on the items reported in Table 8.7, responsiveness of administrative staff was operationalised as the efficiency, speed and sincerity in responding to patients administrative queries and attending to their admission process.

8.5.1.6 Security

The questionnaire contained four items to measure security (SECU1-SECU4). Two of these items loaded on Factor 6 while a third loaded on Factor 4. The fourth item did not load on any of the other factors.

The high Cronbach alpha coefficient of 0.82 confirms the reliability of the measuring instrument for the dimension Security.

Table 8.8: Security

Factor 6: Security		
Item Code	**Questionnaire Item**	**Factor Loading**
SECU3	___ provides adequate security inside the hospital	**0.788**
SECU4	___ provides adequate security outside the hospital	**0.754**
Eigenvalue 0.90		**Cronbach Alpha: 0.82**

Based on the items reported in Table 8.8, security was operationalised, for the purpose of this study, as adequately provided both inside and outside the hospital.

8.5.1.7 Physician responsiveness

As with Empathy of nursing staff, and Responsiveness of administrative staff, physician responsiveness was not one of the ten original dimensions to measure service quality. The dimension responsiveness (RESP1-

RESP6) included items that measured the reaction time of several hospital role players, including doctors, nurses and administrative staff. Two items loaded on Factor 7, namely one item from responsiveness and one item from the dimension reliability (RELI1-RELI6). As mentioned in section 8.5.1.5, one other responsiveness item loaded on Factor 3 and two loaded on Factor 5. Because the two items which loaded on Factor 7 referred to the doctors, Factor 7 was renamed Physician responsiveness.

The moderately high Cronbach alpha coefficient of 0.77 confirms the reliability of the measuring instrument for the renamed dimension Physician responsiveness.

Table 8.9: Physician responsiveness

Factor 7: Physician Responsiveness		
Item Code	**Questionnaire Item**	**Factor Loading**
RESP2	Doctors are punctual when conducting their ward rounds	**0.723**
RELI4	Doctors can be counted on to attend to their patients' needs	**0.540**
Eigenvalue 0.89		**Cronbach Alpha: 0.77**

Based on the items reported in Table 8.9, for the purpose of this study, physician responsiveness was operationalised as physicians being punctual in doing ward rounds and attending to the needs of their patients.

To summarise the above discussion, it is evident that to build and sustain consumer perceptions of "good" service quality of a private hospital, hospital management will have to ensure the following:

- That there is always adequate communication provided to patients pertaining to all aspects of their medical condition;
- That the cleanliness and neatness of the internal and external physical surroundings of the hospital, and the professional appearance of the nursing staff, serve as tangible evidence of overall service delivery;

- That the empathy of nursing staff towards their patients is carried out in such a manner so as to contribute to the recovery process;
- That the hospital inspires a sense of trust and confidence in its patients by giving the assurance that it cares about their well-being;
- That patients can expect the responsiveness of administrative staff to their queries, including the admission process, to be dealt with promptly and efficiently;
- That the hospital will provide adequate security, inside and outside the hospital;
- That punctuality and attending to the patients' needs are important considerations relative to physician responsiveness in the hospital.

8.5.2 Dimensions of customer satisfaction

As with the previous section on service quality, each of the seven factors that emerged from the measuring instrument's seven original dimensions of customer satisfaction is discussed separately. It should be noted that, as with service quality, one of the customer satisfaction dimensions, namely ward arrival also changed in composition by splitting into three distinct factors, of which two were renamed. These factors became Satisfaction with the nursing staff, Satisfaction with the television service in wards and Satisfaction with ward arrival. To ease readability, in this discussion, the questionnaire items for each factor plus their respective item codes used during the data preparation stage are repeated in a summarised table per factor. Factor loadings for each item, Cronbach alpha coefficients and eigenvalues for each factor are included in the respective tables.

8.5.2.1 Satisfaction with meals

The questionnaire contained eleven items (MEAL1-MEAL11) to measure patients' satisfaction with the meals served. Of these, six items loaded on Factor 1, as shown in Table 8.10 below. The remaining items did not load

on any other factor.

The high Cronbach alpha coefficient of 0.94 confirms the reliability of the measuring instrument for the dimension Satisfaction with meals.

Table 8.10: Satisfaction with meals

Factor 1: Satisfaction with Meals		
Item Code	**Questionnaire Item**	**Factor Loading**
MEAL3	Meals were tasty	**0.987**
MEAL4	Meals were nutritious	**0.903**
MEAL5	Meals were attractively presented	**0.899**
MEAL1	On the whole, I enjoyed the food while I was a patient at ___	**0.876**
MEAL2	Meals were always served at the correct temperature	**0.715**
MEAL6	Meals were served in a variety of ways	**0.640**
Eigenvalue 9.76	**Cronbach Alpha: 0.94**	

Since these items measured customer satisfaction with the meals served during the hospital stay, Factor 1 was renamed Satisfaction with meals. Based on the items reported in Table 8.10, satisfaction with meals was operationalised, for the purpose of this study, as the serving and presentation of meals to patients. More specifically, the patient expects that the meals should be tasty, nutritious, attractively presented for enjoyment and served at the correct temperature with an adequate variety offered.

8.5.2.2 Satisfaction with fees charged

The questionnaire contained four items (CHAR1-CHAR4) to measure fees charged by the private hospital and all four items loaded on Factor 2.

The high Cronbach alpha coefficient of 0.89 confirms the reliability of the measuring instrument for the dimension Satisfaction with fees charged.

Table 8.11: Satisfaction with fees charged

Factor 2: Satisfaction with Fees Charged		
Item Code	**Questionnaire Item**	**Factor Loading**
CHAR2	Considering the quality of service at ____, their fees are reasonable	**0.880**
CHAR1	Considering the fees charged, my stay at ____ was worth the money	**0.779**
CHAR4	A stay at ____ is good value for money	**0.773**
CHAR3	____ fees are not expensive	**0.618**
Eigenvalue 2.91	**Cronbach Alpha: 0.89**	

These four items measured customer satisfaction with the fees charged by the hospital for the patient's stay, thus Factor 2 was renamed Satisfaction with fees charged. Based on the items reported in Table 8.11, satisfaction with fees charged was operationalised, for the purpose of this study, as the hospital's fees should be reasonable and not expensive, worth the money paid and provide good value for money.

8.5.2.3 Satisfaction with the nursing staff

Sixteen items were included in the questionnaire to measure customer satisfaction with various aspects related to the patient's ward occupation (WARD1-WARD16). Of these, eight items loaded on three different factors. Four items loaded on Factor 3. Two items each loaded on Factor 6 and Factor 7, respectively. It is interesting to note that in the case of Factor 3 reported here, all four ward items from a list of sixteen, are directly associated with the nursing staff. This is not unexpected considering the amount of contact between nurse and patient as well as the amount of time, compared with other role players, that nurses spend with their patients. The dimension ward arrival, in this case, was therefore appropriately renamed Satisfaction with nursing staff to indicate patients' satisfaction with this aspect of the ward.

The high Cronbach alpha coefficient of 0.91 confirms the reliability of the measuring instrument in the renamed dimension, Satisfaction with the nursing staff.

Table 8.12: Satisfaction with the nursing staff

Factor 3: Satisfaction with the Nursing Staff		
Item Code	**Questionnaire Item**	**Factor Loading**
WARD7	The nursing staff were always cheerful	**0.888**
WARD6	The nursing staff responded promptly at all times to my needs	**0.839**
WARD5	The nursing staff were kind and caring throughout my stay	**0.706**
WARD8	The nursing staff were skilled in administering medical procedures	**0.583**
Eigenvalue 1.69		**Cronbach Alpha: 0.91**

Based on the items reported in Table 8.12, satisfaction with the nursing staff was operationalised, for the purpose of this study, as nurses demeanour and skills, that is, nurses should be cheerful, responsive to patients' needs, kind and caring as well as adequately skilled in their professions.

8.5.2.4 Satisfaction with the admission process

Four items (ADMI1-ADMI4) were used to measure customer satisfaction with admission procedures. Three of these items loaded on Factor 4, which was renamed Satisfaction with the admission process. The remaining item did not load on any other factor.

The moderately high Cronbach alpha coefficient of 0.79 confirms the reliability of the measuring instrument for the dimension Satisfaction with the admission process.

Table 8.13: Satisfaction with the admission process

Factor 4: Satisfaction with the Admission Process		
Item Code	**Questionnaire Item**	**Factor Loading**
ADMI3	Administrative staff were courteous and helpful at the admissions counter	**0.825**
ADMI4	Administrative staff were willing to listen to my concerns	**0.675**
ADMI1	As a patient at _____ my admittance procedure was carried out promptly	**0.634**
Eigenvalue 1.44		**Cronbach Alpha: 0.79**

Based on the items in Table 8.13, satisfaction with the admission process was operationalised, for the purpose of this study, as admission staff should be courteous and helpful, prepared to listen to patients' concerns and deal promptly with the admittance procedure.

8.5.2.5 Satisfaction with the theatre experience

The questionnaire contained seven items (THEA1-THEA7) to measure customer satisfaction with that part of the theatre experience patients would have been aware of before the anaesthetic took effect. Four of these items loaded on Factor 5. Of the remaining three items, none loaded on any other factor.

The moderately high Cronbach alpha coefficient of 0.77 confirms the reliability of the measuring instrument for the dimension Satisfaction with the theatre experience.

Table 8.14: Satisfaction with the theatre experience

Factor 5: Satisfaction with the Theatre Experience		
Item Code	**Questionnaire Item**	**Factor Loading**
THEA2	Pre-medication (for surgery) was administered at the correct time	**0.824**
THEA1	Preparation for surgery was carried out efficiently	**0.569**
THEA4	The nursing staff eased my fears about the surgery	**0.517**
THEA5	The anaesthetist came to explain his role during the operation	**0.403**
Eigenvalue 1.28		**Cronbach Alpha: 0.77**

Factor 5 was renamed Satisfaction with the theatre experience. Based on the items reported in Table 8.14, satisfaction with the theatre experience was operationalised, for the purpose of this study, as patient's preparation for surgery. Specifically, it implies that patients should be given their pre-med in time, receive proper preparation for the surgery, have their fears about the surgery eased and be visited by the anaesthetist to explain his role during the operation.

8.5.2.6 Satisfaction with the television service in wards

As mentioned in section 8.5.2.3, the questionnaire consisted of sixteen items (WARD1-WARD16) to measure various aspects related to ward satisfaction. As previously mentioned, two of these items loaded on Factor 6. Since both items related to the presence of television sets in the ward, which is not unexpected, a new dimension – Satisfaction with the television service in wards – was appropriately formed. Also mentioned in that section were the four items which loaded on Factor 3 and two on Factor 7. None of the remaining eight items loaded on any other factor.

The high Cronbach alpha coefficient of 0.80 confirms the reliability of the measuring instrument for the dimension Satisfaction with the television service in wards.

Table 8.15: Satisfaction with the television service in wards

Factor 6: Satisfaction with the Television Service in Wards		
Item Code	**Questionnaire Item**	**Factor Loading**
WARD12	The television sets functioned properly	**0.993**
WARD11	There was a television set in the ward	**0.671**
Eigenvalue 1.20	**Cronbach Alpha: 0.80**	

Based on the items reported in Table 8.15, satisfaction with the television service in wards was operationalised, for the purpose of this study, as access to a properly functioning television set in the ward is desired.

8.5.2.7 Satisfaction with the ward arrival

The last of the ward satisfaction items (WARD1-WARD16) to load on a separate factor were two items on Factor 7, as indicated in the two preceding sub-sections. These items referred specifically to the patient's arrival in the ward, and were appropriately renamed Satisfaction with the ward arrival. Factor 3 and Factor 6, as previously mentioned, contained the other six items from a total of sixteen originally designed to measure ward satisfaction in general.

The moderately high Cronbach alpha coefficient of 0.77 confirms the reliability of the measuring instrument for the renamed dimension Satisfaction with the ward arrival.

Table 8.16: Satisfaction with the ward arrival

Factor 7: Satisfaction with the Ward Arrival		
Item Code	**Questionnaire Item**	**Factor Loading**
WARD3	Upon arrival in the ward, the nursing staff explained what I had to do next	**0.561**
WARD4	Shortly after arrival, I was shown the bathroom/ward facilities	**0.471**
Eigenvalue 0.84	**Cronbach Alpha: 0.77**	

Based on the items reported in Table 8.16, satisfaction with the ward arrival was operationalised, for the purpose of this study, as the nursing staff explaining to the patient on arrival in the ward what to do and where the ward facilities are located.

To summarise the above discussion, it is evident that to achieve and sustain consistent perceptions of customer satisfaction following a private hospital experience, hospital management will have to ensure the following:

- That meals are always properly prepared and adequately varied for the patient's maximum enjoyment and satisfaction;
- That private hospital fees charged will ultimately deliver value for money and satisfy expectations of the service;
- That the nursing staff respond in a satisfactory manner toward their patients and possess adequate nursing skills;
- That administrative staff attend to patients in a satisfactory manner and carry out the admission process promptly;
- That patients feel satisfied with the manner in which they are prepared for surgery;
- That the provision of a television service in the wards is satisfactory;
- That patients are appropriately received upon arrival in the relevant hospital ward.

8.6 REGRESSION ANALYSIS RESULTS

The multivariate statistical technique, multiple linear regression analysis, or regression analysis for short, was performed to assess the strength of the relationship between the dependent (criterion) variables and two sets of independent (predictor) variables. Firstly, regression analysis was performed to predict the influence of the service quality and customer satisfaction dimensions (the independent variables) on loyalty and 'overall' cumulative customer satisfaction (the dependent variables). And secondly,

regression analysis was performed to determine the statistical significance of the independent variables on loyalty and 'overall' cumulative customer satisfaction.

The results of the regression analysis on the four hypotheses of the present study are presented in this section. From these results, the t-values itemised in Tables 8.17-8.20, will be reported. The t-value (also t-statistic) is a measure of the statistical significance of an independent variable in explaining the dependent variable (Levine, Stephan, Krehbiel & Bereson 2005:525). Leamer (1999:2) indicates that in regression analysis, for each independent variable, three sets of numbers, namely an estimated coefficient (beta), a standard error and a t-value are calculated, but it is the t-value that can be compared across all the independent variables. The t-value is merely the estimated coefficient (beta) divided by the standard error (Leamer (1999:6) and measures how many standard errors the coefficient is away from zero (Levine et al. 2005:525).

Levine et al. (2005:525) suggest that any t-value greater than +2 or less than -2 is generally acceptable. Alternatively however, Leamer (1999:6) argues that in certain situations, the choice of number as the t-value is entirely a matter of choice. The author suggests that while a large t-value implies a strong inference, 'large' should be compared with the other independent variables in the equation. Levine et al. (2005:526) point out that the higher the t-value, the greater the confidence a researcher can have in the coefficient as a predictor on the dependent variable, while low t-values are indications of low reliability of predictive power of the coefficient in question.

8.6.1 Service quality and loyalty

In this section, the following hypothesis was considered:

H^1: There is a positive relationship between perceived service quality at the dimensional level (ten dimensions) and loyalty, as measured by patients' willingness to reuse the same hospital in the future or

recommend it to others (buying intentions).

Multiple regression results showing the impact of the seven service quality dimensions (the independent variables) on loyalty (the dependent variable) are shown in Table 8.17.

Table 8.17: Multiple regression results:
Impact of service quality dimensions on loyalty

Dependent Variable: LOYALTY (buying intentions or willingness to repurchase)					
Source	**DF**	**Sum of Squares**	**Mean Square**	**F value**	**Pr > F**
Model	7	2013.39	287.63	63.56	0.0001
Error	315	1425.56	4.53		
Corrected total	322	3438.95			
R^2	**C.V.**	**Root MSE**	**Loyalty Mean**		
58.5%	11.92	2.13	17.84		
Parameter		**Estimate**	**T-value**	**Exceedance Probability**	**Std Error of Estimate**
INTERCEPT		2.024	2.04	0.0418	0.990
COMMUNICATION		0.048	1.16	0.2478	0.041
EMPATHY: NURSING STAFF		0.160	5.81	0.0001***	0.028
TANGIBLES		0.126	2.97	0.0032**	0.043
ASSURANCE		0.227	4.01	0.0001***	0.057
RESPONSIVENESS: ADMIN		0.026	0.61	0.5440	0.043
SECURITY		-0.147	-2.15	0.0323*	0.068
RESPONSIVENESS: PHYSICIAN		-0.003	-0.04	0.9669	0.076

*** = p<.001
** = p<0.01
* = p<0.05

Table 8.17 shows that four of the seven service quality dimensions influence the dependent variable Loyalty, namely Empathy of nursing staff (t-value 5.81 p<.001), Tangibles (t-value 2.97 p<0.01), Assurance (t-value 4.01 p<.001) and Security (t-value -2.15 p<0.05).

Having determined statistical significance (F-value = 63.56; probability level = 0.0001), the next step is to evaluate the R^2 to determine if it is large enough. From Table 8.17 it can be seen that the R^2 of 58.5% reveals that the modelled independent variables explain 58.5% of the variation in the

dependent variable. Based on the rule of thumb concerning correlation coefficient size as discussed in Chapter 7, the strength of association between the variables can therefore be described as moderate.

The direction of the relationship between service quality and loyalty is positive for three independent variables and negative for one variable. Empathy of nursing staff, Assurance and Tangibles impact positively on loyalty as hypothesized. However, the impact of Security on loyalty is negative.

The results suggest that the greater Empathy of nursing staff is perceived, the greater patients' feelings of Assurance and Security are during the hospital stay, and the more positively they evaluate the Tangible elements of the service (i.e. physical environment), the more likely patients are to remain loyal to the hospital, that is, they will be more willing to reuse the same hospital in the future or recommend it to others. However, it must be pointed out that the negative relationship between security, both inside and outside the hospital, and the dependent variable, imply that the overt presence of too much security will reduce loyalty.

Hypothesis 1 is thus accepted in terms of the independent variables, Empathy of nursing staff, Tangibles, Assurance and Security, but rejected for Communication, Responsiveness of administrative staff and Physician responsiveness.

8.6.2 Service quality and cumulative satisfaction

In this section, the following hypothesis was considered:

H^2: There is a positive relationship between perceived service quality at the dimensional level (ten dimensions) and cumulative customer satisfaction.

'Overall' cumulative satisfaction was the dependent variable in this case. Table 8.18 shows the impact of the seven independent variables for service quality on cumulative satisfaction.

Table 8.18: Multiple regression results:
Impact of service quality dimensions on cumulative satisfaction

Dependent Variable: CUMULATIVE SATISFACTION					
Source	**DF**	**Sum of Squares**	**Mean Square**	**F value**	**PR > F**
Model	7	6797.42	971.06	68.46	0.0001
Error	315	4467.76	4.18		
Corrected total	322	11265.18			
R^2	**C.V.**	**Root MSE**	**Cumulative Satisfaction Mean**		
60.3%	12.37	3.77	30.43		
Parameter		**Estimate**	**T-value**	**Exceedance Probability**	**Std Error of Estimate**
INTERCEPT		1.512	0.86	0.3890	1.753
COMMUNICATION		-0.082	-1.12	0.2651	0.073
EMPATHY: NURSING STAFF		0.274	5.64	0.0001***	0.049
TANGIBLES		0.096	1.28	0.2028	0.075
ASSURANCE		0.653	6.51	0.0001***	0.100
RESPONSIVENESS:ADMIN		0.050	0.66	0.5110	0.076
SECURITY		-0.050	-0.41	0.6806	0.121
RESPONSIVENESS: PHYSI		0.028	0.21	0.8323	0.134

*** = p<.001
** = p<0.01
* = p<0.05

Table 8.18 shows that only two service quality dimensions influence cumulative satisfaction, namely Empathy of nursing staff (t-value 5.64 p<.001) and Assurance (t-value 0.653 p<.001).

The table shows that the R^2 of 60.3% reveals that the modelled independent variables explain 60.3% of the variation in the dependent variable, suggesting that the strength of association between the variables can, as with Hypothesis 1, also be described as moderate.

The direction of the relationship between service quality and cumulative satisfaction is positive for the two independent variables Empathy of nursing staff and Assurance. Therefore, the results suggest that the dimensions of service quality most likely to influence patient satisfaction

will be that the more patients perceive Empathy of nursing staff and the greater their feelings of Assurance, there is an increased likelihood of 'overall' cumulative satisfaction, a better predictor of loyalty, occurring.

Hypothesis 2 is thus accepted in terms of the independent variables, Empathy of nursing staff and Assurance, but rejected for Communication, Tangibles, Responsiveness of administrative staff and Physician responsiveness.

8.6.3 Customer satisfaction and loyalty

In this section, the following hypothesis was considered:

H^3: There is a positive relationship between customer satisfaction at the dimensional level (seven dimensions) and loyalty, as measured by patients' willingness to reuse the same hospital in the future or recommend it to others (buying intentions).

Table 8.19 shows that four of the seven customer satisfaction dimensions influence the dependent variable loyalty, namely Satisfaction with meals (t-value 4.50 p<.001), Satisfaction with the nursing staff (t-value 11.99 p<.001), Satisfaction with fees charged (t-value 2.77 p<0.01) and Satisfaction with the television service in wards (t-value 2.67 p<0.01).

Table 8.19: Multiple regression results:
Impact of customer satisfaction dimensions on loyalty

Dependent Variable: LOYALTY (Willingness to repurchase)					
Source	**DF**	**Sum of Squares**	**Mean Square**	**F value**	**PR > F**
Model Error Corrected Total	7 315 322	2348.97 1089.98 3438.95	335.57 3.460	96.98	0.0001
R^2	**C.V.**	**Root MSE**	**Loyalty Mean**		
68.3%	10.43	1.86	17.84		

Parameter	Estimate	T-value	Exceedance Probability	Std Error of Estimate
INTERCEPT	2.0622	2.46	0.0143	0.837
MEALS	0.066	4.50	0.0001***	0.015
NURSING STAFF	0.386	11.99	0.0001***	0.032
FEES CHARGED	0.080	2.77	0.0060**	0.029
ADMISSION	0.025	0.55	0.5852	0.046
WARD ARRIVAL	0.028	1.02	0.3067	0.027
THEATRE EXPERIENCE	0.020	0.63	0.5260	0.032
TV IN WARDS	0.129	2.67	0.0079**	0.048

*** = p<.001
** = p<0.01
* = p<0.05

Table 8.19 shows that the R^2 of 68.3% reveals that the modelled independent variables explain 68.3% of the variation in the dependent variable, suggesting that the strength of association between the variables, as with the first two hypotheses, can also be described as moderate.

The direction of the relationship between customer satisfaction and loyalty is positive for the four independent variables, namely Satisfaction with meals, Satisfaction with the nursing staff, Satisfaction with fees charged and Satisfaction with the television service in wards. Therefore, the dimensions of patient satisfaction most likely to influence patients' willingness to reuse the same hospital should they need to return in the future, or recommend it to others, will be the quality of the meals served, the calibre of the nursing staff employed by the hospital and the manner in which they treat the patients assigned to their care, the reasonableness of the fees charged and the provision of television sets in the wards.

An important finding emanating from the study is that satisfaction with the nursing staff (estimate 0.386), is shown to be the strongest predictor of loyalty, as Table 8.19 indicates.

Hypothesis 3 is thus accepted in terms of the independent variables Satisfaction with meals, Satisfaction with the nursing staff, Satisfaction with fees charged and Satisfaction with the television service in wards, but rejected in the case of Satisfaction with admission process, Satisfaction with ward arrival and Satisfaction with the theatre experience.

8.6.4 Customer satisfaction and cumulative customer satisfaction

In this section, the following hypothesis was considered:

H^4: There is a positive relationship between customer satisfaction at the dimensional level (seven dimensions) and cumulative customer satisfaction.

As with the second hypothesis, cumulative satisfaction (the overall assessment) was the dependent variable and the seven customer satisfaction dimensions, the independent variables. Table 8.20 shows the impact of these seven independent variables for the customer satisfaction dimension on cumulative satisfaction.

Table 8.20: Multiple regression results:
Impact of satisfaction dimensions on cumulative satisfaction

Dependent Variable: CUMULATIVE SATISFACTION					
Source	**DF**	**Sum of Squares**	**Mean Square**	**F value**	**Pr > F**
Model	7	7439.27	1062.75	87.50	0.0001
Error	315	3825.92	12.15		
Corrected total	322	11265.18			
R^2	**C.V.**	**Root MSE**	**Loyalty Mean**		
66.0%	11.45	3.485	30.43		
Parameter		**Estimate**	**T-Value**	**Exceedance Probability**	**Std Error of Estimate**
INTERCEPT		2.763	1.76	0.0790	1.568
MEALS		0.083	3.03	0.0026**	0.027
NURSING STAFF		0.664	11.00	0.0001***	0.060
FEES CHARGED		0.309	5.71	0.0001***	0.054
ADMISSION		-0.021	-0.24	0.8111	0.086
WARD ARRIVAL		0.0909	1.81	0.0715	0.050
THEATRE EXPERIENCE		0.0504	0.85	0.3936	0.059
TV IN WARDS		0.0714	0.79	0.4286	0.090

*** = p<.001
** = p<0.01
* = p<0.05

Table 8.20 shows that three customer satisfaction dimensions influence cumulative satisfaction, namely Satisfaction with meals (t-value 3.03 $p<0.01$), Satisfaction with the nursing staff (t-value 11.00 $p<.001$) and Satisfaction with fees charged (t-value 5.71 $p<.001$).

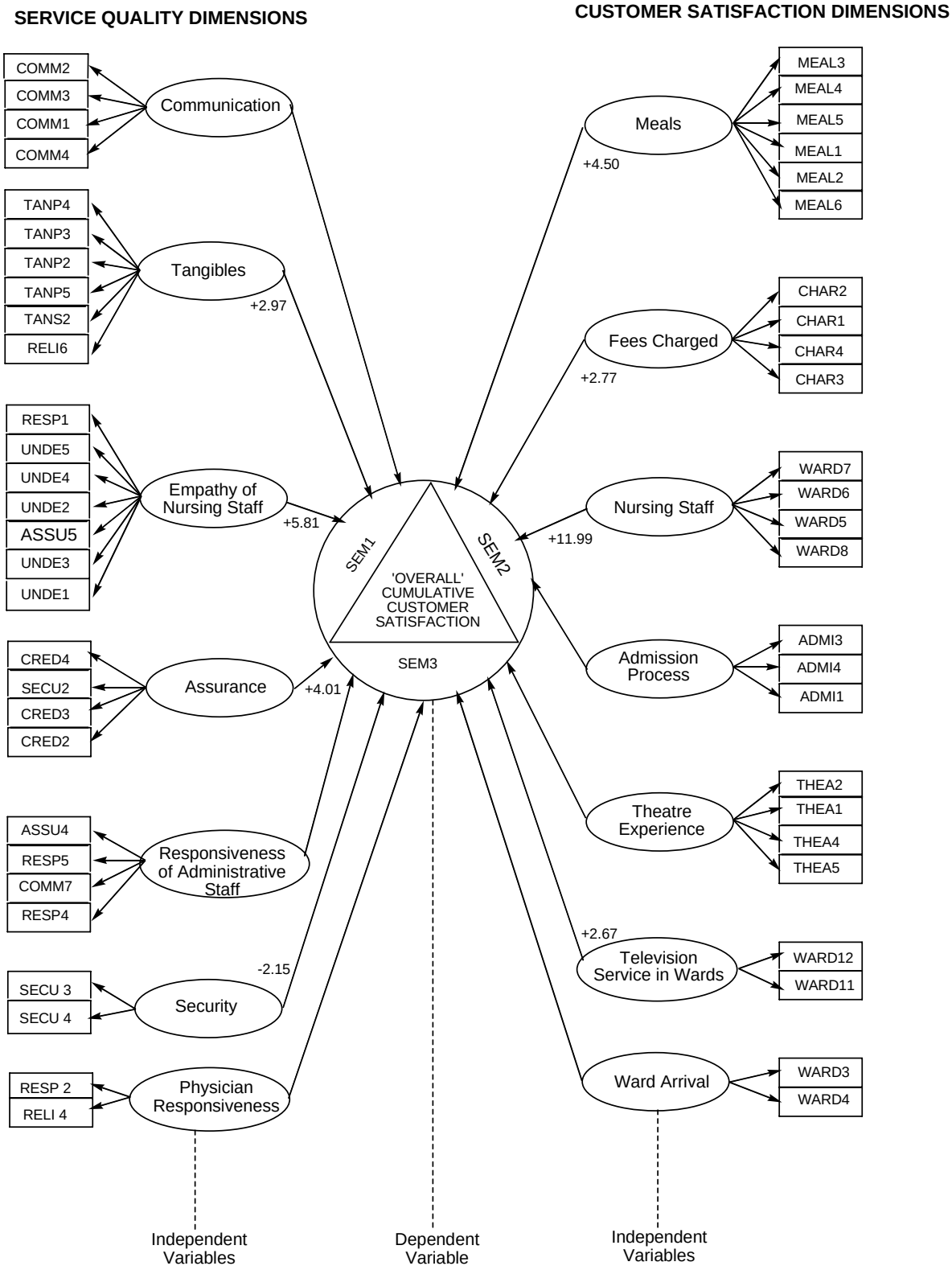
As indicated in Table 8.20, the R^2 of 66.0% reveals that the modelled independent variables explain 66.0% of the variation in the dependent variable, suggesting that the strength of association between the variables can be described as moderate.

The direction of the relationship between customer satisfaction and overall cumulative customer satisfaction is positive for the three independent variables, Satisfaction with meals, Satisfaction with the nursing staff and Satisfaction with fees charged. Therefore, the individual dimensions of customer satisfaction will be satisfaction with the quality of the meals served, satisfaction with the calibre of nursing staff and satisfaction that the fees charged are reasonable.

Hypothesis 4 is thus accepted in terms of the independent variables Satisfaction with meals, Satisfaction with the nursing staff and Satisfaction with the fees charged, but rejected in the case of Satisfaction with admission process, Satisfaction with the ward arrival, Satisfaction with the theatre experience and Satisfaction with the television service in wards.

Figure 8.1 summarises the service quality and customer satisfaction dimensions identified by means of the exploratory factor analysis on patients' 'overall' cumulative satisfaction perceptions with the hospital experience.

Figure 8.1: Empirical model of service quality and customer satisfaction on patients' 'overall' cumulative customer satisfaction perceptions



8.7 INDEPENDENT VARIABLES REMOVED FROM THEORETICAL MODEL

Originally, ten dimensions were used to measure service quality and seven dimensions to measure customer satisfaction. After the exploratory factor analysis and Cronbach alpha coefficient results, four independent variables from service quality and two independent variables from customer satisfaction had to be removed from the theoretical model presented in Figure 1.1 of Chapter 1.

These six independent variables were removed due to poor discriminant validity, as identified by the exploratory factor analysis. It should also be noted that some of the items used to measure the removed independent variables however, did load on other factors, as discussed in section 8.5.

The following independent variables were removed from the theoretical model:

- Service quality
  - Reliability
  - Courtesy
  - Credibility
  - Understanding/knowing customers
- Customer satisfaction
  - Housekeeping
  - Visitors

8.8 CONCLUSION

The empirical results of the present study were presented in this chapter. The theoretical model proposed to predict future behavioural intentions of private hospital patients based on their perceptions of two consumer-owned judgements, namely service quality and customer satisfaction, were empirically tested by means of the multivariate data analysis technique, multiple regression analysis.

More specifically, the study aimed to determine which dimensions of service quality (an overall or global judgement) and customer satisfaction (a transaction specific judgement) would be most likely to improve patient loyalty should a return visit to the hospital ever become necessary.

Ten independent variables for service quality and seven independent variables for customer satisfaction were selected to measure which dimensions exerted the stronger influence on the study's two dependent variables, namely loyalty (measured by willingness to reuse the hospital or recommend it to others) and customer satisfaction (measured as 'overall' or cumulative satisfaction. The entire matrix of responses to the service quality and customer satisfaction variables was subjected to an exploratory factor analysis.

As discussed in this chapter, the empirical results of the exploratory factor analysis revealed that seven distinct factors emerged for each of service quality and customer satisfaction. Thus, the factors most likely to influence loyalty and overall cumulative customer satisfaction are as follows:

- Service quality
    - Communication
    - Tangibles
    - Empathy of nursing staff
    - Assurance
    - Responsiveness of administrative staff
    - Physician responsiveness
- Customer satisfaction
    - Satisfaction with meals
    - Satisfaction with fees charged
    - Satisfaction with the nursing staff
    - Satisfaction with the admission process
    - Satisfaction with the theatre experience
    - Satisfaction with the television service in wards

- Satisfaction with the ward arrival

The empirical results were analysed in order to estimate the regression model and assess the overall model fit for the predictive accuracy of the independent variables. The results were also assessed against the four hypotheses, concluding acceptance for all four, but only in terms of selected service quality or customer satisfaction dimensions since some dimensions were rejected.

In Chapter 9, the final chapter of this study, the empirical results are interpreted, with particular reference to the implications for private hospital management. Recommendations emanating from the study will also be presented in this chapter.

CHAPTER 9

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

"Thank you to <u>all</u> the staff who have been exceptionally caring and efficient. The sisters in the maternity ward have been very supportive and have made it easier to cope with all the worry of the first couple of days after the birth of our twins (premature). We feel that they could not have been in any better hands and feel at ease knowing that they will be in very good hands for the remainder of their stay!"

Respondent in present study, a former patient commenting on the nursing in general.

9.1 INTRODUCTION

In this final chapter of the study, resulting from the examination in Chapter 8 of the processed data into meaningful empirical results, the inferences drawn from these findings and the conclusions arrived at, are presented in relation to the objectives of the study. As the title implies, this chapter is also an assessment of what was learnt through attempting to predict the future behavioural intentions of private hospital patients, and more importantly, to determine whether the study could lead to any future areas of research.

This chapter commences with a review of the study followed by an evaluation of the empirical findings that addressed the research objectives and hypotheses. The findings are evaluated against the background of their relevance to the healthcare industry, with specific reference to the private hospital sector within the South African economy. The recommendations emanating from the study are also included in the empirical findings section of this chapter.

The contribution of this study to the body of knowledge of business management and services marketing in particular, are put forward. The limitations of the research are noted given that it was undertaken at one hospital group only. Implications for managerial decision-making, specifically for private hospital management, and further recommendations

arising from this discussion, are also presented. A final section of closing comments concludes the study.

9.2 REVIEW OF THE STUDY

As previous research in service environments has shown, and discussed in Chapters 5 and 6, service quality and customer satisfaction are important determinants of loyalty, which is demonstrated through such typical behavioural intentions as a consumer's willingness to reuse a service again in the future (repeat usage) or recommend it to others (positive word-of-mouth endorsements).

Such behavioural patterns are true also for patient evaluations of a hospital experience as support from previous empirical findings in several healthcare studies has indicated. Additionally, although it was not measured in this study, the widely held view that superior service quality and superior transaction-specific customer satisfaction imply long-run profitability, in an increasingly competitive private hospital environment, such customer-owned judgements have become essential core competencies to pursue if a hospital is to achieve a sustainable competitive advantage. Currently, given the present structure of the South African healthcare industry, with its two sectors made up of public enterprises and private business enterprises, such competitive positioning strategies would be implemented in the private hospital sector only.

The purpose of this study was to investigate whether a private hospital could differentiate itself by means of superior service quality and transaction-specific customer satisfaction, and whether it would be able to enhance customer loyalty of its patients (measured by willingness to reuse the hospital or recommend it to others).

This objective was achieved by measuring which of the service quality and customer satisfaction dimensions (independent variables) exerted the strongest influence on the study's two dependent variables, namely that of loyalty (see above) and 'overall' or cumulative satisfaction.

During the exploratory research phase of the study, the opinions, perceptions and expectations of a small number of former patients, medical practitioners, and a hospital manager (from one of the hospital group's participating hospitals), were solicited. The information obtained from those informal interviews was used in the development of the research hypotheses.

Four hypotheses were developed from the research objectives to test the dimensions of service quality and customer satisfaction most likely to influence patient loyalty toward a particular hospital. Predictors of loyalty were measured by respondents' willingness to reuse and the willingness to recommend the hospital in which they had just been a patient.

The theoretical model that was constructed to depict these hypotheses was subjected to quantitative research using the survey method to gather the data.

The measuring instrument, a self-administered questionnaire containing structured questions (statements), was pre-tested on a small sample of former patients of private hospitals, after which only minor modifications were necessary. Five hospitals belonging to one of the country's three major private hospital groups were selected on a convenience basis to participate in the study, while random sampling was used to select the individual patients who participated in the study.

Designed as a mail survey, questionnaires were distributed on a random basis in the five hospitals to patients who met the qualifying criteria. Respondents could complete the questionnaires either in the hospital ward or else once they had returned home. The completed questionnaires were mailed back to the researcher in the reply-paid envelopes. In total, 323 returned questionnaires could be statistically analysed.

The processed data were subjected to statistical analyses, using three recognized statistical techniques, namely exploratory factor analysis, reliability analysis and multiple regression analysis. The exploratory factor analysis was conducted to assess the discriminant validity of the measuring

instrument used. The service quality items loaded on seven distinct factors of which three were renamed to more appropriately reflect the items that loaded collectively on these factors.

Similarly, the customer satisfaction items also loaded on seven distinct factors, requiring only two factors to be renamed. The discriminant validity of the measuring instrument was thus confirmed.

To assess the reliability of the measuring instrument, the Cronbach alpha coefficients were calculated for those factors identified by means of the exploratory factor analysis. For all of these factors identified, the Cronbach alpha coefficients, that is, seven factors for service quality and seven factors for customer satisfaction were above the recommended 0.7 threshold. Thus, the reliability of the measuring instrument was confirmed.

Multiple linear regression analysis, the main statistical technique applied in the study, was used to assess the relationships between two dependent variables and several independent variables. Thus, multiple regression analysis was used to predict which dimensions of service quality and customer satisfaction (the independent variables) were most likely to influence 'overall' cumulative satisfaction and loyalty (the dependent variables), the latter variable being willingness to reuse or recommend to others, as measures of loyalty.

The results for each of the four hypotheses tested revealed that:

H^1: In a private hospital environment, the three dimensions of service quality most likely to positively influence loyalty (willingness to reuse the hospital or recommend it to others), are Empathetic nursing staff, the Assurance that patients can feel safe in the hospital and the impression created by the Tangible (physical) evidence of the surroundings. However, the obvious presence of too much Security both inside and outside the hospital will impact negatively on patients, thus reducing loyalty.

The non-significant dimensions of service quality unlikely to influence

loyalty are Communication, Responsiveness of administrative staff and Physician responsiveness.

H^2: Following a hospital visit, the dimensions of service quality most likely to influence a patient's 'overall' cumulative satisfaction in a positive direction, are Empathetic nursing staff and the Assurance of a safe hospital environment.

Communication, Tangible evidence, Responsiveness of administrative staff, Security and Physician responsiveness are the non-significant dimensions of service quality not likely to influence overall cumulative satisfaction.

H^3: In a private hospital setting, the four dimensions of customer satisfaction most likely to positively influence loyalty (willingness to reuse the hospital or recommend it to others), are Satisfaction with the meals provided, Satisfaction with the nursing staff, Satisfaction with the fees charged by the hospital and Satisfaction with the television service provided in the ward.

However, Satisfaction with the admission process, Satisfaction with the ward arrival and Satisfaction with the theatre experience are the non-significant dimensions of customer satisfaction that are unlikely to influence loyalty.

H^4: Following a hospital visit, the dimensions of customer satisfaction most likely to influence a patient's 'overall' cumulative satisfaction in a positive direction, are again Satisfaction with the meals provided, Satisfaction with the nursing staff and Satisfaction with the fees charged by the hospital.

The non-significant dimensions of customer satisfaction unlikely to influence 'overall' cumulative satisfaction are Satisfaction with the Admission process, Satisfaction with the ward arrival, Satisfaction with the theatre experience and Satisfaction with the television service in the wards.

Interpretation of the empirical results and the proposed recommendations emanating from the study are provided in the next section. The significant relationships identified in the research are illustrated in Figures 9.1-9.4, which are presented with the interpretation of results.

9.3 INTERPRETATION OF EMPIRICAL RESULTS AND RECOMMENDATIONS

Having discussed the empirical results in the review section of this chapter, the next step is converting them into meaningful inferences, or the main findings, in accordance with the objectives of the study and confirmed or rejected by the four hypotheses previously formulated and tested.

The interpretation of the results is central to the research process and penultimate to its completion, requiring only the final stage, namely recommendations, to be made. Consequently, recommendations for possible courses of action for hospital management to consider are presented in conjunction with the interpretation of the empirical results. Recommendations of a study represent any logical implications that emerge from the results, plus the experience and judgment of the researcher; they are not necessarily viewed as a function of the research process. (Hair et al. 2003:332; Holbert & Speece 1993:155; Nel et al. 1988:412-413).

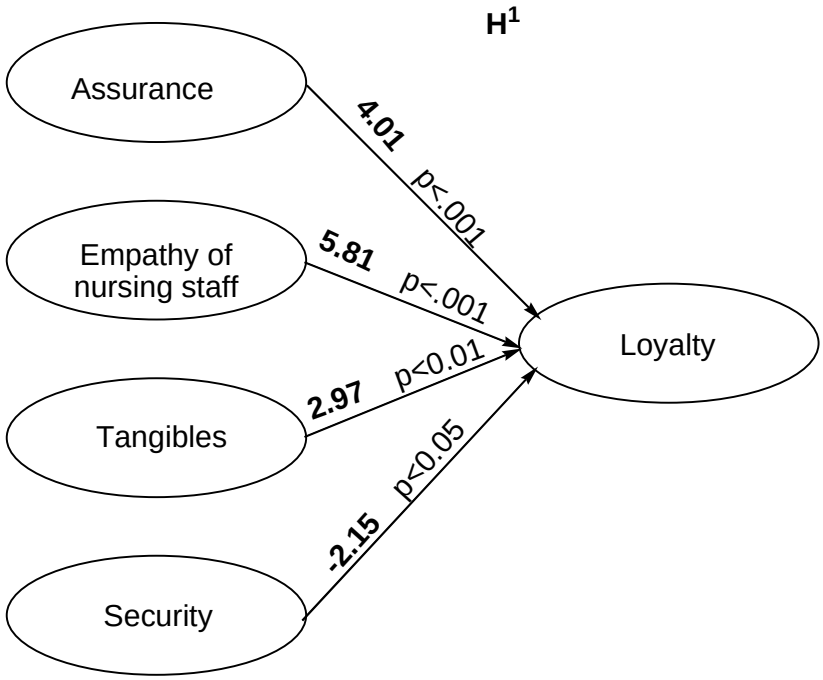
In this section, the interpretation of the empirical results and recommendations for future research are discussed in relation to the dimensions (factors) found to have significant influence on loyalty (willingness to reuse the hospital or recommend it to others) and 'overall' cumulative satisfaction. The discussion is presented under the following subheadings in the same order as the four hypotheses in the preceding section.

9.3.1 The influence of service quality on patient loyalty

Patient loyalty to a private hospital, as with most customer loyalty in any other private business enterprise, is a major competitive advantage and a key area to profitable growth. Pursuing loyalty as a marketing strategy requires long-term commitment and understanding, viewed from the patient's perspective on the total hospital experience.

It is clear from Figure 9.1 that a private hospital wishing to set itself the goal of improving patient loyalty will need to focus its efforts on four main areas of service quality, namely the Empathetic behaviour portrayed by hospital nursing staff to its patients, the conveying of a sense of Assurance to its patients and maintaining a favourable image of its exterior and interior surroundings, that is, the physical or Tangible elements of the service. Lastly, downplaying the Security aspect (both inside and outside the hospital grounds). Respondents found the security arrangements both inside and outside the hospital generally too conspicuous.

Figure 9.1: Service quality dimensions that influence patient loyalty



Several possible courses of action can be adopted for more effectively managing the hospital experience for long-term patient loyalty. To enhance the nurse/patient relationship for the benefit of a more nurse/customer focused relationship, traditional nursing training will need to move beyond the so-called clinical, 'nursing skills' competencies and efficiency, and emphasise ‘softer’ behaviours and skills, such as becoming more aware of and understanding the customer’s needs. More specifically, these behaviours involve the responsiveness of the nursing staff to their patients’ needs, nurses’ understanding of a patient’s concerns and fears, providing individualised attention and cultivating the ability to demonstrate a warm and caring attitude towards their patients – are all important.

To convey a sense of assurance to patients will require the hospital to not only convince patients that they are in a safe environment, that is, in safe hands of the medical staff, but that the whole hospitalisation experience should be focused on meeting their every need. For instance, at each ‘contact point’ during the hospital stay, all employees should demonstrate the same caring attitude to the hospital’s patients: that the hospital has its customers’ health interests at heart.

Furthermore, because employees should be careful to protect and enhance the hospital’s reputation, they must be equipped with the necessary skills to enable them to at least gain the patient’s confidence and trust and thereby ensure that patients feel safe during their hospitalisation period.

Perhaps the most visible dimension of service quality, for which there can be no compromise in a hospital setting, is the physical or tangible evidence of the service. Although the tangible dimension has proved relatively unimportant in many service quality studies (Zeithaml, Parasuraman & Berry 1990:29), perceptions of cleanliness of the hospital in general and the wards in particular, will influence a patient’s willingness to return to the hospital in the future.

Other physical evidence of the service, such as the neatness of the hospital buildings, the décor in the wards and the uniformed appearance of the

nursing staff will also influence patient loyalty. Tangible evidence is arguably the easiest service quality dimension which hospital management can manage and change as it sees fit.

Lastly, the fourth service quality dimension to influence patient loyalty is security. In this case, too much security (both inside and outside the hospital) will have a negative impact on loyalty. The results suggest that too strong a security presence, for example, too many and/or heavily armed guards patrolling the hospital grounds and inappropriate security fencing, or interior precautions such as access control to wards and other restricted areas, could actually produce the opposite effect and scare off patients.

Such measures may reduce willingness to return. While the presence of security guards (and even the absence thereof) is very much part of the South African landscape, the security function will need to be downplayed in a hospital setting. Security arrangements and installations both internally and externally should be implemented discreetly with care taken not to overdo the visibility aspect of security measures.

9.3.2 The influence of service quality on 'overall' cumulative satisfaction

After experiencing a hospital stay, how did the patient evaluate the entire experience in the period immediately following this visit, that is, after discharge from the hospital (and probably overlapping with the recovery period as well)?

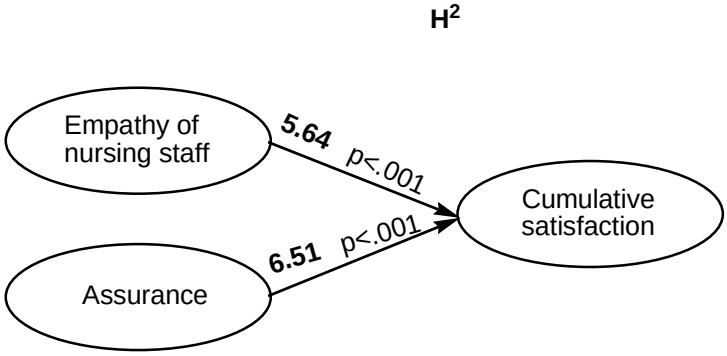
Recognised as a short-term, consumer-owned judgement, customer satisfaction is an important determinant of future behavioural intentions – in this study, willingness to reuse or recommend to others. On the other hand, prior research has shown that 'overall' cumulative satisfaction is influenced by past satisfaction from period to period and that this changes gradually over time.

Hospital surveys of the 'quick-fix', troubleshooting kind might be effective in identifying immediate problem areas which, for the patient, might only get to

be rectified after the patient has left the hospital, in which case the patient does not benefit from the corrective action taken. Such results could produce only short-term solutions, whereas long-term strategies and programmes that target cumulative patient satisfaction will have a greater impact on efforts to improve service quality in hospitals and the ongoing satisfaction of their patients, the paying customers.

Hospital management could also monitor 'overall' patient satisfaction, even after discharge from the hospital and not only upon discharge itself. Additionally, patients who are viewed as likely to require follow-up hospital visits over a period of time could be targeted to participate in ongoing research. The feedback generated from former patients 'post-visit' will provide useful information for implementing long-term patient satisfaction goals.

Figure 9.2: Service quality dimensions that influence cumulative 'overall' satisfaction



As shown in Figure 9.2, Empathy of nursing staff and Assurance of a safe hospital environment are the two dimensions of service quality that will enhance patients' ratings of 'overall' satisfaction (see also previous section). As with patient loyalty, also discussed in the previous section, commitment to and effective management of these two dimensions is essential to addressing and listening to patients' needs.

9.3.3 The influence of customer satisfaction on patient loyalty

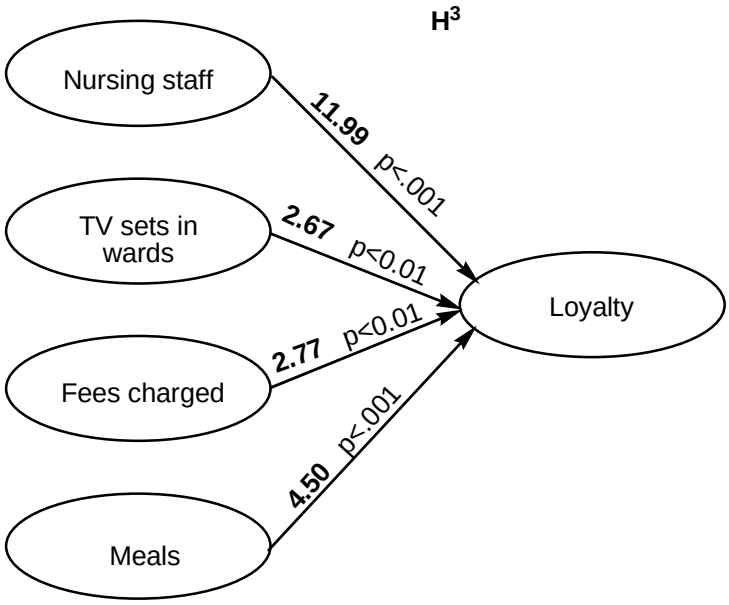
Any feedback generated from monitoring transaction-specific customer satisfaction perceptions in a private hospital setting must be acted on immediately by hospital management, as with private business enterprises in any other industry.

The environment in which private business enterprises compete, is constantly changing and change exerts pressure on the enterprise to foresee and adapt to change. Cronje et al. (2004:83) caution that unless an enterprise can adapt to change, and this includes private hospitals, it will be unable to compete in the new global economy.

One area where a private hospital can gain the upper hand, is to constantly improve its understanding of patient service if it intends to satisfy its patients through superior customer service over time. Patients are a hospital's lifeblood, thus rendering it liable for creating an environment for customer satisfaction if the hospital is to remain viable over the long-run. Environmental change also includes changing consumer habits, preferences and other behaviours, from which a private hospital is not likely to be excluded. It therefore needs to adapt to any changing *consuming* behaviour in its patients.

It is clear from Figure 9.3, that private hospitals will need to compete across four transaction-specific short-term dimensions of customer satisfaction if they aim to improve loyalty in the long-term. The dimension, Satisfaction with the quality of the meals served, refers to patients wanting meals that are tasty, nutritious and attractively presented. In addition, meals should be served at the correct temperature and in a variety of different ways.

Figure 9.3: Customer satisfaction dimensions that influence patient loyalty



Satisfaction with the calibre and quality of nursing staff employed in a private hospital and the role they play in caring for their patients, is of critical importance, as Figure 9.3 indicates. Patients who experienced nursing staff as cheerful, responsive to patients' needs, prompt, kind and caring, and sufficiently skilled in their profession, are significantly more likely to reuse the same hospital should the need arise and also, to recommend it to others.

Patients are entrusted into the care of the nurses in their wards. Nurses do, after all, contribute to the patient's recovery and they constitute a vital link between the doctor, the patient, and in many cases, the patient's family. To reiterate the words of Schoeman (2000:49), 'patients are absolutely dependent on service' and because they are sick, Schoeman (2000:49) emphasises that patients 'should be given extra attention and empathy – it could drastically influence their quality of life.'

Satisfaction with the fees charged infers that patients are more likely to return to the hospital if they perceive the fees charged as reasonable, fair, but not expensive, and not only worth the money paid for the service

rendered, but also good value for money as well. Hospitals must demystify their billing systems so that patients, not only their medical aids, can see exactly what they are being billed for.

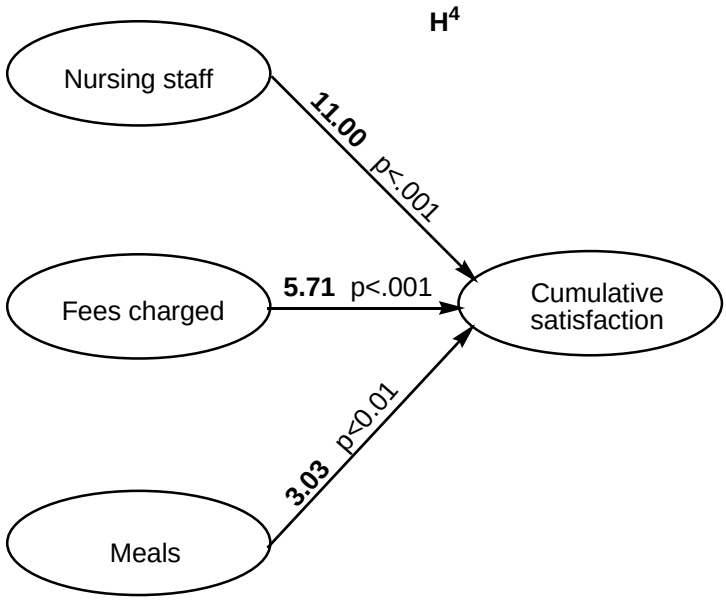
Patients are entitled to receive an itemised account, without first having to ask for it. Hospital management is responsible for ensuring that patients are not overcharged and when necessary, provide proper justification or explanation for exceptional charges.

Evidently, patients would like some form of ‘entertainment’ while in the hospital. The evidence suggests that patients regard the provision of a television set or sets in the ward as ‘given’. However, care must be taken to ensure access to a properly functioning television set. It would not be out of place for patients to expect the hospital to provide a back-up set or have a repair service on hand to ensure their uninterrupted viewing and enjoyment (especially where longer staying patients are concerned).

9.3.4 The influence of customer satisfaction on ‘overall’ cumulative satisfaction

As in the previous diagram, Figure 9.4 here confirms three of the same transaction-specific dimensions of customer satisfaction on ‘overall’ cumulative satisfaction, namely Satisfaction with the quality of the meals served, Satisfaction with the quality of nursing staff employed and Satisfaction with the fees charged. Patients who experience high levels of satisfaction with these dimensions will, besides remaining loyal to the hospital through their willingness to return and/or recommend it to others, also experience high levels of satisfaction with the whole stay. Subsequently, dimensional level customer satisfaction judgements of the service encounter will impact on patients' cumulative satisfaction over a period of time.

Figure 9.4: Customer satisfaction dimensions that influence 'overall' cumulative satisfaction



9.4 CONTRIBUTIONS OF THE STUDY

The main contributions of this study to the body of knowledge of patient satisfaction are contained in the interpretation of the results and are discussed in section 9.3, and consequently will not be repeated here. However, some important additional contributions to the study are summarised below.

- The relationships between service quality, customer satisfaction and their outcomes, specifically future behavioural intentions in the South African private hospital sector, have not until now been considered for empirical study. The present study was thus one of the first to attempt to measure which dimensions of both service quality and customer satisfaction were the most important 'drivers' of loyalty (as measured by willingness to reuse the hospital if the occasion arose in the future and willingness to recommend the hospital to others) and 'overall' or cumulative satisfaction.

- The measuring instrument was extensive. A total of 117 items (variables) including biographical information were measured. A 7-point Likert scale

was developed for the service quality and customer satisfaction dimensions contained in the hypothesised model developed for this study (refer to Figure 1.1 in Chapter 1). Semantic differential scales were used to measure cumulative satisfaction. The theoretical model measured the impact of two groups of independent variables on two dependent variables.

Fifty-four statements were used to measure ten dimensions of service quality, based on the original SERVQUAL scale of ten dimensions (subsequent research reduced it to five dimensions. See Chapter 4). Forty-eight statements were used to measure seven dimensions of customer satisfaction. These statements were based on a thorough literature review and the exploratory study that preceded the empirical research. Five statements were used to measure loyalty and three were used to measure 'overall' cumulative satisfaction.

Based on the results of the Cronbach alpha coefficients calculated for the summated scales, (with alpha values well in excess of the 0.7 threshold), the measuring instrument was considered reliable. It should therefore be possible to replicate this study in the future. The scales developed for the current study could also be reused in future research.

- The numerous unsolicited, but nonetheless relevant comments which many of the respondents appendaged to their questionnaires as personal thoughts of their hospital experience, could provide useful subject matter to warrant exploratory research. If this proves to be the case, the information could even be used to initiate further descriptive research. Some of these comments also have the potential to be used as material for mini services marketing case studies.

- From the empirical results of the study, the dimensions to emerge as most likely to influence patient loyalty and 'overall' cumulative satisfaction could make an important contribution to the body of knowledge on two fronts. Firstly, to contribute to the services marketing literature and provide further insights into the elements that influence patient

satisfaction in the healthcare industry. Patients are customers too and are therefore entitled to receive a high standard of service delivery and experience a high level of customer satisfaction. Secondly, to contribute to private healthcare's current understanding of the 'drivers' of loyalty and cumulative satisfaction and in particular, to private hospital management, the kinds of perceptions that patients expect will be met during a hospital stay, not only as a 'once-off' experience, but also over time, should the need arise in future for another hospital visit.

While much of this information might already be well-known in hospital management circles, the insights gained from undertaking proper scientific research will help to truthfully reveal the realities of a business problem and reinforce to management what is already known about patient satisfaction. The knowledge gained from this study might also assist in more effective management decisions.

- This study is deemed to be the first scientific investigation in the country's private hospital industry to measure two customer-owned judgements of a private hospital visit. The results thereof identified the most important dimensions of service quality and customer satisfaction that would influence a private hospital patient's loyalty (or intentions to repurchase measured by willingness to reuse or recommend to others) toward it.

9.5 LIMITATIONS OF THE STUDY

Service quality and customer satisfaction are two important constructs in the services marketing literature. Although the present study attempted to make a contribution to the body of knowledge concerning the influence of service quality and customer satisfaction on future behavioural intentions of private hospital patients, several limitations should also be noted. These limitations should be considered in any future research on service quality and/or customer satisfaction in the private hospital sector.

The study was limited to one hospital group only and the hospitals that could be visited for data gathering purposes were determined by the

participating hospital group. Five of its hospitals were visited for the study (convenience sampling), a number that was considered adequate to meet the requirements for degree purposes. However, the sample size was drawn from only one of the country's three major private hospital groups, whereas collectively, these three groups own the approximately 178 private hospitals in South Africa.

A further limitation was that the researcher had to rely on hospital staff to distribute the questionnaires randomly to qualifying patients inside the hospital wards within a limited timeframe. Although distribution was done by designated hospital staff, it was carried out largely at their discretion. However, the instructions provided at the briefing session conducted at each hospital beforehand did specify the distribution process that had to be followed. As a consequence of the random sampling procedure, the empirical results and interpretations of the findings could not be generalised to the population.

It is therefore recommended that any future research should be aimed at all three hospital groups and that a sample is also drawn from all three groups.

Access to a database of patients was another limitation. Because of the confidentiality clause that exists between each hospital and its patients, and despite initial efforts to obtain one, access to the participating hospitals' database of patient admissions as a mailing list, could not be granted – hence the random distribution of questionnaires inside hospital wards. One advantage of using a hospital's patient admission list is that respondents can be screened according to the study's qualifying criteria and controlled by the researcher.

As is typically the case with mail surveys, response rate is often low. This study was no exception. Whereas questionnaire distribution took place in the hospital wards, respondents were required to mail them back. Out of a total distribution of 3800 questionnaires only 425 (11,2%) were returned before the deadline date and 323 (8.5%) could be statistically analysed. This figure indicates a somewhat disappointing response rate. One

possible assumption mooted for the low return could have been that respondents, as patients, were in fact not in peak health at the time of participating in the study, having just been in the hospital. Another reason could have been the length of the questionnaire, which was eight pages long in total, in spite of its reduced appearance in an A5 booklet.

An option for future research is to have patients complete and return the questionnaire while still in the hospital, just before discharge, or even as part of the discharge procedure itself. In this way, a greater return rate of questionnaires might be achieved.

The measuring instrument was long, as mentioned in the previous point, and some scales were removed after the exploratory factor analysis due to poor reliability. Since the study can be replicated in another hospital environment, but limited to the South African situation, the measuring instrument should definitely be shortened if used in future research.

In the South African private hospital context, the choice of hospital is very often not the patient's to make. The decision is usually made, or at the very least strongly recommended, by the referring doctor. This poses something of a dilemma in the private healthcare environment as it takes away the customer's prerogative to choose a service provider. Private hospitals must be committed to the task of ensuring that they deliver superior quality service that is not only affordable to their patients, but also designed to ensure ongoing customer satisfaction, even if their customers are mostly referred patients. The study did not attempt to delve into this area of the hospital/patient relationship. It could be the subject matter of an altogether different inquiry or debate.

The services marketing discipline is associated with service provider/ customer relationship obligations. The private healthcare provider, or private hospital, should be as firmly focused on competing for customers (private patients) and developing relationships with these customers, as any other service provider in the marketplace is. The private hospital/ private patient kind of relationship might be a uniquely different one that is

not yet fully understood. This study attempted to make a contribution to the better understanding of this relationship.

The present study focused on one segment of the South African healthcare industry only, namely the private hospital sector. Current literature suggests that a number of persistent and unresolved problems have been plaguing the country's healthcare industry and that major changes to both the private and public sectors are on the cards. Any future developments in this area should be closely monitored.

With so many complex and broad issues at stake in the South African healthcare environment, it is inadvisable to concentrate on one area of the market only, such as private hospitals, especially as far as the healthcare consumer is concerned. A change in one area of healthcare is likely to have an impact on another. Future research into some of these and other areas of South Africa's healthcare industry, with particular emphasis on hospital patients in general, therefore cannot be ignored, and will need to be widened in the future.

9.6 FINAL REMARKS

Private patients are the lifeblood of private hospitals – just like other categories of customers who choose to patronise other kinds of service providers are. Without a steady stream of customers, service providers would not survive and the profit motive hospitals are no exception. Even though the choice of hospital is not always the patient's to make (this prerogative belongs to, or is at least strongly influenced by, the patient's referring doctor), a customer is still always a customer. Satisfaction with the quality of care received after a hospital stay (and as the study has shown, there are many facets to the hospital stay), is ultimately a judgement that only the patient can make.

Countless volumes have been published illuminating the benefits that will be gained by improving quality of service and customer satisfaction, whether the business enterprise is a roadside trader or a multinational

corporation. For private hospitals, the benefits to be accrued if patients return include increased customer loyalty (former patients return when necessary and/or endorse recommendations to others), reduced price elasticities, lower costs, and over the long term, increased profitability.

While the financial returns of service quality and customer satisfaction were not a component of this study, there can be no doubt that the one cannot exist without the other. Private hospitals will need to continue to compete aggressively to attract patients. Striving for superior quality of service to achieve the goal of maximum customer satisfaction in an increasingly competitive healthcare environment, remains as valid a competitive advantage today as it will in the future.

Through an investigation of this nature, an attempt was made to highlight the dimensions of customer-judged service quality (based on previous service quality research) and transaction-specific customer satisfaction that are most likely to exert the strongest influence on patient loyalty, as measured by willingness to reuse the same hospital and recommend it to others, and 'overall' cumulative satisfaction over the long-term. Patients responded by stating their current perceptions of the quality of healthcare they expected to receive. In the South African context, from this research it can be learnt that patients are beginning to exhibit clear expectations of what private hospitals should deliver by way of customer service. Patients must therefore continue to see themselves more as customers rather than just as sick people to ensure that demands for a consistently high standard of customer service are delivered throughout the hospital stay.

The study showed that, from a clinical perspective, high on the agenda remains a hospital's nursing staff: a caring, empathetic attitude and appropriate nursing skills are still tops. So, too, is a hospital conveying 'peace of mind' assurance to its patients that they are in safe hands during their stay.

On the hospitality side, patients expect a clean hospital inside and out, in physically appealing buildings and wards. Understandably, patients expect

quality meals to be served and hospitals to charge reasonable fees. Some entertainment is also expected. Patients at present favour the provision of a television service in their wards. In the future, other forms of ‘entertainment’ and alternative distractions could be demanded.

The influence of service quality and customer satisfaction on patients of private hospitals has not enjoyed the attention it deserves. Empirical research of the South African healthcare industry, specifically private hospitals, and remains limited to the few studies listed in Chapter 1. Such a lack of knowledge in this area suggests that future research is needed to improve the current understanding of patient/customer behaviour in private hospitals. If the current structure of the South African healthcare industry, namely the private and public sector and emerging public private partnership hospitals should change in the future, these changes might shift the present debate around patient satisfaction.

In conclusion, it is hoped that future research will shed additional light on the relationship between service quality, customer satisfaction and the future behavioural intentions of private patients, and the impact that these relationships will have on the private hospitals that compete for them. The delivery of consistent quality service that satisfies customers (patients) is as important in a hospital as it is in a grocery store or bank.

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ANNEXURE A

COVERING LETTER
(ENGLISH/AFRIKAANS)

CENTRE FOR APPLIED BUSINESS MANAGEMENT
SENTRUM VIR TOEGEPASTE ONDERNEMINGSBESTUUR

Dear Respondent

SURVEY ON PATIENT SATISFACTION

The Centre for Applied Business Management at UPE is conducting research on medical services. We are particularly interested to learn how patients, as customers, felt about their stay and whether they would be willing to re-use the hospital again, or recommend it to family and friends. Your perceptions and opinions about this experience will be very valuable indeed.

Please take a few moments to fill in the enclosed questionnaire **after your discharge** from the hospital. It should take no longer than fifteen minutes to complete. Return it in the reply-paid, pre-addressed envelope to reach us no later than **8 December 2000, or at your earliest convenience**. There are no right or wrong answers. Simply record your immediate response to each question as you feel it applies to you. Please note that participation is entirely voluntary.

All responses will be treated in the strictest confidence. Because no personal details have been asked, respondents will remain anonymous.

The sponsor of this survey has generously agreed to donate R5,00 per completed questionnaire which is returned to us by the deadline date, to the Mother of Hope Centre. This community-based organisation provides shelter to victims of family violence, unfortunately, a growing trend in South African society today. These victims are mostly women and their children from all walks of life and from all parts of South Africa, who have suffered physical and emotional abuse. Your participation in the survey will help this very worthy cause in their strive toward stamping out violence against women and their children.

Thank you in advance for your time and willingness to participate. Your valued contribution will allow hospitals to improve their service to their customers.

Yours faithfully

BEVERLEY GRAY: RESEARCHER

Geagte Respondent

MENINGSOPNAME OOR MEDIESE DIENSTE

Die Sentrum vir Toegepaste Ondernemingsbestuur by die UPE doen tans navorsing oor mediese dienste. Ons is besonder geïnteresseerd in hoe pasiënte – as klante – voel omtrent hulle verblyf in 'n hospitaal en of hulle bereid sal wees om weer van die betrokke hospitaal gebruik te maak, of dit aan te beveel by familie en vriende. U mening en persepsies omtrent u ondervinding sal uiters waardevol wees.

Ruim dus asseblief 'n paar oomblikke in om die ingeslote vraelys te beantwoord **nadat u die hospitaal verlaat** het. Dit behoort u nie langer as 15 minute te neem om die hele vraelys te voltooi nie. Stuur dit dan asseblief terug in die ingeslote, voorafbetaalde en geadresseerde koevert om ons nie later nie as **8 Desember 2000, of wanneer dit vir u geleë is,** te bereik. Daar bestaan geen korrekte of verkeerde antwoorde nie. Gee slegs u onmiddellike antwoord wat op elke vraag spontaan na vore kom. Let daarop dat u deelname heeltemal vrywillig is.

Alle antwoorde sal streng vertroulik hanteer word. Aangesien geen persoonlike besonderhede van respondente gevra word nie, bly u dus anoniem.

Die borg van die opname het ingestem om R5,00 vir elke voltooide vraelys te skenk wat teen die sperdatum terug ontvang word. Hierdie geld word aan die *"Mother of Hope Centre"* geskenk – 'n gemeenskapsentrum wat skuiling bied vir slagoffers van gesinsgeweld. Die slagoffers is hoofsaaklik vroue en kinders wat fisieke en emosionele mishandeling ervaar het. U deelname aan hierdie meningsopname kan dus ook 'n waardevolle bydrae lewer om landswyd die geweld teen vroue en kinders hok te slaan.

Baie dankie by voorbaat vir u tyd en bereidwilligheid om aan hierdie opname deel te neem. U gewaardeerde bydrae sal hospitale in staat stel om hul diens aan hulle klante te verbeter.

Vriendelik die uwe

BEVERLEY GRAY: NAVORSER

UNIVERSITY OF PORT ELIZABETH/UNIVERSITEIT VAN PORT ELIZABETH, PO BOX/POSBUS 1600, PORT ELIZABETH, 6000, SOUTH AFRICA/SUID-AFRIKA. TEL +27 41 5042875 FAX/FAKS +27 41 5042574 e-mail: ecasme@upe.ac.za

ANNEXURE B

QUESTIONNAIRE
(ENGLISH VERSION)

UNIVERSITY OF PORT ELIZABETH

CENTRE FOR APPLIED BUSINESS MANAGEMENT

SURVEY

ON

PATIENT SATISFACTION

QUESTIONNAIRE
SURVEY ON PATIENT SATISFACTION

Thank you for participating in this study – and helping a worthy charity in need!

SECTION A: OVERALL OPINION ABOUT QUALITY OF THE HOSPITAL'S SERVICE

This section refers to how you feel about *St George's* Hospital overall. In other words, your opinion generally, about the hospital. Please bear in mind that the following list of questions is intended to find out how you feel about *St George's* generally, **before** being influenced by this recent hospital stay.

INSTRUCTIONS: There are no right or wrong answers. Each question has seven possible alternatives, ranging from strongly disagree to strongly agree. Record your response to each one by circling the alternative that best describes how you feel (usually, it's the one that comes to mind first). For example, circle 1 if you **strongly disagree** with a statement, alternatively, circle 7 if you **strongly agree** with a statement (or any other number between 2 and 6 if you so wish). It is recommended that one works through the questions quickly, and be guided by one's intuition, instead of pondering for too long before making a decision. A more accurate observation is then possible.

PLEASE RESPOND TO ALL QUESTIONS.

OVERALL OPINION	Strongly disagree	Disagree	Some-what disagree	Neither agree nor disagree	Some-what Agree	Agree	Strongly Agree	For Official use
St George's physical facilities are visually appealing	1	2	3	4	5	6	7	TANP1
Doctors look smartly dressed and professional when doing their ward visits	1	2	3	4	5	6	7	TANS3
Generally, *St George's* is a clean hospital	1	2	3	4	5	6	7	TANP3
Overall, the service at *St George's* is excellent	1	2	3	4	5	6	7	RELI6
St George's has tastefully decorated wards	1	2	3	4	5	6	7	TANP5
Overall, *St George's* serves good food to its patients	1	2	3	4	5	6	7	TANP6
Patients have nothing to fear by going to *St George's*	1	2	3	4	5	6	7	SECU1
Nursing staff at *St George's* look professional and neat in their uniforms	1	2	3	4	5	6	7	TANS2
The wards at *St George's* are kept spotlessly clean	1	2	3	4	5	6	7	TANP4
St George's maintains a neat appearance of its buildings	1	2	3	4	5	6	7	TANP2
Generally, *St George's* performs its services by the promised times	1	2	3	4	5	6	7	RELI1
St George's performs its services in the manner patients were told the services would be performed	1	2	3	4	5	6	7	RELI2
When patients have problems, *St George's* is sympathetic and reassuring	1	2	3	4	5	6	7	RELI3
Doctors can be counted on to attend to their patients' needs	1	2	3	4	5	6	7	RELI4
Patients can depend on a service such as an operation to be properly carried out	1	2	3	4	5	6	7	RELI5
Hospital staff have a pleasant attitude toward patients' visitors	1	2	3	4	5	6	7	COUR3

OVERALL OPINION	Strongly disagree	Disagree	Some-what disagree	Neither agree nor disagree	Some-what Agree	Agree	Strongly Agree	For Official use
The nurses are never too busy to respond to patients' needs	1	2	3	4	5	6	7	RESP1
Doctors are punctual when conducting their ward rounds	1	2	3	4	5	6	7	RESP2
Doctors will see patients between ward visits if required to do so	1	2	3	4	5	6	7	RESP3
Administrative staff never show that they are too busy to respond to patients' requests	1	2	3	4	5	6	7	RESP4
Admission of patients is handled quickly and efficiently by administrative staff	1	2	3	4	5	6	7	RESP5
Discharge of patients is handled quickly and efficiently by administrative staff	1	2	3	4	5	6	7	RESP6
St George's has a reputation for using highly skilled medical staff	1	2	3	4	5	6	7	ASSU1
Patients can feel confident in the quality of medical care offered by *St George's*	1	2	3	4	5	6	7	ASSU2
Medical staff display a sound knowledge of their respective fields	1	2	3	4	5	6	7	ASSU3
Administrative staff are efficient at dealing with patients' queries/problems	1	2	3	4	5	6	7	ASSU4
Nursing staff are efficient at dealing with patients' queries/problems	1	2	3	4	5	6	7	ASSU5
Patients are treated with respect by hospital staff	1	2	3	4	5	6	7	COUR1
Patients can expect that *St George's* will deliver on its promises	1	2	3	4	5	6	7	CRED1
St George's uses the latest equipment and machinery (eg., x-ray machines)	1	2	3	4	5	6	7	TANE1
Patients can rely on hospital staff to thoroughly explain procedures	1	2	3	4	5	6	7	COMM1
Patients can be sure of receiving adequate information about their condition	1	2	3	4	5	6	7	COMM2
Patients can be sure of receiving adequate information about their treatment	1	2	3	4	5	6	7	COMM3
Patients can rely on having their discharge care (i.e. how to look after themselves when they go home) thoroughly explained	1	2	3	4	5	6	7	COMM4
St George's provides accounts that are easy to follow	1	2	3	4	5	6	7	COMM5
Patients can depend on hospital staff to listen to their queries/concerns	1	2	3	4	5	6	7	COMM6
Administrative staff show a sincere interest in solving patients' problems	1	2	3	4	5	6	7	COMM7
Hospital staff are courteous and helpful toward patients	1	2	3	4	5	6	7	COUR2
Patients can feel confident in the treatment they will receive	1	2	3	4	5	6	7	CRED2
St George's has an excellent reputation	1	2	3	4	5	6	7	CRED3
St George's cares about its patients	1	2	3	4	5	6	7	CRED4
Patients can feel safe in the hands of *St George's*	1	2	3	4	5	6	7	SECU2
Administrative staff at *St George's* look professional and neat in their uniforms	1	2	3	4	5	6	7	TANS1
St George's provides adequate security inside the hospital	1	2	3	4	5	6	7	SECU3
St George's provides adequate security outside the hospital	1	2	3	4	5	6	7	SECU4

OVERALL OPINION	Strongly disagree	Disagree	Some-what disagree	Neither agree nor disagree	Some-what Agree	Agree	Strongly Agree	For Official use
Nursing staff at *St George's* know how to cope with all types of patients	1	2	3	4	5	6	7	EMPA1
Adequate parking is always available at *St George's*	1	2	3	4	5	6	7	EMPA2
St George's provides informative literature on relevant topics	1	2	3	4	5	6	7	EMPA3
Nursing staff treat patients with a warm and caring attitude	1	2	3	4	5	6	7	UNDE1
Patients at *St George's* are given lots of individual (personal) attention	1	2	3	4	5	6	7	UNDE2
The nursing staff show understanding when patients are feeling at a low ebb	1	2	3	4	5	6	7	UNDE3
Patients will **not** feel that their needs are neglected by nursing staff, irrespective of the time of day or night	1	2	3	4	5	6	7	UNDE4
Nursing staff show understanding toward patients' feelings of discomfort	1	2	3	4	5	6	7	UNDE5
St George's shows concern for family/visitors	1	2	3	4	5	6	7	UNDE6

SECTION B: CUSTOMER SATISFACTION WITH RECENT HOSPITAL VISIT

This section refers only to your recent stay as a patient (a customer) at *St George's* Hospital. How satisfied were you as a customer during this stay? **The following list of questions refers exclusively to this recent stay.** While it might appear that some questions have been repeated, please respond to each one based only on your recent stay at *St George's.*

INSTRUCTIONS: As with the previous section there are no right or wrong answers. Each question has seven possible alternatives, ranging from strongly disagree to strongly agree. Record your response to each one by circling the alternative that best describes how you feel (usually, it's the one that comes to mind first). For example, circle 1 if you **strongly disagree** with a statement, alternatively, circle 7 if you **strongly agree** with a statement (or any other number between 2 and 6 if you so wish). It is recommended that one works through the questions quickly, and be guided by one's intuition, instead of pondering for too long before making a decision. A more accurate observation is then possible.

RECENT STAY	Strongly disagree	Disagree	Some-what disagree	Neither agree nor disagree	Some-what Agree	Agree	Strongly Agree	For Official Use
As a patient at *St George's* my admittance procedure was carried out promptly	1	2	3	4	5	6	7	ADMI1
On the day of admission there was a long queue of patients waiting	1	2	3	4	5	6	7	ADMI2
Administrative staff were courteous and helpful at the admissions counter	1	2	3	4	5	6	7	ADMI3
Administrative staff were willing to listen to my concerns	1	2	3	4	5	6	7	ADMI4
A hospital staff member took me to my ward	1	2	3	4	5	6	7	WARD1
The ward into which I was booked was properly prepared	1	2	3	4	5	6	7	WARD2
Upon arrival in the ward, the nursing staff explained what I had to do next	1	2	3	4	5	6	7	WARD3
Shortly after arrival, I was shown the bathroom/ward facilities	1	2	3	4	5	6	7	WARD4
Considering the fees charged, my stay at *St George's* was worth the money	1	2	3	4	5	6	7	CHAR1
The nursing staff were kind and caring throughout my stay	1	2	3	4	5	6	7	WARD5
The nursing staff responded promptly at all times to my needs	1	2	3	4	5	6	7	WARD6
The nursing staff were always cheerful	1	2	3	4	5	6	7	WARD7
The nursing staff were skilled in administering medical procedures	1	2	3	4	5	6	7	WARD8
The bed linen was changed daily	1	2	3	4	5	6	7	WARD9
Medication was administered at the correct times	1	2	3	4	5	6	7	WARD10
There was a television set in the ward	1	2	3	4	5	6	7	WARD11
The television sets functioned properly	1	2	3	4	5	6	7	WARD12
The volume of the television sets around me was too loud	1	2	4	4	5	6	7	WARD13
The bedside radio stations all worked	1	2	3	4	5	6	7	WARD14
The decor in the ward was pleasantly appealing	1	2	3	4	5	6	7	WARD15
It was a pleasure to stay in this ward	1	2	3	4	5	6	7	WARD16
Preparation for surgery was carried out efficiently	1	2	3	4	5	6	7	THEA1
Pre-medication (for surgery) was administered at the correct time	1	2	3	4	5	6	7	THEA2
Surgical procedures were thoroughly explained	1	2	3	4	5	6	7	THEA3

RECENT STAY	Strongly disagree	Disagree	Some-what disagree	Neither agree nor disagree	Some-what Agree	Agree	Strongly Agree	For Official Use
The nursing staff eased my fears about the surgery	1	2	3	4	5	6	7	THEA4
The anaesthetist came to explain his role during the operation	1	2	3	4	5	6	7	THEA5
On route to the operating theatre, theatre staff were kind and reassuring	1	2	3	4	5	6	7	THEA6
In the theatre, I felt that I was in safe hands	1	2	3	4	5	6	7	THEA7
I would not mind returning to *St George's* again	1	2	3	4	5	6	7	WILL1
Considering the quality of service at *St George's*, their fees are reasonable	1	2	3	4	5	6	7	CHAR2
On the whole, I enjoyed the food while I was a patient at *St George's*	1	2	3	4	5	6	7	MEAL1
Meals were always served at the correct temperature (eg hot meals were still hot on arrival)	1	2	3	4	5	6	7	MEAL2
Meals were tasty	1	2	3	4	5	6	7	MEAL3
Meals were nutritious	1	2	3	4	5	6	7	MEAL4
Meals were attractively presented	1	2	3	4	5	6	7	MEAL5
Meals were served in a variety of ways	1	2	3	4	5	6	7	MEAL6
The food at *St George's* should be improved substantially	1	2	3	4	5	6	7	MEAL7
I was satisfied with the times when the meals were served	1	2	3	4	5	6	7	MEAL8
I would have preferred *St George's* to serve meals at different times than those utilized	1	2	3	4	5	6	7	MEAL9
Meals were selected from a daily choice off a menu	1	2	3	4	5	6	7	MEAL10
Meals catered for special dietary requirements	1	2	3	4	5	6	7	MEAL11
Ablution facilities were kept clean throughout my stay	1	2	3	4	5	6	7	HOUS1
St George's fees are not expensive	1	2	3	4	5	6	7	CHAR3
My ward was cleaned daily	1	2	3	4	5	6	7	HOUS2
Lights were not left burning all night	1	2	3	4	5	6	7	HOUS3
Noise levels were kept to a minimum during the night	1	2	3	4	5	6	7	HOUS4
My visitors were satisfied that parking was adequate	1	2	3	4	5	6	7	VISI1
My visitors were treated courteously by hospital staff	1	2	3	4	5	6	7	VISI2
I would definitely return to this hospital in future if necessary	1	2	3	4	5	6	7	WILL2
I would recommend this hospital to family and friends	1	2	3	4	5	6	7	RECO1
In an emergency, this is the hospital I would like to be admitted into	1	2	3	4	5	6	7	WILL3
I regard myself as a “loyal” customer of *St George's*	1	2	3	4	5	6	7	WILL4
A stay at *St George's* is good value for money	1	2	3	4	5	6	7	CHAR4

INSTRUCTIONS CONTINUED: On a scale from one to seven, starting with a positive description on the extreme left, please circle the number which best describes your opinion to each of the following questions listed below:

									For official use
Overall, how satisfied were you with your stay at *St George's*?									
	Satisfied	7	6	5	4	3	2	1	Dissatisfied	SEM1
How would you rate the overall standard of service at *St George's*?									
	Excellent	7	6	5	4	3	2	1	Poor	SEM2
Did you comment on any aspect of your hospital stay to any hospital staff member?									
	Praised	7	6	5	4	3	2	1	Complained	SEM3
If you received poor service from *St George's*, did you tell any friends, family members, or acquaintances about this poor service?									
	Told	7	6	5	4	3	2	1	Kept quiet	SEM4
Were you satisfied with the manner in which *St George's* dealt with your medical aid or insurance cover?									
	Efficient	7	6	5	4	3	2	1	Inefficient	SEM5

HOW LONG WAS THIS HOSPITAL STAY?	**Insert total days in box provided**		**DUR1**
How many days did you spend in the hospital?			

SECTION C: PERSONAL DATA

Please complete this section. The information will be used for statistical purposes only. Working through each category, place an X in the appropriate blocks which best describe you.

GENDER	
MALE □ 1	FEMALE □ 2

AGE GROUP			
20-24 □ 1	35-39 □ 2	50-54 □ 4	65-69 □ 5
25-29 □ 1	40-44 □ 3	55-59 □ 4	70-74 □ 6
30-34 □ 2	45-49 □ 3	60-64 □ 5	75+ □ 6

HOME LANGUAGE (tick more than one if applicable)				
English □ 1	Afrikaans □ 2	Xhosa □ 3	Zulu □ 4	Other (please specify) □_____ 1

NUMBER OF PEOPLE LIVING IN YOUR HOUSEHOLD					
1 □ 1	2 □ 2	3 □ 3	4 □ 4	5 □ 5	6+ □ 6

TOTAL MONTHLY HOUSEHOLD INCOME (BEFORE TAX)					
R0-R2999 □ 1	R3000-R5999 □ 2	R6000-R8999 □ 3	R9000-R11999 □ 4	R12000-R14999 □ 5	R15000+ □ 6

WHAT TYPE OF MEDICAL COVER DO YOU HAVE?				
Medical aid □ 1	Hospital plan □ 2	Medical aid + 'gap cover' □ 3	No medical cover at all □ 4	Other (please specify) □_____ 5

HIERDIE VRAELYS IS OP AANVRAAG IN AFRIKAANS BESKIKBAAR

THANK YOU FOR YOUR PARTICIPATION. THE INFORMATION PROVIDED WILL BE OF IMMENSE VALUE TOWARD IMPROVING HOSPITAL SERVICES.

CONTACT DETAILS

Should you have any further enquiries, or wish to receive a summary of the results of the study, please note our contact details as follows:

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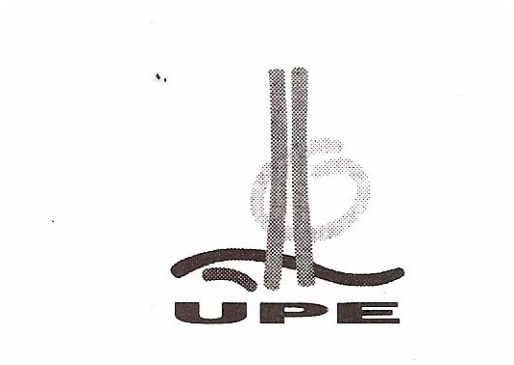
ANNEXURE C

QUESTIONNAIRE
(AFRIKAANS VERSION)



UNIVERSITEIT VAN PORT ELIZABETH

SENTRUM VIR TOEGEPASTE ONDERNEMINGSBESTUUR

MENINGSOPNAME

OOR

MEDIESE DIENSTE

VRAELYS
MENINGSOPNAME OOR MEDIESE DIENSTE

Dankie vir u deelname aan hierdie studie - ten einde 'n waardige liefdadigheidsorganisasie te help!

AFDELING A:
U ALGEHELE MENING OMTRENT DIE KWALITEIT VAN DIE HOSPITAAL SE DIENS

Hierdie afdeling verwys na u algehele gevoel omtrent *St George's* Hospitaal. Hou asseblief in gedagte dat die volgende vrae gestel is om uit te vind hoe u oor *St George's* in die algemeen voel, voordat u onlangs in hierdie hospitaal gebly het.

INSTRUKSIES: Daar is geen regte of verkeerde antwoorde nie. Elke vraag het sewe moontlike alternatiewe wat wissel vanaf stem beslis nie saam nie tot stem beslis saam. Omsirkel u antwoord op elke vraag, of die alternatief wat u mening die beste beskryf (gewoonlik is dit die een wat eerste in u gedagte kom). Byvoorbeeld, as u met 'n stelling beslis nie saamstem nie, omsirkel 1, of alternatiewelik, as u beslis saamstem met 'n stelling, omsirkel 7 (of, as u so voel, enige ander nommer tussen 2 en 6). Dit word aanbeveel dat 'n mens vinnig deur die vrae werk en deur 'n mens se intuïsie gelei word, in plaas daarvan om te lank daaroor te dink voordat u 'n besluit neem. 'n Meer akkurate waarneming is dan moontlik.

BEANTWOORD ASSEBLIEF ALLE VRAE

U ALGEHELE INDRUK VAN ST GEORGE'S	Stem beslis nie saam nie	Stem nie saam nie	Verskil effens	Neutraal	Stem effens saam	Stem saam	Stem beslis saam	Vir Kantoor-gebruik
St George's se fisiese fasiliteite vertoon goed	1	2	3	4	5	6	7	TANP1
Die dokters by *St George's* is netjies geklee tydens saalrondtes en lyk professioneel	1	2	3	4	5	6	7	TANS3
In die geheel gesien is *St George's* 'n skoon hospitaal	1	2	3	4	5	6	7	TANP3
In die geheel gesien is die diens by *St George's* uitmuntend	1	2	3	4	5	6	7	RELI6
St George's se sale is smaakvol gemeubileer	1	2	3	4	5	6	7	TANP5
In die geheel gesien verskaf *St George's* goeie maaltye aan pasiënte	1	2	3	4	5	6	7	TANP6
Pasiënte het niks om te vrees tydens 'n besoek aan *St George's* nie	1	2	3	4	5	6	7	SECU1
Die verpleegpersoneel by *St George's* lyk professioneel en netjies in hul uniforms	1	2	3	4	5	6	7	TANS2
Die sale by *St George's* word onberispelik skoon gehou	1	2	3	4	5	6	7	TANP4
St George's se geboue word in 'n netjiese toestand gehou	1	2	3	4	5	6	7	TANP2
In die geheel gesien lewer *St George's* hul dienste op die verwagte tye	1	2	3	4	5	6	7	RELI1
St George's lewer hul dienste op die wyse soos vooraf deur hulle onderneem	1	2	3	4	5	6	7	RELI2
Indien 'n pasiënt 'n probleem het, is *St George's* simpatiek en bemoedigend	1	2	3	4	5	6	7	RELI3
Mens kan op die dokters staatmaak om na die behoeftes van pasiënte om te sien	1	2	3	4	5	6	7	RELI4
Pasiënte kan daarop staatmaak dat 'n diens soos 'n operasie behoorlik uitgevoer sal word	1	2	3	4	5	6	7	RELI5
Die hospitaalpersoneel is aangenaam in hul interaksie met pasiënte	1	2	3	4	5	6	7	COUR3

U ALGEHELE INDRUK VAN ST GEORGE'S	Stem beslis nie saam nie	Stem nie saam nie	Verskil effens	Neutraal	Stem effens saam	Stem saam	Stem beslis saam	Vir Kantoor-gebruik
Die verpleegpersoneel is nooit te besig om na pasiënte se behoeftes om te sien nie	1	2	3	4	5	6	7	RESP1
Die dokters is stiptelik tydens hul saalrondtes	1	2	3	4	5	6	7	RESP2
Dokters is bereid om op versoek pasiënte buite geskeduleerde saalrondte tye te besoek	1	2	3	4	5	6	7	RESP3
Die administratiewe personeel laat nooit blyk dat hulle te besig is om op pasiënte se versoeke te reageer nie	1	2	3	4	5	6	7	RESP4
Die toelating van pasiënte word vinnig en effektief afgehandel	1	2	3	4	5	6	7	RESP5
Die administratiewe personeel handel die ontslag van pasiënte vinnig en effektief af	1	2	3	4	5	6	7	RESP6
St George's het 'n reputasie vir die gebruik van hoogsbevoegde mediese personeel	1	2	3	4	5	6	7	ASSU1
Pasiënte kan vertroue hê in die gehalte van mediese sorg by *St George's*	1	2	3	4	5	6	7	ASSU2
Die mediese personeel toon 'n diepgaande kennis van hul verskillende vakgebiede	1	2	3	4	5	6	7	ASSU3
Die administratiewe personeel hanteer pasiënte se probleme en vrae op 'n effektiewe wyse	1	2	3	4	5	6	7	ASSU4
Die verpleegpersoneel hanteer pasiënte se probleme en vrae op 'n effektiewe wyse	1	2	3	4	5	6	7	ASSU5
Die hospitaalpersoneel behandel pasiënte met respek	1	2	3	4	5	6	7	COUR1
Pasiënte kan verwag dat *St George's* alle ondernemings gestand sal doen	1	2	3	4	5	6	7	CRED1
St George's benut die mees moderne mediese toerusting (bv X-straalmasjiene)	1	2	3	4	5	6	7	TANE1
Pasiënte kan daarop staatmaak dat die hospitaalpersoneel alle prosedures volledig sal verduidelik	1	2	3	4	5	6	7	COMM1
Pasiënte kan gerus wees dat hul voldoende inligting oor hul toestand sal ontvang	1	2	3	4	5	6	7	COMM2
Pasiënte kan gerus wees dat hul voldoende inligting oor hul behandelingsmetodes sal ontvang	1	2	3	4	5	6	7	COMM3
Pasiënte kan daarop staatmaak dat hul na-hospitalisasie versorging (hoe om tuis na hulself om te sien) behoorlik aan hulle verduidelik sal word	1	2	3	4	5	6	7	COMM4
St George's se rekeninge is maklik verstaanbaar	1	2	3	4	5	6	7	COMM5
Pasiënte kan daarop staatmaak dat die hospitaalpersoneel na hul vrae en bekommernisse sal luister	1	2	3	4	5	6	7	COMM6
Die administratiewe personeel toon 'n opregte belangstelling om pasiënte se probleme op te los	1	2	3	4	5	6	7	COMM7
Die hospitaalpersoneel is bedagsaam en hulpvaardig teenoor pasiënte	1	2	3	4	5	6	7	COUR2
Pasiënte kan vertroue hê in die behandeling wat hulle sal ontvang	1	2	3	4	5	6	7	CRED2
St George's het 'n uitstekende reputasie	1	2	3	4	5	6	7	CRED3
St George's is besorgd oor sy pasiënte	1	2	3	4	5	6	7	CRED4
Pasiënte kan veilig voel in *St George's* se hande	1	2	3	4	5	6	7	SECU2
Die administratiewe personeel kom professioneel en netjies voor in hul uniforms	1	2	3	4	5	6	7	TANS1
St George's verskaf voldoende sekuriteit binne die hospitaal	1	2	3	4	5	6	7	SECU3

U ALGEHELE INDRUK VAN ST GEORGE'S	Stem beslis nie saam nie	Stem nie saam nie	Verskil effens	Neutraal	Stem effens saam	Stem saam	Stem beslis saam	Vir Kantoor-gebruik
St George's verskaf voldoende sekuriteit buite die hospitaal	1	2	3	4	5	6	7	SECU4
Die verpleegpersoneel by *St George's* weet hoe om alle soorte pasiënte te hanteer	1	2	3	4	5	6	7	EMPA1
Voldoende parkering is altyd by *St George's* beskikbaar	1	2	3	4	5	6	7	EMPA2
St George's verskaf insiggewende leesstof oor relevante onderwerpe	1	2	3	4	5	6	7	EMPA3
Die verpleegpersoneel is warm en besorgd oor pasiënte	1	2	3	4	5	6	7	UNDE1
Pasiënte by *St George's* ontvang persoonlike aandag	1	2	3	4	5	6	7	UNDE2
Die verpleegpersoneel toon begrip wanneer pasiënte terneergedruk voel	1	2	3	4	5	6	7	UNDE3
Die verpleegpersoneel sal pasiënte nie verwaarloos laat voel nie, ongeag die tyd van die dag of nag	1	2	3	4	5	6	7	UNDE4
Die verpleegpersoneel openbaar begrip vir pasiënte se ongemak	1	2	3	4	5	6	7	UNDE5
St George's is besorg oor pasiënte se familie en besoekers	1	2	3	4	5	6	7	UNDE6

AFDELING B: KLIËNTETEVREDENHEID MET ONLANGSE HOSPITAALBESOEK

Hierdie afdeling verwys slegs na u onlangse besoek as pasiënt (kliënt) by *St George's* Hospitaal. Hoe tevrede was u as kliënt gedurende hierdie besoek? Die volgende vrae verwys eksklusief na hierdie onlangse verblyf. Terwyl dit lyk asof sommige vrae herhaal word, baseer asseblief u antwoord op elkeen slegs met betrekking tot u onlangse verblyf by *St George's* .

INSTRUKSIES: Soos met die vorige afdeling, is daar geen regte of verkeerde antwoorde nie. Elke vraag het sewe moontlike keuses wat wissel vanaf stem beslis nie saam nie tot stem beslis saam. Omsirkel u antwoord op elke vraag, of die alternatief wat u mening die beste beskryf (gewoonlik is dit die een wat eerste in u gedagte kom). Byvoorbeeld, as u met 'n stelling beslis nie saamstem nie, omsirkel 1, of alternatiewelik, as u beslis saamstem met 'n stelling, omsirkel 7 (of, as u so voel, enige ander nommer tussen 2 en 6). Dit word aanbeveel dat 'n mens vinnig deur die vrae werk en deur 'n mens se intuïsie gelei word, in plaas daarvan om te lank daaroor te dink voordat u 'n besluit neem. 'n Meer akkurate waarneming is dan moontlik.

U ONLANGSE BESOEK AAN ST GEORGE'S	Stem beslis nie saam nie	Stem nie saam nie	Verskil effens	Neutraal	Stem effens saam	Stem saam	Stem beslis saam	Vir Kantoor-gebruik
As 'n pasiënt by *St George's* was my toelating flink afgehandel	1	2	3	4	5	6	7	ADMI1
Daar was 'n lang tou wagtende pasiënte die dag toe ek tot *St George's* toegelaat is	1	2	3	4	5	6	7	ADMI2
Die administratiewe personeel was bedagsaam en hulpvaardig tydens my toelating	1	2	3	4	5	6	7	ADMI3
Die administratiewe personeel was gewillig om na my bekommernisse te luister	1	2	3	4	5	6	7	ADMI4
'n Hospitaalpersoneellid het my na my saal vergesel	1	2	3	4	5	6	7	WARD1
Die saal waar ek moes bly was behoorlik voorberei	1	2	3	4	5	6	7	WARD2
Met my aankoms by die saal het die verpleegpersoneel aan my verduidelik wat my te doen staan	1	2	3	4	5	6	7	WARD3
Kort na my aankoms is die badkamer en ander fasiliteite aan my uitgewys	1	2	3	4	5	6	7	WARD4
Teen die agtergrond van die fooie, was my verblyf by *St George's* die geld werd	1	2	3	4	5	6	7	CHAR1
Die verpleegpersoneel was bedagsaam en besorgd dwarsdeur my verblyf	1	2	3	4	5	6	7	WARD5
Die verpleegpersoneel het vinnig gereageer op al my behoeftes	1	2	3	4	5	6	7	WARD6
Die verpleegpersoneel was altyd gemoedelik	1	2	3	4	5	6	7	WARD7
Die verpleegpersoneel was altyd bevoeg in die uitvoering van mediese prosedures	1	2	3	4	5	6	7	WARD8
Die beddegoed was elke dag omgeruil	1	2	3	4	5	6	7	WARD9
Alle medikasie is op die toepaslike tye toegedien	1	2	3	4	5	6	7	WARD10
Daar was 'n televisiestel in my saal	1	2	3	4	5	6	7	WARD11
Die televisiestel het behoorlik gewerk	1	2	3	4	5	6	7	WARD12
Die televisiestelle naby my saal was steurend	1	2	4	4	5	6	7	WARD13
Die radio langs my bed kon alle stasies opvang	1	2	3	4	5	6	7	WARD14

U ONLANGSE BESOEK AAN ST GEORGE'S	Stem beslis nie saam nie	Stem nie saam nie	Verskil effens	Neutraal	Stem effens saam	Stem saam	Stem beslis saam	Vir Kantoor-gebruik
Die dekor in my saal was aantreklik	1	2	3	4	5	6	7	WARD15
Dit was 'n plesier om in my saal te kon bly	1	2	3	4	5	6	7	WARD16
Die voorbereiding vir my operasie is bevredigend uitgevoer	1	2	3	4	5	6	7	THEA1
Alle voor-operasie medisyne is op die regte tyd toegedien	1	2	3	4	5	6	7	THEA2
Die operasieprosedures is volledig aan my verduidelik	1	2	3	4	5	6	7	THEA3
Die verpleegpersoneel het my vrese oor die operasie besweer	1	2	3	4	5	6	7	THEA4
Die narkotiseur het sy rol ten opsigte van die operasie aan my verduidelik	1	2	3	4	5	6	7	THEA5
Op pad na die operasieteater was die teater personeel bedagsaam en bemoedigend	1	2	3	4	5	6	7	THEA6
In die operasieteater het dit gevoel of ek in goeie hande was	1	2	3	4	5	6	7	THEA7
Ek sal nie omgee om weer na *St George's* terug te keer nie	1	2	3	4	5	6	7	WILL1
In ag genome die gehalte diens wat *St George's* lewer, is hul fooie redelik	1	2	3	4	5	6	7	CHAR2
In die geheel gesien het ek die etes wat *St George's* bedien, geniet	1	2	3	4	5	6	7	MEAL1
Etes het teen die korrekte temperatuur opgedaag (bv warm etes was warm toe dit opdaag)	1	2	3	4	5	6	7	MEAL2
Die etes was smaaklik	1	2	3	4	5	6	7	MEAL3
Die etes was heilsaam	1	2	3	4	5	6	7	MEAL4
Die etes was aantreklik aangebied	1	2	3	4	5	6	7	MEAL5
Etes was op 'n verskeidenheid maniere aangebied	1	2	3	4	5	6	7	MEAL6
Die etes by *St George's* behoort aansienlik verbeter te word	1	2	3	4	5	6	7	MEAL7
Ek was tevrede met die tye wat etes bedien was	1	2	3	4	5	6	7	MEAL8
Ek sou verkies het dat etes op ander tye by *St George's* bedien word	1	2	3	4	5	6	7	MEAL9
Etes kon van 'n spyskaart gekies word	1	2	3	4	5	6	7	MEAL10
Etes het vir spesiale dieetvoorkeure voorsiening gemaak	1	2	3	4	5	6	7	MEAL11
Die badkamerfasiliteite was altyd skoon tydens my verblyf	1	2	3	4	5	6	7	HOUS1
St George's se fooie is nie duur nie	1	2	3	4	5	6	7	CHAR3
My saal is elke dag skoongemaak	1	2	3	4	5	6	7	HOUS2
Ligte is nie heelnag aangelos nie	1	2	3	4	5	6	7	HOUS3
Raserigheid is tot die minimum beperk deur die nag	1	2	3	4	5	6	7	HOUS4
My besoekers was tevrede dat daar voldoende parkering beskikbaar was	1	2	3	4	5	6	7	VISI1
My besoekers is hoflik deur hospitaalpersoneel behandel	1	2	3	4	5	6	7	VISI2

U ONLANGSE BESOEK AAN ST GEORGE'S	Stem beslis nie saam nie	Stem nie saam nie	Verskil effens	Neutraal	Stem effens saam	Stem saam	Stem beslis saam	Vir Kantoor-gebruik
Indien nodig, sal ek definitief na die hospitaal terugkeer in die toekoms	1	2	3	4	5	6	7	WILL2
Ek sal die hospitaal aan vriende en familie aanbeveel	1	2	3	4	5	6	7	RECO1
In 'n noodgeval is dié die hospitaal waar ek toegelaat sal wil word	1	2	3	4	5	6	7	WILL3
Ek beskou myself as 'n lojale "kliënt" van *St George's*	1	2	3	4	5	6	7	WILL4
'n Verblyf by *St George's* is goeie waarde vir geld	1	2	3	4	5	6	7	CHAR4

INSTRUKSIES VERVOLG: Op ’n skaal van een tot sewe, beginnende met ’n positiewe beskrywing aan die linkerkant, omkring asseblief die nommer wat u mening die beste beskrywe ten opsigte van elkeen van die volgende vrae soos hieronder gelys:

									Vir Kantoor-gebruik
In die geheel gesien, hoe tevrede is u met u verblyf by *St George's*?									
Tevrede	7	6	5	4	3	2	1	Ontevrede	SEM1
Hoe sou u die gehalte van diens by *St George's* beoordeel?									
Uitstekend	7	6	5	4	3	2	1	Swak	SEM2
Het u enige opmerking teenoor hospitaalpersoneel gemaak oor u verblyf by *St George's*?									
Geprys	7	6	5	4	3	2	1	Gekla	SEM3
Indien u swak diens by *St George's* ontvang het, het u vir enige van u vriende, kennisse of familielede vertel?									
Vertel	7	6	5	4	3	2	1	Stil gebly	SEM4
Hoe tevrede is u met die wyse hoe *St George's* u mediese fonds of mediese versekering gehanteer het?									
Effektief	7	6	5	4	3	2	1	Oneffektief	SEM5

VIR HOE LANK (AANTAL DAE) WAS U IN DIE HOSPITAAL?	Dui aantal dae aan in die blokkie langsaan		DUR1

AFDELING C: PERSOONLIKE DATA

Voltooi asseblief hierdie afdeling. Die inligting sal slegs vir statistiese doeleindes gebruik word. Werk deur elke kategorie en plaas 'n X in die toepaslike blokkies wat u die beste beskrywe.

GESLAG	
MANLIK □ 1	VROULIK □ 2

OUDERDOMSGROEP			
20-24 □ 1	35-39 □ 2	50-54 □ 4	65-69 □ 5
25-29 □ 1	40-44 □ 3	55-59 □ 4	70-74 □ 6
30-34 □ 2	45-49 □ 3	60-64 □ 5	75+ □ 6

HUISTAAL (dui meer as een aan, indien van toepassing)				
Engels □ 1	Afrikaans □ 2	Xhosa □ 3	Zulu □ 4	Ander (spesifiseer asseblief) □_____ 1

AANTAL MENSE WAT IN U HUISGESIN WOON					
1□ 1	2 □ 2	3 □ 3	4 □ 4	5 □ 5	6+ □ 6

TOTALE MAANDELIKSE HUISHOUDELIKE INKOMSTE (VOOR BELASTING)					
R0-R2999 □ 1	R3000-R5999 □ 2	R6000-R8999 □ 3	R9000-R11999 □ 4	R12000-R14999 □ 5	R15000+ □ 6

WATTER TIPE MEDIESE BESKERMING HET U?				
Mediese hulp/ □ 1	Hospitaal-plan □ 2	Mediese hulp + tekortdekking □ 3	Geen mediese beskerming □ 4	Ander (spesifiseer asseblief) □_____ 5

BAIE DANKIE VIR U DEELNAME. DIE INLIGTING WAT U VERSKAF HET, SAL BAIE BYDRA TOT DIE VERBETERING VAN HOSPITAALDIENSTE.

KONTAKBESONDERHEDE

Indien u enige verdere navrae het, of graag 'n opsomming van die resultate van die studie wil ontvang, let daarop dat ons kontakbesonderhede soos volg is:

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