



# **An assessment of Service Failures and Customer Complaints Management in the delivery of Health Care in the Municipal Hospitals in Ghana**

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## **Abstract**

**This study assessed Service Failures and Customer Complaints Management in the delivery of Health Care in three Municipal Hospitals in Ghana. Responses were gathered from the perspective of both Management and Staff and Clients (patients). In all 50 questionnaires were sent to the Management and Staff (making a total of 150); and 500 also sent to clients in each of the hospitals (making a total of 1,500). Responses from the field revealed that clients in the Municipal Hospitals in Ghana are likely to engage in these behaviours in the event of services failure (such as voice out, engage in third party action and private action and exit); the rate at which hospitals respond to complaints lodged by their clients is low and the major visible failure points usually evidenced in all the three hospitals are unclean environments, lack qualified personnel (specialists), lack of modern equipment and drugs. Lastly, it was concluded that clients in the hospitals complained of poor communication during service failures, lack and shortage of drugs in the pharmacies and poor attitude of health workers towards duty.**

**Keywords:** Service failures, Customer Complaints, Health Care, Municipal Hospitals, Patients (clients)

## **INTRODUCTION**

In today's global business world, it is held strongly that how companies respond to customer or consumer complaints have become key aspect of providing customer service that ultimately affects consumers' choices of service (Goodwin and Ross, 1990). Customer satisfaction / or dissatisfaction is gaining recognition in marketing management strategies; complaints management are gradually becoming central in customer relationship management and is considered as an important strategic tool for firms across industries (Strauss and Hill, 2001). Companies have agreed to this position and have become increasingly interested in customers' feedback received to the extent that dissatisfied customers, in particular, are often encouraged to voice out their complaints to companies' service representatives (Garrett and Meyers, 1996). Challenges always evidenced in managing service quality, combined with the important role played by customers in the service production process give clear indication that customer loyalty drives profitability, and for that matter make complaint handling a critical "moment of truth" for service organizations in their efforts to acquire, and maintain customers through satisfying them (Schoefer and Ennew, 2005).

It needs to be stressed that despite the existence of the mantra "the customer is always right", sometimes the expected or received service does not seem to satisfy the customer and that can lead into getting the customer disappointed. Grönroos (2000) holds an open view that if the relationships exist between the company and the customer is defective due to the provision of bad service from the point of view of the customer; it is still possible to gain satisfaction back through good complaint management and service recovery. If the strategic options adopted to manage the complaints aimed at service recovery work to perfection, it will lead to the restoration of trust and customer loyalty. It is not always the case for customer satisfaction to have only the service dimension. It can also be influenced by other factors, such as product features, the perception of product and service quality and the perception held by both potential and established customers in the marketplace. Also, personal factors in the form of mood or other people's opinions are

capable of influencing customer satisfaction (Wilson, Zaithamel, Bitner, and Gremler, 2008). From the discussion above, it is safe to submit that in order for people not to spread negative word –of- mouth about an organization and its products or services; it is essential for it, to have a good complaint management and service recovery system.

However, little in the complaint management literature defines or empirically identifies an important facet of most complaint management situations, the nature or the scope of communication competence necessary to implement effective complaint management (Garrtt, Meyers, and Camey, 1991). In addition, previous customer satisfaction research failed to put much emphasizes on customers' evaluations of a company's complaint response (Goodwin and Ross, 1992), and on how customers respond to the organizational responses impact a customer complaint in order to provide a company a buffer against the consequences of ineffective complaint handling (Homburg and Fürst, 2005). "In the perspective of the consumer, complaining is a means of making one's feelings known when unfair seller practices are encountered; when disappointment with a product arises; and when disapproval of business conduct more generally occurs" (Fornell and Westbrook, 1979). In typical service context, disappointment is referred to as exceptional levels of dissatisfaction in consumer experiences which is seemed important because research findings report that these extreme experiences can have profound effects on subsequent consumer judgments and behavior, including purchase, word of mouth, and defection (Oliver, Rust, and Varki, 1997; Singh, 1990). Conceptualised this way, dissatisfaction can also be referred to as the attitude resulting from disconfirmation of expectancies, whilst complaining is a behavioral expression of the dissatisfaction. Another aspect of the forgoing discussion that can be disastrous is that services providers may unknowingly be losing business to their competitors because of negative comments made by dissatisfy customers (Blodgett, Wakefield and Barnes, 1995). The source of disappointments always encountered by customers in service delivery can be attributed to service failure. Many researchers have explained 'Service failure' to mean a clear inability on the part of service institutions to meet the expectations of their customers regarding the standard of service delivered (Ahmad, 2002; Palmer, 2001). From the perspective of the customer, service failure as a concept refers to any situation where something has gone wrong regarding service delivered by the institution and received by the customer (Palmer, 2001). This means that, there is defective performance in the service delivery that has or causing the failure to occur.

This suffice to say that irrespective of all the effective strategies put in place by a service organisation, it is certain to happen that the organisation in question will fail at some point where customers and the producer of services meet each other. Palmer (2001) agrees with this position and stresses on some of the causes of service failure. The author explains that the 'inseparability' of a service offering and the service provider – as well as the very intangibility of services – gives rise to service failures. For the purpose of this study, the nature of business in the health care industry involves many interactions that always ensued between range of health workers (doctors, nurses, pharmacists, lab technicians and the paramedics) and patients who normally visit the health facilities for all forms of health care. These interactions if not properly and effectively managed provide sufficient recipe for service fail.

It is obvious that staff of health institutions (such as hospitals, medical centres, clinics, health posts etc) who deal with patients play a pivotal role in ensuring the quality of service encounters. Since service failures occur at points where the service is received and consumed, and due to the inseparability of the production and consumption of services delivered, service recovery is unlikely to occur without causing inconvenience or whatsoever to patients. It is indicative that hospitals are noted for service operations that take place at all hours of the day, which is 24/7. Demand for services in any hospital may vary according to a patient's need(s). These indicators all come into play to make the hospitals highly susceptible to experience failures in the services delivered to their clients or patients.

It is instructive note that despite the existence of strategic options adopted by service institutions to manage the likely or potential failures always evidenced in service delivery, Cranage (2004) submit that this will be seen very well in theory, but in practice it is very difficult to adopt completely to avoid service failure. This is to maintain safely that the occurrence of service failure in Municipal Hospitals in Ghana is inevitable and unavoidable so far as systems and humans (in this case trained health workers who are bound to make mistakes at any point) are involved in the entire service delivery process.

As earlier stated health care like many of the services delivered in Ghana is powered by systems which are operated by various health personnel. These systems which are both mechanical and manual put in place by owners of health institutions (hospitals) can evidence breaks or failures which can directly affect the consumer in terms of consumption and finally satisfaction or service experience. The effect of this state of the service delivery will undoubtedly create dissatisfaction for both potential and established clients who use the facility. Clients or patients dissatisfaction will sometimes lead them becoming aggrieved hence resorting to making complaints about bad service provision experienced. There are different kinds of customers (in this case clients or patients) in the health care delivery; and they are identified by the nature of behaviours they exhibited during complain process. These behaviours according to (Kimdao, 2013) can range from exit, loyalty and voice. Each of these behaviours can put any health facility operating in a competitive marketplace in disadvantaged position. The problem under discussion here is what steps or strategic options always put in place by health service operators in Ghana to respond to complaints lodged by the aggrieved

clients who have experienced bad or defective service. The focus of this study was to attempt an assessment of possible service failure points in service delivery and customer complaint management strategies if adopted and implemented effectively and more efficiently can amount to service recovery in these hospitals with most of their clients always lodging complaints about the evidence of defective service.

The general objective of this research was to contribute to the body of knowledge and research work in the area of service failures and Customer Complaints Management in the delivery of Health Care in the Municipal Hospitals in the Ashanti Region of Ghana with cases in the St. Patrick's Hospitals, Ejisu Hospital, and Bekwai Hospital. This study sought to achieve the following as specific objectives: (1). To identify behaviours exhibited by clients in typical complaint situations usually evidenced in Municipal hospitals in Ghana. (2). To determine the strategic approaches health institutions specifically Municipal hospitals adopt to respond to complaints lodged by their aggrieved clients. (3). To determine the main possible service failures evidenced in service delivery in Municipal hospitals in Ghana.

## LITERATURE REVIEW

This section deals with review of related literature concerning varied forms of behaviours exhibited by customers in typical complaint context, approaches adopted by organizations to respond to customers' complaints and possible areas of failures evidenced in service delivery.

### Behaviours exhibited by customers in typical complaint context

In managing customer complaints, it is considered imperative for organizations to understand why customers or consumers of their services choose specific complaint behaviours, particularly those that do not involve the direct voicing of a complaint to the organization. Kim Dao (2013) assumes that anytime customers face dissatisfaction, they exhibit several alternatives as behaviours: exit, loyalty and voice. A lot of modern researchers recognize the theory of Hirschman (1970) in contributing to customer complaint behaviours. The Hirschman theory hypothesizes that consumer complaining behaviour depends on the "value of voicing the complaint," the "probability that the complaint will be successful," and on "the ability and willingness to take up the voice," and that exit is often a last resort (Blodgett et al, 1993).

A model developed by Day (1984) lays significant emphases on consumers' decision to voice or not voice their complaint to an organization. The model explains that, in the event of bad or defective service received; the consumer does the following:

First, considers the costs and benefits of complaining, also, performs an analysis, and lastly, decides whether or not to complain. In addition to the cost / or benefit (e.g., cost/importance, degree of dissatisfaction, effort and past experience) and situational variables (e.g., social pressure, situation conducive, mood and time), the author also included personality variables as moderators. That means, a customer or consumer's attitude towards complaining can moderate the relationship between the results of the cost/benefit analysis and the actual decision of whether to complain. This gives explanation to why some customers regardless how satisfied they are they will still complain.

The reasons that account for why satisfied customers still complain are that they want better services or to be seen as the cross section of customers who provide feedback for service improvement (Blodgett et al., 1995; Singh and Wilkes, 1996). The extant body of studies (e.g. Day and Ash, 1979, TARP, 1986) also reveals two main reasons why consumers do not voice their complaint to the organization. First, consumers felt it was not worth the time and effort, and second, consumers did not think they could get anyone to do anything about it.

It is in this regard therefore that service organizations are advised to encourage customers or consumers who patronize their services to voice out their complaints to an organization. This is because failure on the part of an aggrieved customer or client to voice out when encountered defective service becomes disastrous to the organization since such an individual is capable of punishing the organization with spreading negative word-of-mouth communications to external customers; engages in disloyalty; at times switch to a competitor with other set of customers and among others. To understand this, it is necessary to understand the alternative behaviours to voicing a complaint to the organization and the consequences to the organization of these alternative behaviors. Singh (1988) put forward a widely accepted typology of consumer complaint behaviours which consist of three categories:

- Voice as the first behaviour refers to complaints always directed at individuals or organizations external to the consumer's social circle and directly involved in the dissatisfying exchange.
- Third-party action, on the other hand, refers to complaints expressed to an external party who may have some authority or influence over it (legal agencies) if it comes imposing sanctions.

- Private action lastly refers to behaviour ranging from aggrieved customers warning friends and families not to use that service provider which in turn indicate a decision to put a stop to the purchase of its products and services.

### How organisations respond to customer complaints

In order to aim at service recovery, at the event of occurrence of service failures in the delivery process; there is the need for organizations to adopt effective and more efficient strategic approaches to help handle or respond to complaints made by aggrieved customers or clients who have experienced defective service in all forms. According to Davidow (2000), there are six different approaches organizations adopt to respond to complaints lodged by their various customer groupings. These are as follows:

**Timeliness:** This approach refers to the time frame in which an organization takes to respond or handle a complaint made by customers. Conlon and Murray (1996) supports this approach by maintaining that it has a positive correlation with repurchase intentions; which mean the faster the response, likely the higher the repurchase intentions.

**Facilitation:** This refers to laid down policies, procedures and structures that an organization always has to put in place to support customers engaging in complaints and communications. Activities such as toll-free lines, availability of comments' cards, service guarantees, and hassle-free complaint procedures are several ways an organization can encourage complaints. Facilitation as an approach has a positive connection with satisfaction or experience from the complaint handling and with repurchase intentions.

**Redress:** According to Day(1984) in his cost/benefit analysis, the author submitted that compensation is the most talked about aspect of complaint handling. It is reported to significantly impact on complain.

**Apology:** An apology as strategic approach is considered very important in the overall complaint recovery process (Goodman, Malech, and Boyd, 1987). It indicates companies' effort in resolving customers' problem and recognizes the customer's perceived seriousness of the situation. *It refers to accounts that involve an admission and acceptance of service failure and an expression of remorse.* Tedeschi and Norman (1985) define apology as an approach to handling customer complaints as "confessions of responsibility for negative events which include some expression of remorse" There are two goals of every sincere and professional apology always made in typical customer complaint context: (1) to inform the customer that the organization accepts responsibility for the event, and (2) to express sincere regret. Apology is considered the lowest level of action after a service failure and should always be provided. Other authors assume that apologies are relatively ineffective when a customer experiences a service failure and the customer expects some gain for a loss (i.e. assistance or compensation).

**Credibility:** This approach refers to an organization's willingness to account for the problem constituting the service failure. Organizations are evaluated not only by the rate or extent at which they respond to individual customers' complaints made but by giving explanations or accounts into what happened and what they are putting in place to help to prevent future same or similar occurrences (Morris, 1988). Conlon and Murray (1996) agree that it has a significant impact on post-complaint satisfaction and behavior.

**Attentiveness:** As an approach adopted to respond to complaints always made by aggrieved customers, attentiveness refers to the interpersonal communication between customer service representative and the aggrieved consumer. This includes virtues and values such as respect, effort, empathy, and an express willingness to listen to the customer with rapt attention. The findings of many studies report that attentiveness is the single most important approach having the largest effect on satisfaction and post-complaint behaviour.

**Compensation:** As a strategic approach always adopted to handling customer complaints, it comprises of forms such as refunds, replacements, and/or discounts, which organizations provide to complainants. This is similar to the term "redress" used by Davidow (2000, 2003a), with which he describes as a benefit or response outcome that the organization provides to address a customer complaint lodged. It represents series of tangible benefits in the form of monetary and intangible response outcomes that can be considered to be psychological compensation such as apology. Further, monetary compensation should cover for a customer's loss, if necessary, in order to uphold satisfaction. According to Levesque and McDoughall (2000), the amount of compensation to be paid should be considered with caution since over-compensation may lead to less satisfaction in the same way that under-compensation may. The effectiveness of the service recovery depends on the severity of the situation (e.g. delay or denial), criticality of the service, and the type of service. Recovery effectiveness is also influenced by the employee's ability to handle the situation; responsiveness, empathy and understanding increase the effectiveness of the recovery. This implies that the effect of recovery strategy is determined by what and how a problem is taken care (Levesque and McDoughall, 2000).

**Employees behaviour:** Employees' behaviours are capable of been an approach always adopted by organizations experiencing service failures. Estelami (2000) catalogues several of positive employees' behaviours when resorted to is capable of recovering a service experiencing clear failures. These behaviours according to the author include being empathic, friendly, responsible, careful, and informative behavior of the service person.

Davidow's (2000, 2003a) framework on employees' behaviour covers the interpersonal aspect of complaint handling by encapsulating other behaviours like attentiveness (i.e., listening carefully) and credibility (i.e., explaining the problem). TARP(1985;1986) put forward the basic responsibilities expected of frontline employees in most consumer complaint context:

- (1). Get background information about the complainant made by the aggrieved customer.
- (2). The service personnel must identify the nature of the complaint and its potential causes, and
- (3). Lastly, the service employee should resolve the customer's problem brought to the fore.

### **Possible failure points in service delivery**

Cranage (2004) identifies physical surroundings as possible failure points in service delivery. Hoffman, Kelley and Chung (2003) agree with Cranage (2004) and theorized that three main types of service failure points usually occur in the physical environment: cleanliness issues, mechanical problems, and facility-design issues. Hoffman *et al.* (2003) confirm that facilities maintenance contributes highly on customer retention, and that regular facility maintenance will assist in preventing service failures. Cranage (2004) stresses the following as possible failure points in typical service delivery: The unwillingness of service personnel to take responsibility and be accountable for things that *do* go wrong is considered one of the main failure points. Lastly, service failure can occur when the service task involves a set of multifaceted activities. It is necessary to analyse multifaceted customer service procedures and tasks: these should then be broken down into more manageable components (Cranage, 2004).

### **MATERIALS AND METHODS**

Research design describes the data collection methods and its analysis (Burns and Bush, 2002). This study adopted a mixed method or multi method as the required research design. Creswell, Fetters and Invankova (2004) indicate that the underlying logic to mixing methods is that neither qualitative nor quantitative methods are sufficient in themselves to capture the trends and details of the situation....when used in combination, both qualitative and quantitative data yield a more complete analysis, and they complement each other. Combining qualitative and quantitative data ensured effectiveness of the research process as one can enhance the findings of the other (Ofori-Okyere and Kumah, 2014). The aim of adopting qualitative approach aimed at obtaining detailed information so that the researchers later on could obtain a deeper understanding of the problem in matter, (Yin, 2003) that is service failure and customer complaints management in the Municipal Hospitals in Ghana. On the other hand, Quantitative approach sought to quantify the data and typically applied some form of statistical analysis (Malhotra, 2004). A descriptive research was used to gain an insight into the possible failures in the delivery of health care that always lead to behaviours exhibited by aggrieved hospital clients in typical complaint situations. Data sources used include both primary and secondary. Primary data was gathered through the use of questionnaire design and administration; interviewing respondents for clarifications based on the responses provided on the questionnaire; and critically observing events at the premises of the three hospitals. The adoption of these three data collection devices or techniques also termed, triangulation, offered the researchers the opportunity to collect first-hand information from the field. Conversely, the secondary data included the extant literature couched from published articles, and textbooks. The research strategy adopted was case study. Case study was of particular interest to the researchers because they sought to gain richer understanding of the context of the research processes being enacted (Morris and Wood, 1991). Multiple cases (that is three hospitals) were selected. The decision for selecting the three hospitals or cases was informed by the need to establish whether the findings of the first hospital or case would occur in other hospitals or cases and, as a consequence, the need to do easy generalisation from the expected findings. The population of the study comprised of all the hospitals and health workers in Ghana whereas, the target population also consisted of health workers in the three Municipal Hospitals. Selection of respondents is crucial in research, if wrong respondents are interviewed, the study may turn out to be invalid or insignificant (Holme and Solvang, 1997), hence the purposive and conveniently selection of medical staffs and patients from the three hospitals. Due to the issue of finance and time constraints, three Municipal Hospitals were selected for this study. Secondly, the population had no variation. Non-probability sampling technique was adopted in the form of specifically using snowballing, purposive and convenient sampling to select participants for the study. According to Saunders, Lewis, and Thornhill, (2009), they offered the researchers the easiest opportunity to obtain the real respondents including the staffs of the hospitals (i.e. Hospital administrators, doctors, physician assistants, nurses, pharmacists, and dispensary technicians) and the patients who were considered the right participants to provide the right responses regarding management of clients or patients' complaints that usually emanate from service failures that evidence in the delivery of health care in the municipalities.

**Table 1.** Indicate the response rate

Selected Staffs in the Municipal Hospitals				Selected Patients in the Municipal Hospitals			
Selected cases	No. of questionnaires distributed	No. of questionnaires retrieved	Valid percent	Selected cases	No. of questionnaires distributed	No. of questionnaires retrieved	Valid Percent
1	50	47	94	1	500	489	97.8
2	50	42	84	2	500	492	98.4
3	50	39	78	3	500	421	84.2
Total	150	128 (85.3%)	N/A	N/A	1,500	1,402 (93.4)	N/A

Field Report, (2014)

**Under selected cases, 1,2,3 represents each of the hospital chosen as a case for this study as indicated as follows: 1 - St. Patrick's (Offinso-Maase); 2- Ejisu Juaben Municipal Hospital 3- Bekwai Municipal Hospital.** Table 1, indicate that 50 questionnaires were sent to management and staff purposely selected from each of the case hospital. 47 were obtained from the first case representing 94%, 42 were also retrieved from the second case, making 84% and lastly, 39 were taken from the third case denoting 78%. On the other hand, it is reported that 500 questionnaires each were distributed to patients or clients conveniently selected from each of the case hospital. 489 were received from the first case hospital that represented 97.8%, 492 also from the second case hospital denoting 98.4% and lastly, 421 retrieved from the third case hospital making 84.2%. The above reports indicate in totality high response rate gained in this study.

### Statistical Analysis

The current researchers sought to find the valid percent of responses for each case study (that is, each hospital), and the average percentage in terms of responses for the three hospitals. This makes this current study conform to a study conducted by Ofori-Okyere and Kumah (2014) that adopted embedded case studies to investigate how SERVQUAL Dimensions are applied in the domestic airline industry in Ghana. In this regard the mathematical formulae used to report the findings are relevant in this study.

Thus clients or patients of the three hospitals were asked to select as many as possible expected investigated item(s) for a particular question posed on the questionnaire. The number of investigated items chosen by respondents (i.e. figures found in the bracket = nx) were divided by the total number of questionnaires retrieved from the field, represented by (nqr) which was multiplied by 100 to get the valid percent for each hospital (=y); given by the formula  $\frac{nx}{nqr} \times 100 = y$ . This was followed by finding the mean of the percentages for the three case hospitals to get the average percent (ap) given by its formula  $\frac{\sum y_{1,2,3}}{3} = ap$ .

### Results

The findings on the Table 2 report that on average, from the point of view of the staffs and management 94.9% of the responses indicated agreement to engagement in behaviours when service failure occurs as against 4.9%. On the side of the patients or clients, 99.4% of the responses indicated agreement to their engagement of behaviours during service failures. On the actual behaviours, the data on the table 2, report that from the perspective of the staffs and management of the three hospitals, 96.4% of the responses indicated that patients or clients who visit the hospitals are likely to voice out; 94.4% of the responses indicate that the patients will take third party action; and lastly, 92.9% of the responses indicate agreement to embarking on private action. Conversely, on the view of the patients or clients, it is reported that, 96.9% of the responses indicated agreement to voicing out; 92.9% of the responses indicated agreement to taking third party action; and lastly, 98.8% of the responses indicate agreement to embarking on private action.

The findings on the Table 3, report that on average, from the point of view of the staffs and management 92.2% of the responses indicated agreement to handling or responding to patients or clients' complaints by hospitals management as against 6.9% that indicated disagreement. On the side of the patients or clients, 1.6% of the responses indicated agreement to handling of patients or clients' complaints lodged as against 92.2% indicating disagreement to the fact that patients' complaints lodged are handled by management. On the specific approaches adopted, the data on the table 3

**Table 2.** Indicate the responses regarding actual behaviours likely to be exhibited by patients or clients during service failures in the hospitals

Investigated Item(s)	Staff and Management of the hospitals				Patients or clients of the hospitals			
	St. Patrick	Ejisu Hospital	Bekwai Hospital	Avg. percent	St. Patrick	Ejisu Hospital	Bekwai Hospital	Avg. percent
Agreement to patients engaging in behaviours during service failures	100% (47)	95.2% (40)	89.7% (35)	94.9	98.7% (483)	99.7% (491)	100% (421)	99.4%
Disagreement to patients engaging in behaviours during service failures	0% (0)	4.7 (2)	10.2% (4)	4.9	1.2% (6)	0.2% (1)	0% (0)	0.5%
Voice	89.3% (42)	100.0% (42)	100.0% (39)	96.4%	98.1% (480)	100.0% (489)	92.8% (391)	96.9%
Third- party action	95.7% (45)	92.8% (39)	94.85 (37)	94.4%	81.5% (399)	97.7% (481)	99.5% (419)	92.9%
Private action	91.4% (43)	97.6% (41)	89.7% (35)	92.9%	99.1 (485)	99.5% (490)	97.8% (412)	98.8%

**Table 3.** indicate the responses regarding approaches adopted by the Hospitals' Mgt. to handling or responding to complaints of patients or clients

Investigated Item(s)	Staffs and Management of the hospitals				Patients or clients of the hospitals			
	St. Patrick	Ejisu Hospital	Bekwai Hospital	Avg. percent	St. Patrick	Ejisu Hospital	Bekwai Hospital	Avg. percent
Agreement to handling of clients' complaints	91.4% (43)	90.4% (38)	94.8% (37)	92.2%	1.8% (9)	1.6% (8)	1.4% (6)	1.6%
Disagreement to handling of clients' complaints	8.5% (4)	7.1% (3)	5.1% (2)	6.9%	93.2% (456)	97.1% (478)	98.0% (413)	96.1%
Timeliness	48.9% (23)	45.2 (19)	30.7% (12)	41.6%	4.7 (23)	3.2 (16)	4.0 (17)	3.9%
Facilitation	31.9% (15)	42.8 (18)	53.8% (21)	42.8%	7.5 (37)	3.4 (17)	5.4 (23)	5.4%
Redress	21.2% (10)	50.0% (21)	25.6% (10)	32.2%	18.2 (89)	5.8 (29)	2.8 (12)	8.9%
Apology	61.7% (29)	54.7 (23)	79.4 (31)	65.2%	2.4 (12)	7.1 (35)	1.4 (6)	3.6%
Credibility	42.5% (20)	45.2% (19)	71.7% (28)	54.1%	2.6 (13)	9.1 (45)	8.0 (34)	6.5%
Attentiveness	82.9% (39)	33.3 (14)	43.5% (17)	53.2%	2.8 (14)	4.8 (24)	5.4 (23)	4.3%
Compensation	19.1% (9)	11.9 (5)	20.5% (8)	17.1%	3.4 (17)	4.8 (24)	3.0 (13)	3.7%
<b>Employees Behaviour</b>	89.3% (42)	50.0% (21)	61.5% (24)	66.9%	2.0 (10)	1.8 (9)	3.5 (15)	2.4%

report that from the perspective of the staffs and management of the three hospitals, 41.6% of the responses indicate agreement to employing of timeliness; 42.8% indicated agreement to facilitation; 32.2% indicated agreement to redress; 65.2% recorded agreement to apology. Others include 54.1% indicated agreement to credibility; 54.1% indicated agreement to attentiveness; 17.1% indicated agreement to compensation and 66.9% denoted agreement to employees' behaviour. Conversely, on the part of the patients or the clients, 3.9% of the responses indicated agreement to timeliness; 5.4% signified agreement to facilitation; 8.9% represented agreement to redress; 3.6% recorded agreement to apology; and 6.5% indicated agreement to credibility. Others include 4.3% represented indicated agreement to attentiveness; 3.7% signified agreement to compensation and lastly, 2.4% opted for agreement to employees' behaviours.

**Table 4.** Indicate the responses possible failure points of service delivery existed in the hospitals

Investigated Item(s)	Staffs and Management of the hospitals				Patients or clients of the hospitals			
	St. Patrick	Ejisu Hospital	Bekwai Hospital	Avg. percent	St. Patrick	Ejisu Hospital	Bekwai Hospital	Avg. percent
Agreement to the existence of possible failure points	100% (47)	95.2% (40)	92.3% (36)	95.8	99.3 (486)	100% (492)	98.8% (416)	99.3
Disagreement to the existence of possible failure points	0% (0)	4.7 (2)	7.6% (3)	4.1	0.6 (3)	(0)	0.7 (3)	0.4
Cleanliness issues	1.4% (7)	26.1% (11)	23.0% (9)	16.8%	98.7% (483)	99.3% (489)	94.7% (399)	97.5%
Mechanical problems	44.6% (21)	45.2% (19)	38.0% (16)	42.6%	88.0% (401)	83.9% (413)	92.8% (391)	88.2%
Facility – design issues	21.2% (10)	45.2% (19)	35.7% (15)	34.0%	94.6% (463)	97.3% (479)	98.3% (414)	96.7%
Lack of responsibility and accountability during service failure	65.9% (31)	64.2% (27)	58.5% (25)	62.8%	89.7% (439)	92.2% (454)	97.1% (409)	93.0%
Multifaceted service - tasks.	76.5% (36)	95.2% (40)	94.8% (37)	88.8%	97.7 (479)	98.1 (483)	97.8 (412)	97.8%

The findings on the table 4, report that on average, from the point of view of the staffs and management 95.8% of the responses indicated agreement to the existence of possible failure points in service delivery as against 4.1% that indicated disagreement. On the side of the patients or clients, 99.3% of the responses indicated agreement to the existence of possible failure points in service delivery as against 92.2% indicating disagreement to that fact. On the possible and specific failure points, the data on the table 4, report that from the perspective of the staffs and management of the three hospitals, on average, 16.8% indicated agreement to cleanliness issues; 42.6% indicating agreement to mechanical problems; 34.0% indicating agreement to facility design issues and lastly, 62.8% represented agreement to lack of responsibility and accountability during service failure, and lastly, 88.8% indicated agreement to multifaceted service-tasks. However, on the part of the patients or the clients 97.5 % indicated agreement to cleanliness issues; 88.2% recorded agreement to mechanical problems; 96.7% indicated agreement to facility design issues; and lastly, 97.8% represented agreement to lack of responsibility and accountability during service failure, and lastly, 97.8% indicated agreement to multifaceted service-tasks indicated

## Discussions

The findings clearly reported in this article raise a number of potential theoretical as well as practical implications. These will be discussed in turn, with future research directions identified for each set of implications.

Responses from the field indicated that respondents are likely and or have been engaging in all forms of behaviours when services delivered by the three hospitals fail or become defective.

Majority of the respondents contacted on the field agreed that they will voice out (comment) when a service they have paid for turns out to be bad in terms of delivery. This behaviour recorded 96.4% from Management and Staff, and 96.9% from the patients or the clients. Another majority of the respondents said if after series of voicing out and nothing is done to remedy or redress the defective service provided it is likely that the issue will be reported to an external authority or regulator in this case can be the Ministry of Health, civil or criminal court unbearable sanctions to be imposed. On this, 94.8% was recorded for the Management and staff where as 92.9% was also recorded from the patients or clients. Apart from reporting the issue to an external authority, it was found out that private action could be engaged. This means that negative word of mouth communications will be passed to family members, friends and loved ones about the bad service received. This will be done to influence potential clients to change the positive perception they have about the services of the hospital. Also, the aggrieved clients will persuade the established clients to discontinue using the health facility which can also lead to dangers like decrease in clientele base, market share and above all profit margins. It can be said that all these findings gathered from the field are consistent with previous studies that assumes that anytime customers face dissatisfaction, they exhibit several alternatives as behaviours (Hirschman, 1970; Day, 1984; Day and Ash, 1979; Blodgett et al., 1995; Singh and Wilkes, 1996; TARP, 1986; Singh1, 988; Kim Dao, 2013).

A part from the expected responses provided on the questionnaire, the posturing of majority of the respondents indicated that they will exit the service after experiencing failures and nothing is done to aim at its recovery. This means

they will be left with no option to switch to the nearest competitor who is ready and willing to provide quality health care devoid of failures; service that is capable of creating positive experience and will be deemed as value for money. Others also said, they will take no action due to reasons like: no one is ready to show concern about the problem complained about or show willingness towards its resolution; undefined or visible appropriate quarters to channel complaints; and lastly, they perceive they lack the power to influence the transaction or the process especially when it involves the doctors or any of the senior nurses.

The second results suggest that all the respondents found in the three hospitals are familiar with the approaches adopted to respond to clients' complaints elucidated in existing literature. This can be said to be in conformity with existing studies ( e.g. Gilly and Gelb, 1982; Goodman, Malech, and Boyd, 1987; Tedeschi and Norman, 1985; Levesque and McDoughall, 2000; Morris, 1988; Colon and Murray, 1996; Estelami, 2000; Davidow, 2000, 2003a) on adopting approaches to respond to clients' complaints or aim at service recovery.

There was total disagreement between the management and staff of the three hospitals and their patients or clients on the issue of the hospitals' authorities responding or handling complaints about various forms of service failures experienced. On average, 92.2% from the management and staff said YES complaints were handled as against 96.1% who said NO, their complaints were not handled. In practice, the various data gathered from the field and processed indicated that the authorities of the three hospitals do not pay much attention to the handling or responding to the complaints made by aggrieved clients or patients who have experienced various forms of service failures.

It was further gathered from the Management and Staff that concerning the adoption of service recovery approaches to responding to or handling complaints; on average 41.6% recorded for timeliness; 42.8% for facilitation; 32.2% indicated for redress; 65.2 shown for apology and 54.1 represented credibility. Others include 53.2% recorded for attentiveness; 17.1% recorded for compensation and lastly, 66.9% indicated for employees' behaviours. On the part of the patients or clients, the data indicated woefully insignificant figures at the extent at which service recovery approaches are adopted to respond to complaints lodged by them: On timeliness, the findings indicated that hospitals' staff take a long time even to show signs of doing something about complaints that come to their notice. There is lack of systems such as toll-free lines, customer service lines, and availability of comments' cards visible in the hospitals to facilitate clients to make complain about service failures experienced. Though some of the hospitals have suggestion boxes but clients said suggestions that get into them are not responded to. If a follow up is done by the patient who made it, sadly, the reply sometimes gotten from some of the staff shown that the suggestion made cannot be traced. At times one will be lucky to hear that the suggestion made has gotten to the appropriate quarters and they are working on it and that will be the last time something is said about the complaint made. This means in practical terms that no serious and encouraging attempts and steps are taken by the hospital authorities to redress faulty services provided to clients. Concerning apology as an approach to service recovery, almost all the clients contacted on the field responded that there has not been situations where a defective service has been provided and the entire hospital fraternity taking the responsibility to admit and accept their faults and follow it up to and express remorse to the aggrieved patient(s). Some of the staff goes to the extent of denying vehemently of being the cause of negative events. The behaviours of majority of the staffs according to patients are considered appalling and unprofessional; instead of apologising for doing something wrong to a patient; they will rather vent unnecessary anger and frustration on the poor patient suffering from pain. Compensation as a service recovery approach is out question in the operations of the three hospitals studied. Cases such as faulty or defective surgery performed on patients, loss of patients on admission and babies during delivery due to the gross negligence on the part of hospital staffs are not compensated. The study also found "promptness" and "assistance" as additional approaches that can be adopted to aim at service recovery or handling of clients' complaints in the three hospitals. With promptness, hospital staff must be trained to adopt timely and more effective steps to remedy and recover a service failure when a complaint of that effect come their notice.

There has been clear indication and agreement from respondents contacted on the field that there are visible and possible failure points evidenced in various forms of service delivery by all the three hospitals studied. That is, on average, 95.8% of the Management staff and 99.3% of the patients or clients contacted indicated YES to the issue. On the issue of possible failure points as evidenced in services provided by the three hospitals; it was found that on average 94.5% of the responses recorded for cleanliness, 42.6% mechanical problems; 34.0% for facility design and 88.8% also recorded for multifaceted service –tasks. Greater majority of the patients or clients contacted voiced out that all the three hospitals do not pay particular attention to issues regarding cleanliness. This stems from unclean wash or bath rooms, dirty lobbies with rubbish strewn; dirty with an unbearable odour in the ward, broken toilets; no hand towels or driers, soap, shortage of toilet paper at times; over-crowding the OPDs; dusty and dirty mirrors; unchanged bed sheets; sticky floors; gloomy and insufficient lightening and among others. The consequence of the filthy nature of these places found within the hospitals is that a patient who comes for medication or treatment will automatically leave with various forms of infection which can lead to contracting of a disease or two. Most of the hospital buildings have been designed without taken the physically challenged patients or visitors in mind. Service personnel show clear unwillingness to take responsible and be accountable for various forms of service failure. They are found of shifting blames on authorities and

government even for their own contribution to a service failure. The personnel are saddled with multitasking in all the hospitals studied hence, cannot function effectively. Most of the patients also mention that they know some of the health workers such as Dentists, Doctors, Nurses, laboratory technicians also working part time in other distant hospitals. In this wise some have to cover longer distances in order to attend to their own duties or emergencies.

There is lack of communication, which usually occurs in the process of delivering the service. This according to the patients or clients takes place when service personnel refuse to inform patients who have been in queue for long hours when a doctor on duty will report to work; when actual services like surgery will commence and among others. The discussions concerning the third results suggest that indeed the hospitals like any service firm have certain areas of possible failures which are also in agreement with the studies of (Hoffman, Kelley and Chung, 2003; Cranage, 2004).

Again, it was gathered from the field that all the three hospitals studied lack qualified personnel in the form of specialists (surgeons, urologists) with the expertise to operate in certain branches of medicine. Related to this, the hospitals also lack modern equipment such as CT scan, MRI to help in their diagnosing duties. Little wonder series of medical cases are usually referred to the teaching hospitals located in either Accra or Kumasi for specialists' attention and care. Pharmacy departments of the hospitals do not have in stock most of the drugs always prescribe by the doctors, so patients or their relatives have to travel to Kumasi Metropolis (the regional capital) in search for them from private pharmacy shops. Some of the patients interviewed complained that several lives have been lost as a result of longer distances always covered to procure prescribed medicines to be used to emergency cases. Lastly, all the hospitals studied though can boast of tidy and well kempt surroundings in-house, however, other surroundings like roads leading to their premises are in bad condition, unspacious parking lots, no emergency exits, no fire extinguishers stuck on the walls; no safety cautions or communications. Others include refuse dumps and choked and stinking gutters situated just fifty meters away from one of the hospitals.

## **RECOMMENDATIONS**

From the results and their discussions presented above it can be concluded that all the three hospitals receive clients who at any point in time will exhibit various complaint behaviours during service failure; the hospitals do not pay serious attention to the complaints lodged by clients; there are possible and visible areas of failure in all the three hospitals. Practically, from a managerial perspective, the following recommendations are made to aim at resuscitating the hospitals to success.

First and foremost, as a way of been tag as customer centric or customer focused health institutions in Ghana and to avoid not been seen as customer unfriendly, the authorities at the helm of affairs in all the three hospitals must offer some kind of service support to all patients who will in the near future be experiencing and affected by service failures. Assistance to be provided can be based on different dimensions of the needs of patients or clients. Managers should effectively monitor and supervise duties of the health workers in all the three hospitals so as to pay particular attention to clients' complaints lodge concerning service failures.

Secondly, to make it as their strategy to link the different departments within together, it is recommended that all the three Municipal Hospitals should consider adopting Customer Relationship Management. This is because CRM is capable of making all the "touch points" where clients interact with the hospitals as effective as possible, through accessing valued information that can better and faster serve the clients (Chen and Popovich, 2003). Another benefit associated with the adoption of CRM is to synchronise the different access points in the hospital to provide a unified message to the customer at each interaction point thereby improve the customers experience with the firm.

Again, it was found out that service personnel such as doctors, physician assistants, nurses, pharmacists, administrative staff engage in multitasking of services which sometimes render them ineffective in their quests of providing quality services to clients. So to solve this problem, authorities must identify and brake down multitasking jobs into more manageable components as proposed by (Cranage, 2004). Also, the Ministry of health should put steps in place to recruit or transfer specialists to the Municipal hospitals, and supply them with modern equipment and drugs. This will go a long way to reducing the unnecessary queues that always occasioned in the Teaching hospitals as result of series of referral cases from the municipal hospitals.

Lastly, this study did not cover all the health facilities in the country, it is suggested that further research is relevant to be conducted in the teaching hospitals to assess how clients complaints are handled. Also, further studies are recommended to be done to investigate the extent at which customers' or clients' complaints are handled in other service industry like the Banking, Insurance, Telecommunications, Hospitality, Airlines etc.

## **LIMITATIONS AND DIRECTIONS FOR FURTHER RESEARCH**

This current study like other academic studies of scientific nature cannot be said to be foolproof or without limitations. The current study is prone to the following limitations. The first limitation associated with the current study is that, it was

carried out in one industry (health sector), and in a specific geographic and political region of a country, that is Ashanti Region in Ghana. So the authors advise that the findings cannot be generalised to other service sectors and different geographical areas. It is therefore suggested that, this study or similar one needs to be replicated in other industry settings such as, construction, manufacturing, airline, hospitality (hotel and restaurants), automobile, education, and banking or across industries and other different countries before conclusions can be completely generalised. A second limitation refers to the type or the sample strategy used of this study. This study used purposive or judgmental and convenience as non- probability sampling methods consisting of one thousand selected medical staffs (550 from each hospital comprising of both paramedics and patients). Further studies can overcome this limitation by maintaining the same sample or larger but randomly-selected, and which may provide a more comprehensive result.

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