STAKEHOLDERS' PARTICIPATION AND QUALITY SERVICE DELIVERY AMONG PRIVATE MEDICAL PRACTITIONERS IN KAMPALA: A CASE STUDY OF CASE MED CARE

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JANUARY, 2011

DECLARATION

I, Norah Okot, declare that this is my original work and that the contents herein have never been submitted elsewhere. All materials used from other sources have been duly acknowledged.

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APPROVAL

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DEDICATION

This work is dedicated to the members of my family: Mr. P. C. Okot, Richard, Moses, Nancy, Brenda and William; and above all, to God almighty.

ACKNOWLEDGEMENT

My sincere gratitude goes to all those who have selflessly sacrificed to make this study a success.

I am particularly indebted to my supervisors, Dr. Benon C. Basheka, Benedict Mugerwa and Ruhemba Kweyamba for their tireless efforts in guiding this study to a successful end.

To my family members, who have without reservation always encouraged, guided and supported me throughout this entire study.

Special gratitude goes to the management and staff of Case Medical Hospital, and all the respondents of Case Med Care for their contribution towards this study.

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ACRONYMS AND ABBREVIATIONS

AAR	-	African Air Rescue
ACCA	-	Association of Chartered Certified Accountants
APA	-	American Psychological Association
BIFM	-	British Institute of Facilities Management
CEO	-	Chief Executive Officer
CIPS	-	Chartered Institute of Purchasing and Supplies
CLAS	-	Culturally and Linguistically Appropriate Services
CMC	-	Case Med Care
CMH	-	Case Medical Hospital
CQI	-	Continuous Quality Improvement
CSOs	-	Civil Society Organizations
CVI	-	Content Validity Index
DHL	-	Dalsey, Hillblom, & Lynn
DV	-	Dependent Variable
FM	-	Facilities Management
IAA	-	International Air Ambulance
ICEA	-	Insurance Company of East Africa
ICU	-	Intensive Care Unit
IOS	-	Inter Organizational Systems
IV	-	Independent Variable
KHF	-	Kadic Heath Foundation
MIS	-	Management Information Systems
NGOs	-	Non Governmental Organizations
NHI	-	National Health Insurance
NOAA	-	National Oceanic and Atmospheric Administration

ODA	-	Overseas Development Agency
OPD	-	Out Patient Department
PACE	-	Program for Accessible Health Communication and Education
PHR*plus*	-	Partners for Health Reform*plus*
PMBOK	-	Project Management Body of Knowledge
PMI	-	Project Management Institute
PPPH	-	Public Private Partnership in Health
SCM	-	Supply Chain Management
SHI	-	Social Health Insurance
SPSS	-	Statistical Program for Social Scientists
STIs	-	Sexually Transmitted Infections
SWOT	-	Strengths, Weaknesses, Opportunities, Threats
TQM	-	Total Quality Management
UMI	-	Uganda Management Institute
URA	-	Uganda Revenue Authority
WHO	-	World Health Organization

ABSTRACT

This study investigated the influence of stakeholders' participation on quality service delivery in Case Med Care (CMC), a medical scheme owned and managed by Case Medical Hospital (CMH) in Kampala. The objectives of the study were: to assess the influence of the service organization's participation on quality service delivery; to determine the influence of the service provider's influence on quality service delivery; and to examine the influence of the customers' participation on quality service delivery.

In the study, both qualitative and quantitative methods were used, based on a cross sectional design. Out of a target population of 930 participants, a total of 270 respondents out of an expected sample of 274 people successfully participated representing a response rate of 98.5 %. Data were collected by way of questionnaires, observations, interviews and documentary reviews, and engaged the sampling methods of stratified, systematic, judgmental, and simple random sampling. Qualitative data were analyzed by thematic and deductive techniques, while quantitative data analysis was done with the help of Statistical Program for Social Sciences (SPSS), version 16.

Overall, stakeholder participation had a positive influence on quality of healthcare. The strength of participatory influence however varied among the three stakeholders studied which were; the *service organization, the service provider* and *customers.* It was found out that service organization and customers influenced quality service delivery significantly, but that of the service provider was very weak. Therefore, there is need to affirmatively interest and engage the service provider more in participation in view of their great potential in influencing quality healthcare delivery; also especially because, they are the final renderers of the actual service to the final consumers, who are the ultimate determinants of quality healthcare.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This study was about stakeholders' participation and their influence on quality service delivery among private medical practitioners in Kampala using Case Med Care (CMC) as the case study. The study sought to investigate this relationship through the effect of a series of independent variables (IV) on the dependent variable (DV). The independent variables comprised elements of stakeholders' participation, namely the service organization's participation, the service provider's participation and the customers' participation, while the dependent variable was quality service delivery.

This chapter presents the background to the study, statement of the problem, purpose and then objectives of the study, research questions and hypotheses, the conceptual framework, scope, justification and significance of the study in that order. To guide the reader, operational definitions of terms and concepts used were also defined.

1.2 Background to the Study

1.2.1 Historical Background

From the earliest contributions of Aristotle and Plato through to the more recent works of Kant and others on service quality, various discussions have since been forwarded (Mitchell & Lang, 2004). Quality as a modern concept, however, can be traced back to the beginning of the manufacturing era when the concept of Total Quality Management (TQM) was consequently developed (Forker, 1991) from efforts of continuous improvement (Arasli & Ahmadeva, 2004). Although some opinions were held then that continuous improvement processes could not be

applied to the intangibles of the service sector (Cavaness & Manouchehri, 1993; Tenner & De-Toro, 1992), there has been a steady shift since from manufacturing to service orientations and a consequent need today to focus more on quality service enhancement (Carr, 1992; Drucker, 1991). Only recently has the service sector and in particular, the hospital services received the same attention as the bias then for tangible goods had during the manufacturing era (Mostafa, 2005).

Porter (1980) asserts that, "Competitive advantage comes from the value a company creates for its customers whereby, value is the worth the product or service; what it costs the organization to produce and what the customer is willing to pay for it". This view does not only consider the customer as the major determinant of quality service but also considers the input of other stakeholders for instance that of the service producing organization in determining quality service. Such a view allowed for the innovative and creative input of other relevant stakeholders alongside the contribution of the customer in influencing and determining quality service.

Marketing-oriented firms believe that achieving quality service delivery depends on not only determining and producing to the specifications of the needs and desires of the customers but also producing innovatively and creatively targeting potential markets, and delivering the desired projected customer service satisfaction more effectively and efficiently than competitors (Kotler, 2002). This has caused a drift today from customer focused orientations to target markets orientation to encompass other stakeholder views and/or efforts alongside that of the customer in influencing quality service delivery (Wright, 2008).

Mostafa (2005) contends that, service quality has become an important research topic in view of its significant relationship to costs (Crosby, 1979), profitability (Rust & Zahorik, 1993), customer satisfaction (Boulding et al, 1993), customer retention (Reichheld & Sasser, 1990), service guarantees (Kandampuly & Butler, 2001), and financial performance (Buttle, 1996). Recent studies have also added to this list to include stakeholder participation (Wright, 2008). The concept "stakeholder" was known to have been first recorded in 1708 and defined as, "A person who held a stake or stakes in a bet (Bisset, 1998, as cited by Wright, 2008)." To date, it has been variously defined by a number of authorities (Ref. subsection 1.2.3, chapter 1). However, common among these definitions is the concept of the participation of key interested parties/stakeholders who have a stake in the service so as to achieve their specific goals and objectives (Wright, 2008).

In many countries, a high proportion of patients prefer to use private-for-profit medical providers to solve their medical needs as they are keener at offering better medical services in order to attract a higher profit margin compared to government medical providers which are not after making profits. This is evident in the vibrant and growing private medical sector today that is perceived by some as having grown in response to public health sector failures (Zikusooka & Kyomuhangi, 2008). Patouillard (2007) contends that, private medical practice has been found to offer better services that included; ease of access, shorter patient-wait periods, much more flexible service hours, better availability of staff and drugs, more sensitive health worker to client attitudes, and a greater confidence in patient perceptions of better diagnosis and treatment, among others. Patouillard cites a related study carried out in 1996, where it was found out that in India, an estimated 60 to 84 % of annual health expenditures took place in the private sector

where approximately 73% of all medical practitioners worked (Bhat, 1993). The same study showed that in Guatemala, 40 to 45% of the population sought medical services from private-for-profit health establishments. In the South East Asia region, studies done in the management of sexually transmitted infections (STIs) and tuberculosis also showed that 50 to 70% of such patients were cared for by the private sector (WHO, 2001).

In Africa, the private for profit sector has gained much popularity as a result of the strained costs of financing public sector health care provision, inadequate tax revenues and the unsustainable nature of donor funding characterizing government provided health services (Zikusooka & Kyomuhangi, 2008). This has prompted the realization that the government health sector needed more money from other reliable sources other than the above suggested conventional financing sources. The single largest source of alternative funding for medical service provision was found to be from *out-of-pocket* or *private payments* which is said to contribute to an extent slightly exceeding 25 percent of the total health care expenditures in more than 75 percent of sub Saharan countries (Mclntyre et al, 2005 as cited by Zikusooka & Kyomuhangi).

Out-of-pocket payment however, was found to exert undesirable pressure on especially poorer householders who form a significant percentage of the populace in Africa. However, in spite of such potential catastrophic consequences of private payments, and amidst limited social health insurance (SHI) and/or a national health insurance (NHI) system, some of the populations in several African countries including South Africa, Zambia, Kenya and Uganda, have had to venture into accessing their medical services from private health insurance and private pre-payment medical scheme providers. Another related study also indicated that the majority of

malaria cases in Africa were treated outside government health facilities. In South Africa alone, a country of slightly over 24 million people, over 33% did seek private health services (Patouillard, 2007).

Uganda currently does not have a sustainable social health insurance (SHI) system or a national health insurance (NHI) working system in place. Yet, in spite of the fact that public health services being rendered are subsidized by government and therefore cheaper in terms of out-of-pocket pay, the quality of these services is poor (Brugha & Zwi, 1998). As such, large proportions of the population seek these services by way of their own private arrangements with various medical practitioners. Accordingly, Zikusooka & Kyomuhangi (2008), this has given rise to a vibrant private healthcare sector comprising of three main categories; the *not for profit providers*, *for profit providers* (also called private medical/health practitioners) and the *traditional healers* also, referred to as "complementary" medical providers.

By 2008, Uganda had 19 private health insurance schemes, also referred to in some literature as health maintenance organizations (Zikusooka & Kyomuhangi, 2008) like the East African underwriters Limited (EAUL), Insurance Company of East Africa (Uganda Limited), and Jubilee Insurance Company of Uganda Limited, to mention but a few. There were also a wide range of private medical practitioners, some of which have their own private medical pre-payment schemes such as Case Medical Hospital (CMH) that has CMC, and Kadic hospital that has the Kadic Health Foundation (KHF), respectively. It is not very clear how many of these private medical practitioners are operating in Uganda today. However, the Partnership for Health Reform*plus* (PHR*plus*), in a study conducted with the Ministry of Health - Public Private

Partnership Health Policy (PPPH) desk in 2005, created a data base that comprised of 2,154 private medical facilities in Uganda (Mandelli et al, 2005) including CMH.

CMH located on Plot 69/71 Buganda Road in the central division of Kampala city owns and manages the private medical scheme – CMC, which was the case study for this research. It is not clear when CMC began. Interactions made by the researcher at CMH during this study gathered that the conceptualization and initiation of a medical scheme service provision began in about 2003, and then gradually progressed into CMC today. Mandelli, et al (2005) however reported that, initially CMH offered treatment to its clients' chargeable up-front on a case-by-case basis. This acted as a basis from which a simple pre-payment arrangement named CMC was developed in 2004 with a few patients, mainly those who had been clients for several years and whose history was known. Later in April, 2006, this pre-payment scheme was better defined to include individuals, families and corporate clients. CMC was not considered to be strictly insurance, but purely a pre-payment arrangement that allowed their clients to access services throughout the year on an agreed pre-paid lump sums of money. With time, other clients of CMH were also handled on a pay-as-you-go basis in CMC. No co-payments were charged. Yet in spite of such advances, CMC has registered a decline in its performance levels to date in terms of membership numbers registered by the medical scheme (CMH/CMC records, 2006 - 2009). It is against this background that specific interest in the study of stakeholders' participation as a management concern was adopted by the researcher.

1.2.2 Theoretical Background

A number of authorities have presented interesting theories on stakeholders' participation and their influential effect on quality service delivery in various disciplines. In this theoretical background, a few of such theories are highlighted as follows: -

The mainstream stakeholders' participation theory, at times also referred to as the traditional stakeholders' participation theory, presents the view that managers should make decisions to take into account the interests of all the stakeholders of the firm (Wright, 2008). In this way, the participation of all stakeholders in pursuit of their various interests expectedly results into the delivery of quality services to the stakeholders' benefit. The involvement, participation and satisfaction of all these stakeholders ensures that their contribution is maximally tapped, eventually enabling the best quality service output. Wright however also argues that not all stakeholders are necessary and that only the most influential should be emphasized upon to maximize quality service outputs at minimal costs.

Other theories that have also been developed borrow largely from the above mainstream stakeholders' participation theory, but go further to specialize in various disciplines as follows:

In relation to project orientations, the descriptive stakeholders' participation theory indicates that, "At any given stage of a project's life cycle, certain stakeholders, because of their potential to satisfy crucial organizational needs, say, quality service delivery enhancement, are more important than others at different stages as the project evolves from one phase to another" (Jawahar & Mclaughlin, 2001). As such, stakeholders' participation strategies that a project manager engages in, prioritizes the participation of its various stakeholders at various stages of its project's life cycle depending on the importance of that particular stakeholder/s to the project

at a specific project phase. This maximizes quality service delivery outputs at minimal effort and cost. However, the descriptive theory does not give a practically well defined process of deciding which stakeholders should participate, to what extent, and at what stage.

Mitchell (1997) adds to this descriptive theory with her normative approach to stakeholders' participation which in addition to what the descriptive theory offers, also provides a technique, that project managers should adopt when identifying and prioritizing stakeholders accordingly. The identification and prioritization of stakeholders need special consideration for practicability purposes and require a very well thought-out set of procedural guidelines to govern the process (Jepsen & Eskerod, 2008). A Strength-Weaknesses-Opportunities-Threats (SWOT) analysis of the stakeholders, their needs and interests is considered to be vital in assessing and prioritizing their participatory influence on quality service delivery. A logical set of guidelines developed, tested and followed right when identifying and engaging relevant stakeholders in their participation at different phases of a project ensures quality healthcare delivery outcomes.

The Instrumental stakeholders' participation theory on the other hand presents a synthesis of the mainstream stakeholders' participation theory in the disciplines of economics, insights from behavioral science and ethics (Jones, 1995). The most compelling instrumental argument is its ability to proactively create and preserve organizational flexibility. An organization is likely to exhibit organizational inertia during stable periods in its environment, and worsen during turbulent times when environments are more complex and uncertain because of its inability to promptly adapt to such situations. Having active stakeholders' participation in such dynamic circumstances where quality service delivery is usually compromised creates a web of

interdependencies which buffers the organization's ability to conform to the required quality service changes (Harrison & St. John, 1996).

In addition, the network stakeholders' participation theory emphasizes the dynamic, flexible and contextual nature of inter-organizational relationships where stakeholders participate and complement their respective efforts. In their relations, perceived as interactive and ever changing overtime, stakeholders influence each other in one way or the other and therefore can not be viewed in isolation (Boonstra & Vries, 2008). According to this theory, inter-organizational relationships can be manipulated in various ways in the interest of enhancing quality service aspects. For instance, deliberately winning over the support of one most influential stakeholder group in the interest of enhancing quality service will help an organization to promote its quality service interests by way of this "won-over group", consequently influencing others in your favor. Winning over other stakeholders ensures that the efforts of those won-over complement that of the initiating stakeholder/s. At the end of it all, efforts of various stakeholders are eventually aligned with an organization's quality service delivery interests.

The stakeholders' participation systems theory brought forth the idea that stakeholders need to be socially responsible. It says that in today's turbulent global economy, the element of resource dependencies has a positive impact on social interactions among stakeholders. Resource dependencies introduce positive check measures on the participation of stakeholders in relation to their influential intentions/power relations, and value interests which ensure that stakeholders participate in a more socially responsible manner in their endeavors (Savage et al, 1991). This ensures that they cautiously act in the interest of influencing quality service delivery positively in order to maintain good relations. When stakeholders develop a more socially responsible

attitude, they avoid negative consequences that would otherwise arise in their social interactions including isolation. This systems theory assumed that no single stakeholder can claim to "be an island" by having all resources they needs at all times without the help of others. As such, stakeholders need to acquire quality service resources from those who have through negotiations. Acquisition of quality resources through successful negotiations could only be possible through a good interrelationship among the different stakeholders involved. A more responsible stakeholder attitude in their participation encourages positive inter-relations among stakeholders considered vital in acquiring quality service inputs, resulting in quality service outputs.

1.2.3 Conceptual Background

For any given organization, there will be individuals and/or groups that have some kind of relationship with it called stakeholders. The term stakeholder can be looked at as two separate and different words being "stake" and "holder". By *stake* we mean "legitimate interest" in an organization's activities, and "holder" simply means a "share in possession". A stakeholder as such is an individual and/or group with a legitimate interest in share of the activities of an organization resulting from their potential to affect or be affected by the same organization's existence (Wright, 2008). Stakeholders can either be internal or external. For the purpose of this study, the service organization and service provider were looked at as internal stakeholders while the customers, external stakeholder.

Stakeholders' participation on the other hand for the purpose of this study was considered to be a process whereby the active roles of stakeholders play in decisions made regarding quality health care delivery and in the subsequent activities which affect them (Bisset, 1998 as cited by Wright, 2008; Johnson & Scholes, 2005; Jobber, 2007; PMI, 2004). Achieving quality healthcare

delivery standards can be done through the identification and analysis of stakeholder interests, their receptiveness, and optimizing engagement strategies (Bourne & Walker, 2007; cited by Weaver, 2007). Today, the concept of stakeholders' participation is an increasingly fashionable discipline and corporations are increasingly taking into account the wider stakeholder environment in view of its benefits to quality healthcare delivery enhancement (Wright, 2008).

In contrast to the mainstream stakeholders' participation theory which upholds the engagement of all stakeholders in quality decisions, Boonstra & Vries (2008) in their study on inter organizational systems (IOS) in health facilities in the United States of America, United Kingdom, Bangladesh, China, India, Nigeria and Uganda contend that not all stakeholders are necessary and need to be prioritized by identifying them, and assessing their interests and power to influence any quality service intervention. This prioritization helps assess the stakeholders' potential in influencing quality service for engagement purposes. As a critical factor for consideration, stakeholder engagements as such warrant careful judgment in any quality service intervention or policy (Syed et al, 2009) for quality service delivery outputs at minimal costs.

Wright (2008) also agrees that not all stakeholders are necessary and for that suggests that managers who are accountable to everyone are in fact accountable to no one. The role of a manager is to set the pace and direct an organization towards achieving its set goals and objectives. These goals and objectives are many times in conflict with the interests of most of the other stakeholders. In a manager's pursuance to satisfy all stakeholders, even those less significant, managers find themselves torn between trying hard to fulfill these conflicting interests and achieving the organization's goals and objectives. As such, a manager would rather be held accountable to a few stakeholders that really matter in order to effectively and capably

influence their interests positively and align these interests to achieve set organizational goals and objectives that include achieving a desirable level of quality service delivery, among others.

She further urges that stakeholders may have interests in the activities of an organization but this does not necessary give them rights. Stakeholder rights have to be earned through their exercise of responsibilities towards the organization's goals and objectives. This reduces the risk of recklessness in stakeholder demands in their pursuance to satisfy their own often conflicting interests that may be at the expense of desired organizational goals and objectives.

Also, the legitimate purpose of a business is to create shareholder wealth. This wealth varies with the degree of stake held by the respective stakeholders. Satisfying key and/or active stakeholders such as customers, suppliers and employees is considered a good thing but only because it enables the business to satisfy its primary purpose which is the long term growth in the wealth of the organization's owners. As such, Wright (2008) urges that, long term growth of wealth can be achieved with the involvement of a skeleton number of stakeholders, a fact that the traditional view of stakeholder participation is not necessarily considered important.

However, Wright (2008) also notes that not all stakeholder demands can be legitimately balanced as they may be genuinely conflicting. This is because different stakeholders have different demands. Some may be in line with the organization's goals and objectives while others may be for selfish individual interests that do not benefit the organization. As such, these demands need to be carefully sorted and stakeholders prioritized according to the interest of the organization and the available of resources.

With the realization that stakeholder groups must be prioritized, a balance has to be met that strikes an appropriate position considering the two main stakeholder perspectives (traditional view and modern view) to a point at which best meets an organization's interests in its pursuance of set goals and objectives.

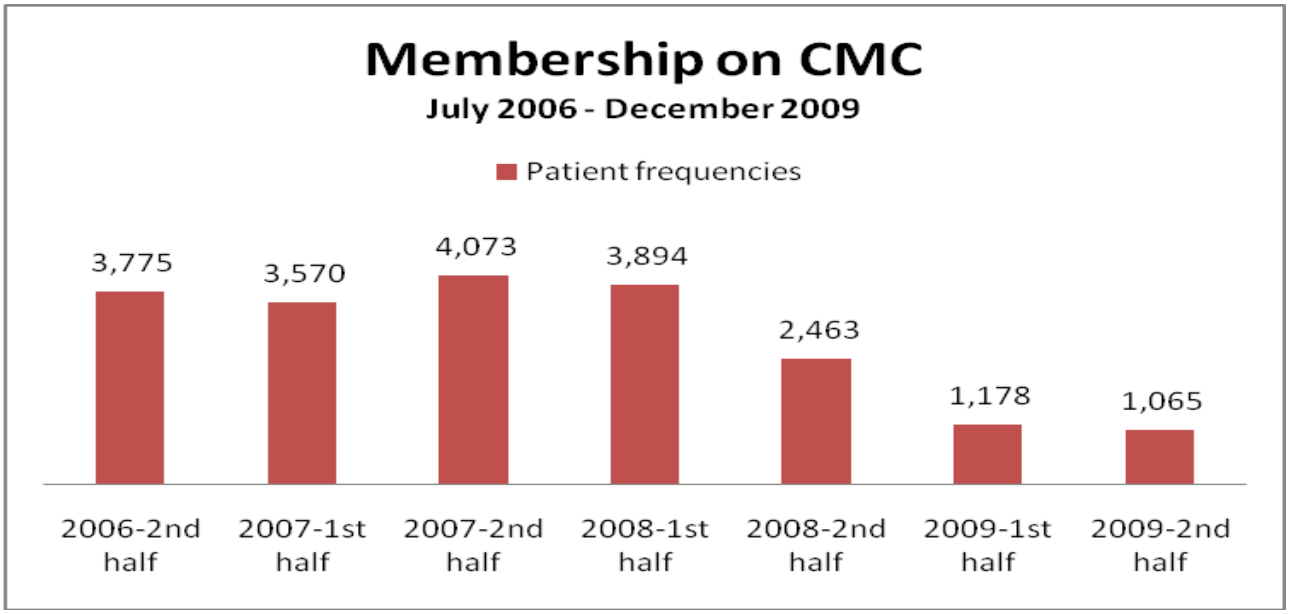
However, stakeholder participation is not void of possible limitations. To overcome many of its limitations, stakeholder participation must be institutionalized, creating organizational cultures that can facilitate processes where goals are negotiated and outcomes are realized communally. In this light, stakeholders' participatory processes may seem risky, but there is growing evidence that if well designed, these perceived risks may be worth taking (Wright, 2008).

1.2.4 Contextual Background

Trends in membership numbers registered on CMC for the period July, 2006 to December, 2009 has indicated an annual decline in the number of customers of approximately 31.4%. Brown & Reingen (1987) portray that customers who are dissatisfied with the quality of a service are likely to leave, but also, through the negative word-of-mouth causes loss of other customers to the service providing establishment. In this context (among other factors), loss in customers can be attributed to a decline in the quality of services delivered on CMC. This is because service quality is said to be antecedent to customer satisfaction, and customer satisfaction antecedent to purchase intentions (Cronin & Taylor, 1992) suggesting a strong link between quality and customer retention in the service sector (Carson et al, 1997).

Statistics on CMC indicated that, from July to December, 2006, CMC had a clientele number of 3775 members registered which declined by June 2007 to 3570 members. By December 2007,

the medical scheme registered an increase to 4073 members. But from then on, there was a constant decline in membership numbers. Members registered for the next two years from January 2008 to December 2009 (split into four halves) were 3894, 2463, 1178 and 1065, respectively. (CMH Data Base; CMC Records, 2006-2009). The decline in membership numbers on CMC observed was of special interest to the researcher and the main reason why this study was undertaken. These trends are illustrated in figure 1 below: -



Source: *Case Medical Hospital data base; Case Med Care records (2006-2009)*

Figure 1: An illustration of CMC membership numbers bi-annually.

Poor quality service provision is attributed to among other factors, insufficient stakeholders' participation. According to Heider (1958) as cited by Carson, 1997, when one or more stakeholders withdraw their participation, then the quality of services delivered is said to decline, which explains why customer numbers are dropping in CMC.

This study supported the fact that CMC is profit-oriented, operating in a competitive environment. It has to strive to provide quality healthcare services to its clients, not only to their

expectations but also beyond, through innovation and creativity. The provision of a competitive standard of quality health care, among other factors, is considered important in helping CMC gain a competitive advantage over other schemes providing similar services in the medical sector. The negative trend observed in membership numbers in CMC was looked at as a reflection of the quality of health care delivered.

1.3 Statement of the Problem

The survival and success in the performance of any business undertaking in today's competitive environment largely lies in the provision of high quality services (Parasuraman, Zeithaml & Perry, 1990; Reichheld & Sasser, 1990). The service quality reflected in terms of the performance in membership numbers in CMC between July 2006 and December 2009 has raised much concern. Statistics indicated that during this period, bi-annual registration of membership in CMC were 3775, 3570, 4073, 3894, 2463, 1178 and 1065, respectively; a trend that registered a loss on average per every six months analysis of 387 members (CMH Data Base; CMC Records, 2006-2009). This was in spite of various interventions by the management of CMH to improve the quality of services delivered to its clients including, the redefinition and expansion of structures, increased financial investments, and even increased stakeholder engagements, to mention but a few (CMC reports, 2006 - 2010). Among other factors thought to have caused the loss of customers in CMC was insufficient stakeholders' participation in issues of quality health care and its delivery, resulting into a reduction in purchase intentions as customer satisfaction is antecedent to purchase intention. It was against this background that the researcher undertook this study to investigate the influence of stakeholders' participation on quality service delivery in CMC.

1.4 Purpose of the Study

The purpose of this study was to investigate the influence of stakeholders' participation on quality service delivery in CMC.

1.5 Objectives of the Study

1. To assess the influence of the service organization's participation on quality service delivery in CMC.
2. To determine the influence of the service provider's participation on quality service delivery in CMC.
3. To examine the influence of the customers' participation on quality service delivery in CMC.

1.6 Research Questions

1. To what extent does the service organization's participation influence quality service delivery in CMC?
2. How does the service provider's participation influence quality service delivery in CMC?
3. What is the influence of the customers' participation on quality service delivery in CMC?

1.7 Research Hypotheses

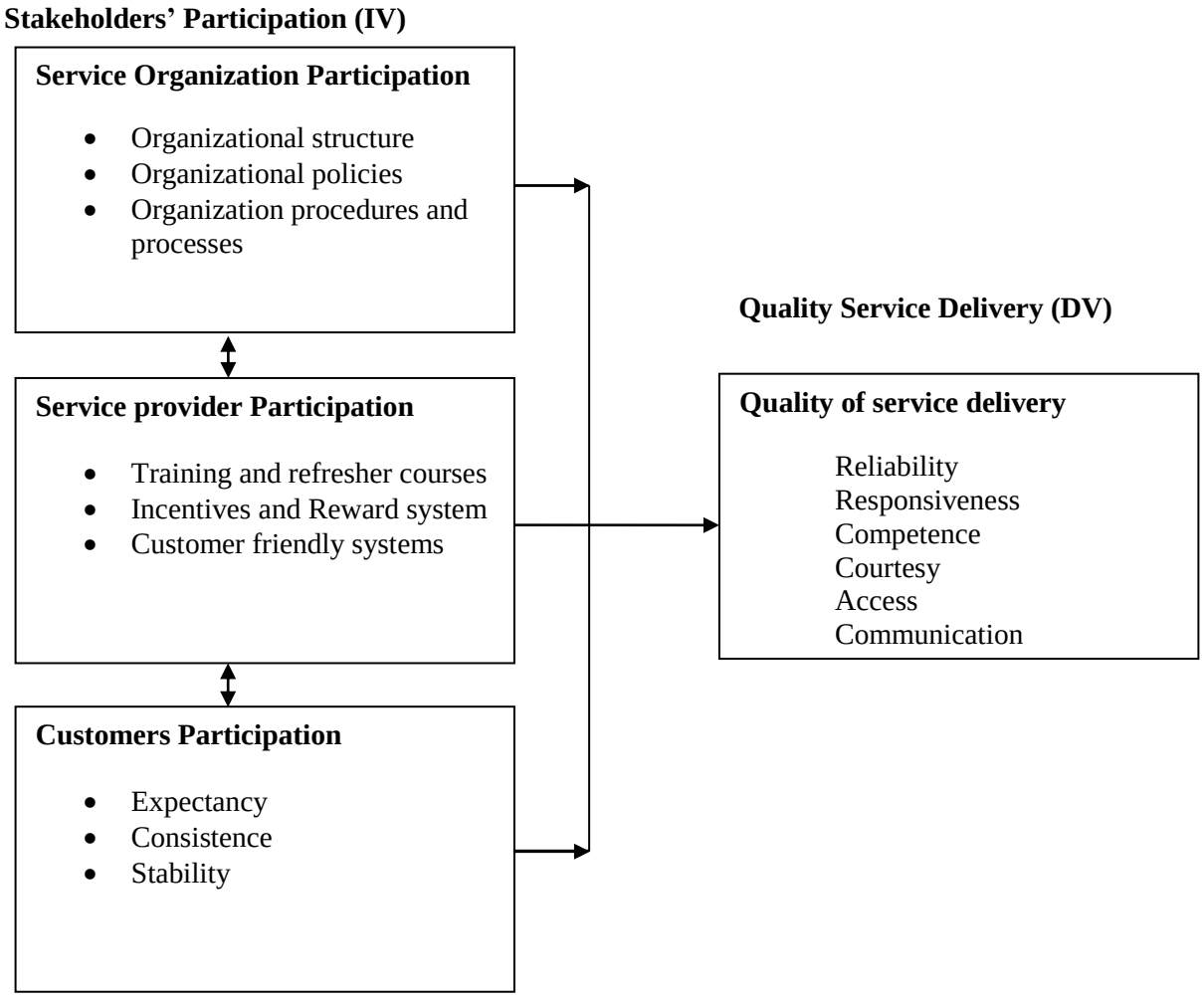
1. The service organization's participation influences quality service delivery in CMC.
2. There is a significant positive influence of the service provider's participation on quality service delivery in CMC.
3. The customers' participation influences quality service delivery in CMC positively

1.8 Conceptual Framework

The relationship between concepts can be best explained with the support of a theory or theories (Neuman, 2000) adopted wholly, partially, in combination and/or even modified by the author.

This study was guided by Fritz Heider (1958)'s Balance Theory, also referred to as a Social Psychological theory. This Balance theory provided the basis for the conceptual framework for this study as illustrated in figure 2 below: -

Figure 2: Conceptual Framework showing the relationship between stakeholders' participation (IV) and quality service delivery (DV).



Source: *Adopted from Heider (1958) as cited by Carson et al, (1997), Balance Theory applied to service quality: A focus on the organization, provider, and consumer triad*; *with modification by the author*.

The three dimensions indicated in the balance theory that made up the independent variables (IVs) were the service organization's participation, the service provider's participation and the customers' participation. The researcher opted to use the balance theory in this study because it

not only considered the participation of the customers as the sole determinant and influencer of quality service (Zeithaml, Parasuraman, & Berry, 1990), but also considered the contribution of other stakeholders - the service organization and service provider as active participants on a more or less equal footing, alongside the customer. The dependent variable (DV) was operationalized into reliability, responsiveness, competence, courtesy, access and communication.

The relationships in this study in respect to CMC firstly, assessed the influence of the service organization's participation on quality service delivery, and considered three indicators that were, organizational structure; organizational policies; and organizational procedures and processes. Secondly, the study determined the influence of the service provider's participation on quality service delivery, and looked at three indicator categories that were, training and/or refresher courses; incentives and reward system; and customer friendly systems. And thirdly, the study examined the customers' participatory influence on quality service delivery, containing three indicators that were expectancy, consistence, and stability.

Modifications by the researcher to the balance theory as described below were based on expert judgment: -

For the Independent Variable:-

The original indicators for the service organization's participation (outputs that offer more benefits than they cost, access, secure and authentically pleasing delivery locales, and, appropriate marketing and promotion), as indicated in the works of Babber (1992) and Berry & Parasuraman (1992) cited by Carson et al, 1997 were dropped as being abstract and not being directly relevant to CMC/CMH. Instead, organizational structure, organizational policies and

organizational procedures and processes were opted for. Access was however carried along but as an indicator more fitting as a quality aspect for the DV.

For the service providers' participation, the proposed indicators were effective selection, socialization and/or training. Training was carried along but modified to training and/or refresher courses. Incentives and reward system, and, customer friendly systems were also taken up as being more relevant to this study compared to selection and socialization that were also considered as abstract terms.

The indicators of the balance theory for the customers' participation that were expectancy, consistence and stability were adopted by the researcher without any modifications.

For the Dependent Variable:-

The recommended indicators of reliability, responsiveness, competence, courteous, credibility, understanding, appropriate demeanor, communication and confidence (Zeithaml, Parasuraman & Berry, 1990) were also modified. The researcher adopted five of them namely; reliability, responsiveness, competence, courtesy and access, and, also added communication to form the sixth indicator for the DV.

1.9 Scope of the Study

The geographical scope was limited to CMC, a private-for-profit medical scheme, which was the case study for this research. CMC is the medical scheme owned and managed by CMH, a private hospital based on plot 60/71, Buganda road, in the central division of Kampala city. The content

scope covered stakeholders' participation and quality service delivery. Stakeholders' participation comprised of three stakeholder participation categories namely; the service organization's participation, the service provider's participation and the customers' participation. These three formed the independent variables for the study. The dependent variable that was quality service delivery was operationalized and included the indicators, reliability, responsiveness, competence, courtesy, access and communication. The time scope for this study considered the period July 2006 to December, 2009. Though moderating factors like competing insurance companies offering health insurance and other medical pre-payment schemes also existed, none was considered for the purpose of this study as it was not in the interest of the researcher.

1.10 Justification of the Study

CMC's performance in terms of membership registered on the medical scheme has been more on the decline between July 2006 and December 2010. Statistics indicated that for every six months period when analysis of CMC's performance was carried out, the medical scheme was found to have lost approximately 387 members (CMH data base; CMC records – 2006 to 2009). This loss in customer numbers was undesirable and needed to be investigated in order to find durable solutions that immediately addressed the cause. One way this was thought could be done was through the effective and adequate adoption of stakeholders' participation in quality service issues in CMC in a bid to enhance quality service delivery and consequently attract more customers into the scheme; hence the need for this study.

1.11 Significance of the Study

This study derived practical solutions by way of effective stakeholders' participation engagements to remedy the poor performance in quality service delivered in CMC, which

resulted into some members quitting the scheme. This was essential to CMH that holds the responsibility of nurturing and managing CMC, to its benefit. This would in turn help CMH attain competitive market levels and remain relevant to its clientele in the medical field. Other stakeholders that could use this information include; other private and public health providers, non-governmental organizations (NGOs), the Civil Society Organizations (CSOs), Community Based Organizations (CBOs) with healthcare related interests and academicians. The findings added to the body of knowledge in regard to stakeholders' participation and its influence on quality service delivery. The findings of the study can also be used to inform policy, and where necessary, used for interventional purposes especially in similar circumstances, and/or modified to the relevance of specific wanting situations. Areas for further research were also identified as recommendations for future study.

1.12 Operational Definitions of Terms and Concepts

Key operational definitions of terms and concepts as used in this study were defined with some adopted wholly, partially and/or modified by the author to best suit the intended meanings in this study. These were as follows: -

Stakeholders' Participation: - Stakeholder participation is the formal process of relationship management through which effort is made to align stakeholders' mutual interests to the goal and vision of the organization so as to mitigate negative influences (Bourne & Walker, 2007; cited by Weaver, 2007). For the purpose of this study, stakeholder participation was considered to be a process through which stakeholders play active roles in decision making and in the subsequent activities which affect them.

The Service Organization: - The support system that exists to fulfill the needs of the customer as well as the needs of the providers who are serving the customer (Albrecht, 1988) in respect to the organizational structure, policies, procedures and processes in CMC.

The Service Provider: - The individual who furnishes an organization services to the customer (Carson et al, 1997).

The Customer: - The purchaser and recipient of a service (Carson et al, 1997).

Quality Service Delivery/Service Quality Delivery: -The extent of discrepancy between customers' expectations or desires and their perceptions (Funston, 1992); Whereby quality in itself is the degree to which a set of inherent characteristics of a service fulfils the requirements of its users over and over again with every use, and consequently have a retention effect upon them. Quality service delivery, Service quality delivery and quality of service delivery mean one thing in this study.

Expectancy:-The quality of the state of a service rendered in anticipation of the belief and/or desire of the user. (http://dictionary.reference.co./browse/stability) - 10/12/2009.

Consistency: -Reliability of a service over time (Punch, 2005).

Stability: -Constancy of character or purpose (http://dictionary.reference.co./browse/stability), 10/12/2009.

CHAPTER TWO

LITERATURE REVIEW

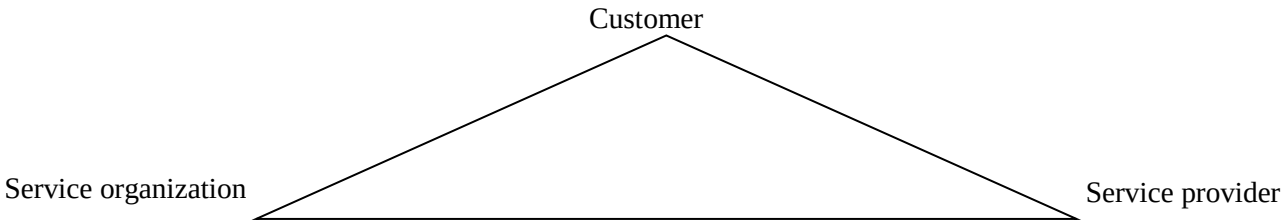
2.1 Introduction

Both print and electronic literature was reviewed. This provided knowledge and a better understanding of the research study. In this chapter, the theoretical and conceptual reviews of the study are presented, followed by reviews on the service organization's participation on quality service delivery; the service provider's participation on quality service delivery; and the customers' participation on quality service delivery, respectively. The chapter then ended with a brief summary.

2.2 Theoretical Review

This study was guided by the balance theory which sought to explain how three stakeholders, namely; the service organization, the service provider and the customer interact in a triad relationship to influence quality service delivery. It was initially developed by Heider (1958) and later expanded by Newcomb in 1968 and Insko in 1984 respectively (Carson et al, 1997). The service organization was defined as the support system that existed to fulfill the needs of the customer as well as those of the service providers (Albrecht, 1988). The individual who furnishes an organization's services to the customers was referred to as the service provider, while the customer was the final purchaser and recipient of a service (Carson, et al, 1997).

The following figure is a visual expression of the tripartite relationship among the three stakeholders, illustrated with the help of a service triangle called the balance theory triad in figure 3: -



Source: *Albrecht (1988), At America's service: How corporations can revolutionize the way they treat their customers. Homewood, IL: Jones-Irwin.*

Figure 3: An illustration of the Balance Theory Triad

For the highest quality service to be delivered, the balance theory suggests that it is necessary for positive relations among all the three parties (Mastenbroek, 1991) if quality service is to be influenced positively. Positive relations exist where employees, through their sufficient participation, experience increased levels of motivation, satisfaction and commitment. There will also be a decrease in the level of intent to withdraw from the service organization (leaving the employment), a reduction in the gap between consumer expectations and actual quality service delivered. Consumers will be more loyal and will have much higher repurchase intentions as compared to when positive relations do not exist.

Heider (1958) on the other hand describes positive relations as, harmonious and tension-free; referred to as a balanced state. This balanced state is characterized by; *desirability* where the three parties enjoy and benefit from their participation in the relationship, *value congruence* involving respect among parties who also share the values of the others involved, and *choice* where parties are voluntarily involved other than forced into the relationship. All these described influenced quality service delivery in many ways depending on the level and attitudes of the stakeholders involved.

Positive relations are affected negatively when tension set in the balanced state, destabilizing it and causing the occurrence of three unbalanced states, described as follows: -

The first involves a positive relation between the service organization and the customer and both the service organization and the customer have a negative relation with the service provider. In this state, the service provider is most likely to be de-motivated, dissatisfied and less committed towards influencing quality service delivery positively, thereby causing a decline in the quality of service delivered. In extreme cases, the service provider may altogether opt out of the service triad depending on the availability of better similar employment engagement opportunities elsewhere in the market, and related cost of change.

The second is where there is a positive relationship between the service organization and the service provider but both the service organization and the service provider alienate the customer. Similarly, the customer will most probably withdraw from the triad rendering the quality of service being delivered irrelevant; in other words, negatively influencing quality service. The customer's withdrawal also depends on other available options of comparable or substitutable services in the service market, and related economic costs associated with changing the service organization and service provider in favor of a better alternative elsewhere.

The third state is composed of a positive relationship between the service provider and the customer but both have a negative relationship with the service organization. In this case, the service provider will most probably withdraw, negatively influencing quality service delivery. The withdrawal of the service provider will most likely encourage the customers to follow suit, abandoning the service organization. The service organization stands to lose in this situation. The first attempt usually involves the service organization winning back the customer which is

difficult especially when the customer regards his/her relationship with the service provider to be more valuable than that with the service organization.

The balance theory in addition suggests that, given a positive relationship between the service organization and the service provider, and between the service organization and the customer, there is a greater chance that the relationship between the service provider and customer will be positive if managed well, thus positively influencing quality service delivery, as compared to when the service organization has a negative relationship with either the service provider or customer thus influencing quality service delivery negatively.

The balance theory as described above was found to be relevant to this study in that it provided a basis for the conceptual framework of this study (as earlier discussed in subsection 1.8), linking variables in a relationship that explained stakeholders' participation in influencing quality service delivery. The dimensions of stakeholders' participation (IV) comprised of the service organization's participation, service provider's participation and the customers' participation, while quality service delivery (DV) was operationalized as reliability, responsiveness, competence, courtesy, access and communication. The most desirable level of quality service delivery was according to this study benchmarked as the balanced state against which all other states were graded and therefore strived to achieve.

However, the balance theory was limited to the study of three stakeholders, (the service organization, the service provider and the customer), leaving out other vital stakeholders like suppliers, the government and insurance companies offering health care packages, to mention but a few, who may have had a significant influence on quality service delivery.

2.3 Conceptual Review

Hannah (2008) contends that the objective of stakeholders' participation in quality service enhancement should be to improve the effectiveness of that implementation as it brings a range of stakeholders around a table to discuss, exchange knowledge and develop initiatives critical for the success of the quality intervention, while also raising awareness and disseminating information to a wider audience.

However, improving the effectiveness of the implementation requires the alignment of efforts to set quality goals and objectives. Kaza (1988) eloquently analyses the need for stakeholders' participation as a means of achieving set quality service objectives. He argues that, with involvement comes understanding, with understanding comes support and commitment, also reducing potential conflicts and the need for heavy enforcement measures (Cocklin, Craw, & McAuley, 1998; Gilman, 1997; National Research Council, 2001; Kelleher, 1999; Salm, Clark, & Siirila, 2000; Wells & White, 1995). It is urged that compliance and involvement were an interrelated phenomena, and that involvement contributed to compliance through the participation process (Hall, 1996). Stakeholders view their involvement as meaningful and as making a difference in regard to their contribution in the process as helpful in shaping a decision (Pirk, 2002) in the pursuit of set goals and objectives.

Wright (2008) adds that stakeholders' participation encourages enhanced understanding, commitment, support, ownership, accountability and transparency in quality service intervention among others, with associated benefits being acknowledged by all stakeholders involved which in turn increases the legitimacy of the quality service intervention. In fact, Sutinen & Kuperan (1999) demonstrated that, "the perception of legitimacy is linked to the participants' view of fairness of the process. Stakeholders who participate view the process as legitimate and generally

felt a strong obligation to comply with the results, even if the mandates contradicted their self interests".

The enhanced partnership among stakeholders has the potential for the provision of a cost effective way of obtaining good or better quality service knowledge in an increasingly resource constrained environment (ODA, 1995). Consequently, resource conflicts diminish, access rights to resources distributed more effectively, management initiatives are better implemented, and resources better managed when stakeholders are effectively involved in management initiatives (Pomeroy, 1995).

Stakeholders' participation involves a number of people of widely varying backgrounds, values, abilities to absorb information and tendencies to interpret situations differently. These differences in perspective are one of the primary reasons that stakeholders disagree (Harrison & St. John, 1996) and as such the proper management of stakeholders is critical (Wright, 2008).

However, stakeholders' participation is not void of costs. These costs should not be ignored but instead mitigated to ensure effective stakeholder engagements. Costs may include delays in service decision making, increased expenses, tension among stakeholder groups that consequently lead to lack of consensus, and misuse of resources. Mitigation strategies for these costs may include conflict management, prioritizing stakeholder engagements and controlling the levels of their participation (NOAA, 2004) in quality intervention.

2.4 The influence of the Service Organization's Participation on Quality service delivery.

2.4.1 Organizational structure

Stoner et al, (1995) contends that organizational structures are designed with the main purposes of developing, assigning and clarifying roles and responsibilities, responsibility centers, accountability, and power and authority, among others to the different faculty activities of the organization. This avoids overlaps of activities in the organization that caused conflict and wastage of resources. Organizational structures spells out who is to do what, within which demarcations, who is responsible for what and why, to what extent, who is accountable, and the like. They continue to add that, it is alongside such structures that organizational procedures and processes, policies and structures are developed to govern the operations of the organization in alignment with its goals and objectives. An appropriate organizational structure with clearly defined structural, functional linkages/processes, a clear system of accountability and an adequate number of appropriately trained personnel of high integrity, are recommended as the minimal requirements for ensuring a desired quality of service is delivered (Business Synergies, 2001).

Harrison & St. John (1996) add to the above argument that, well organized structures developed and managed well are vital in governing an organization's operations with the interest of achieving its goals and objectives. Development of such appropriate structures is challenged among others by much variability in its clientele. In a bid to mitigate this much variability, organizations are encouraged to get themselves certified by quality standards monitoring establishments that will require them to conform to certain minimal recommended organizational standards. These standards encourage structural redefinition in the interest of enhancing quality

service delivery; in essence addressing much variability in clientele. Quality recognition initiatives such as the European quality awards and Baldrige National Quality highly encourage this.

Today, health care services increasingly use modern management tools and techniques such as continuous quality improvement (CQI), process reengineering, benchmarking, supply chain management (SCM), Six Sigma, Total Quality Management (TQM) and several others, to satisfy both internal and external stakeholders (Dey & Hariharan, 2006 as cited by Dean & Bowen, 1994). Total Quality Management (TQM) for instance has been developed as an approach to improving service quality that is now characterized as an integrated, systematic organization–wide strategy (Dean & Bowen, 1994).

But simply adapting a management tool is not enough. The organization has to develop and exhibit the attributes of a quality oriented organization structure in order to realize organizational objectives. Ravichandran & Rai (2000) contends that a quality service oriented organization is characterized by paramount top management leadership for quality, management infrastructure sufficiently sophisticated so as not to introduce complexities, process management efficacy, effective stakeholder participation and quality performance to required standards. This can only be achieved through appropriate organizational structural change to realize any measure of success.

2.4.2 Organizational policies

Organizational policies have been found to be a vital ingredient in influencing the quality of services delivered today. Most organizations are finding it necessary to develop their policies in

conformity to national and international law in order to govern relatively important actions within the organization (Fleet, 1988).

Brown et al, (1996) as cited by Baron et al, 2009 assert that organizational policies are important in the service industry to counter the challenges posed by the negative characteristics of services that include; intangibility, heterogeneity, perishability and inseparability. Each negative service characteristic is seen in other words as, a problem to be faced in the quality delivery, marketing and promotion of services which, by implication is not present to the same when it comes to goods. The quality of a good can be predetermined before it reaches its final consumer which is attributed to its positive characteristics including tangibility, homogeneity, durability and separability. It is however the opposite for services where quality is only determined by a consumer as and when actually consumed; a situation usually too late to improve on the quality of that service. In view of this setback, a well developed set of organizational policies to remedy this setback is important. Policies in place that address service failures like warrants, guarantees, free periodic serving over a reasonable period of time, among others that reassure the users of the service of reasonable compensation for cases of genuine poor quality service delivered, has been identified as a common frontline tactic for enhancing quality service delivery, customer perceptions of quality of service and customer satisfaction (Brown et al).

Furthermore, even when organizational policies in place have been drafted to recover service failures, Ahmed (2002) cited by Baron et al, 2009 demonstrates that there is need to recognize the fact that improved service design actually reduces the number of service failures; through among other strategies, enhancing stakeholder participation. Organizational policies designed to

cater for improvements in service designs that should be developed and effectively implemented during the service production.

In respect to the occupational health of employees of an organization especially in the medical sector, the impact of occupational injuries often transcends the worker or even the employer. High rates of occupational injuries resulting into significant disability burdens can have a broader impact on quality service delivery. Organizational policies developed and put in place to mitigate the impact of occupational injuries in quality healthcare provision can go a long way in ensuring a sustainable delivery of quality standards in healthcare delivery (Wickizer, Franklin, Plaeger, & Mootz, 2001).

2.4.2 Organizational procedures and processes

Wiehrich & Koontz (2001) assert that organizations are able to furnish an environment in which stakeholders contribute most efficiently and effectively to the goals and objectives of the establishment through a well planned organizational structure that eventually give rise to among others, organizational procedures and processes. In many cases, organizational procedures and processes are designed along the main management processes that include planning, organizing, leading, and controlling (Stoner et al, 1995).

Planning organizational procedures and processes start with the identification of activities and objectives and ends with analysis of relationships, in that sequence, in the pursuit of achieving organizational goals and objectives successfully (Drucker, 1954 as cited by Drucker, 1974). However, planning can be a challenge. Planning is among other factors greatly hindered by environmental conditions, resistance to change, labour laws, government regulations, abstract

goals and objectives set, limited skills and resources. In view of this, managers can facilitate effective organizational planning through effective communication, stakeholder participation and integration, as portrayed by Fleet, 1988).

Stoner et al, (2002) assert that organizing arranges and allocates work, authority and resources among organizational members to achieve organizational goals beginning with the definition of the organizational design which follows logically from the planning stage and draws back to the decision making process in which managers choose an organizational structure that is appropriate to the organization's strategy and its environment. This gives rise to an organized set of procedures and processes which is important for the engagement of stakeholders in quality service delivery.

In relation to leading, Stoner et al, (1995) add that, directing and influencing the task-related activities of stakeholders is another important process that encompasses the principles of involving people in unequal power distribution relations, with those with more power able to influence those with less power in respect to values that they possess. This brings in the concept brought forward as asserted by Boonstra & Vries (2008) with their network stakeholder participation theory that demonstrates the interdependency among stakeholders in unequal power relations in a manner that complements their respective efforts; the complementation of which enhances quality service delivery among them.

Wiehrich & Koontz (2001) on the other hand state that organizational control as a systematic effort to set service quality performance standards with planned organizational service objectives compares actual performance with predetermined standards. The discrepancy between actual

performance and predetermined quality standards then warrants corrective measures to undesired discrepancies taken in order to enhance quality service delivery.

However, even with a streamlined organizational structure, policies, procedures and processes, satisfying stakeholders as and when they are engaged is important and yet also challenged by much variability. This variability is due to the fact that groups of stakeholders have several requirements that vary in importance, difference and many times in conflicting performance requirements (Tregunno et al, 2004 as cited by Mclaughlin).

2.5 The influence of the Service provider's participation on Quality Service Delivery

2.5.1 Training and Refresher Courses

Bowen & Lawler III (1992) assert that, in any business entity, human resources have been regarded as its most valuable resource for quality service delivery which explains why companies are increasingly embracing human resource empowerment approaches as opposed to the standardized, procedural driven operations of service production lines in the mid 1970s.

Healthcare service provision in hospitals is divided into two main distinctive parts being clinical and the non clinical support services. The clinical services provide the services of care and cure to patients' sicknesses as the essential functions of any hospital and can only be provided by medical professionals like doctors, nurses, laboratory technician and physiotherapists among others. The non clinical services on the other hand provide a wide range of administrative and managerial support to the clinical services. Non clinical personnel do not have a strong medical background, if any, compared to clinical personnel and comprise of cleaners, food and beverage personnel, cashiers, and receptionists to mention but a few. Non clinical personnel are mainly

involved in the facilities management (FM) aspect of medical service delivery in support of the clinical services.

However, Heng, McGeorge & Loosemore (2005) demonstrate that, much as clinical services are regarded as very important in a hospital, non-clinical services are as much important in managing the diverse range of FM related activities because they ensure optimum delivery of quality clinical services. FM as an integral part of quality service delivery involves an integration and management of a multi disciplinary of non-clinical activities within the hospital's built in environment that manages the impact of quality service delivery upon patients and workers (BIFM, 2002) and as such should not be overlooked. FM activities include, record keeping, cashing, cleaning services, and front desk operations.

Maister & Lovelock (1982) contend that, understanding these two distinctive parts of clinical and non clinical services helps organizations in the identification of appropriate training and/or refresher course needs that need to be promptly financed, implemented and impact evaluated for future reference. These training and refresher courses ensure that the services being offered are of quality, relevant and acceptable to the needs of the users.

Many times, the inadequacies of an establishment's staff as and when experienced by clients rarely go unnoticed. When the client is not satisfied with the quality of service delivery, he or she is more likely to blame the business organization rather than the service provider, but not vice versa (Maister & Lovelock, 1982); holding the service organization liable for the sub-standard quality of services being rendered to clients.

Carson et al, (1997) confirm that, the service provider deficiencies negatively influence quality service delivery and can alienate the customer from the business organization as well as from the service provider prompting the customer to seek the service elsewhere. This is as a result of an unacceptable level in the quality of service being rendered by the staff. Close attention needs to be given to the recruitment process to ensure that appropriate human resources are employed and refreshed thereafter as they are a reflection of what and how the customer will perceive the business organization's quality service delivery to be, and the consequent business level determined.

2.5.2 Incentives and Reward System

Incentives and appropriate reward systems put in place can go a long way in enhancing quality service delivery. In a study done by Connexions Loyalty Travel Solutions (2010), incentive programs that were carefully selected and implemented using rewards can increase service performance by an average of 22%, and that, team incentives in particular can increase quality service delivery by as much as 44%. It was also reported that incentive programmes were also vital in engaging stakeholders' participation and encouraged the delivery of quality services not only in the short run, but more importantly in the long run as well, in a sustainable manner.

In view of the fact that incentives and appropriate reward systems put in place can go a long way in enhancing quality service delivery, Franklin, Lifka & Milstein, (1998) contend that there is need to offer quality incentives and appropriate reward systems to human resources for quality returns. Quality incentives and appropriate reward systems provide the motivational force for workers to perform well in producing and delivering quality services. Motivation provides the driving force for employees to come to work with a new attitude, creating a happier work

environment for quality performance in service delivery. Workers compensation for instance, that provide for payment of medical care needed to treat occupational injuries and/or illnesses even if it represents a portion of lost earnings arising from temporary or permanent impairment of an employee, increases the motivation and confidence of staff in their effort to enhance quality service delivery.

Also, Wickizer et al, (2001) state that, appropriate administration and financial incentives to employees, should be improved to encourage the delivery of quality care that will lead to improved health outcomes. They go ahead to add that, programmes that give a chance to be rewarded based on meeting or exceeding goals typically generate the best quality service results. Least effective are "tournament" based programmes, closed ended programmes that do not allow for stakeholders' participation but only reward a certain number of winners.

Reward systems in particular, if inappropriately designed and implemented can negatively affect quality of service delivery. Kilo et al, (2000) in a related study indicate that, in many hospitals, it was found out that general doctors who were paid a standard fee did not necessarily pay attention to the quality of their service care delivery. This could be worsened by the fact that general doctors who might make an effort to provide better quality services are not necessarily paid more for their effort. This creates an indifferent attitude towards the quality of services delivered by general doctors; the quality only being held by a thin thread of professional and personal motivation (Kilo et al).

2.5.3 Customer Friendly Systems

Customer friendly systems as an interdependent and interrelated set of hospital activities function as a whole in harmony and in the favor of its clients in order to achieve a quality service delivery (Fleet, 1988). These customer friendly systems mainly involve the routine maintenance of facilities and equipment, effective operational management, and the planning and coordination of processes and procedures involved towards managing a hospital's continuous development and change pattern needs in relation to the needs of the clients they serve; in other words referred to as FM.

Grimshaw & Keeffe (1993) in line contend that, FM is based on the premise that quality service delivery depends on the efficiency of any organization's operations that are linked to the physical environment in which it operates, and that that environment can be improved to increase efficiency to ensure quality service is delivered. FM therefore recognized the need for process improvement as means to ensure acceptable levels of customer friendly systems, where, emphasis is on how the work is done during a service delivery and the facilities, equipment and technology involved, in a bid to add quality service value for the benefit of the customers.

It is important to link customer friendly system localized process improvement initiatives to the strategic directions of an organization. In the long term, a sustainable customer friendly system role within organizations must be built within an aspiration to continuously add value through skilful manipulation of all business resources, thus, the optimum balance between people, physical assets and technology (Sarshar & Moores, 2006). Lack of strategic customer friendly systems integration within the core organization could result in contradictory organizational and

facilities goals and objectives, leading to unfriendly customer systems that would compromise the quality of services delivered.

Ramani (2004) also demonstrates that, adequate resource provisions through Management Information Systems (MIS) allows for the planning, monitoring and control of an organization's quality oriented activities which enable the development of appropriate customer friendly systems including patient flow management, inventory management, and billing for services. MIS is as such vital in determining customer friendly systems in planning decisions in regard to allocation of available resources to support the delivery of hospital services. This requires a clear understanding of the entity's logistical capacity in order to best coordinate and manage the various units of the hospital including clinical wards, operating theatres, investigative sections, and the like. With the help of MIS, appropriate allocation of available resources within resource limits act as aid in the provision of adequate resources for the development of quality customer friendly systems.

2.6 The influence of the Customers' Participation on Quality Service Delivery

2.6.1 Expectancy

Expectancy, the quality of state of a service in relation to ones anticipated belief or desire (http://dictionary.reference.co./browse/stability - 10/12/2009) is a crucial factor in quality service delivery. Cronin & Taylor (1992) contend that, quality service as perceived by the customer is the extent of discrepancy between customer expectations and their related perceptions. Service quality perceptions stem from how effectively the service is being delivered as compared to customer expectation (Babbar, 1992).

Expectancy can be said to be a measure/yardstick of customer satisfaction. For any business undertaking to be viable today, managers need to increasingly pay attention to customer expectations. Cronin & Taylor (1992) agree to this and demonstrate that, quality service is antecedent to customer satisfaction, and consumer satisfaction is antecedent to purchase intentions of that customer (Cronin & Taylor, 1992), arising as a result of satisfying customer's expectations. In line, the expectations of every customer therefore needs to be fully met since they hold the greatest stake in determining and thereby influencing the quality of service, as the end users of that service (Levitt, 1960 as cited by Carson et al, 1997).

Funston (1992) asserts that, the concept of quality service is deeply rooted in the traditional school of thought that contends that quality is defined solely by the consumer. The production of quality services in this case is capitalized on based on the expectations of its customers. Meeting customers' expectations by delivering quality services is said to be a sure way organizations can offer quality services and remain viable to its customers (Zeithaml, Parasuraman & Berry, 1990).

Carson et al (1997) on the other hand contend that, consumers expect the service provider to be reliable, responsive, competent, courteous, credible, understanding, accessible, and even exhibit appropriate demeanor, communicate effectively and inspire confidence. As such, a deficiency in any of or all of these customer expectations is considered by the customer as a decline in the quality of service.

However, meeting customer expectations is a big challenge in today's dynamic service industry. This is largely due to the unpredictability of customer behavior which has much to do with the wide range of individual differences among the customers and the way these customers categorize purchase decisions (Teare, 1998).

2.6.2 Consistence

Consistency means reliability (Punch, 2005). Consistency in quality health services can be enhanced by stakeholder participation. Providers, consumers, purchasers, and policy makers have a strong and mutual interest in assuring quality patient care across all health settings (Mitchell & Lang, 2004). Inability to consistently satisfy customer expectations in the service performance of an establishment means repeat buying may not take place (Levitt, 1981 as cited by Carson et al, 1997) especially with inconsistencies in the quality of service being rendered. Here, when customers' expectations of the service performance do not meet their specific needs or desires, then the business managers do not understand the quality requirements of its customers and do not produce the service to a required quality. This encourages inconsistency in the organization's service performance.

Firms should consider the views of their customers as partners in quality decision making for quality service consistence and organizational success. A partnership perspective gives insight to an organization about its customers' behavior. The close and consistent study over time of these customer expectations will help an organization determine its quality performance and achieve consistency in that performance in order to ensure competitive quality service delivery. Direct contact with customers is correlated with an emphasis on consistent quality service, holding customers as crucial stakeholders in related quality decision making (Grant, Shani & Krishnan, 1994 as cited by Schuler & Harris, 1992). Only by engaging and understanding the customer well, as stakeholders, and producing to their quality specifications over time can a firm achieve and maintain consistency in its operations.

As customers' expertise increases, their ability to make effective contributions to quality production activities also increases (Hall, 1996), encouraging consistency in quality service delivery. Consistency in quality service can also be enhanced through the delivery process that also deserves attention because a customer's loyalty depends primarily upon rendering consistent quality service (Tener & DeToro, 1992). Consistency in quality service delivery can be a challenge as service demands widely vary with every individual (Teare, 1998). Attaining consistency can be helped by the adoption of various service enhancement strategies like customer care and serve guarantees. For instance, customer care aspects like sensitivity and empathetic listening can often go a long way in enhancing consistency in quality service delivery between the health care organization (service organization and service provider) and patients (customers) who bring cultural differences to the health encounter (CLAS, 2001).

2.6.3 Stability

Stability means constancy of character or purpose in the quality of service delivery overtime (*http://dictionary.reference.co./browse/stability* - 10/12/2009). Stability in today's dynamic business world can be enhanced through organizations moving beyond the traditional stakeholder management techniques to partnering tactics that lead to the achievement of stability in an organization's quality performance (Harrison & St. John, 1996). Successful partnering with stakeholders create such valued benefits as increased quality service success rates, increased service delivery efficiency, the development of distinct quality competencies, reduced unfavorable litigation, and reduced levels of negative publicity (Harrison & St. John) among others. It was found out through the interviews conducted that CMC had moved into partnerships, noticeably with Maristopes Uganda as part distributors; an NGO supporting the promotion of health care in Uganda. This is to help CMC offer their services through Maristopes

outlets that are spread out over a wider geographical scope of the country than CMC is. However, more partnering is necessary, especially to provide other especially medical services not on CMC but that can be included and provided for by another partner organization.

Defining service quality is complex and yet necessary for any measurement efforts in determining desired levels of service consistency and stability respectively of a business. Study experiences conducted in Bangladesh (Andalleb, 1999), China (Yip et al, 1998), and Vietnam (Guldner & Rifkin, 1993) provide growing evidence that the perceived quality of health care services have a strong impact on utilization patterns (Brugha & Zwi, 1998). This suggests that studying service quality perceptions of customers can let known their utilization patterns that can be used to determine utilization and profit projections. As such, if the quality of a service is good, customer perceptions of the quality of that service is positive which would suggest a positive projection in utilization patterns and profit margins, and vice versa. If the suggested good quality of service is maintained and consistent over time, then desired stability levels can be achieved. However, what defines stability is relative and may vary in range from the definition of quality service stability, to the type of organization, to the nature of the different markets. CMC therefore needs to properly define its stability standards and develop a working methodology to achieve stability relative to its own practical context.

Mostafa (2005) asserts that, an excellent understanding of customers helps in determining consumer patterns and therefore predicting and managing desired stability. Particularly vital is the retention of long term customers, for the value of loyal customers increase stability as time passes (Albrecht & Zemke, 1985) to benefit the firm in terms of increased profit margins and consequent stability of the firm. It has been claimed that as hospital services improve, the

number of satisfied and loyal patients also increases in such a way that these clients may play an active role in the positive "word of mouth" and may exert repurchase intentions, reduce organizational costs (Meehan et al, 2002) and stir the organization to stability. CMC was found to have a very poor culture in customer retention during one of the interviews held. Though no statistics were readily available, this was a management concern currently then on table for emergency intervention.

To further enhance stability, standards are proposed as a means to correct inequalities that currently exist in the provision of health care and to make these services more responsive to the individual needs of all patients/consumers. Ultimately, the aim of the standards is to contribute to the elimination of health disparities and to improve health (CLAS, 2001), thus contributing to stability of quality service and business as a whole.

However, correct predictability of consumer utilization patterns can be a challenge. Teare (1998) suggests that, "the unpredictability of customer behavior has much to do with individual differences and the way people categorize purchase decisions". As such, defining quality of service to satisfy unpredictable consumers causes a challenge in predicting their utilization pattern consistencies and thereby making it difficult to attain and manage desired stability levels. In the absence of a well defined and recognized standard of quality service delivery, it is important to note that ensuring a constancy in quality of service encourages predictability in customer consumption partners and if sustained over time results into stability in the quality of service. Patients' perception and expectation of quality of care are critical to understanding the relationship between quality of care and utilization of health services (Baltussen et al, 2002).

In summary, in order to achieve, enhance and sustain an acceptable standard of service quality delivery, stakeholder participation is regarded as a vital ingredient in the service sector. A participatory approach is recommended, though the degree of engagement may vary according to the various disciplines. As a prerequisite, stakeholder analysis needs to be properly conducted to ensure that the approach eventually arrived at and adopted would be suitable for the quality service delivery intervention.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the research design, the population of the study, the sample size and sampling techniques used data collection methods used, the data collection instruments engaged, the validity and reliability testing of the research instruments, the procedure of data collection, measurement of variables and then data analysis.

3.2 Research Design

The research design engaged in this study was a cross sectional survey. A cross sectional design was chosen particularly because it permitted for an in-depth descriptive study of phenomenon (rather than in breadth) as it existed (Kabanza, 2001; & Kothari, 1990) at one particular point in time to be carried out. Both qualitative and quantitative approaches referred to as triangulation were engaged as they allowed for the complementation of the strengths of one method with the strengths of the other for more accurate results; a strategy best suited to fit the need of the researcher (Borg, Gall & Gall, 1996 as cited by Kabanza, 2001; Kothari, 1990; Punch, 2005), to reflect variance between the two approaches and not of the method (Bouchard, 1976, as cited by Jick, 1979).

3.3 Study Population

The study population, a complete set of individual cases or objects with some observable characteristics (Mugenda & Mugenda, 1999) was limited to the customers in CMC, CMH's medical scheme, and its staff. CMH is a hospital located on Plot 69/71 Buganda road in the central division of Kampala city. The target population of the study was 930 participants comprising of 759 customers who had renewed their membership with CMC medical scheme at

the time of data collection (February, 2009), and 171 staff members of CMH employed at the time (CMC registry, 2009; Staff registry, 2010). The 930 participants excluded 77 participants (45 customers and 32 staff members) who formed the team upon whom data collection instruments were pretested with the aim of developing them, in preparation for actual data collection.

3.4 Sample Size and Sampling Techniques

3.4.1 Sample Size

The sample for this study was 274 participants, derived from a targeted population of 930 participants (Krejcie & Morgan, 1970; as cited by Amin, 2005, pp. 454 - Ref. Appendix 1). The expected sample comprised of 224 customers in CMC, and 50 CMH staff members. Details of the target population, sample size and sampling techniques for the study are presented in Appendix 2. Table 1 below gives a summary of the study sample size and strategies used.

Table 1: A table showing target population, accessible population, sample size and sampling methods for the study.

Category of respondents	Stakeholder/s represented	Accessible population	Category Sample size recommended	Actual sample after data collection	Sampling Techniques
Staff of CMH	Service organization (Top Management key informants)	7	2	3	Stratified random sampling, Judgmental sampling,
	Service provider (Middle and lower level staff)	164	48	48	Stratified random sampling, Simple random sampling
Customers in CMC	Customers	759	224	219	Stratified random sampling, Systematic sampling
Totals		**930**	**274**	**270**	

Source: *CMH data base; CMC Records, 2009.*

3.4.2 Sampling Techniques

There were two main categories of stakeholders from whom data was collected. These were the staff of CMH and customers in CMC medical scheme. The sample population of 274 participants was apportioned between these two categories using a method called proportionate sampling to give their respective category sample sizes as 224 and 50 respectively. The 224 customers and 50 staff were further apportioned in respect to their representative portions to give their respective

strata sample sizes using a sampling method called stratified sampling (Ref. Appendix 2, titled subsamples). Thereafter, the methods used for the selection of individuals were as follows; in the case of customers from each subsample, systematic sampling was used. This involved the collection of data from every 3rd (N/n) eligible CMC member who visited CMC during the period of data collection. Systematic sampling allowed for random selection of individual customers on a fair chance basis from a large population, without necessarily having a numbered sampling frame (Amin, 2005). For the staff, judgmental and simple random sampling methods were used. Judgmental sampling allowed for key respondents to be deliberately selected on the basis of their expertise in the subject being investigated (Sekaran, 2003). This helped pick out two key respondents who represented top management. The total number of key respondents interviewed was three, one being a result of reference during data collection. Simple random sampling that involved obtaining a set of respondents from a population given an equal chance of being chosen as the subject (Sekaran, 2003; Amin, 2005), was used to handpick individual staff respondents from middle and lower levels of employment to answer the staff questionnaire.

3.5 Data Collection Methods

Both quantitative and qualitative methods were used in this study which incorporated the collection of both primary and secondary data. These data collection methods used included the administering of questionnaires – a quantitative method, interviewing - qualitative methods and documentary reviews – considered both qualitative and quantitative methods.

A triangulation of data collection methods enabled the researcher to get more reliable results from the study as the strengths of one method complimented the strengths of the other method (Amin, 2005).

3.5.1 Questionnaires

Two closed ended structured questionnaires based on a 5 likert scale were used, in a self administered manner, and collected quantitative data. These included the questionnaire for the middle and lower level staff, and the questionnaire for the customers in CMC. It was divided into four sections being the demographic (background) information, quality service delivery for the DV, service provider's participation for the IV, and, staff opinions on the service organization. Data using the questionnaire method was collected from 267 respondents. The questionnaire method allowed for the collection of data from a large sample size within a short period for more dependable and reliable results, offering greater assurance of anonymity and confidentiality, and enabling the respondents to give sensitive information without fear. (Amin, 2005; Mugenda & Mugenda, 1999; Kabanza, 2001; Kothari, 1990).

3.5.2 Key Informant Interviews

Interviews, a qualitative data collection method was used to collect data from three key respondents comprising of top management figures in representation of the service organization, The interview method was found to be particularly helpful as it allowed for in-depth data collection (Amin, 2005) made possible by among other techniques, clarifications, probing, body language analysis, and confirmation of responses. Interviews also required relatively lesser skill on the side of the interviewer (Kothari, 1999). Ironically, figures and numbers from quantitative data alone did not always provide answers to the questions about "how?", "what?" and "why?" certain things happen the way they do (Neuman, 2000). Interviews were hence engaged in this study to fill in this gap and answer the "how?", "what?" and "why?" that arose during the study. Interviews were also found to be an appropriate method of data collection in this case of top management figures arising as a result of their seniority.

3.5.3 Documentary reviews

Reviewing documents, also referred to as literature review allowed for the collection of both qualitative and quantitative data. The main documents reviewed for this study were administrative documents, company/archival records and personal documents got from sources including electronic journals, CMC data base, journal libraries, key respondents, textbooks and research dissertations. Documentary review allowed the researcher to get familiar with the study, also allowing for an in-depth study of documents (Sarantakos, 2005) from which lessons were learnt, and gaps identified. Documentary review was a continuous process that began way before the researcher started writing this research paper and went on throughout the entire research process. Literature was reviewed in accordance to three study objectives and themes derived from the IV and DV of the study.

3.6 Data Collection Instruments

Data collection was carried out using three research instruments that were questionnaires, interview guides, and a documentary review checklist.

3.6.1 Questionnaires

Two different self administered questionnaires were used for the customers and, middle and lower level segments of staff at CMH/CMC, and collected quantitative data. The questionnaire developed for the customers was different from that developed for middle and lower level staff. This difference in questionnaires allowed and ensured for the relevance of each questionnaire in content to their respective respondents (Ref. Appendices 3 and 4).

3.6.2 Interview guide

An interview guide was used in order to obtain in-depth primary information from three key respondents at the top management level. Interviews were opted for because of the seniority of

the top management respondents; the personal-touch involved enabled the researcher to engage them better. Also, being a small number of three, made the use of interviews possible as it was easier to manage than in the case of big numbers (Ref. Appendix 5).

3.6.3 Documentary review checklist

Literature was reviewed with the help of a documentary review checklist, also referred to as a documentary review guide, in order to confine the study review relevant to the research (Amin, 2005). The documentary review guide was structured in accordance to the study objectives and theme of interest to the researcher (Ref. Appendix 6).

3.7 Validity and Reliability Testing of Research Instruments

3.7.1 Validity Measures

Validity refers to the extent to which an instrument measures what it set-out to expectedly measure (Punch, 2005). It determines whether the research instrument truly measures that which it is intended to measure or how truthful the research results would otherwise be. Validity in this study ensured that the researcher measured the variables set out to be measured and not something else (Sekaran, 2003). Face and content validity were the main measures used for the pretesting of the research instruments.

Face validity established whether the tools and questions chosen rationally were an appropriate way of finding out what was being measured (Punch, 2005). Face validity was done on a general scale, mainly with the help of literature reviewed that provided ideas from related instruments where ideas were derived to develop this study's instruments.

Content validity focused on the extent to which the contents of the instruments corresponded to the contents of the theoretical concept that it was designed to measure (Amin, 2005). Amin

further recommended the use of Content Validity Index (CVI) to determine the validity of an instrument, whereby a computed ratio of (number of items declared valid) / (total number of items) of an instrument, if found to be 0.7 and above was considered valid. The CVI computed for the instruments used in this study are presented in table 2 as follows: -

Table 2: Content Validity Index (CVI) of the study Instruments

No.	Instrument	N	Valid responses	CVI
1.	Questionnaire for middle	42	37	0.88
	and lower level staff			
2.	Questionnaire for Customers	33	30	0.91
3.	Interview guide for top management	14	12	0.86

Source: Primary data

Since all the derived CVIs were above the recommended 0.7, the instruments pretested were considered valid and used as a basis on which data was collected.

To ensure that the researcher attained the highest possible level of validity, expert judgment was also used and involved frequent consultative sessions held with research experts, assigned supervisors and other researchers. Through these interactions, the researcher was able to make corrections, eliminate any inadequacies in the questions, and develop the instruments fully.

3.7.2 Reliability Measures

The consistency (Punch, 2005) of the questionnaires was measured as follows: -

The questionnaires that were used in this study were subjected to a ***test-retest*** method to improve the reliability of the instruments before the actual data collection was carried out. For each phase, a series of corrective measures made to the instruments was done to ensure that the results of the data collected were error free, as much as possible. Error free meant that the same research tool

used repeated over and over again on the same characteristics of population was able to give the same results (Amin, 2005). This was done on a general level.

The co-efficient of reliability, also referred to as the Cronbach's Alpha was also used to further determine how reliable data are or how well the items measured a construct; measuring *internal consistency.* The Cronbach Alpha - reliability test results for the questionnaires using SPSS version 16 are presented in table 3 as follows: -

Table 3: Cronbach Alpha - reliability test results for the questionnaires

No.	Instrument	N	Cronbach Alpha-reliability test	
			Test	Re-test
1	Questionnaire for middle	42	0.9	0.922
	and lower level staff			
2	Questionnaire for customers	33	0.87	0.911

Source: Primary data

The questionnaires indicated tested above were considered reliable as a co-efficient of reliability of 0.8 and above was considered a pass on the reliability of an instrument (Mugenda & Mugenda, 1999).

The interview guides were developed by pre-testing. This was done at two different times and with different participants. Each phase followed corrective measures taken. This helped perfect the interview guides and build the researcher's confidence in the eventual findings of the data collected, as the interview guide sufficiently collected the required data.

All respondents who participated in this pretesting exercise (32 staff – 30 for the staff questionnaire and 2 for the top management interview guide, and 45 customers for the customer questionnaire) were excluded from those that participated in the actual data collection exercise.

This ensured no double counting of participants that would have otherwise compromised the findings of the study.

Pre-testing of instruments helped the researcher meet specific constructed meanings (Amin, 2005) and also helped ensure that the instruments were in line with expectations. Pre-testing of instruments was done within the hospital setting on a few respondents to ensure consistence with use within the similar environment during actual data collection.

No background information was considered in the computation of reliability as they did not directly answer the objectives of the study.

3.8 Data Collection Procedure

Following the successful defense of the study proposal on 5th February, 2010, corrections were done before the researcher went to the field for actual data collection. Data collection was centrally done at CMH. A letter that introduced the researcher and the purpose of the research got from Uganda Management Institute (UMI) was presented to the management of CMH and sought permission to collect the required information. This was permitted and the actual data collection process immediately began. Data collection started on 8th February, 2010 up to 18th April, 2010. Data was successfully collected from a total of 270 respondents by the end of the data collection period.

Prior to the actual data collection exercise, the researcher ensured that all the personnel involved in the data collection exercise were trained in order to manage the exercise properly. The purpose of the study, confines of which participants were eligible and which were not, the study timeframe, exclusions of persons who participated in pre-testing, and sorts were defined.

Every third patient (CMC out-patients) who went to CMH was requested to fill a questionnaire by the front office personnel. These respondents filled in the questionnaires during the course of their visit, handing them back at the front office desk on their way out, on the basis of once per person.

Because in-patients first began as out-patients, issuing of questionnaires was centrally done at the front office desk. Collection and submission of the questionnaires for the in-patients who received them was delegated to five key nurses in the admissions, theaters, Intensive Care Unit (ICU) and labour wards sections as the researcher was not able to get direct access. These key nurses were purposively chosen and trained.

Data collected from the staff of CMH was obtained from two categories; top management level, and the middle and lower level staff. Middle and lower level staff respondents were engaged using the method of simple random sampling. A total of 48 middle and lower level staff were handpicked who each filled in a questionnaire after individually being approached by the researcher and requested to do so.

For the top management level, three top management key respondents were successfully engaged in separate interviews, at a time and place agreed upon; one being a case of a reference by one key respondent. Each interview was conducted by the researcher in a face to face question and answer session. The key respondents were selected using judgmental sampling.

The researcher maintained a focal point at the front desk of CMH for the purpose of any inquires and/or concerns that the respondents might have had. This focal point also acted as the central point where all completed questionnaires and responses to the interviews eventually converged.

The researcher was able to successfully obtain the required data with the help of a research assistant.

3.9 Measurement of Variables

It has been indicated that the interest in social science research is in the understanding of the relationship between indicators of variables measured (Kothari, 2004). In this study, indicators were measured at different levels incorporated in the research instruments used in the data collection exercise. The main measures were as follows: -

The nominal scale applied to variable indicators that were mutually exclusive and exhaustive and where there was no order of category that suggested one category was better than the other. Such variables included sex, marital status and category of occupation.

The ordinal scale was used to measure order or rank categories that implied level of importance. The ordinal scale was applied to such variable indicators like education, duration spent by a customer on CMC scheme, and also in the five point likert scale range continuum of response categories used in the questionnaires (5 to mean *strongly agree*, 4 to mean *agree*, 3 to mean *not sure*, 2 to mean *disagree* and 1 to means *strongly disagree*). Each range of five options given respectively represented alternative strengths of answers to each statement posed to the various respondents.

The interval scale measured such variable indicators involving equal interval settings or meaningful distance between ranks. Such variables included the age range of respondents and period a respondent spent in the employment of CMH/CMC scheme.

3.10 Data Analysis

Qualitative and quantitative data analysis formed the basis for the presentation, analysis and interpretation of findings of the data collected.

3.10.1 Qualitative Data Analysis

Qualitative data analysis was done using thematic and deductive analysis with the purpose of identifying common trends of agreement or disagreement on the items under discussion (Amin, 2005). Qualitative data collected was sorted, edited and categorized to ensure its completeness, accuracy, consistency and comprehensiveness. Thereafter, logical relationships were identified and drawn up to form themes that where then logically analyzed to derive specific conclusions from the general data collected. This summary of deductions was incorporated in the analysis and interpretation of the descriptive of the study findings.

3.10.2 Quantitative Data Analysis

Quantitative data collected was on the other hand analyzed with the help of the software program called Statistical Program for Social Sciences (SPSS), version 16.0. Numerical data was collected from respondents based on a five point likert scale that sorted the various responses in accordance to pre-determined categories. These coded responses were then entered into the SPSS program, forming data sets that were then cleaned, before the entries were manipulated through a process referred to as quantitative data analysis to derive specific meanings of the numeric entries. Manipulation of entries was majorly based on the five point likert scale that was, 1. Strongly Agree; 2. Agree; 3. Not sure; 4. Disagree; and 5. Strongly disagree. The five point likert scale was later merged into a three point likert scale of A – Agreed; NS – Not sure; and, D – Disagreed (Strongly agree and agree responses to essentially mean agreed, and strongly disagree and

disagree responses to mean disagreed) for the purpose of the presentation, analysis and interpretation of findings.

Findings are presented in chapter four following in the form tables, figures, descriptive, correlation coefficients and linear regressions, accordingly. Data analyzed and interpreted later on also formed the basis for the study summary, discussions, conclusions and recommendations in chapter five; also ascertaining whether the study answered the study purpose and objectives**.**

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter presents the research findings of the influence of stakeholders' participation on quality service delivery. The sub sections herein include the introduction, the response rate, the demographic information of the respondents, the influence of the service organization's participation on quality service delivery, the influence of the service provider's participation on quality service delivery, and the influence of the customer's participation on quality service delivery.

4.2 Response rate

Out of a targeted sample population of 274 participants, the researcher was able to successfully collect data from 270 respondents deriving a response rate of 98.5%. A response rate of 98.5% was considered very good as it was over and above the recommended rate of 70 percent (Lin, 1976). Response rate was computed in this respect using the formula, (Number of respondents/Total sample population) 100; that is, 270/274 x 100 = 98.5%. The total of 270 respondents comprised of 219 customers and 51 staff members. The above response findings are illustrated in table 4 below: -

Table 4: Study response rates

Stakeholder represented	Sample category	Expected sample portion	Actual sample portion collected	Response rate (%)
Service organization's participation	Key respondents from Top management	2	3	150
Service provider's participation	Staff (excluded key respondents)	48	48	100
Customers' participation	Customers	224	219	97.8
	Total	**274**	**270**	
			Overall response rate	**98.5**

Source: Primary data

Findings of this study are as such based on the 98.5 % response rate in representation of the target population of 930 customers and staff.

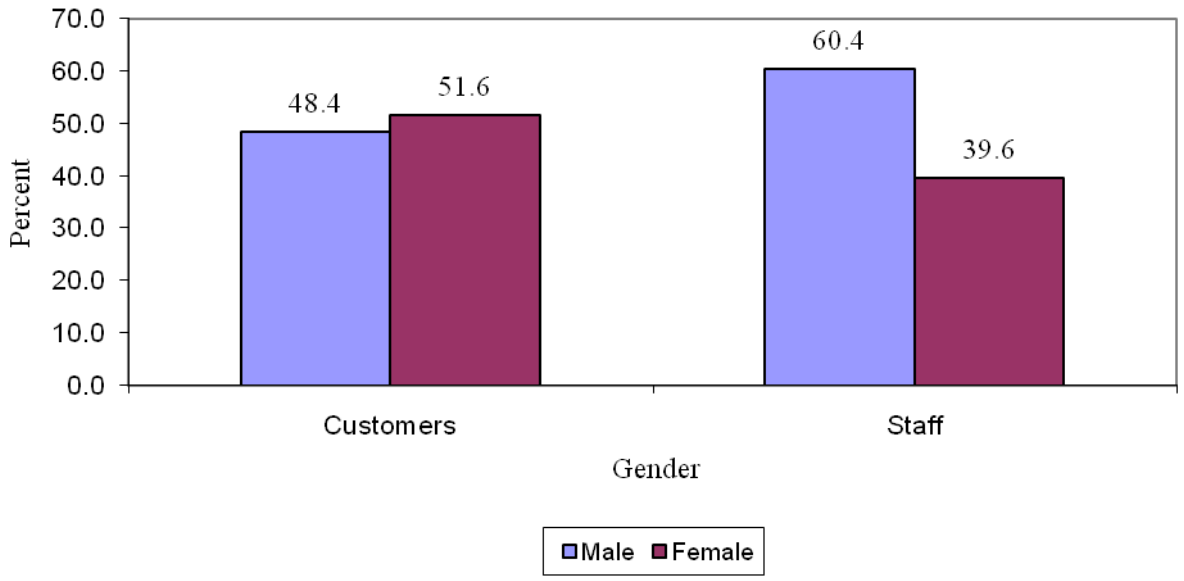
4.3 Demographic characteristics of respondents

The demographic characteristics of the study of 270 respondents were analyzed to describe their characteristics. Top management represented the service organization's participation, other staff other than the three top management key respondents represented the service providers' participation, and customers represented the customers' participation.

The demographic characteristics considered were; gender, age, marital status, highest level of education attained, category of occupation, period spent on the CMC scheme (Customers) and length of service in employment (staff). The findings were as follows: -

4.3.1 Gender distribution

The gender of respondents was considered. Overall findings indicate that, 49.4 % (132) respondents were female while 50.6 % (135) were male. The gender distribution for the respondents is illustrated graphically in figure 4 below: -



Source: Primary Data

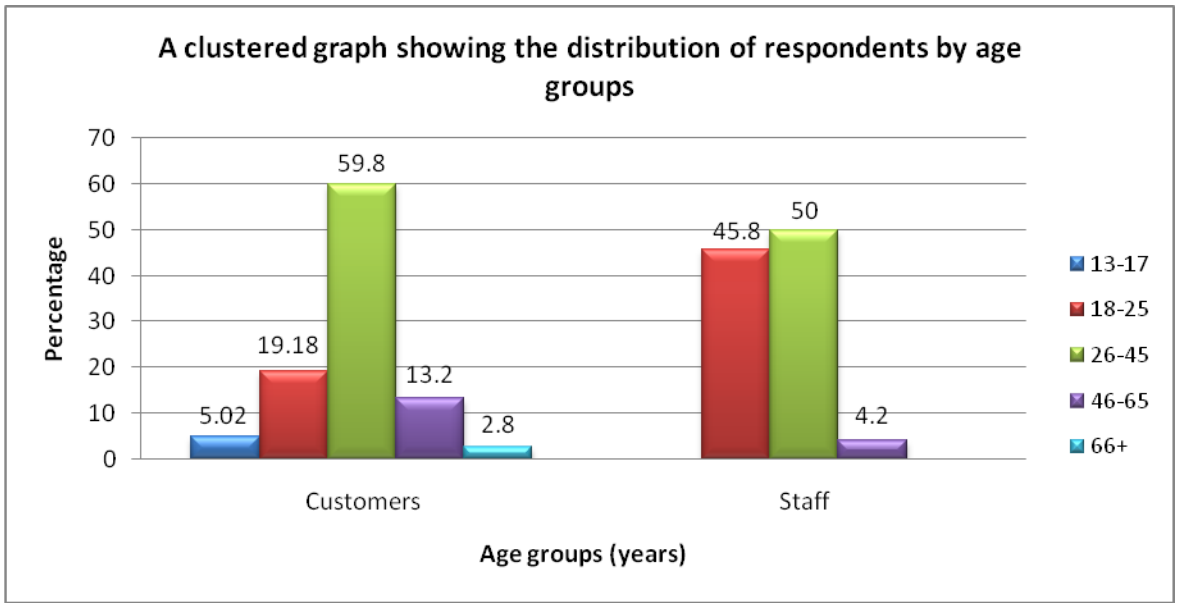
Figure 4: Gender distribution for the respondents

Of the 219 customer respondents who participated, results showed that the majority 51.6 % (113) were female while 48.4 % (106) were male. An almost equal number of women accessed medical services under the CMC arrangement during the time of data collection with a difference of only 3.2% (7) in excess of female respondents. This finding indicates that more and more men are accessing medical services, including accessing gynecological services and bringing children for pediatric help; areas of reproduction and child care traditionally dominated by females in patriarchal societies in Africa.

In the case of the staff, even though CMH employed more females than males (131:109 respectively - CMH staff registry, 2010), a lesser number 39.6 % (19) of females participated in this study, as compared to 60.4 % (29) of males.

4.3.2 Age distribution

Respondents' participation can be influenced by age. This study examined the age distribution of the respondents. The findings are illustrated in table 5 below as follows: -



Source: Primary Data

Figure 5: Age distribution for the respondents

It was found out that, the majority of respondents fell in the age bracket of 26-45 years old and comprised of 59.8% (131) customers and 50% (24) staff. The next majority of the respondents were within the age bracket of 18-25 years comprised of 19.18% (42) customers and 45.8% (22) staff. This was followed by those that fell in the age group of 46-65 years that comprised of 13.2% (29) customers and 4.2% (2) staff. Among the customers, 5.02% (11) were aged between

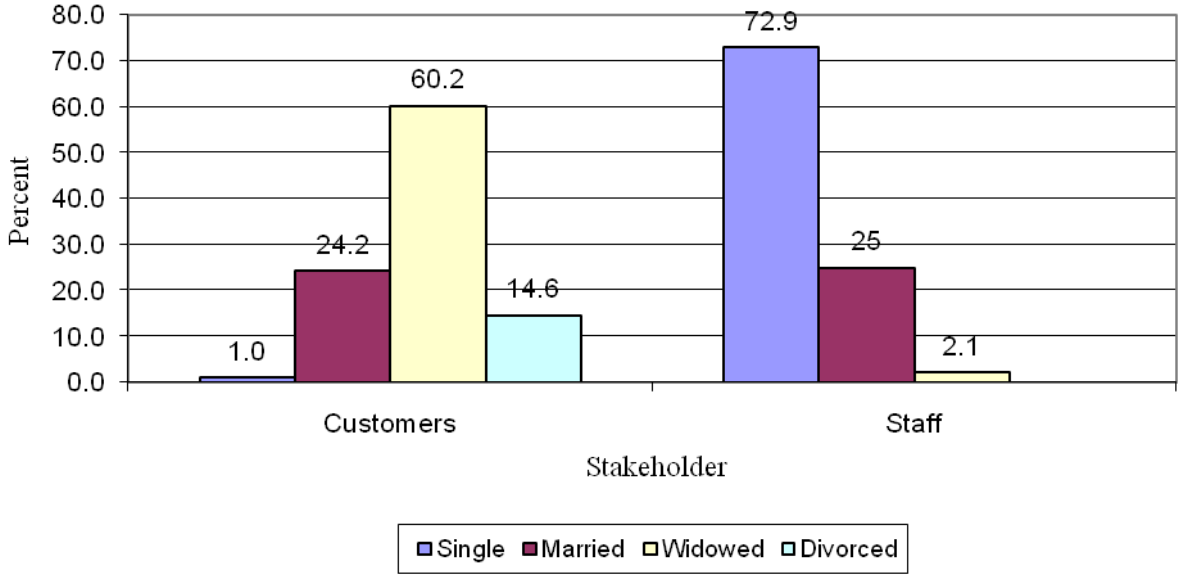
13-17 years old, and 2.8% (6) were 66 years old and above. In the case of the staff, there were no cases of respondents falling below the age of 18 years old, nor were there staff respondents above 65 years of age.

Findings depict that the majority of the customers who accessed the services of CMC during the time of data collection fell within the age group of 18-45 years and accounted for a majority of 79% (173) of customer respondents. Their dominancy is because this age group (youth) are in their most active stages of life (productive and reproductive). They do access medical care more often. Most of them have the resources to spend on medical care as they are working, or are entitled to a medical package by virtue of their employment. They tend to live life to its fullest and visit the hospital whenever they need to see the doctor.

For the staff, the majority fell within the same age group of 18-45 years, accounting for 96% (46) of the staff respondents. Apart from being the most productive age group any employer will opt for, the findings also confirm that CMH/CMC employed most of its staff within the age range of 18-45 years for the benefits arising from their more productive capabilities compared to other age groups.

4.3.3 Marital Status distribution

The marital status of respondents was also studied to assess if it has influence on quality service delivery. The distribution of the respondents by marital status is shown in the Figure 6 as follows: -



Source: Primary Data

Figure 6: Distribution of respondents by marital status

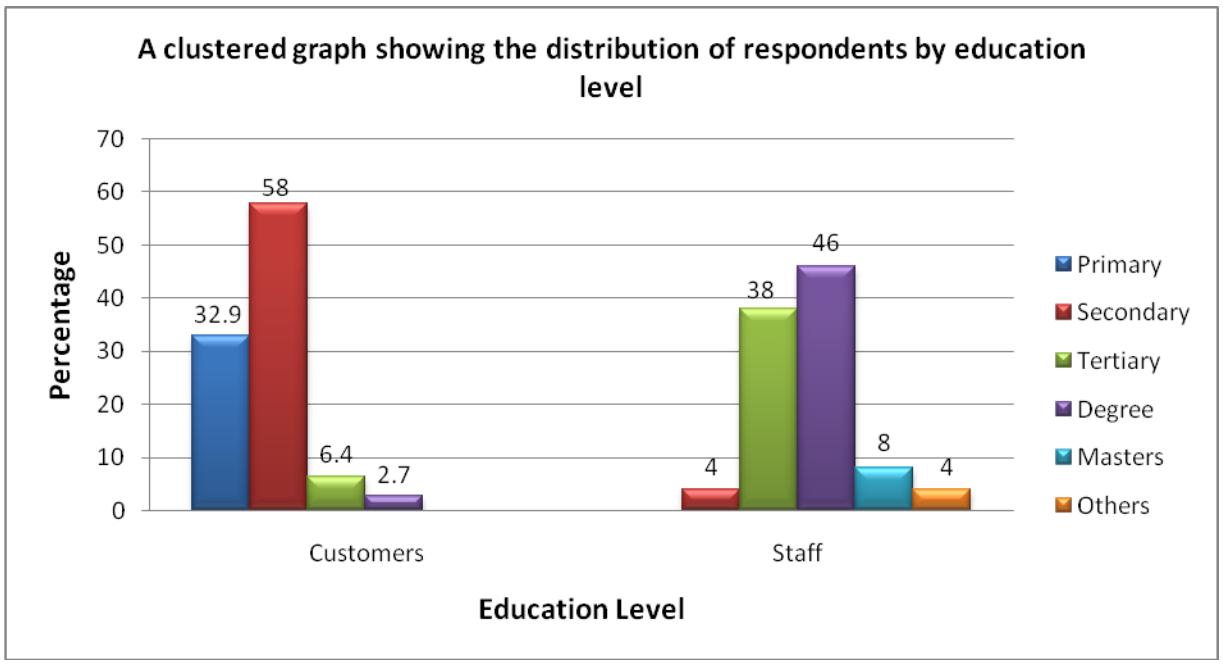
Amongst the 219 customers, more than three quarters were either married or widowed accounting for 84.4% (185) of the total. 14.6% (32) were divorced, and only 1.0% (2) were single. The highest percentage of 60.2% (131) represented the widowed. A high widowed rate was the result of a combination of many factors including, the increasing rate of HIV/AIDS prevalence among the married that has led to the loss of one spouse, like accidents, and the poor health habits adopted in most cases by the widowed encouraging them to visit CMC more often. There were also cases of dependants in CMC like parents, grandparents, grandaunts and granduncles, registered by the principle members who were in the majority of cases already widowed.

In contrast, of the 48 staff, about three quarters, 72.9% (35) members were single, 25.0% (12) married, 2.1% (1) were widowed, and none were divorced. The majority 72.9%, also confirmed

in the interviews conducted by the researcher, indicated that CMH management employed more people in their youthful age (18 – 45 years): a very resourceful category of labour force capable of increased productivity at minimal cost to the hospital. The highest percentage of staff being single was a deliberate tact by CMH as this category "*came with less baggage"* meaning no family commitments yet and could therefore concentrate more on their work.

4.3.4 Highest level of education attained

Respondents were also described in terms of their education status as it too was considered to have an influence on quality service delivery. Findings in figure 7 below illustrate the highest level of education attained by all respondents: -



Source: Primary Data

Figure 7: Distribution of respondents by highest level of education attained

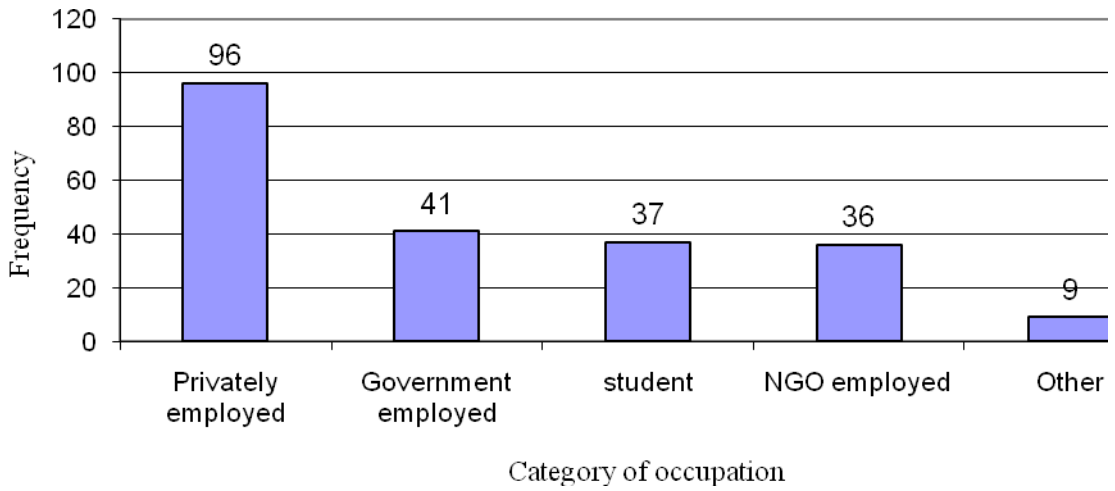
Among the customers, majority 90.9 % (199) had attained primary and secondary education. Those who attained tertiary education were 14 (6.4 percent), and only 6 (2.7 percent) had Bachelor's degrees. There were no cases of other education qualifications registered. Among the 48 staff, the majority 84 % (40) had attained tertiary and Bachelor's degree level of education. 4 others (8%) had master's degrees, and a total of 8% (4, 4) secondary and others qualifications.

The high number of customers in the primary-secondary category reflected the fact that at least 60% of the registered members in the CMC registry were dependants to principle members. The high numbers of tertiary and degree categories in the case of the staff, reflected that CMH employed more human resources in the two categories who capably did the work and even had the ability to perform better when empowered at a relatively cheaper cost as compared to employing the highly learned and experienced human resources.

Overall, findings suggest that the majority 92.6 % (250) of the respondents that participated in the study had attained education levels ranging from primary to Bachelor's degree level of education.

4.3.5 Customers' description by occupation

Customers were categorized by their occupation status. Following in figure 8 is an illustration of the customers by their category of occupation: -



Source: Primary Data

Figure 8: Distribution of customers by category of occupation

As shown in figure 8 above, majority of the respondents 43.8% (96) were privately employed, 18.7% (41) were employed by government, 16.5% (37) were students, 16.4% (36) were employed by NGOs, and the remaining 4.1% (9) didn't disclose their employment.

Findings suggest that the majority 79.0 % (173) of the customers who accessed healthcare under CMC arrangement during data collection were employed privately, by government and by NGO categories as a reflection of the three main employment sectors in the country. Private employment being the biggest occupation category, a part from their proprietors being keener in their investment, also explains the fact that this sector makes more profit margins compared to other sectors and can therefore invest more in health.

4.3.6 Period spent by customers on CMC

Period spent by customers on CMC was considered important and studied as another demographic characteristic for the customers. Findings in this regard are illustrated in Table 5 below: -

Table 5: Period spent by customers on CMC

Period spent (years)	No. of Respondents (frequency)	Percent
Less than 1	48	21.9
1 to 2	71	32.4
Above 2 to 3	50	22.8
Over 3	50	22.8
Total	219	100.0

Source: Primary Data

A total of 54.3 % (119) had spent at most two years on CMC while 45.6 % (100) had spent at least two years on the CMC medical scheme.

A majority of respondents 78 % (171) had at least one year of experience accessing healthcare on the CMC arrangement, implying that they possessed adequate experience in regard to quality of healthcare being accessed by customers, and as such ably made informed responses as contributions to the study findings. A minority of only 21.9 % (48) had less than a year's experience meaning that their participation in the study was not sufficient enough to distort the findings.

4.3.7 Length of service of staff members

The length of service spent by the staff in the service of CMH was considered. The distribution of the staff members by the length of service is shown in Table 6 below: -

Table 6: Length of service by staff members

Length of service (years)	No. of Respondents (frequency)	Percent
Less than 6 months	7	14.6
6 months to 1	9	18.8
above 1 to 3	23	47.9
Above 3 to 5	3	6.2
Over 5	6	12.5
Total	48	100.0

Source: Primary Data

In the case of the middle and lower level staff, only 14.6 % (7) of the respondents had been in the employment of CMH for less than six months, with 66.6 % (32) for at least a year. The majority amounting to 81.3 % (39) of the respondents had been in the same employment for up to 3 years. Only 18.7 % (9) of the respondents had been employed longer than 3 years.

The above table shows that the majority 47.9% of the respondents had worked in Case Medical Center/CMC for a period of 1-3 years, this was followed by a category that had worked for a period of 6 months to 1 year with 18.8%, the least was the category of 3 to 5 years with 6.2%. Others included below 6 months and over 5 years with 14.6% and 12.5% respectively.

Findings indicated that, with a majority of 66.6% of the respondents with work experience in CMC/CMH for at least a year indicated that these staff had sufficient experience in employment and ably contributed to the study findings in an informed manner.

4.3.8 Departmental representation of the staff

Staff participation by departmental representation was also considered to find out the distribution of their participation in the study. Table 7 below summaries staff responses by departmental representation as follows: -

Table 7: Departmental representation of staff respondents

No	Departmental Category	Frequency	Percentage representation
1.	Customer care	4	8
2.	Administration	4	8
3.	Medicine (General doctors and Specialists)	6	13
4.	Pharmacy	2	4
5.	Laboratory	3	6
6.	X-Ray/ Scan Unit	2	4
7.	Nursing (in-patients, out-patients including Housekeeping)	10	21
8.	Accounts	4	8
9.	Cafeteria	3	6
10	In-patients (Wards, Maternity, ICU, theatre)	6	13
11.	Security and Transport	4	8
Total		48	100

Source: Primary data

The researcher found out that majority respondents were from the nursing department that was the largest in staff numbers in the hospital at the time of data collection, followed by medicine (general doctors and specialists). Results as such implied that staff representation was fairly distributed throughout a wide range of the departments at the hospital, making the study findings representative of its target population.

4.4 The influence of service organization's participation on quality service delivery

This subsection is presented in accordance to the first study objective that sought to find out the influence of the service organization's participation on quality service delivery. Responses were got from the staff of CMH, comprising of 3 key respondents representing the service organization (top management) and 48 other staff representing the service provider's opinions on the service organization's participation. It was found out that the organizational structure, policies, and procedures and processes played a significant role in the service organization's influence on quality service delivery in CMC. Findings are as follows: -

4.4.1 Organizational structure

The organizational structure of CMC as was found out could not be discussed in isolation of CMH's structure as the hospital's structure was found to form the basis of how the organizations' activities, including that of CMC, were divided, organized and coordinated. It was found out that, in the absence of a board of directors, CMH was headed by a Chief Executive Officer (CEO) and assisted by a general manager, as the two top most functional positions at the time of data collection. Immediately below were 8 branch managers (by August, 2010) including the Financial Manager, Specialists' coordinator, General Doctors' coordinator, CMC manager, the Nursing Director, the Customer Care Manager, the Clinical Director (OPD), and the Nursing Development Manager, with the last one being the latest addition. Below the branch managers were supervisors, also referred to as team leaders. CMC in particular was headed by one of these branch managers, who were directly answerable to the CEO and general manager. The CMC manager had no subordinates in the department but worked closely in coordination with other departmental branch managers. It was found out that this structure formed the basis along which

all strategic decisions were made, and tactical and operational plans of the hospital including standing plans, policies, standard operating procedures and processes and, rules and regulations were aligned with. As such, this structure accorded significant powers to the service organization, and explained why its participation had significant influence on quality service delivery.

The management approach adopted by the CMH/CMC organizational structure was mainly top – bottom. The bottom – up approach was weak, as power and authority was concentrated at the top-middle managerial levels. In fact, one respondent confirmed this by mentioning, "*Lower level staff contribution towards quality service delivery decisions as taken by top management is very limited as a result of the hospital's structure along which power and authority lies. It is dominated by top and middle level management with very little if any regard to the views and opinions of staff at the bottom ends, who, though render the ultimate service to the customers are simply given directives to follow*". It was as such observed that this structure maintained power and authority concentrated with a tendency towards top management levels.

Because the organizational structure accorded much power and authority centralized at the top management level, also is decision making much centralized. Findings also revealed that, in the words of another key respondent, "*Most quality decisions are made proactively by an 11-man top management team to avoid unnecessary delay involved in the participatory approach. In such a competitive industry where life is a serious concern, there is little time to involve most stakeholders. However, we consult with key stakeholders occasionally, when found to be necessary*". This meant that there was little contribution from stakeholders, including

middle and low level staff, as well as CMC customers towards quality service delivery decisions made; a structural managerial tendency bluntly stated by another key respondent as "*a one-man's show*".

4.4.2 Organizational policies, procedures and processes

It was also found out that organizational policies had a significant influence on quality of service delivery in CMC. Some of these were found to have been developed by CMH while others arose from national and international laws. The main purposes of organization policies at CMH/CMC was found to included; governance of organizational operations, adherence to ethical consideration, prevention of abuse and exploitation of CMH/CMC and the services rendered, protect users of the services from abuse, conformity to and enforcement requirements of organizational, national and international operational standards and, control of operations. Organizational policies also ensured the alignment of efforts of stakeholders with the goals and objectives of the organization. Also, it was discovered that during the time of data collection, CMH/CMC was in its initial stages of transition from a clinic setting (Case Medical Centre) to a fully fledged hospital (CMH). In the words of a key respondent, "*CMH is in a restructuring process at the moment, also affecting CMC. Many of its structures, policies, procedures and processes of operations, human resources and sorts are being reviewed and changing accordingly. Policies are still being reviewed, others newly drafted, structures are changing that have also caused procedures and processes to be considered for redirection, job descriptions are being redefined in alignment with structural activities, also affecting human resource placements, to mention but a few. When we (top management) are through with most of these, a clear picture of how the service organization's participation on quality service delivery will be*

more evident. Otherwise, to the extent CMH has come (from a clinic to hospital status), one can generally say that the service organization's participation significantly influenced quality service delivery through among others, the then policies". The researcher was hence not able to access adequate information on organizational policies, procedures and process in this regard.

4.4.3 Human resources

Another important aspect of the service organization's influential participation on quality service delivery was that of human resources management. The researcher established that the service organization had a significant role to play in regard to the quality of staff and therefore, how this quality translated into quality services delivered. It was found out that the establishment did not have a human resources department. The role of human resource management was being carried out by the general manager's office. By August, 2010 CMH had 240 staff employed (109 were male and 131 female) up from 203 in March, 2010 in July, 2010. This was due to the hospital's recent expansion and attainment of a hospital status (2010), and as a result of the ongoing restructuring process that the centre was undergoing. One key respondent estimated that of this staff, about 85 % had medical backgrounds. The staff was divided into two evident segments; top management comprising of 10 members, and 230 middle and lower level staff (including 15 middle and 8 frontline managers). This totaled to 240 staff, with an estimated 86 % at the middle and lower levels of employment. This staff was distributed among 15 departments comprising of the Administration, Finance, Catering, Laundry/Housekeeping, Nursing, Theatre, Customer care, General doctors, Procurement/Stores, Maintenance, Laboratory, X-ray/Scan unit, Data, Specialists/consultants and Security. Appropriate placement of human resources was put at 90 percent by one key respondent who urged that this was very necessary due to the sensitive nature

of the services rendered by CMC that involved life. However, it was also found out that there existed no well defined and transparent standard of among others, recruitment, staff placements, dismissals, incentives and reward allocations, and procedure of redress of staff concerns. The researcher also observed that there was a wide salary gap between top management figures and those below. For instance, as another key respondent mentioned, "*There is a wide salary gap between the top management and the rest of the staff by an approximate ratio of at least on average 4:1* (Payroll register, 2009)".

4.4.4 Stakeholder management

CMH and CMC in particular worked with some stakeholders who were solely managed by top management, as they were capable of influencing quality service delivery. It was found that effectively and efficiently managing these stakeholders gave the service organization significant powers to influence quality service delivery. Some were actively involved while others were partial, depending on the CMH's need at the time. Examples of these stakeholders included suppliers, patients, and other medical facilities like Marie Stopes and Care Dental clinic for reference purposes. However, relevant to this study were considered staff of CMH (as described above) and customers on the medical scheme. Customers in particular were reported to have a major say in the quality service delivery decisions as the final users and main reason for the existence of CMH. On CMC, customers participated mainly by way of negotiations, dialogue, and written suggestions forwarded. But most importantly, as was stated by a key respondent, "They s*imply voted the quality of service delivered with their legs*"; meaning that those who were discontented with the quality of service delivered simply found an alternative service provider elsewhere. Staff participated through meetings, interactions and participating in training programmes. However, one respondent noted, "*the participation of customers in quality issues in*

CMC/CMH was usually considered much more seriously by top management than the participation of staff in quality concerns. In the unfortunate occurrence of an ignorant complaint on the side of the customer, staff usually bore the brunt of blame, even when they were not at fault". This was found to be attributed to the slogan, "*The customer is king and therefore always right".* It was also found out that there was no set of guidelines/standard procedure/s and/or process/es for the participatory engagement of stakeholders.

The influence of the service organization's participation in the organizational structural set up as described above, concentrated power and authority on quality issues at the top and did not encourage a participatory approach. This indicates that the service organization's participation in quality service delivery in CMC and CMH as a whole was significant.

4.4.5 Descriptive findings of the opinions of the service provider regarding the service organization's participatory influence on quality service delivery.

To substantiate the qualitative findings above, views and opinions given by middle and lower level staff on the participatory influence of the service organization's participation on quality service delivery in CMC/CMH, was collected and analyzed by the researcher. Here, 9 statements posed were measured which solicited the service providers' opinions accordingly. Results of these findings are presented in table 8 below: -

Table 8: Descriptive findings of the opinions of the service provider

Opinions of the service provider		A	NS	D
1.	The organizational structure of CMH/CMC potentially encouraged the delivery of quality services.	**97.9**	**2.1**	**-**
2.	The organizational structure of CMH/CMC enables for a participatory approach to be taken in regard to quality service delivery decisions.	**70.8**	**-**	**29.2**
3.	The organizational structure of CMH/CMC enables practices that influence quality service delivery.	**54.2**	**8.3**	**37.5**
4.	Organizational policies are relevant to quality service delivery needs	**62.5**	**8.3**	**29.2**
5.	Organizational policies are reached using a participatory approach	**43.8**	**8.3**	**47.9**
6.	Organizational policies in place are sufficient to motivate staff to deliver quality services	**37.5**	**10.4**	**52.1**
7.	Organizational procedures and processes influence quality service delivery	**31.2**	**4.2**	**64.6**
8.	Organizational procedures and processes in place enable staff delivery quality services	**37.5**	**4.2**	**58.3**
9.	Organizational procedures and processes are determined using a participatory approach	**28.0**	**2.4**	**69.6**

Source: Primary Data

KEY: **A** – Agreed, **NS** – Not Sure, **D** – Disagreed.

Overall, the researcher found out that most responses were in agreement that the service organization's participation influenced quality service delivery. The majority of the responses were in favour of the facts that the organizational structure of CMH/CMC potentially encouraged stakeholders participation and the delivery of quality services (97.9%), and also enabled for a participatory approach (70.8%). The minority in agreement (28.0%) to the statement, "organizational procedures and processes are determined using a participatory approach" also gave rise to a majority (69.6%) in disagreement to the same. There was larger tendency in disagreement in regard to organizational procedures and processes compared to organizational structure and policies. The majority

of the not sure responses were in regard to organizational policies in place being sufficient to motivate staff to deliver quality services (10.4 %).

The findings indicate that, though the organizational structures and policies were found to enable for stakeholders' participation in quality service delivery, the organizational procedures and processes were less favorable and therefore limited stakeholders' participation.

4.4.6 Correlation coefficient of the service provider's responses

The correlation coefficient of the service provider's responses was thereafter computed to find out if there was a relationship between the service organization's participation and quality service delivery. Results are as follows in table 9: -

Table 9: The correlation coefficient showing the relationship between the service organization's participation and quality service delivery.

Correlations			
		Service organization's Participation	Quality of service delivery
Service organization's participation	Pearson Correlation	1	.761**
	Sig. (2-tailed)		.000
	N	48	48
Quality of service delivery	Pearson Correlation	.761**	1
	Sig. (2-tailed)	.000	
	N	48	48

**. Correlation is significant at the 0.01 level (2-tailed).

The results in table 9 above indicate that there is a strong and statistically significant positive correlation between the service organisation's participation and quality service delivery in CMC at 0.761** with a statistical significance of 0.000 at the level of 0.01. This implies that the service organisation's participation positively contributes to the quality of healthcare delivery in

CMC. Thus the hypothesis that service organisation's participation influences quality service delivery in CMC is substantiated.

4.4.7 Regression coefficient for the service provider's responses

A linear regression ran to determine the extent of the relationship between the service organisation's participation and quality service delivery in CMC was derived. It indicated positive results in confirmation of the earlier findings as presented in table 10 below: -

Table 10: Regression coefficient for service organization's participation and quality service delivery

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	.137	.246		.558	.579
	Service organization	.851	.094	.763	9.069	.000
a. Dependent Variable: Quality of service delivery						
Model Summary						
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate		
1	.763[a]	.582	.575	.48094		
b. Predictors: (Constant), Service organization						

From the table 10 above, the R squared (R^2), which tells how a set of independent variables explains variations of a dependent variable, was 0.575. This means that the independent variable

dimension – service organisation participation, accounts for 57.5% of the variations in quality service delivery. The findings suggest that the independent variable is positively related to the dependent variable by 57.5%. The results further show that statistically, the service organisation's participation has a standardised coefficient (B) of 0.763, meaning, that service organisation's participation as a dimension of the independent variable affects quality of service delivery by 76.3%. This therefore implies that the service organisation's participation is positively related with quality service delivery in CMC. Hence, if there is any alteration on service organisation participation, there is likely to be a corresponding effect on quality service delivery in CMC.

4.5 The influence of the service provider's participation on quality service delivery.

The analysis here was guided by the second objective that sought to determine the influence of the service provider's participation on quality service delivery. Responses were got from 48 members of staff of CMH who also rendered their services to CMC. These 48 staff represented the service provider's participation. Findings are presented here as follows: -

4.5.1 Descriptive findings for the Service provider's participation

Descriptive findings were derived and gave insight into the service provider's response patterns in regard to quality service delivery and their participatory influence. Nineteen statements were measured which solicited the respondents opinions. Finds are presented in table 11 below based on a three likert scale, as strongly agree and agree were essentially taken to mean agreed, and strongly disagree and disagree to mean disagreed, accordingly.

Table 11: Descriptive findings showing the service provider's participation and Quality service delivery.

Quality service delivery		A	NS	D
1.	Services offered to clients are accomplished within the recommended standard time of 45 minutes per visit	**77.1**	**6.2**	**16.7**
2.	Ailments of clients are diagnosed and treated right the first time	**58.4**	**29.1**	**12.5**
3.	Level of service offered to clients is the same every other day	**43.8**	**8.3**	**47.9**
4.	Customers are willing to disclose their concerns to staff	**89.6**	**2.1**	**8.3**
5.	Staff exhibit professional behavior at all times	**85.4**	**4.2**	**10.4**
6.	Facilities are adequate to the needs of clients	**83.3**	**14.6**	**2.1**
7.	Staff hold courteous dialogue with customers	**91.7**	**-**	**8.3**
8.	Staff are conscious about the property and valuables of customers	**41.7**	**31.2**	**27.1**
9.	The hospital is conveniently located	**100**	**-**	**-**
10.	Service responsibility centers within the hospital are easily accessed	**85.4**	**10.4**	**4.2**
Service Provider's Participation		**A**	**NS**	**D**
Training and /or refresher courses				
1.	Staff are offered relevant training and/or refresher courses at least once annually.	**52**	**4.2**	**43.8**
2.	Resources available for staff empowerment is adequate (i.e. internet access, library etc)	**45.9**	**8.2**	**45.9**
3.	The criterion of decisions reached by top management on training and/or refresher courses offered to staff is participatory	**14.5**	**41.7**	**43.8**
Incentives and reward system				
4.	Staff participate in determining their actual contractual entitlements	**54.2**	**25**	**20.8**
5.	Staff participate in ensuring that their contractual entitlements conform to Uganda's legal labor requirements	**18.8**	**47.9**	**33.3**
6.	Incentives and rewards offered are sufficient motivators to staff to dedicate themselves to improving quality service delivery	**29.1**	**22.9**	**48**
Customer friendly systems				
7.	Staff participate in determining appropriate customer friendly systems adopted by the hospital to improve the quality service delivery	**60.5**	**8.3**	**31.2**
8.	Staff participate in decisions made to determine the safety gadgets provided for them	**77**	**10.4**	**12.6**
9.	Systems change is participatory	**25**	**18.8**	**56.2**

Source: Primary data

KEY: **A** – Agreed, **NS** – Not Sure, **D** – Disagreed.

There was an overall majority response in favour of the importance of quality service delivery in healthcare provision in CMC. This is with a majority in agreement that, CMH was conveniently located for its users (100%); staff were able to hold courteous dialogues with customers (91.7%); customers were willing to disclose their concerns to staff (89.6%); Staff exhibited professional behavior at all times (85.4 %); service responsibility centers within the hospital were easily accessed (85.4 %); and, services offered to clients were accomplished within the recommended standard time of 45 minutes per visit (77.1 %). Of the not sure responses, the biggest categories was in relation to staff being conscious about the property and valuables of customers (31.2 %), and facilities being adequate for the needs of clients (14.6 %).

In respect to the influence of the service provider's participation on quality service delivery, the majority of those in agreement responded in favour of customer friendly systems. The majority under this dimension (77.0%) the majority agreed that staff participated in decisions made to determine the safety gadgets provided for them, but, a majority on the opposite side (56.2%) were in disagreement that systems change was participatory. 18.8 % were the majority not sure whether systems change was participatory.

Training and/or refresher courses that score second to customer friendly systems overall, had a majority (52.0%) in agreement that staff were offered relevant training and/or refresher courses at least once annually. Equal portions (45.9%) agreed, and (45.9%) disagreed that resources available for staff empowerment were adequate. 41.7 % was the largest category under this indicator of not sure responses that indicated that the criterion of decisions reached by top management on training and/or refresher courses offered to staff is participatory.

Incentives and reward systems had a majority (54.2%) in agreement that staff participated in determining their contractual entitlements. Another majority (48.0%) of those respondents who agreed felt that incentives and reward systems did not offer sufficient motivation to staff to dedicate themselves to improving quality services being delivered. However, a majority (47.9%) were not sure that they actually participated in ensuring that their contractual entitlements conformed to Uganda's legal labour requirements.

4.5.2 Correlation coefficient between the service provider's participation and quality service delivery

The Pearson correlation coefficient was used to determine if there existed a relationship between service provider's participation and quality service delivery. The results showed that the correlation coefficient between the two variables as computed in Table 12 below were statistically insignificant.

Table 12: Correlation coefficient between the service provider's participation and quality service delivery

		Service provider	quality service delivery
Service provider	Pearson Correlation	1	**.037**
	Sig. (2-tailed)		.803
	N	48	48
Quality service delivery	Pearson Correlation	**.037**	1
	Sig. (2-tailed)	.803	
	N	48	48

Source: Primary Data

Results indicate that there was a very weak and insignificant positive correlation between service providers' participation and the quality of service delivery ($r = 0.037$; $p > 0.05$). This therefore

indicates that improvement in the level of the service providers' participation would have a very minimal impact on the quality of service delivery in CMC. The findings imply that the relationship between the service providers' participation and quality service delivery is too weak. As such, any additional unit invested in the service provider's participation would not yield much improvement in quality healthcare delivery in CMC. Thus, the hypothesis that there was a significant positive influence of the service provider's participation on quality service delivery in CMC was disproved.

4.5.3 Linear Regression Model of the effect of service provider's participation on Quality Service Delivery

The regression coefficient for the service providers' participatory effect on quality service delivery was computed with the intention of finding out the extent to which the service providers' participation and quality service delivery related. Findings are illustrated in table 13 below: -

Table 13: Regression coefficient for service provider's participation on quality service delivery

Coefficients[a]									
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.			
		B	Std. Error	Beta					
1	(Constant)	2.103	.292		7.202	.000			
	CMC Staff Average Response	.024	.096	.037	.251	.803			
a. Dependent Variable: Quality of Service									
Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.037[a]	.001	.020	.419	.001	.063	1	46	.803
b. Predictors: (Constant), CMC Staff Average Response									

Source: Primary data

From the table 14 above, findings indicate that service provider's participation predicts only 2.0 % of the total variation in the level of quality service delivery at CMC given R^2 = (0.020). This therefore implies that the service provider's participation would affect quality healthcare service delivery by 2.0 % and the remaining 98 % could be attributed to other factors, other than the service provider's participation. The findings also indicated that a unit change in service providers' participation would lead to only 0.037 positive change in the quality of healthcare.

Though there is a positive relationship between the service provider's participation and quality service delivery, the relationship was insignificant with the significant level far above 0.05 (β =

0.037, p = 0.803). Results depicted that the service provider's participation negligibly influenced quality service delivery.

4.6 The influence of the customers' participation on quality service delivery

The third objective of this study guided the analysis in this subsection based on the objective that sought to examine the influence of the customers' participation on quality service delivery. Out of an expected customer sample population of 224 participants, only 219 respondents successfully participated, the remaining five being cases marred by non responses. No additional procedures were conducted for the case of the five non responses, as a response rate of 97.8%, over and above the recommended margin of 85% was considered more than adequate and did not pose a threat to the study findings (Miller & Smith, 1983; Smith & Kotrlik, 1990; Borg & Gall, 1983 as cited by Lindner et al, 2001). Questionnaires containing non responses were not considered by the researcher in this study. Descriptive response, the correlation coefficient and regression of the influence of the customers' participation on quality service delivery were derived and presented as follows: -

4.6.1 Descriptive findings of the customers' participation on Quality service delivery by indicators measured

Descriptive findings were derived to describe the customers' responses to their participatory influence on quality service delivery. Nineteen statements were measured which solicited the respondents opinions. Findings are presented in table 15 below based on a three likert scale, as strongly agree and agree were essentially taken to mean agreed, and strongly disagree and disagree to mean disagreed, accordingly. Results are as presented below in table 15: -

Table 15: Descriptive findings of Customers' participation on Quality service delivery

Quality service delivery		A	NS	D
1.	Services offered to clients are accomplished within the recommended standard time of 45 minutes per visit	**74.4**	**6.9**	**18.7**
2.	Ailments of clients are diagnosed and treated right the first time	**80.8**	**7.3**	**11.9**
3.	Level of service offered to clients is the same every other day	**81.7**	**2.3**	**16**
4.	Customers are willing to disclose their concerns to staff	**89**	**2.8**	**8.2**
5.	Staff exhibit professional behavior at all times	**90.7**	**2.1**	**7.2**
6.	Facilities are adequate to the needs of clients	**82.4**	**5.2**	**12.4**
7.	Staff hold courteous dialogue with customers	**87.2**	**5**	**7.8**
8.	Staff are conscious about the property and valuables of customers	**87.7**	**5.9**	**6.4**
9.	The hospital is conveniently located	**88.5**	**4**	**7.5**
10.	Service responsibility centers within the hospital are accessible	**92.3**	**3.1**	**4.6**
Service Provider's Participation		**A**	**NS**	**D**
Expectancy				
1.	Customers feel that they are part of the Case Med Care family	**56.6**	**21.5**	**21.9**
2.	Customers are encouraged by management to get involved in decisions made to better the quality of services delivered	**45.2**	**25.1**	**29.7**
3.	Customers actively participate in determining quality of services offered to them	**37.9**	**21.5**	**40.6**
Consistence				
4.	Customers participation is recognized by management	**36.5**	**24.2**	**39.3**
5.	Decision making is dominated by customers	**34.7**	**25.5**	**39.8**
6.	Customers feel that they have a say in the quality of services offered	**53**	**20.1**	**26.9**
Stability				
7.	Decision making is dominated by management	**55.7**	**28.3**	**16**
8.	Decision making is dominated by customers	**36.1**	**31.1**	**32.8**
9.	Decision making is participatory	**38.8**	**23.7**	**37.5**

Source: Primary Data. KEY: **A** – Agreed, **NS** – Not Sure, **D** – Disagreed.

Generally, the majority of the respondents agreed to the importance of quality service healthcare delivery with the highest regard in favour of, service responsibility centers within the hospital were accessible (92.3%); staff exhibited professional behavior at all times (90.7 %); and, customers were willing to disclose their concerns to staff (89%). A majority of 7.3 % were not sure of the quality aspect of importance of ailments of clients being diagnosed and treated right the first time.

In regard to the influence of the customers' participation on quality service delivery, the importance of the dimensions studied was prioritized as expectancy, stability and then consistence. With expectancy, the majority (56.6%) agreed that customers felt that they were part of the CMC family of customers, while another majority (40.6%) disagreed that customers actively participated in determining quality service delivery offered to them. 25.1% were a majority of the not sure responses that indicated that the customer was encouraged by management to get involved in decisions made to better the quality of services offered to them. 25.1 % were not sure whether customers were encouraged by management to get involved in decisions made to better the quality of services delivered.

In respect to stability, a majority (55.7%) agreed that decision making was dominated by management, while the majority in disagreement (37.5%) felt that decision making was participatory. However, another majority (31.1%) were not sure that decision making was dominated by the customers. 31.1% of the respondents were not sure whether decision making was dominated by customers.

The majority (53.0%) in the dimension consistence agreed that customers felt they had a say in the quality of services delivered to them. 39.8% disagreed and 25.5% were not sure that customers were made aware of quality decisions finally taken by management. 25.5 % of the respondents were not sure whether decision making was dominated by customers.

4.6.2 Correlation coefficients between customers' participation and quality service delivery

The Pearson correlation coefficient was also computed for the customer responses to determine if there was a relationship between the customers' participation and quality service delivery. Findings are illustrated in table 16 below.

Table 16: Correlation coefficients between the customers' participation and the aspects of quality service delivery

Correlations			
		Customers' Participation	Quality of service delivery
Customers' Participation	Pearson Correlation	1	.493**
	Sig. (2-tailed)		.000
	N	219	219
Quality of service delivery	Pearson Correlation	.493**	1
	Sig. (2-tailed)	.000	
	N	219	219
**. Correlation is significant at the 0.01 level (2-tailed).			

Source: Primary Data

The results showed that there is a statistically positive and significant correlation between the customers' participation and quality service delivery ($r = 0.493^{**}$; $p < 0.01$). This shows that an improvement in customers' participation is accompanied by an improvement in the level of quality service delivery in CMC. Additional units invested in the customers' participation would

yield much improvement in quality healthcare delivery in terms of reliability, responsiveness, competence, courtesy, access and communication in CMC. Thus, the hypothesis that the customers' participation influenced quality service delivery positively in CMC was proved right.

4.6.3 Linear Regression Model of the influence of the customers' participation on Quality Service Delivery

A linear regression model estimate using the least square estimation method was used to establish the impact of customer participation on the quality of service delivery. Results are illustrated in table 17 below.

Table 17: Regression coefficient for customers' participation on quality service delivery

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	.964	.117		8.236	.000
	stkd_avge	.336	.040	.493	8.352	.000
a. Dependent Variable: Quality of service delivery						

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.493[a]	.243	.240	.38191	.243	69.762	1	217	.000

b. Predictors: (Constant), Customers' Participation

Source: Primary Data

The findings in table 19 indicate that the customers' participation explains up to 24% of the variation in the quality of service delivery given the coefficient of determination R^2 = (0.243) and an adjusted R^2 = (0.24). This therefore means that the customers' participation explains 24% of the variations in quality healthcare service, and the remaining 76% attributed to others factors, other than the customers' participation. The result therefore indicates that a unit change in the level of customer participation is accompanied by a 0.493 change in the quality of service delivery.

The regression results shows that customers' participation has a significant positive influence on the quality of service delivery ($\beta = 0.493$, $P < 0.01$). This result implies that quality of service delivery is affected positively when there is active customer participation and negatively when there is less customer participation in quality service delivery.

CHAPTER FIVE

SUMMARY, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The study investigated the influence of stakeholders' participation on quality service delivery among private medical practitioners in Kampala: A case study of Case Med Care (CMC), and based on the study of three specific objectives which were: to assess the influence of the service organization's participation on quality service delivery; to determine the influence of the service provider's participation on quality service delivery; and to examine the influence of the customers' participation on quality service delivery. This chapter presents the summary, discussions, conclusions and then the recommendations of the findings of the study. The limitations of the study experienced, the contributions of the study, and areas for further research are also included.

5.2 Summary of findings

Stakeholders' participation in service quality delivery was found to be a relatively new concept especially in the medical sector. However, it was increasingly being adopted as a fashionable discipline in efforts to enhance quality service delivery. Apart from the mainstream stakeholders theory, also called the traditional stakeholders theory, various other theories in relation to stakeholders participation have been developed including; the descriptive theory, the normative approach, the instrumentalist stakeholders theory, the network theory, and the systems theory. The service organization and service provider were regarded as internal stakeholders while the customers were external. Stakeholders' participation in quality service enhancement was among other factors considered an important strategy in view of its many benefits as compared to costs. The study investigated the persistent decline in the number of customers as was registered in

CMC between the study period July, 2006 to December, 2009. Among other factors thought to have caused the loss of clients was insufficient stakeholders' participation in quality health care issues; and thus the justification of the study.

Literature was reviewed from a number of sources in accordance to the study objectives mentioned above and respective indicators; that were the service organization's participation – *organizational structure, organizational policies, and organizational procedures and processes*; the service provider's participation – *training and/or refresher courses, incentives and reward systems, and customer friendly systems*; and the customers' participation – *expectancy, consistence and stability.* The Balance theory (Fritz Heider, 1958, as cited by Carson et al, 1997) guided this study and explained how the three stakeholders mentioned above in a triad interrelationship influenced quality service delivery. Perspectives on quality healthcare service delivery enhancements through stakeholders' participation was found to be a relatively new concept and varied as much as there were individual consumers (Karlsen, 2002). Negative characteristics of services like intangibility and inseparability was found to greatly hinder the delivery of quality services (Baron et al, 2009). As a result, pieces of literature reviewed recommend increased stakeholders participation in service rescue strategies to recover service failures including guarantees, warrants, training and/or refresher courses (Brown et al, 1996)

A cross sectional study design was adopted in this research, based on the case study of CMC. Of the study target population of 930 participants comprising of 759 customers and 171 staff, 270 respondents, out of a recommended sample of 274 participants (Krejcie and Morgan, 1970, as cited by Amin, 2005) successfully participated and formed the basis for the study findings. Research instruments were considered valid with the staff questionnaire at 0.88, the customer

questionnaire at 0.91 and the interview guide at 0.86 (Amin, 2005). Also, the same questionnaires were found to be reliable at 0.922 and 0.911 respectively (Mugenda & Mugenda, 1999). Measurement of study indicators was based on a five point likert scale (later merged into a three point likert scale for the purposed of analysis). Variables were measured based on nominal, ordinal and interval scales. Quantitative data was analyzed with the help of the software programme, Statistical Packages for Social Sciences (SPSS) version 16.0, while qualitative data was analyzed by way of thematic and deductive analysis.

The response rate for the study was 98.5%. Data analysis established that the service organization's participation and customers' participation had a statistically significant positive influence on quality service delivery ($r = 0.761$ and $r = 0.493$) with a unit change investment in the service organization's and customers' participations resulting into a positive change in quality healthcare delivery. However, though the relationship between the service provider and quality service delivery was positive, it was found to be a very weak correlation ($r = 0.037$) with a unit change in the service provider's participation resulting into a very minimal impact on quality service delivery enhancement.

5.3 Discussions

5.3.1 The influence of the service organization's participation on quality service delivery

Findings indicated that the service organization in their participation played a major role in influencing quality service delivery in CMC. Interviews conducted by the researcher confirmed this by noting in the words of one key respondent that, "*The service organization's participation in quality service delivery is managed by a top management team; the service organization and top management team of which are much the same and cannot be divorced from each other. The*

service organization in its participation has significant powers and authority and acts as a major engine that directs and progresses CMC and CMH to greater heights. "

Scot & Lane (2000) agree with the above view in the specific discipline of stakeholder management and indicates that, "*The service organization in its participation played an important role in Management – Stakeholder relationships that was considered an important determinant of quality service delivery"*, and added that, *"Management – Stakeholder relationship in turn defined the organizational image (external appraisals) and identify (internal perceptions)*". External appraisals and internal perceptions were looked at as important factors that conditioned the perceptions of what service quality the organization delivered from the stand point of the users. If these perceptions were considered positive, quality service delivered was defined as meaningful and acceptable to customers, and vice versa.

But even when the service organization was perceived to have significant influential power over quality service delivery, the challenge of correct diagnosis and application of its power and authority remained a challenge. In the study findings, one respondent said that, "*A number of decisions were many times taken by top management in a proactive manner because of insufficient stakeholders participation; especially from middle and lower level staff who were as a result simply directed on what to do*". Proactive decision making exposed the service organization to a high change of getting misled in its actions, as the decisions finally taken did not necessarily reflect the views and opinions of its various stakeholders and as such was not owned and supported.

Proactive decision making also encouraged a narrow range of views and opinions of top management. Many times, this encouraged a habitual tendency to address quality service

delivery issues in a manner predisposed because of their attention to rules, regulations, routines, procedures, processes and practices that to an extent constrained and blurred the service organization's focus in their participation (Ashmos et al, 1998).

5.3.2 The influence of the service provider's participation on quality service delivery

PMI (2004) asserts that, human resources are the most important resource in most undertakings and as such must be well managed for positive results. Though the findings of this study indicated a positive correlation coefficient between the service provider's participation and quality service delivery, the relationship was very weak and insignificant ($r = 0.037$; $p > 0.05$). This suggested an insignificant level of the service provider's participation in quality service delivery issues; a situation undesirable in CMC as the service provider directly influenced quality service delivery as a result of their position as the final furnishers of an organization's services to the customers (Carson et al, 1997).

Bowen & Lawler III (1992) add to the assertion made above by the PMI (2004) in affirmation that, businesses today have rushed to adopt human resources empowerment approach, as opposed to the standardized, procedural driven operations production line of the mid 1970s, to service delivery. However, this was contrary to the findings of this study where it was found out that human resources were not effectively being empowered to enhance quality service delivery. For instance, in the case of training and/or refresher courses, a majority 47.9% agreed that they got their training and/or refresher course needs outside the arrangement of CMC/CMH suggesting that training and/or refresher courses offered by the institution were either insufficient or irrelevant to their needs. The poorly stocked library that accounted for 52.1% in agreement of its inadequacy did not help matters either.

On the other hand, empowerment of the service provider is directly correlated to the quality of performance and quality services therefore delivered. The management of empowerment efforts for the service provider by the organization's top management is challenged by the desires and interests of the individuals comprising of the service provider. Many times, these interests and desires are in conflict with the interests of the organization in its pursuance to achieve its goals and objectives. In this regard, top management is forced to adopt management strategies that will align the various interests and desires of the service provider in quality service delivery with the goals and objectives of the organization. Waddock & Graves (1997) agree with this and assert that perceived quality of management can best be explained by quality of performance with respect to specific primary stakeholders; the service provider being one of the primary stakeholders in question.

5.3.3 The influence of the customers' participation on quality service delivery

Because customers are major stakeholders in influencing quality service delivery, any business undertaking strived as a result of their existence. Businesses as such owe their customers the highest quality of service possible to satisfy their customers' expectations. The findings of the study indicated that the customers' participation in quality service delivery was significant, suggesting that customers were more interested in services that best meant their needs and expectation (Zeithaml & Bitner (1988) assertion, as cited by Bitner, 1995).

However, a significant level of customer participation in quality service delivery could also be interpreted as a call for improvements. Blogett et al (1993) revealed that, customers were more inclined to participate in a bid to ensure that they received at least the minimum tolerable and

acceptable standard of a quality service perceived deserved, especially if they did not have a better alternative to resort to or simply did not have the will to change.

Delivering quality service means conforming to customers' expectations on a consistent basis (Lewis & Boom, 1983). Consistence was found to be important in regard to service quality delivery. Findings revealed that the indicator of consistence in quality service delivery measured had the least responses in agreement compared to the remaining two indicators of expectancy and stability. Quality of services delivered that is not reliable (Punch, 2005) act as a breeding ground for uncertainty and unpredictability, making efforts to enhance and/or sustain quality service delivery, and therefore retain customers difficult.

Zeithaml (1988) in addition, mentioned that it was rarely the fact that something went wrong in delivering quality services that caused the number of customers to drop but rather the effectiveness and consistence in the way in which the organization responded to recover service failures. Responses to service failures was reported to have a significant impact on customer's perceptions and therefore their participation and evaluation of the service outcome, because customers are usually more observant of recovery to service failures than in routine or first time service and are often more dissatisfied by an organization's consistent failure to recover than with the failure itself (Parasuraman & Berry, 1991).

5.4 Conclusions

The study of CMC could not be looked at in isolation from CMH. CMC and CMH were as a result looked at hand in hand.

5.4.1 The service organization's participation in quality service delivery

The service organization's participation was found to have a significant influence on quality service delivery with a unit change in the service organization's participation leading to a 76.3% change in quality service delivery.

The service organization in its participation was also found to accord significant powers and authority to top management; evident in tactical and operational plans developed, policies, standard operations, procedures, rules, regulations and practices. This significant power and authority greatly influenced quality service delivery decisions.

The significant power and authority accorded to the top management largely accounted for the dominate top-bottom management approach adopted by CMH/CMC, leveled by some key respondents to "*a one-man show*".

The tendency of proactive decision making found to have been adopted by the 11-man-strong top management team did not necessarily encourage adequate stakeholders' participation and as such to that extent it did not, compromise quality service delivery enhancements.

Inadequate stakeholder participation as a result saw no need for effective stakeholder management that meant that stakeholder satisfaction and therefore retention was very weak.

The service organization (support system) was modernized mainly in terms facilities, equipment and technology; the hospital referred to by some as "*a dot-com hospital"*.

Findings in conclusion indicated that the study hypothesis that the service organization's participation influenced quality service delivery was substantiated.

5.4.2 The service provider's participation in quality service delivery

The relationship between the service provider's participation and quality service delivery was very weak with an insignificant positive correlation ($r = 0.037$; $p > 0.05$) meaning that any additional unit invested in the service provider's participation would not yield much improvement in the quality of service delivery.

The bigger percentage of the service provider, estimated by a key respondent to at least 85%, were engaged elsewhere mainly in forms of employment in similar healthcare establishments and/or pursuing further studies; some of whom considered their other engagements as primary to their employment by CMH. As a result, most dedicated little of their time and effort in quality issues.

The service provider perceived their participation in quality service delivery as minimal and not making much of a difference if they did due to their perception that decision making including that on quality issues was dominated by top management.

Human resources management was handled by the general manager's office, in the absence of an entity set up with the specific responsibility of fully or majorly managing human resources. Human resources procedures, processes and practices were as such not clearly defined in respect to recruitment, placements, discharges, human resources empowerment, incentives, rewards systems, and exploiting untapped human resources employed among others.

There was an evident gap between top management and lower level staff in respect to incentives and rewards; most evident in their salary distribution. This was one of the factors responsible for

at least 85% of the service provider found to be in similar forms of employment and/or pursuing further studies to make ends meet.

Findings in conclusion indicated that the study hypothesis that there was a significant positive influence of the service provider's participation on quality service delivery was disproved.

5.4.3 The customers' participation in quality service delivery

The relationship between the customers' participation and quality service delivery was statistically positive with a significant correlation ($r = 0.493$; $p = 0.01$) meaning that additional units invested in the customers' participation would yield much improvement in quality service delivery.

Customers in their participation in quality service delivery were found to be a major influential player, but not a sole player as other stakeholders were also regarded important.

Quality service enhancement trends today not only recommended attention paid to customers' expectations for organizations to remain relevant to its clientele, but also go beyond this traditional view through innovation and creativity to produce and deliver quality services in anticipation of the untapped expectations of customers; thereby gaining market headways in the medical industry.

Customers mainly voted the quality of service delivery "*with their feet"* made worse by the fact that there were no clearly defined channels through which customers could voice their concerns and receive prompt feedback in response. Recovering service failures, usually at the expense of customer loss, posed a great challenge in view of the negative characteristics of service delivery including perishability, intangibility and indivisibility.

As such, stakeholder satisfaction and retention, but more specifically customer satisfaction and retention, remained a management concern, evident in among other indicators, loss in membership numbers in CMC since its inception in 2006 to December, 2009.

Findings in conclusion indicated that the study hypothesis that the customers' participation influenced quality service delivery was approved.

5.5 Recommendations

Based on the study findings, the researcher came out with the following recommendations: -

5.5.1 The service organization's participation on quality service delivery

More resources should be invested in the service organization's participation for the highest margin of returns to investment in quality service delivery compared to the service provider's and customers' participation.

The significant powers and authority accorded to top management need to be checked in the sense that requires a review of top management structures in itself to encourage and enhance stakeholders' participation, especially in quality service delivery.

The organizational structure of CMH/CMC enables for a participatory approach in quality healthcare delivery enhancement. However, this is marred by among other factors practices being undertaken in the operations of CMC and CMH as a whole, hence retarding quality improvement efforts. Practices, policies, operating procedures and processes should be revised in the interest of enhancing quality healthcare delivery.

As a result, decentralization of power and authority from the top most levels to lower level managers should be effected in a bid, among other strategies, to enhance stakeholders' participation.

Empowerment/sensitization of mainly staff affected by the above mentioned restructuring specifics is important to deter abuse of the power and authority, and yet aid increased stakeholders' participation.

Proactive decision making is necessary in some instances owing to the sensitive nature of medical service provision involving life. However, to the extent possible, a more participatory decision making approach should be embraced in view of its benefits. The negative effects of proactive decision making should also be better managed.

Increased stakeholders' participation will also require better management, especially in stakeholder satisfaction and retention efforts so as not to retard quality healthcare delivery efforts already achieved. This will improve on quality enhancement and decrease waste on resources spent in winning back lost/dormant stakeholders.

Modernization efforts of CMH/CMC were good and serviced to enhance quality service delivery to a greater extent. However, the adoption of modern ways should be engineered only to the extent relevant to its users.

5.5.2 The service provider's participation on quality service delivery

Findings indicated that there was a very weak relationship between the service provider's participation and quality service delivery, greatly underscoring the influence of the service provider's participation on quality service delivery. It is recommended that more units in

investment should be put into the service provider's participation in view of the fact that the service provider is the final renderer of the actual service to the customers and as such directly play in "selling" the end product to the final users.

Flexible shifts should be put in place as a motivational factor to staff needed to be reviewed in light of its negative impact on quality service delivery. This can be done among other factors through increased sensitization of staff to improve on their commitment to service quality delivery, review of the policy supporting flexible shifts, and improving the salary and allowances of especially the lower level staff.

A fully fledged human resources/quality assurance unit charged fully or majorly with the proper management of human resources, as the most important productive resource in most business needs to be put in place. This will improve the service provider's participation in quality delivery issues, and also among others, address quality issues in regard to recruitment, placement, performance, incentives and reward systems, empowerment and reward systems, and, exploitation of the already wealthy skills attained by its staff but not yet tapped.

Staff entitlements, incentives and reward systems need to be reviewed in order to among others, motivate staff, and improve on commitment in regard to quality issues to improve on quality performance. More importantly, there is need for staff retention that can be enhanced through full time employment on a permanent basis. This will help commit the service provider to quality healthcare delivery enhancements and minimize the common practice of staff having more than one employment running concurrently with the main interest of "*making ends meet*".

There is also need to decrease the inequality gap between the top management and lower level staff. This will encourage stakeholders to participate with more interest on a fairly level playing field.

Systems change should take a more participatory approach to improve on quality outcomes, and compliance among others. This will also ensure the success of the implementation.

Trainings and/or fresher course, ideally offered to some staff quarterly should be consistently offered to all staff. Bias of this practice in favour of staff with medical orientations demoralizes others outside the bracket and affects quality service delivery. The choice of training offered should be arrived at in a more participatory manner making it more relevant to the staff. Enforcement measures in regard to attendance should be effected to cub laxity as has been the case. Resources for staff empowerment need to be improved including internet access and relevant print materials for the library.

5.5.3 The customer's participation on quality service delivery

Investment in the customers' participation as major stakeholders in influencing quality service delivery needs to be effected for increased improvement in quality service delivery.

"Customers are Kings and Queens" and "Customers are always right" are some of the common slogans that suggest the early school of thought that the customer is the sole determinant of the quality of services delivered. Customers are not always Kings or Queens after all (Serunkuma, 2007) and at times can be misleading. It is therefore recommended that quality service enhancements incorporate the contributions of a variety of relevant stakeholders alongside the customers for best results.

There is also need to improve quality service delivery through innovation and creativity in all efforts.

Management of service failures is important and needs to be promptly adopted as a management tool to satisfy and retain customers. To most customers, it is not the failure in itself that discourages them, but the consistent failure of the organization to promptly recover service failures.

Formal channels through which customer contributions/concerns can be effectively channeled and timely feedback got need to be well defined and further developed. This will encourage their effective participation knowing that their efforts are not in vain and that they can identify with the organization in their efforts to improve the quality of services delivered.

5.6 Limitations of the study

1. It was difficult to separate CMC from CMH as they shared much in common including structures, human resources, records, technology, facilities and equipments.

2. During the study, CMH progressed into a restructuring process. There have since been some changes after the study period.

5.7 Contributions to the study

1. This study added valuable information to the body of knowledge in relation to the applicability and practicability of the Balance theory in efforts to enhance quality service delivery through the participations of the service organization, service provider and customers.

2. Findings suggest solutions that can be used and/or modified to remedy specific wanting situations in regard to stakeholders' participation and their influential efforts to enhance quality service delivery.

3. In the case study of CMC, the Balance theory indicated that the state of affairs was unbalanced with the participations of the service organization and the customers in unison but both in dis-harmony with the participation of the service provider. The realization in this unbalanced state indicates that efforts to enhance quality health care services delivered are compromised.

In specific to CMC/CMH, the following contributions can be adopted to realize a better quality of services delivered, among other strategies: -

a) A human resource unit and/or quality assurance department needs to be set up as a vital requirement needed for the effective management of the hospital's human resources for better quality in healthcare returns. This study has led to the realization that quality service delivery can be better enhanced through the better management of human resources, among other factors. Lessons in this regard can be learnt from examples including AAR and IHK.

b) The unbalanced state indicated by the Balance theory showed that the service provider is de-motivated, dissatisfied and less committed to upholding quality service delivery. As such, there is need to bridge this discord among the study stakeholders in order to encourage more participation to realize better quality health care delivery returns.

c) Also, there is need to put measures in place that will narrow the wide inequality gaps between top management and lower level staff. This would greatly encourage more participation among the study stakeholders that when well managed, is expected to result into better quality service delivery.

d) The study also offered the realization that middle and especially lower level staff were underutilized, indicating an undesirable level of their participation in quality service delivery in face of skills and talents that still remained untapped among these categories of employees. Appropriately utilizing such untapped skills and talents would increase participation and enhances quality service delivery outcomes.

e) Ways and means of affirmatively engaging the customers as vital stakeholders in influencing quality service delivery need to be streamlined and formalized.

f) The study brought forth the realization that checks and measures need to be put in place when engaging stakeholders in quality service delivery efforts in order to align their various interests that are often in conflict with the goals and objectives of the hospital. However, the engagement of stakeholders remains wanting in the specific areas of their selection and retention.

4. The Balance theory in itself was limited to the study of only three stakeholders (the service organization, the service provider and customers). However, there are other stakeholders that can have a significant influence on quality service delivery including the government, suppliers, distributors, and professional bodies.

5.8 Areas for further research

Some areas for further research were identified and are listed as follows: -

1. Most literature suggests that the human resources of any organization is its most valuable resource. Under what circumstances do staff, even when they don't seem to be participating, influence quality service delivery?

2. Other than the participation of internal stakeholders (management and staff) and customers, what impact do other stakeholders including the government, suppliers, distributors, financiers, the press/media have on quality service delivery?

3. How do insurance companies with medical cover influence stakeholders' participation in relation to quality service delivery to the final consumer in the medical sector in Uganda?

4. Account for the finding that the service provider's participation in CMH/CMC is insignificant in regard to their influence in quality healthcare service delivery.

REFERENCES

Albrecht, K., & Zemke, R (1985). *Service America! Doing Business in the New Economy.* Homewood, IL:Dow Jones-Irwin.

Albrecht, K. (1988). *At America's Service: How Corporations Can Revolutionize the Way they Treat their Customers.* Homewood, IL:Dow Jones-Irwin.

Amin, M. E. (2005). *Social Science Research. Concepts, Methodology and Analysis.* Kampala: Makerere University Printery.

Arasli, H., & Ahmadeva, L. (2004). "No more tears!" A local TQM formula for health promotion. *International Journal of Health Cars Quality Assurance,* 17 (3), 135-145. (Retrieved November 5, 2009 from http://www.emeraldinsight.com/0952-6862.htm).

Ashmos, D. P., Duchon, D. & McDaniel, R. R. (1998). Participation in strategic decision making: The role of organizational predisposition and issue interpretation. *Decision Sciences, 29, 25 – 51* (Retrieved October, 2010 from http://onlinelibrary.wiley.com).

Babbar, D. (1992). A dynamic model for continuous improvement in the management of service quality. *International Journal of Operations and Production Management*. 12 (2), 38-48.

Baltussen, R., Haddad, S. & Sauerborn, R. (2002), "*Perceived Quality of Care of Primary Health"* (Ed.). London: Facilities Management: Research Directions, RICS Books.

Baron, S., Harris, K. & Elliot, D. (2009). Stakeholder in service crises: Perspectives from service marketing. *Palgrave Macmillan Journals,* 7 (2) 49-63 (Retrieved November 30, 2009 from http//www.jstor.org/stable/3867687).

BIFM. (2002). *British Institute of Facilities Management.* Key Facilities Management International Limited.

Bitner, M. J. (1995). Building service relationships: It's all about promise. *Journal of the Academy of Marketing Science, 23 (4) 246 – 251.*

Boonstra, A., & Vries, J. D. (2008). Managing stakeholders around inter-organizational systems: A diagnostic approach. *Journal of Strategic Information Systems, pp 190-201*. (Retrieved April 1, 2010 from http://www.elsevier.com/locate/jsis).

Brown, J. J., & Reingen, P. H. (1987). Social ties and word-of-mouth referral behavior. *Journal of Consumer Research, 14, 350-362.*

Brugha, R. & Zwi, A. (1998). *Improving the Quality of Private Sector Delivery of Public Health Services: Challenges and Strategies*. UK: Oxford University press.

Business Synergies. (May 15, 2001). *Organizational and Management Consultancy report*. Kampala, Diamond Trust building.

Carr, L. P. (1992). Applying cost quality to a service business. *Sloan Management Review, 33, 72 – 77.*

Carson, P. P., Carson, K. D., Knouse, B. S., & Roe, C. W. (1997). Balance Theory applied to service quality: Focus on the organization, provider and customer triad. *Journal of Business and Psychology, 12 (2), 99 - 120.*

Cavaness, J. & Manoocherhri, G. H. (1993). Building quality into services. *SAM Advanced Management Journal, 58 (4), 4-8.*

Connexions Loyalty Travel Solutions (2010). *Finding the Right Company and Program that Works* (Retrieved 27/07/2010, www.cltsloyalty.com)

Cronin, J. J. Jr., & Taylor, S. A. (1992). Measuring service quality: A re-examination and extension. *Journal of Marketing, 56 (3), 55 – 68.*

Dean, J. D, & Bowen, D.B. (1994). Management theory and total quality: Improving research and practice through theory development. *The Academy of Management Review. 19 (3) 392-418* (Retrieved November 18, 2010 from http://www.jstor.org/pss/258933).

Drucker, P. F. (1974). *Management Tasks, Responsibilities, Practices*. Herper and Row Publishers, Inc. USA.

Fleet, D. D. V. (1988). *Contemporary Management*. Houghton Mifflin Company, Boston, USA.

Forker, L. B. (1991). Quality: American, Japanese and Soviet perspectives. *Academy of Management Executive*, 5 (4), 63 - 74.

Funston, R. (1992). Great expectations: Improving customer care. *CMA Magazine, 66 (3), 24-28.*

Grimshaw, R. and Keeffe, G. (1993). "Facilities Management: the potential for research", in Guldner, M. and Rifkin, S. (1993). *Sustainability in the Health Care Sector, Part 1:* London: Save the Children Fund.

Hall, C. A. L. (1996, July). Customer contributions to quality: A different view of the customer–oriented firm. *The Academy of Management Review, 21 (3), 791-824.* (Retrieved November 30, 2009 from http//www.jstor.org/stable/259002).

Hannah, S. (2008). *Enhancing the Role of Major Groups and Stakeholders in the Implementation of UNEP' Programme of Work 2010 – 11*; *A Paper by Stakeholder Forum for a Sustainable Future.*

Harrison, J. S., & St. John, C. H. (1996). Managing and partnering with external stakeholders. *The Academy of Management Executives*, 10 (2) 46 -60. (Retrieved April 1, 2010 from http://jstor.org/stable/4165323).

Heider, F. (1958). *The Psychology of Interpersonal Relations*. New York: Wiley.

Heng, H. K. S., McGeorge, W. D., & Loosemore, M. (2005, November). Beyond strategy. Exploring the brokerage role of Facilities Manager in hospitals. *Journal of Health Organization and Management*, 19 (1), 16-31. (Retrieved November 5, 2009 from http//www.emeraldinsight.com/1477-7266. htm).

Insko, C. A. (1984). Balance theory, the Jordan paradigm, and western tradition. In Berkowitz (Ed.), *Advances in Experimental Social Psychology, 18, 89-141*. New York: Academic Press.

Jawahar, I. M., & Mclaughlin, G. L. (2001). Towards a descriptive stakeholder theory: An organizational life cycle approach. *Academy of Management Review,* 26 (3).

Jensen, M. C. (2002). Value maximization, stakeholder theory, and the corporate objective function. *Business Ethics Quarterly, 12, (2) 235-256.*

Jepsen, A. L., & Eskerod, P. (2008). Stakeholder analysis in projects: Challenges in using current guidelines in the real world. *International Journal of Project Management*, 27, 335-343. (Retrieved April 1, 2010 from http://www.elsevier.com/locate/ijproman).

Jick D. Todd. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly, Johnson Graduate School of Management*. 24, 602-611.

Jobber, D. (2007). *Principles and Practice of Marketing* (5th Ed). McGraw Hill Education, Maidenhead Berks.

Johnson, G. & Scholes, K. (2005). *Exploring Corporate Strategy* (6th Ed). London, Prentice Hall.

Jones, T. M. (1995). Instrumental stakeholder theory: A synthesis of ethics and economics. *Academy of Management Review, 20 (2*).

Kabanza, N. P. (2001). *A Critical Analysis of the Factors Influencing Acceptance of Institutions Meals by Students in Public and Private Universities in Uganda.* Kampala, Uganda.

Kaza, S. (1988). "Community involvement in marine protected areas". *Oceanus. Volume 31, (1), 75 - 81.*

Kothari, C. R. (1990). *Research Methods: Methods and Techniques,* 2nd Ed. New Delhi.

Kotler, P. (2002). *Marketing Management,* 11th Ed. USA, Imports and PHIPES.

Lin, N. (1976). *Foundation of Social Research.* New York: McGraw-Hill Book Company.

Lindner, J. R., Murphy, T. H., & Briers, G. E. (2001). Handling non response in social science research. *Journal of Agricultural Education, 42 (4) 43-52.*

Maister, D. H., & Lovelock, C. H. (1982). Managing facilitator services. *Sloan Management Review, 23, 19 – 29.*

Mandelli, A., Kyomuhangi, L. B., & Scribner, S. (2005). *Survey of private health facilities in Uganda*. Bethesda, MD: The Partners of Health Reform*plus* Project, Abt Associates Inc. (Retrieved April 6, 2010 from www.PHR*plus*.org).

Mastenbroek, W. F. (1991). Who cares about quality? Organizational conditions and motivation. In Mastenbroek, W. F. G. (Ed.), *Managing Quality in the Service Sector.* Oxford, UK: Basil Blackwell, pp. 14-28.

Mclntyre, D. (1997). "*Health Care Financing and Expenditure in South Africa: An Economic Evaluation*." PHD dissertation to be submitted to the University of Cape Town: South Africa.

Meehan, T., Bergen, H. and Stedman, T. (2002). "Monitoring consumer satisfaction with inpatient service delivery: the inpatient evaluation of service questionnaire", *Australian and New Zealand Journal of Psychiatry, 36, 807-11.*

Mitchell, P. H., & Lang, N. M. (2004). Framing the problem of measuring and improving health care quality: Has the quality health outcome model been useful? *Medical Care, 42 (2) Supplement: Measuring and Improving Health Care II-4 – II-11.* (Retrieved April 1, 2010 from htpp://www.jstor.org/stable/4640719).

Mitchell, R. K. (1997). Towards a theory of stakeholder identification and Salience: Defining the principle of who and what really counts. *Academy of Management Review, 22, (4),* 186 – 207.

Mostafa, M. M. (2005). An empirical study of patients' expectations and satisfaction in Egyptian hospitals. *International Journal of Health Care Quality Assurance, 18 (7), 516-532.* (Retrieved November 5, 2009 from http://www.emeraldinsight.com/0952-6862.htm)

Mugenda, O. & Mugenda, A. G. (1999). *Research Methods: Qualitative and Quantitative Method.* African Centre for Technology Studies (ACTS), Nairobi: Kenya.

National Oceanic and Atmospheric Administration (NOAA). (2004). *Stakeholder Participation: A Synthesis of Current Literature.* National Marine Protected Areas Centre. Silver Spring, Maryland: Brianne Leigh Kessler. (Retrieved November 30, 2009 from http//www.mpa.gov).

Neuman, W. L. (2000). *Social Research Methods: Qualitative and Quantitative approaches* (4th Ed). Boston: Allyn and Bacon.

Newcomb, T. M. (1968). Interpersonal balance. In Abelson, R. P., Aronson, E.,McGuire, W. J., Newcomb, T. M., Rosenberg, M. J., & Tannenbaum, P.H. (Eds.), *Theories of Cognitive Consistency.* Chicago: Rand McNally.

Overseas Development Agency (ODA), (April, 1995). *Note on Enhancing Stakeholder Participation in Aid Activities.*

Patouillard, E., Goodman, C. A., Hanson, K. G., Mills, A. J. (2007). Can working for the private-for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature. *International Journal of Equity in Health, 6:17doi:1186/1475-9276-6-17*(Retrieved March 25, 2010 from http://www.equityhealthj.com/content/6/1/17)

Pirk S. 2002. "Expanding public participation in environmental justice: Methods, legislation, litigation and beyond." *Journal of Environmental law and legislation, 17 (207 - 240).*

Pomeroy, R. S. (1995). "Community-based and co-management institutions for sustainable coastal fisheries management in South East Asia.". *Ocean and Coastal Management. 27, (3)143 - 162*.

Porter, M. E. (1980). *Competitive Strategy*. New York: Free Press.

Project Management Institute (PMI). (2004). *"A guide to the Project Management Body of Knowledge."* (3rd Ed), Project Management Inc. Pennsylvania, USA.

Punch, K. F. (2005). *Introduction to Social Research*. London: SAGE Publications Ltd.

Ramani, K. V. (2004). Practical applications. A management information system to plan and monitor the delivery of health-care services in government hospitals in India. *Journal of Health Organization and Management. 18 (3), 207-220.*

Ravichandran, T., & Rai, A. (2000). Quality management in systems development: An organizational system perspective. *Management Information Systems Research Centre - MIS quarterly, 24(3), 381 - 415.* (Retrieved November 30, 2009 from http//www.jstor.org/stable/3250967).

Reichheld, F. F., & Sasser, W. E., Jr. (1990). Zero defections; Quality comes to services. *Harvard Business Review*. 68 (5), 105-111.

Sarantakos S. (2005). *Social Research,* 3rd Ed. Palgrave Macmillan, New York.

Sarshar, M. (2006). "Improving service delivery in FM: Case study of a UK hospital facilities directorate. *Journal of Facilities Management*, 4 (4), 271 – 285. (Retrieved November 5, 2009 from http://www.emeraldinsight.com/1472-5967.htm).

Savage, G. T., Nix, T. W., Whitehead, C. J., Blair, J. D. (1991). Strategies for assessing and managing organizational stakeholders. *The Executive,* 5 (2), 61-75. (Retrieved April 4, 2010 from http://www.jstor.org/stable/4165008).

Schuler, R. S., & Harris, D. L. 1992. *Managing Quality: The Primer for Middle Managers*. MA: Addison-Wesley.

Scott, S. G., & Lane, V. R. (2000). Stakeholder approach to organizational identity. *The Academy of Management Review. 25 (1) 43 – 62.*

Sekaran, U. (2003). *Research Methods for Business. A Skill-Building Approach* (4th Ed). Southern Illinois: John Wiley & Sons. Inc.

Stonner, J. A. F., Freeman, R. E., & Gilbert, D. R. (1995). *Management.* 6th ed. India, New Delhi. Prentice-Hall

Sutinen, J.G., and K. Kuperan. 1999. "A Socio-Economic Theory of Regulatory Compliance."*International Journal of Social Economics, 26 (11) 174 - 193.*

Syed, H. A., S., Puvanachandra, P., Bloom, G., Sundaram, S., Mahmood, S., Iqbal, M., Hongwen, Z., Ravichandran, N., Oladepo, O., Pariyo, G., Peters, D. (2009). Stakeholder analysis for health research: Case studies from low and middle income countries. *Public Health (2010), doi:10.1016/j.puhe.2009.12.006.* (Retrieved April 1, 2010 from http://www.elsevierhealth.com/journals/pubh).

Teare, R. E. (1998). Interpreting and responding to customer needs. *Journal of Work Place Learning, 10 (2), 76-94.*

Tenner, A. R., & De Toro, I. J. (1992). *Total Quality Management: Three Steps to Continuous Improvement.* MA:Addison-Wesley.

U.S Department of Health and Human Services, OPHS Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services -CLAS in Health Care*. Washington, DC: IQ Solutions, Inc.

Waddock, S. A., & Graves, S. B. (1997). Quality of management and quality of stakeholder relations: Are they synonymous? *Business & Society*, 36, 250 – 279.

Weaver, M. (2007). *Getting the Soft Stuff Right, Effective Communication is the Key to Successful Project Outcomes.* Atlanta Georgia, USA.

Weihrich, H., & Koontz, H. (2001). *Management. A Global Perspective*. 10th ed. Tata New Delhi, McGraw-Hall Publishing Company Limited.

Wickizer, T. M., Franklin, G., Brockway, R. P., & Mootz, R. D. (2001). Improving the quality of workers' compensation health care delivery: The Washington state occupational health service project. *The Milbank Quarterly, 79 (1), 5-33.* (Retrieved November 30, 2009 from http//www.jstor.org/stable/335079).

Wright, C. (2008). *Stakeholder Marketing* (1st Ed). London: BPP Learning Media Ltd. York: The Free Press.

Yip, W., Wang, H. & Liu, Y. (1998). "Determinants of patient choice of medical provider: a case study in China". *Health Policy and Planning, 13 (3), 311-22.*

Zeithaml, V. A., Parasuraman, A., & Berry, L. L. (1990). *Delivering Quality Service.* New York: The Free Press.

Zikusooka, C. M., & Kyomuhangi, R. (2008). *Private Medical Pre-Payment and Insurance Schemes in Uganda: What can the Proposed SHI Policy Learn from Them?* EQUINET discussion paper, series 53. EQUINET: Harare.

APPENDICES

Appendix 1

Table giving recommended sample size (s) for given populations (N)

N	**s**	**N**	**S**	**N**	**S**	**N**	**S**	**N**	**S**
10	10	**100**	80	**280**	162	**800**	260	**2800**	338
15	14	**110**	86	**290**	165	**850**	256	**3000**	341
20	19	**120**	92	**300**	169	**900**	269	**3500**	346
25	24	**130**	97	**320**	175	**950**	**274**	**4000**	351
30	28	**140**	103	**340**	181	**1000**	278	**4500**	354
35	32	**150**	108	**360**	186	**1100**	285	**5000**	357
40	36	**160**	113	**380**	191	**1200**	291	**6000**	361
45	40	**170**	118	**400**	196	**1300**	297	**7000**	364
50	44	**180**	123	**420**	201	**1400**	302	**8000**	367
55	48	**190**	127	**440**	205	**1500**	306	**9000**	368
60	52	**200**	132	**460**	210	**1600**	310	**10000**	370
65	56	**210**	136	**480**	214	**1700**	313	**15000**	375
70	59	**220**	140	**500**	217	**1800**	317	**20000**	377
75	63	**230**	144	**550**	226	**1900**	320	**30000**	379
80	66	**240**	148	**600**	234	**2000**	322	**40000**	380
85	70	**250**	152	**650**	242	**2200**	327	**50000**	381
90	73	**260**	155	**700**	248	**2400**	331	**75000**	382
95	76	**270**	159	**750**	254	**2600**	335	**100000**	384

From R. V. Krejcie and D. W. Morgan (1970). Determining the sample size for research activities, Educational and psychological measurement, 30,608, Sage Publications

Appendix 2

A table showing target population, accessible population, sample size and sampling strategy for the study.

Category or strata of Study population	**Accessible Population(AP)**	**Sample size**	**Sampling methods**
1. ***Membership on CMC Scheme***	***AP Category*** ***759 (less pretest number of 45)***	***Category sample size*** ***224***	***Proportionate sampling*** ***(Amin, 2005 pg. 246))***
Subcategories strata 1. *Kawacom Uganda* 2. *PACE* 3. *Multichoice Uganda* 4. *URA* 5. *DHL* 6. *Others:- (Ethiopian airlines, Meghani, Ngege, Orombi, Mutimba, Dental studios, Basajja, National council for disabilities, and Star Pharmaceticals)*	*Sub-AP* *132* *76* *52* *335* *84* *125* *804 (Total)*	*Subsamples* *37* *21* *15* *93* *23* *35* *stratified random sampling* *(Amin, 2005 pg. 246)*	*-Stratified random sampling* *-Systematic sampling* *(Amin, 2005 pg. 246)*
1 Sstaff of CMC	***AP Category*** ***171 (less pretest number of 32)***	***Category sample size*** ***50***	***Proportionate sampling*** ***(Amin, 2005 pg. 246))***
Subcategories strata 1. *Top Management* 2. *Middle & Lower level staff*	*Sub-AP* *7* *164* *171 (Total)*	*Subsamples* *2* *48* *Proportionate sampling* *(Amin, 2005 pg. 246)*	*-Stratified random sampling* *-Judgmental sampling* *-Simple random sampling* *(Sekaran,2003 pg. 277, 282)*
Totals respectively	***930***	***274***	

Source: Case Medical Centre data base; 2006 – 2009

Appendix 3

Questionnaire for the Employee/staff at Case Med Care

Dear Respondent,

Thank you for showing interest in this research. Your views and opinions are very important and you are invited to participate by filling in this questionnaire, fully and honestly. Only **one answer**, your best alternative, is required per statement.

Research Topic: Stakeholder participation and quality service delivery among private medical practitioners in Kampala. A case study of Case Med Care (CMC).

The purpose of this study is purely academic. Your responses will be treated with strict anonymity and utmost confidentiality.

Feel free to directly refer to the researcher for any concerns about this questionnaire.

The researcher/research assistant will collect your completed questionnaire at a time agreed upon. Alternatively, please drop your completed questionnaire at the front desk anytime you are through.

Thank you for participating.

Norah Okot

(Researcher – 0772 593 750)

Key Operational Terms

Quality service delivery	**:**	An acceptable extent of the discrepancy between expectations or desires, and perceptions.
Service Provider's Participation	**:**	The formal process of relationship management through which Staff efforts is aligned to achieve set management goals and objectives.
Staff	**:**	The individual employees of Case Medical Hospital in the middle and lower and lower levels of employment.

NOTE: Tick only one answer per question for your most appropriate option accordingly.

Section A : Background information		
1.	Gender	☐ 1. Male ☐ 2. Female
2.	Age range	☐ 1. 18 – 25 years ☐ 2. 26 – 45 years ☐ 3. 46 – 65 years ☐ 4. Above 65 years
3.	Marital status	☐ 1. Single ☐ 2. Married ☐ 3. Widow/Widower ☐ 4. Divorced
4.	Level of education	☐ 1. Primary/Secondary ☐ 2. Tertiary ☐ 3. Degree/Masters ☐ 4. Professional qualifications
5.	Length of service at CMC	☐ 1. Less than 6 months ☐ 2. 6 months – 1 year ☐ 3. Above 1 year – 3 years ☐ 4. Above 3 years - 5 years ☐ 5. Above 5 years
6.	Current department	(Specify) ……

Use the scale above each box proceeding to indicate by ticking the most appropriate answer number of each statement, the best option that reflects your view and opinion, accordingly**.**

1. Strongly Agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree

Section B : Quality service delivery						
Statements		**Scale (Tick only one)**				
1.	Services offered to clients are accomplished within the recommended standard time of 45 minutes per visit	1	2	3	4	5
2.	Ailments of clients are diagnosed and treated right the first time	1	2	3	4	5
3.	Level of service offered to clients is the same every other day	1	2	3	4	5
4.	Customers are willing to disclose their concerns to staff	1	2	3	4	5
5.	Staff exhibit professional behavior at all times	1	2	3	4	5
6.	Facilities are adequate to the needs of clients	1	2	3	4	5
7.	Staff hold courteous dialogue with customers	1	2	3	4	5
8.	Staff are conscious about the property and valuables of customers	1	2	3	4	5
9.	The hospital is conveniently located	1	2	3	4	5
10.	Service responsibility centers within the hospital are accessible	1	2	3	4	5

1. Strongly Agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree

Section C –Service Provider's Participation						
Training and /or refresher courses: - Sessions held to increase the human capacity of employees to make choices and to translate those choices into desired actions and outcomes.		**Scale (Tick only one)**				
1.	Staff are offered relevant training and/or refresher courses at least once annually.	1	2	3	4	5
2.	Resources available for staff empowerment is adequate (i.e. internet access, library etc)	1	2	3	4	5
3.	The criterion of decisions reached by top management on training and/or refresher courses offered to staff is participatory	1	2	3	4	5
Incentives and reward system: Reinforcing staff loyalty to show that the organization values them.		**Scale (Tick only one)**				
4.	Staff participate in determining their actual contractual entitlements	1	2	3	4	5
5.	Staff participate in ensuring that their contractual entitlements conform to Uganda's legal labor requirements	1	2	3	4	5
6.	Incentives and rewards offered are sufficient motivators to staff to dedicate themselves to improving quality service delivery	1	2	3	4	5
Customer friendly systems: Systems, procedures, technology and information flows that support the efforts of staff to provide a high quality of service delivery.		**Scale (Tick only one)**				
7.	Staff participate in determining appropriate customer friendly systems adopted by the hospital to improve the quality service delivery	1	2	3	4	5
8.	Staff participate in decisions made to determine the safety gadgets provided for them	1	2	3	4	5
9.	System change is participatory	1	2	3	4	5

1. Strongly Agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree

Section D. Staff opinions on the service organization's participation						
1.	The organizational structure of CMH encourages the delivery of quality services.	1	2	3	4	5
2.	The organizational structure of CMH enables for a participatory approach to be taken in regard to quality service delivery decisions.	1	2	3	4	5
3.	The organizational structure of CMH enables practices that influence quality service delivery.	1	2	3	4	5
4.	Organizational policies are relevant to quality service delivery needs	1	2	3	4	5
5.	Organizational policies are reached using a participatory approach	1	2	3	4	5
6.	Organizational policies in place are sufficient to motivate staff to deliver quality services	1	2	3	4	5

7.	Organizational procedures and processes influence quality service delivery	1	2	3	4	5
8.	Organizational procedures and processes in place enable staff delivery quality services	1	2	3	4	5
9.	Organizational procedures and processes are determined using a participatory approach	1	2	3	4	5

Comments, if any: -

_____
_____
_____
_____

Thank you for Participating

Appendix 4

Questionnaire for the Customer on Case Med Care Medical Scheme

Dear Respondent,

Thank you for showing interest in this research. Your views and opinions are very important and you are invited to participate by filling in this questionnaire, fully and honestly. Only **one answer**, your best alternative, is required per statement.

Research Topic: Stakeholder participation and enhancement of quality service delivery among private medical practitioners in Kampala. A case study of Case Med Care (CMC).

This study is purely for academic purposes. Your responses will be treated with strict anonymity and utmost confidentiality.

Feel free to refer directly to the researcher or the front desk staff for any concerns about this questionnaire.

Please drop your completed questionnaire at the front desk on your way out.

Thank you for participating.

Norah Okot

(Researcher)

Key Operational Terms

Quality service delivery	:	The extent of discrepancy between expectations or desires, and perceptions.
Customers' Participation	:	The formal process of relationship management through which Staff efforts are aligned to achieve set management objectives.
Customer	:	The final recipient/consumer of the service provided.

Tick only one answer per question for your most appropriate option accordingly.

Section A : **Background information**		
1.	Gender	☐ 1. Male ☐ 2. Female
2.	Age range	☐ 1. Below 13 years ☐ 2. 13 – 25 years ☐ 3. 26 – 45 years ☐ 4. 46 – 65 years ☐ 5. Above 65 years
3.	Marital status	☐ 1. Single ☐ 2. Married ☐ 3. Widow/Widower ☐ 4. Divorced
4.	Level of education	☐ 1. Primary/Secondary ☐ 2. Tertiary ☐ 3. Degree/Masters ☐ 4. Professional qualifications
5.	Category of occupation	☐ 1. Student ☐ 2. Government employed ☐ 3. Privately employed ☐ 4. NGO employed ☐ 5. Other (Specify)……
6.	Period spent on medical scheme	☐ 1. below 1 year ☐ 2. 1 year – 2 years ☐ 3. Above 2 years – 3 years ☐ 4. Above 3 years

Use the scale above each box below to indicate by ticking the most appropriate answer number of each statement, the best option that reflects your view and opinion, accordingly**.**

1. Strongly Agree **2. Agree** **3. Not sure** **4. Disagree** **5. Strongly Disagree**

Section B : Quality service delivery						
Statements		**Scale (Tick only one)**				
1.	Services offered to clients are accomplished within the recommended standard time of 45 minutes per visit	1	2	3	4	5
2.	Ailments of clients are diagnosed and treated right the first time	1	2	3	4	5
3.	Level of service offered to clients is the same every other day	1	2	3	4	5
4.	Customers are willing to disclose their concerns to staff	1	2	3	4	5
5.	Staff exhibit professional behavior at all times	1	2	3	4	5
6.	Facilities are adequate to the needs of clients	1	2	3	4	5
7.	Staff hold courteous dialogue with customers	1	2	3	4	5
8.	Staff are conscious about the property and valuables of customers	1	2	3	4	5
9.	The hospital is conveniently located	1	2	3	4	5
10.	Service responsibility centers within the hospital are accessible	1	2	3	4	5

1. Strongly Agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree

Section C. Customers' Participation						
A. Expectancy The quality of the state of a service rendered in anticipation of the belief and/or desire of the user.		**Scale (Tick only one)**				
1.	Customers feel that they are part of the Case Med Care family	1	2	3	4	5
2.	Customers are encouraged by management to get involved in decisions made to better the quality of services delivered	1	2	3	4	5
3.	Customers actively participate in determining quality of services offered to them	1	2	3	4	5
A. Consistence Reliability of a service over time.		**Scale (Tick only one)**				
4.	Customers participation is recognized by management	1	2	3	4	5
5.	Customers are made aware of decisions finally taken by management	1	2	3	4	5
6.	Customers feel that they have a say in the quality of services offered	1	2	3	4	5
B. Stability Constancy of character or purpose.		**Scale (Tick only one)**				
7.	Decision making is dominated by management	1	2	3	4	5
8.	Decision making is dominated by clients	1	2	3	4	5
9.	Decision making is participatory	1	2	3	4	5

Comments, if any: -

_____
_____
_____
_____

Thank you for Participating

Appendix 5

INTERVIEW GUIDE FOR THE SERVICE ORGANISATION

Section A : **Introduction**

My names are Norah Okot.

This face to face interview with you follows our appointment scheduled for this time today.

Thank you for meeting with me for this interview.

The information you will provide is purely for academic purposes. Your responses will be treated with strict anonymity and utmost confidentiality. Please give your honest opinions without reservation.

Research Topic: Stakeholder participation and enhancement of quality service delivery among private medical providers in Kampala. A Case Study of Case Med Care.

May we proceed?

The interview will be conducted in form of a discussion during which, you may ask questions.

Section A : **Preliminaries**

Date: - ……

Time: - …….....

Gender: - ……

Age range: - ☐ 1. 25 – 35 ☐ 2. 36 – 45 ☐ 3. 46 – 55 ☐ 4. 56 and above

Job title: - ……..

Years of experience on CMC: - ……

Section B. The Service organization's participation and Quality service delivery

1. It is in the service organization's interest to realize outputs that offer more benefits than they cost in order to remain relevant and profitable. Discuss how decisions taken by the service organization influences quality service delivery.

2. Discuss the participatory influence of the service organization on quality service delivery

in relation to the provision of secure and authentically pleasing locales at the hospital.

3. Medical practitioners are limited and guided by law in their efforts to market and promote its services. How then does the hospital market and promote its services? What influence do the undertaking have on

Section C. The Service Provider's participation and Quality service delivery

4. The service organization does influence quality service delivery to a big extent. Discuss the participation of the service organization in relation to their engagement of the service provider's participation, and how it influences quality service delivery.

Discuss:

5. Training and/or refresher courses offered to staff by the hospital's management to influence quality service delivery.

6. Incentives and reward systems to staff at the hospital, and their effects on staff participation in influencing quality service delivery.

7. Customer friendly systems in the hospital and their effect on staff participation in influencing quality service delivery.

Section D. The Customers' participation and Quality service delivery

The expectancies of customers, consistence and stability of services rendered are important variables in the customers' assessment of quality service delivery.

8. In view of the participation of the service organization in their engagement of the customers' participation in influencing quality service delivery, discuss:

1. Customer expectancy.

2. Customer consistence.

3. Customer stability.

Additional Notes**:** -

_____

_____

Thank you for having accorded me the time you have. May I refer back to you for more information when and as required during the course of this study? Thank you again.

Appendix 6

Documentary Review checklist

Entity of study: - Case Med Care **Study period:** - July, 2006 to December, 2009

Variables of study: -

1. Stakeholder participation (Independent variable)

- Service organization participation (outputs that offer more benefits than they cost; Secure and authentically pleasing locales; appropriate marketing and promotion)
- Service provider's participation (training and/or refresher courses; Incentives and reward systems; Customer friendly systems)
- Customer participation (Expectancy, Consistence, Stability)

2. Quality of service delivery (Dependent variable)

- Reliability, Responsiveness, Competence, Courtesy, Access, Communication

Objectives of study: -

1. To assess the contribution of the service organizations participation to quality service delivery.

2. To determine the contribution of the service provider's participation to quality service delivery.

3. To examine the contribution of the customers participation to quality service delivery.

Sample size: - 274

Composition of sample: -

- 224 customers
- 50 employees (2 top management, 48 middle and lower management)

Literature was reviewed in the order of the objectives stated above. The literature reviewed was got from Case Medical Centre's data base on CMC, text books, journals, and related report.