Public Service Quality

Dimensions and Determinants

(A Study of Health Services in Nepal)

For the partial fulfilment of the requirement of Master of Philosophy (MPhil)
in Public Administration

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Recommendation Letter

Mr. Dhruba Nepal completed dissertation report on **Public Service Quality: Dimensions and Determinants(A Study of Health Services in Nepal)**under my supervision and guidance. He made thesis ready as per prescribed format of Central Department of Public Administration, Faculty of Management, Tribhuvan University. Therefore I recommend this thesis for the evaluation.

……..
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Dedication

To

my father Shovakant Nepal

and

mother Shushila Nepal

Acknowledgement

As I am giving final shape to this dissertation, I am remembering cooperation and good help extended to me, without that it would not have come in this form.

While I was slowing down in doing my work by veering off to other works, my wife Puspa Nepal always reminded me to complete this task first. Besides, she took all burden of taking care of running home, so I could solely engaged in it.

In course of conducting the study, while I could not making head or tail from collected data using SPSS, Dr. Narendra Raj Paudel, who is also the Guide for preparing my dissertation, rescued me out from the possibility of drowning in the deep pond of data. Not only this, he always remained more worried in my dillydallying in completing the study. Despite his such kind of wonderful support, I could not finish it within the planned time.

Besides, Dr. Dinesh Pant's guidance in designing questionnaire, Dr. Bimal Thapa's kindness to spare time to answer my questions are unforgettable help. At this juncture of recalling the marvellous good hands extended to me, I would also like to thank to those who kindly helped me by filling up the questionnaires.

Dhruba Nepal

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Chapter 1: Introduction

1.1 Background

On watching the policy, programme, projects and activities of any State, we find that they surrounds a human individual before beginning to end of life. So, there is a popular saying that the State's obligations towards its people ranges from womb to tomb. It means that State's obligation stretches from birth planning to management of cremation site or grave management. It provides ample ground to emphasize the State obligations towards human life is so much important that no one can spare his/her without any role of the State. It is said that no aspect of human life remainsbeyond the purview of the State. Then it is obvious that what and howthe State fulfils its obligations towards its people is major determinant of the life standard of the people of a country. If the State fulfils its obligations rightly, people's life standard rises, otherwise or remains low. For example, if people receive better health services, easily accessible quality education is available, then certainly people's standard of life goes up. To compare countries in terms of the life standard of its people, different reports are prepared annually and occasionally ranking the countries of the world.

Most of the indicators developed to compare the status of people or performance of the States of the world, Nepal normally comes in the category with poor or dismal performance. See the example of Human Development Index (2014), Nepal's rank is 145 out of 187, Nepal's per capita income is $ 700 only while highest per capita is $ 98,860 of Norway (World Development Report, 2014), The Least Developed Countries Report (2013) (Nepal falls even below than LDC's average real growth rate – 5.3 percent in 2012 and 5.7 in 2013 whereas Nepal growth rate remained 4.6 percent and 3 percent respectively (UNCTAD, 2013). Above indicators speak loudly that the State performance in Nepal lagging very behind in global ranking.

Nepal's achievement in uplifting the status of people is dismal not only in global ranking of countries, but also development is unbalanced. The income inequality among citizens was found the highest in Nepal as per the report of Asian Development Bank, i.e. Key Indicators 2007. The latest Nepal Human Development Report 2014, a joint publication of National Planning Commission of Nepal and UNDP/Nepal, shows that the Human Development Index (HDI) of people living in between Kathmandu and Bajura differs from 0.632 (highest) to

0.364 (lowest). This difference is so huge to show that whether these two districts are of the country and the same government is operating.

The culprit of such dismal position in global ranking and imbalance in HDI, which denotes differences in quality of life, such difference can be ascribed to difference also in availability of qualitative public service. This is so because had public service produced as per intended, such dismal condition would have been improved. For example, good health and education services would have impact on HDI.

Public service is considered a major responsibility of the State. It should impart benefit to public from outputs and outcomes of the given service, not merely inputs. (World Bank, 2014). Not merely the availability of service (of any quality), but service of good quality contributes in improving the living condition of people. For example, quality health service (medical check-up by appropriate medical doctor, provision of medicine) and qualitative education improves life quality. High rate of failure that is 3 in 4 students of community schools failed in School Leaving Certificate (SLC) of 2015 examination speaks about quality of service, which certainly affects negatively the future of young population of the country.

We have noticed and felt numerous cases of poor quality of public services in Nepal. Most of the time, if services of the same nature are provided by the government and private sector or NGOs, we normally find people preferring to go to other providers, not to the government service outlets. For example, people prefer to go to private hospitals, similarly to private schools. It is clear that public services are either beyond access of poor and marginalized people, that means too far to go to receive service or they are so poor in quality that cannot yield output as per expectation. Schools located too far from villages hinders access to basic education which is considered basic obligation of the State towards its people. Both of these conditions can be considered as examples of poor quality of service.

Regarding the state's overall scope of obligations, the flagship annual report of the World Bank, i.e. World Development Report 1997 gives clear recommendation based on extensive analysis. The Report with the theme – *the State in a Changing World*, in which five first jobs of the State have been identified:

i. Establishing a foundation of law,

ii. Maintain a non-distortionary policy environment, including macroeconomic stability,
iii. Investing in basic social services and infrastructure,
iv. Protecting the vulnerable,
v. Protecting the environment (WB, 1997).

As the State has the obligations towards its people covering entire range of life (as mentioned in the beginning), above five are the areas it (State) should focus on to undertake its active role instead to mobilization of other actors like private sector, non-governmental organizations and others. Whole gamut of these activities contribute to the public service in terms of quantity and quality. For example, establishing legal framework would contribute in laying down the rule of the game for the actors either private or public, and investing in basic social services like health, education, drinking water and so on also contribute to public service – both in quantitative and qualitative terms.

The State discharges its duties and responsibilities by directly providing services or create environment to provide services by other actors like private sector or community organizations. In addition, the State has to regulate and monitor the services of different actors.

As we assume that whatever government does, provides to people – tangible or intangible – is public service. Above five priority areas for the State's involvement, investing in basic social services and infrastructure and protection of vulnerable people need direct relationship with people. The provision of basic social services, of course, everybody with especial focus on people falling in lower socio-economic rung should be benefitted. As social equity has been recognised a primary area of concern for public administration as the vital instrument of the State (Frederickson, 2010).

The State carries out its obligations through policy decisions, programme design and implementation. The policy and programmes are to be evaluated on six bases: effectiveness, efficiency, equity, appropriateness, responsiveness and adequacy (Sapru, 2010). Among these six, the equity criteria emphasizes on equitable opportunities to the citizens of a country.

Ensuring equity to its people is considered the obligation of the State from the point of view of social justice. Social justice is explained as:

> ..has a heritage that lies in early social scientists, who defined inequality as unjust social relations. The principle of equality that underpins social justice entails material distribution such as income and (as well as) 'the distributive paradigm' that encompasses power and domination. (Morvaridi, 2008)

If we see the case of Nepal, many indicators show that equality has been dismally fared in Nepal. The Gini coefficient (it measures the income distribution among citizens; 0 coefficient means all people have the same income and 1 coefficient means one earn 0 and another earn 100) is the highest among Asian countries. Nepal Human Development Report 2009 indicates that "Poverty incidence of Nepal in 2003-04 was 30.8 percent on average. The disaggregated data by caste and ethnicity indicates the highest level of poverty in Dalits at 45.5%, hill Janjatis 44%, Muslims 41.3% and TeraiJanjati at 34.4% respectively. Likewise Newar have 14%, Brahmin/Chhetri 18.4% and Terai middle caste 21.3% (Awasthi and Adhikary, 2012). So, it is evidently clear that Nepal's macro and micro level performance for upgrading the life standard of its citizen is lower. It is clear indication of the State obligations not being carried out effectively and efficiently to provide equitable opportunities to its people.

Thus, it is clear from above grim picture described above shows that inequality among people of Nepal on different bases deems the need of public service. Public service helps to meet the need of through governmental interventions.

> A public service is a service benefiting the public that is provided for by the government because it is underprovided by the market. The public benefits from outputs and outcomes of the given service, not merely instance buildings, textbooks, assurance of pedagogical training and quality instruction, are all inputs for delivery of education service, but the public service is to yield an output of students with skills.
> **Local Service Delivery in Nepal**
> Report No. 87922-NP, April 2014
> World Bank, South Asia Governance and Public Sector

As mere legal, programmatic and budgetary provisions are not enough to uplift the quality of life of people, rather it should be with quality. In common parlance, quality means the gamut of attributes that satisfy or meet the needs of consumer or service user. Regarding private sector, customer satisfaction is considered major indicator of quality whereas regarding public service, meeting the needs of citizens or service users is to be focused in terms of

quality (Øvretveit2005). It does not mean that service user's satisfaction aspect is to be ignored, emphasis is to meet needs. For example, private service may satisfy customers by offering smoking or alcohol consumption provision, public service cannot focus on these, rather has to discourage though it might satisfy customers.

In a nutshell, law, programme, budget and other resources are prerequisites to uplift the life quality or standard of the people, but the service quality itself is the product of many prerequisites like motivation, important. If a health personnel is available to examine the patient but cannot diagnose the disease or treat the disease in absence equipment or medicine, s/he would not be cured. What's the use of establishing health service outlet if the service does not help a sick person?

There are basic differences in the quality of goods and services, and also between private and public service quality. The basic differences are discussed in literature review chapter, here, it is apt to mention that service quality related studies are skewed to private services. Limited studies related with public service quality heavily draws model and methodology used for private service quality, which may not be applicable in many respects owing to basic differences between them. So, it seems relevant to conduct a study of public service quality modifying the model to examine it in Nepali context of health services.

1.2 Statement of the problem

Whatever government provides to its people can be considered public service irrespective of whether it is tangible or intangible or combination of both. Tangible services are like construction of road, bridge, building etc, and intangible services are like health education, agriculture advice, environmental awareness raising etc. Combination of both comes in the form of service supplemented by tangible things like medical check-up and giving medicines, scrutiny of personal records and giving citizenship certificate or passport. While providing such services, major component is intangible but people receive service in tangible form. It receive services, in many occasions, people need to visit government offices to receive service, e.g. health, land registration and transfer, passport etc and in other hand people do not need to visit government offices, e.g. security through patrolling, regulation of market etc. A wide range of services the government provides to its people, including infrastructure, security to day to day service like health, education, agriculture services and so on. Many public services are monopolistically provided by the government and similarly, many

necessary services are provided by the government and private sector or non-government sector in parallel. In the case of parallel service provision, government performance fall quite lower than the private sector or the NGOs. Its glaring example is the School Leaving Certificate examination results of 2070 BS. The students of private schools got through by 92 percent while public school result remain dwarf at 22 percent. This is clear evidence of public service quality.

Service quality can be assessed on two bases – first, perception based, and second, objective criteria based. Perception based assessment may include mainly the perception of service users and another objective criteria-based emphasizes on technical aspect of quality. In our context, first kind national level assessments were conducted under the project – Nepal Living Standard Surveys (NLSS). They were conducted in 1995, 2003/04 and 2010/11 by Central Bureau of Statistics, a government department. As per the latest NLSS 2010/11, more than two third, i.e 71 percent people of entire country think that health service quality is just fair. Very small percentage of people, i.e. 12.2 health service is good. This percentage is lower than the percentage of people, i.e. 16.8, who think service is bad. National percentage is quite different from the people's perception living in mountainous region. 35.2 percent of people of mountainous region think that health service is bad, which is quite higher, more than double in percentage point than national average. Following table gives the snapshot of people's perception about health service quality.

Table 1.1

People's perception on health services

(Percentage of valid responses)

Respondents from different geography	**Respondent's perception about health service quality**		
	Good	**Fair**	**Bad**
Ecological zones			
Mountains	12.1	52.7	35.2
Hills	13.2	69.0	17.7
Tarai	11.2	75.7	13.1
Urban-rural			
Urban	14.0	72.8	13.3
Rural	11.8	70.5	17.7
Development region			
Eastern	7.6	80.4	12.1
Central	14.5	67.6	17.9
Western	13.1	71.9	15.0

Mid-west	13.7	64.5	21.8
Far-west	11.6	65.6	22.8
NEPAL	**12.2**	**71.0**	**16.8**

Source: Nepal Living Standard Survey, 2010/11 Vol 2, Central Bureau of Statistics, 2011, p. 112

The table above shows that most of the people perceive health, education and drinking water related services are fair. Not much change in perception is found in the service quality in two survey periods – 2003/04 and 2010/11.

A plethora of literature is available on quality of service of private sector but there is very less studies have been conducted in public service quality. If we find some literature, they are found adapted the dimensions and determinants of private sector. Numerous service quality models have been suggested (Robledo 2001; Philip and Hazlett 1997), but the perceived quality model (Gronroos1982) and the SERVQUAL model (Parasuraman et al. 1988) appeared to be the most extensively cited. The perceived model representing Grönroos' (Nordic) approach acknowledges that service quality, as perceived by customers, has two dimensions: a technical one (or "what" is perceived by the customer) and a functional one ("how" the service is being provided). The second model representing Parasuraman, Berry and Zeithamal's (NorthAmerican) approach evaluates quality not solely from the outcome of service, but it also involves evaluations of the service-delivery process itself. It primarily addresses functional quality. The SERVQUAL instrument, also known as the *disconfirmation approach*.

Its clear evidence is that even the public service quality studies are carried out based on SERVQUAL (Service Quality) model, which was prepared for private service business. The nature of private service differs from public service, and that clearly implies that the dimensions of private service and the reasons of gap between expectation or standard from reality do not fit to public sector as it is popularly said, 'one size does not fit to all'.

The answer is intended to seek through this study the perception of service users and providers on dimensions of public service quality and determinants in Nepali context in special case of clinical health service.

1.3 Objective of the Study

Following are the objectives of this study:

1. To examine the perception of **service users and service providers** about service quality status along different dimensions.
2. To identify the **determinants of service quality.**

1.4 Importance of the study

Many studies related with public service concentrated so far on delivery aspect, almost no study has been done on comprehensive quality aspect, however, one or two aspect/s of quality were considered as the stuff of the study. So, this study will contribute in meeting the need of such studies in Nepali context. Normally, it is said that quality dimensions are determinants are universal phenomenon, not country specific study is required. As we go further to solve the problem through studies, it needs to be context specific, thus study would serve that need. For example, if we look into the problems of health service quality outside Kathmandu valley or big urban centres, the shortage of doctor and para-medical staffs is very pressing one, that may not be the case in developed countries or even of hospitals in Kathmandu valley. Similarly, access to public service is very important for us, which may not be the problem of developing countries. In short, this study will contribute the need of the study of public service quality in our context.

1.5 Limitation

- Though this study is on public service quality, it has chosen health service quality to make to feasible to conduct by a researcher who is under time and resource constraint. Even for the study of quality of health service, one Primary Health Care Centre and one Hospital are chosen.
- The determinants service quality may be of different levels – at operational, strategic and policy ones. For example, knowledge and skills of health personnel are important determinants of service quality. Producing, selecting, deploying, developing, utilizing, motivating are other interventions to ensure capable health personnel to provide qualitative health service. In this study, only up to operational level factors are considered as determinants – strategic and policy level factors are not taken as consideration. It means this study includes only those factors and determinants which should present at operational level, that means it says to ensure better service quality knowledge and skills are indispensable. How to ensure knowledgeable and skilful personnel by the intervention at strategic and policy level does not fall under its purview.

1.6 Chapter plan

This dissertation will include following chapters and contents.

Introduction: This chapter introduces the background, study rationale, content, and objectives of the study. In this section, it has been argued that public service is major basis of relationship between the State and its citizens and such service should be of quality. Services without quality cannot ensure what is expected.

Literature review: It includes the review of relevant findings of the studies and literature produced so far in the area of public service quality. It lays foundation to prepare conceptual framework for the study. The study is designed based on the conceptual framework.

Methodology: This Chapter of the study presents how the research has been designed. It deals with the philosophical aspect, methodology, source of information collection, tools to be used for gathering information and analysis.

*Data presentation and analysis:*In this Chapter, the information – quantitative and qualitative - collected is analysed and presented. Quantitative and qualitative information are presented side by side.

Summary, conclusion and recommendations: This Chapter presents the summary of entire study and then conclusion is drawn. As the study has its social worth, so it presents recommendations, which could be helpful for decision-make to make efforts for improving the public service quality.

Chapter 2: Literature Review

2.1 Service quality

The term "quality" has a relative meaning. This is expressed by the ISO definition: *"The totality of features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs"*. In simpler words, one can say that a product has good quality when it *"complies with the requirements specified by the client"*. When projected on analytical work, quality can be defined as *"delivery of reliable information within an agreed span of time under agreed conditions, at agreed costs, and with necessary aftercare"*. The "agreed conditions" should include a specification as to the precision and accuracy of the data which is directly related to "fitness of use" and which may differ for different applications.

(Source: http://www.fao.org/docrep/w7295e/w7295e03.htm)

Crosby (1979) defines quality as conformance to requirements. Garvin (1983) measures quality by counting the incidence of “internal” failures (those observed before a product leaves the factory) and “external” failures those incurred in the field after a unit has been installed.

Service quality is different from goods quality due to its main three features – *intangibility, heterogeneity and inseparability* (Parasuraman, Zeithaml and Berry, 1985). Since, for this study, service refers not only intangible services but also goods, it is not applicable but it is true that most of the public services are intangible ones.

Intangibility means service is intangible, which is not physical object, so cannot be taken home and stored. So, it is difficult to develop the specification in detail as applicable to goods. In addition, it makes difficult also to understand how consumers perceive the service and evaluate service quality.

Heterogeneity means too high variation in service. The factors that affect service quality vary provider to provider, customer to customer and time to time. It makes difficulty in maintaining uniformity in service quality. As service quality is mainly judged on the basis of customer satisfaction and it may vary quite high, it is difficult to measure.

Inseparability means production and consumption cannot be separated, as the service is produced, it is consumed at the same time. For example, a medical check-up conducted by a medical doctor is produced and consumed at the same time. In labour intensive services, quality occurs during service delivery, usually in an interaction between the client and the contact person of the service providing entity. The service providing entity may also have less managerial control because client's role in the determination of service is quite significant.

Further, the video lecture provided in youtube by Mexus Education (https://www.youtube.com/watch?v=OOa2tkDBRi4) has added two more characteristics of service, i.e. inventory and involvement. *Inventory (negation)* means service cannot be stored for future use like goods, so as service recipient and service provider are ready for service provision, that time service is delivered. *Involvement* is another characteristics, it means the service and its provider are not separate, combination of both is required for service. For example, a radiologist and his/her Ultrasonogram machine jointly provide services.

Regarding service quality, following are the summarised observations made by different studies (Parasuraman et al., 1985, p. 42) :

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

Based on these observations, it can be said that service quality can be evaluated from two dimensions: first, from the content of the service itself, for example, whether a medical doctor diagnosed a patient correctly, and second, the behaviour shown by a service provider to his/her client. It means whether a doctor behaved nicely to a patient (Walsh, 1991).

Two types of service quality exists: *technical quality*, which involves what a customer is actually receiving from the service, and *functional quality*, which involves the manner in which the service is delivered (Gronroos, 1982). This classification of service quality is quite the same as argued by Walsh.

The common definition of service quality says that a service becomes of quality if it conforms the specification. This definition is true only from static view because even the specification may not remain preferable for different times. It changes, so the service quality also needs to be adjusted as per new need and desire. This is dynamic view. (Walsh, 1991)

As per the nature of service, a client may know about its quality at two stages – before utilizing the service, so can look for quality, it is known as *search* product (goods or service), and second one is *experience* product. For consumer, it is impossible, impracticable or too expensive to investigate before purchase a product to know about quality of such kind of goods. To some extent all products will have characteristics of two categories, but there are clearly goods that fall predominantly into one category or the other (Nelson, 1970).

In the first article on conceptual model of service quality, the proponents of SERVQUAL Model proposed ten determinants of service quality. In the article, writers proposed ten determinants with examples:

Table 2.1

Determinants of service quality

RELIABILITY involves consistency of performance and dependability. It means that the firm performs the service right the first time. It also means that the firm honors its promises. Specifically, it involves: -accuracy in billing; -keeping records correctly; -performing the service at the designated time.
RESPONSIVENESS concerns the willingness or readiness of employees to provide service. It involves timeliness of service: -mailing a transaction slip immediately; -calling the customer back quickly; -giving prompt service (e.g., setting up appointments quickly).
COMPETENCE means possession of the required skills and knowledge to perform the service. It involves:

-knowledge and skill of the contact personnel;

-knowledge and skill of operational support personnel;

-research capability of the organization, e.g., securities brokerage firm.

ACCESS involves approachability and ease of contact. It means:

-the service is easily accessible by telephone (lines are not busy and they don't put you on hold);

-waiting time to receive service (e.g., at a bank) is not extensive;

-convenient hours of operation;

-convenient location of service facility.

COURTESY involves politeness, respect, consideration, and friendliness of contact personnel (including receptionists, telephone operators, etc.). It includes:

-consideration for the consumer's property (e.g., no muddy shoes on the carpet);

-clean and neat appearance of public contact personnel.

COMMUNICATION means keeping customers informed in language they can understand and listening to them. It may mean that the company has to adjust its language for different consumers-increasing the level of sophistication with a well-educated customer and speaking simply and plainly with a novice. It involves:

-explaining the service itself;

-explaining how much the service will cost;

-explaining the trade-offs between service and cost;

-assuring the consumer that a problem will be handled.

CREDIBILITY involves trustworthiness, believability, honesty. It involves having the customer's best interests at heart. Contributing to credibility are:

-company name;

-company reputation;

-personal characteristics of the contact personnel;

-the degree of hard sell involved in interactions with the customer.

SECURITY is the freedom from danger, risk, or doubt. It involves:

-physical safety (Will I get mugged at the automatic teller machine?);
-financial security (Does the company know where my stock certificate is?);
-confidentiality (Are my dealings with the company private?).

UNDERSTANDING/KNOWING THE CUSTOMER involves making the effort to understand the customer's needs. It involves:
-learning the customer's specific requirements;
-providing individualized attention;
-recognizing the regular customer.

TANGIBLES include the physical evidence of the service:
-physical facilities;
-appearance of personnel;
-tools or equipment used to provide the service;
-physical representations of the service, such as a plastic credit card or a bank statement.

Source: (Parasuraman et. at. 1985, p. 47)

Though above 10 elements are considered the determinants that influence service quality, this researchers believe that it would be appropriate to consider these factors as attributes of service quality rather than dimensions because attributes are inherent elements and their presence gives the feeling of service quality. For example, reliability and courtesy are the factors people look for in the service they receive. On other hand, determinants are considered independent variable that affect the result. Later, the writers have considered five out of above ten factors after refinement as measuring subject of service quality. (Parasuraman et.al. 1988)

To improve the service quality, there is a need to identify gap/s, so that necessary remedial policies and actions can be undertaken. SERVQUAL researchers identified five gaps that block the provision of high quality service in private sector (Parasuraman et al, 1985). This gap may also be pertinent to public sector as well but needs to be examined in public sector context.

Gap 1: Consumer expectation – management perception

This gap arises when the management does not correctly perceive what the customers want. For instance, hospital administrators may think patients want better food, but patients may be more concerned with the responsiveness of the nurse. Key factors leading to this gap are:

- Insufficient marketing research
- Poorly interpreted information about the audience's expectations
- Research not focused on demand quality
- Too many layers between the front line personnel and the top level management.

Gap 2: Management perception – service quality specification

Although the management might correctly perceive what the customer wants, they may not set an appropriate performance standard. An example would be when hospital administrators instruct nurses to respond to a request ‘fast’, but may not specify ‘how fast’. Gap 2 may occur due the following reasons:

- Insufficient planning procedures
- Lack of management commitment
- Unclear or ambiguous service design
- Unsystematic new service development process

Gap 3: Service quality specifications – service delivery gap

This gap may arise through service personnel being poor training, incapable or unwilling to meet the set service standard. The possible major reasons for this gap are:

- Deficiencies in human resource policies such as ineffective recruitment, role ambiguity, role conflict, improper evaluation and compensation system
- Ineffective internal marketing
- Failure to match demand and supply
- Lack of proper customer education and training

Gap 4: Service delivery-external communication gap

Consumer expectations are highly influenced by statements made by company representatives and advertisements. The gap arises when these assumed expectations are not fulfilled at the time of delivery of the service. For example, the hospital printed on the brochure may have clean and furnished rooms, but in reality it may be poorly maintained, in which case the patients' expectations are not met. The discrepancy between actual service and the promised one may occur due to the following reasons:

- Over-promising in external communication campaign
- Failure to manage customer expectations
- Failure to perform according to specifications

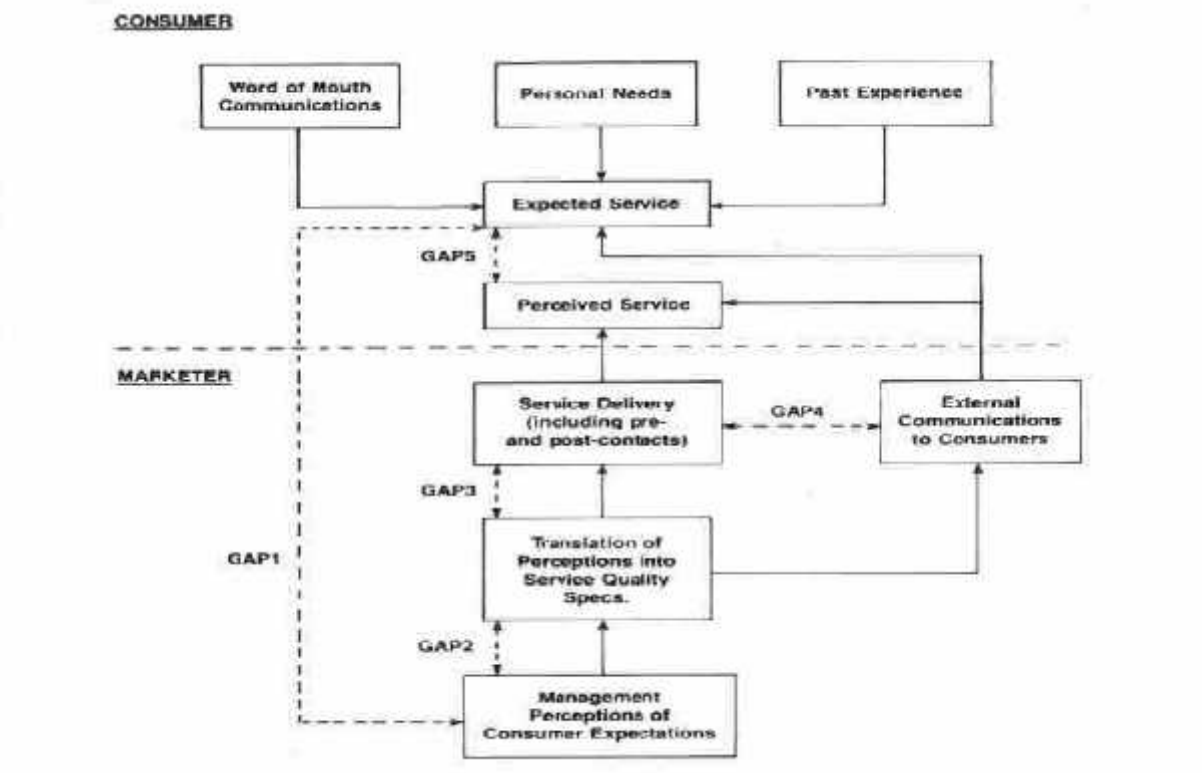
Gap 5: Expected service-perceived service gap

This gap arises when the consumer misinterprets the service quality. For example, a physician may keep visiting the patient to show and ensure care, but the patient may interpret this as an indication that something is really wrong.

In an endeavour to improve service quality, an assessment to identify gap is required, thus intervention through policy or implementation decision becomes possible.

Fig.2.1

Service quality gaps



Source: Adapted from Parsuraman et al, p. 44

As above mentioned literature focused mainly the quality of service of private sector, it may not be exactly true with quality of service of public sector. As this research is focusing on public service quality, it is necessary to map out the literature on public service quality.

2.2 Public service quality (PSQ)

It is necessary to be clear in basic terms related with public service quality (PSQ). The dictionary meaning of these terms may not be exactly the same as the operational ones. Operational definitions are those used for study or work purpose.

Public – The government or the State related.

Service – Tangible goods or intangible services or combination of both.

Quality - Meeting the wants and needs of targeted people, without waste and within regulations, available resources and the control of the service (Øvretveit, 2005).

In combined form, public service quality means the provision of goods or the services that satisfy the wants or needs of the targeted populations within certain constraints by the state to its own people and even foreigners. So, everything tangible or intangible the state produces and provides to people either free or with charge comes under the domain of public service.

PSQ is late comer in new public management in comparison to other elements like organizational transformations (such as breaking bureaucratic organizations into separate agencies, decentralizing management authority within public services from setting policy) as well as changes in human resource management (such as requiring staff to work to performance targets, and shifting towards term contracts and performance-related pay) occurred earlier than the focus on service quality (Rieper and Mayne, 1998). This is evidenced from research article topics covered by research journals in the west. Service quality assessment and analysis of public sector is not exactly likely to private sector. It has some complexities like it is not simply a matter of meeting expressed needs but finding out unexpressed needs, setting priorities, allocating resources and publicly justifying and accounting for what has been done (Gowan et al, 2001). Service quality practices in public sector is slow and is further exacerbated by difficulties in measuring outcomes, greater scrutiny from public and press, a lack of freedom to act in an arbitrary fashion and a requirement for decision to be based in law (Teicher et al, 2002).

Table 2.2

The literature on public service organization governance regimes

	1980–1990	1991–2000	2001–2009	Overall
Number of articles	29	45	110	184
Articles per year (mean)	2.64	4.50	12.22	19.36
Type				
Conceptual	7 (24%)	17 (38%)	28 (25%)	52 (28%)
Empirical	22 (76%)	28 (62%)	82 (75%)	132 (72%)
Total	29 (100%)	45 (100%)	110 (100%)	184 (100%)
*Main research topic**				
1. Efficiency	21 (73%)	10 (22%)	17 (16%)	48 (26%)
2. Governance	1 (3%)	7 (16%)	48 (43%)	56 (30%)
3. E-government	0 (0%)	0 (0%)	4 (4%)	4 (2%)
4. Innovation	0 (0%)	6 (13%)	10 (9%)	16 (9%)
5. Accountability	0 (0%)	6 (13%)	12 (11%)	18 (10%)
6. Public services quality	0 (0%)	9 (20%)	9 (8%)	18 (10%)
7. Public value-interest	7 (24%)	5 (11%)	7 (6%)	19 (10%)
8. Ethics	0 (0%)	2 (5)	3 (3%)	5 (3%)
Total	29 (100%)	45 (100%)	110 (100%)	184 (100%)

Source: Calabrò, Andrea (2011). Governance Structures, Mechanism and Public Service Organizations, London, New York: PhysicaVerlag, p. 23

Service quality assessment and analysis of public sector is not exactly likely to private sector. It has some complexities like it is not simply a matter of meeting expressed needs but finding out unexpressed needs, setting priorities, allocating resources and publicly justifying and accounting for what has been done (Gowan et al, 2001). Service quality practices in public sector is slow and is further exacerbated by difficulties in measuring outcomes, greater scrutiny from public and press, a lack of freedom to act in an arbitrary fashion and a requirement for decision to be based in law (Teicher et al, 2002).

Despite difficulties in applying SERVQUAL model in public sector, there are many examples of assessing service quality of public sector. The study on service quality in India (Mulla and Saini, 2014) and Mauritius (Ramseook-Munhurrun et al, 2010) were few examples such studies conducted in public sector.

Public service has another connotation as well, that is the body of people employed by the state and paid their salary and allowances from the state coffer. For example, civil service,

police service, military service, teachers/professors and employees of public enterprises. For this article, public service is what government provides to general people, not the body of employees.

The table below shows the differences between private and public sector from the service quality perspective. These differences are the major sources to have influence on disparity between private and public service and its quality.

Table 2.3

Differences between private and public service

Basis	**Private**	**Public**
1. Motive	Profit making	Upgrading quality of life people.
2. Mismatching objectives	Private sector is normally clear on what to achieve. For example, though profit making and maintaining service quality may seem counteracting, the ultimate purpose is profit making.	Public sector is normally marred by dubiousness in objectives, the service quality suffers. For example, quality in service can be ensured by meritorious persons, but as government has another objective of social inclusion that opens up the provision of reservation of seats in recruitment. It is said that merit is compromised by reservation.
3. Monopoly	Monopoly is not allowed to private sector. Syndicate, cartel to undermine competitive condition is considered unlawful.	Some of public services remain fully under government domain like issuing land ownership, citizenship certificates and passport. There are some services which can be provided parallel by private and public services like health and education

		services, though there is strong argument that these essential services should remain fully under public domain.
4. Nature	Private sector can survive only when there features like excludability, rivalry and very less spill over effect do exist.	Public service has features of characters like non-excludability, non-rivalry and high spill over effect do exist.
5. Ultimate responsibility	Private sector can choose – who should be its clients/customers. As its ultimate goal is profit making, it may choose only affluent people its clients.	Public sector does not have laxity to choose its clients. It needs to focus more on poor and marginalized people who cannot afford costly services provided by private sector.

(Note: This table is prepared by researcher.)

2.3Service quality and social inclusion

Obviously two reasons are found in reserving seats to certain groups while recruiting fresh candidates in civil service. One, uplifting the status of socio-economically disadvantaged groups, second, making civil service representative and third one is making civil service more diverse.

Let's discuss on each explanation. First, the justification is for social inclusion. In her famous policy related book of Deborah Stone, it was mentioned that State policies have four objectives,

- Equality/equity – "treating likes alike".
- Efficiency – "getting the most output from a given input."
- Liberty – "do as you wish as long as you do not harm others".
- Security – "satisfaction of minimum human needs". (Stone, 2011)

Among above four, to ensure equality/equity is considered social justice. Its major emphasis remains on uplifting socio-economic status of people who falls in lower stratum. Economic parameter to make stratum is objective because it could be in monetary term but it does not

happen in social parameter. It is based on values that society gives, for example, in the Hindu society, caste is one basis.

To ensure social justice, efforts are made to provide opportunities to socially marginalized groups, thus they rises up to the level of other people. Social inclusion is one tool of social justice. People are assumed being included as all rights – economic, social, cultural, political and civil are provided.

As Nepal is multi-lingual, multi ethnic, multi religious and caste-based social structure and income disparity, which obviously raised demand at political level for seats allocations in political positions and public employment just after the in spring of 2006, called popularly Jan Aandolan – 2 (People's Movement 2). In following days of that movement, proportional representation in Constituent Assembly and Legislative-Parliament allocating 335 seats (out of 601) and 45 percent seats for new recruitment to be allocated for 6 categories of socially and economically excluded groups in civil service.

Second, bureaucracy or civil service needs to be representative (Esman, 1999). The diversity of the population should be reflected in civil service. If the population is diverse in nature based on ethnic groups or geography, gender etc,

In Nepal, both reasons have played role in introducing social inclusion provision in civil service. Women, Madhesi, Janjati, Dalit, disabled and backward regions demanded social inclusion in all the State provided opportunities including civil service. Similarly, voices raised every time – how many Secretary, Joint Secretary, Chief District Officer and other important officials are from each broad category is the evidence of going further from getting space in civil service, they want the representation in senior positions, thus they can have reasonable influence in the State through representation.

2.4 Conceptual framework for this study

Some basic differences between public and private service raises a question – whether exactly the same dimensions and determinants of private sector could be applied to public sector. Sayre(Sayre 1953, p. 102) had opined that public and private organizations are 'fundamentally alike in all unimportant respects.' But, George Boyne found by conducting 34 empirical studies of public agencies and private firms that three hypotheses were supported by data: public organizations are more bureaucratic, and public managers are less materialistic and have weaker organizational commitment plan than their private counterparts

(Boyne, 2002). Actually, what Sayre said is endorsed by Boyne's empirical study considering that the differences he found are really very significant ones.

The Table 2.1, highlights the points of differences that underline the fact that public service is different from private service on different bases, which may have implications on dimensions, determinants and even more the intervention mechanism to solve the problem of quality. For example, private sector does not need to bother about availability of service to everyone, instead it can concentrate on more profit is possible. Similarly, as public sector has ultimate responsibility towards public, it has to provide a very wide range of services in which private sector may not have interest and also it has to focus on even regulatory services that private sector may not have even mandate. So, a public service is not one which produces which just produces happy customers, but is one which has to meet other higher level regulations and do so economically (Øvretveit, 2005).

To measure the quality of service, SERVQUAL scale is already very popular in private sector. Many researchers have used the same SERVQUAL model or scale for private sector quality study with some modifications. After refinement by its proponents in 1988, the researchers have proposed five dimensions for the measurement of private service: reliability, assurance, tangible, empathy, responsiveness. These dimensions could be useful also to public service quality but it may not be enough for public service quality due to the scope and nature. Above dimensions relate 'how' or process and behavioural aspect of how services are provided. As a customer (service recipients of private service) may have option to choose service from a number of providers (assuming that market is competitive), but in respect to public service it could be monopolistic. Thus, content aspect of quality, i.e. in simple term can be understood as the standard. Thus, this researcher from own experience and intuition has thought that in public service quality research, two additional qualities are to be added: **access and standard**. Access is indispensable dimension of service quality in public sector. As to ensure equality and equity is basic objective of the State, every citizen should have access on the public services, there should not be any barrier to receive service. More important is that the State should focus on access of marginalized people. Some people may argue that access should be the pre-requisite of public service rather than a quality dimension because unless people have access over service, even the best service cannot be of any use. This argument has high worth, however, level of access that means good access or moderate level access can be judged by its users. People may have to travel 2 hours or 15 minutes get access on the service. There is no question that people cannot travel 2 hours in case of dire

need to receive the service, but him/her service quality can be of lower quality in terms of access than a person who get services by walking 15 minutes. Similarly, standard is another dimension. This dimension is necessary because public service has to meet certain standard. In layman term, quality and standard seem synonymous. But, in respect service quality certain aspects may not be the subject of experience by service user. Service is experience good not production good, thus which cannot be experienced by service user immediately, thus no correction or immediate accountability system be established. In such case, the State or professional body should stipulate the standard to ensure the quality of service. For example, a patient may not know whether a medicine in form of tablet of capsule is within expiry date or expired one. Similarly, what kind of reagents are used to conduct laboratory test is beyond the limit of comprehension of patient. In such a case – whether there is a mechanism of ensure the standard of service becomes the basis to judge the quality instead of service itself by a user. Considering this important aspect into consideration this dimension has also been added in the dimensions proposed in SERVQUAL model.

Table 2.4

Service quality dimensions: Conceptual framework for this study

Dimension	Operational definition	Attributes	Elements
Reliability	Ability to perform the promised service dependably and accurately.	- Sincerity of staffs in service - Authority - Skill	- Staff keeps promise related with response and time - Interest in solving problems - Right first time - Error free records
Assurance	Knowledge and courtesy of employees and their ability to inspire trust and confidence.	- Knowledge - Courteousness - Morality/ethics	- Staff instil confidence - Feel safe in transactions - Friendliness and courtesy - Knowledge to answer questions.
Tangible	Physical facilities, equipment and appearance of personnel.	- Physical condition of premises, building - Impressive physical look and smartness of staffs - Appropriate equipment and its condition.	- Modern looking equipment - Excellent physical facilities - Employees neat appearing - Appealing materials
Empathy	Caring, individualized attention the firm provide its customers	- Putting on client's shoes to understand the need of clients. - Customization of service provision.	- Individual attention - Convenient operating hours - Staff giving personal attention - Companies with customer's best interest at heart - Understand specific needs
Responsiveness	Willingness to help customers and provide prompt service.	- Prompt response to client's need and demand	- Tell exactly when services will be performed - Prompt service - Staff willingness to help - Prompt response from staff.
Access	Availability of service.	- Service is within the reach of everybody irrespective of geographic and economic disadvantage.	- Distance to travel to receive service - Rate of service fee - Difficulty to receive service disabled person.
Standard	Technical and procedural standard.	- Technical and procedural standard.	- Technical and professional quality of service - Process standard.

Note: The source of third column: Andreas P. Kakouris&ElinaMeliou (2011): **New Public Management: Promote the Public Sector Modernization through Service Quality. Current Experiences and Future Challenges,** Public Organization Review (2011) 11:351–369, DOI 10.1007/s11115-010-0134-3. Access and standard related information the researcher has added based on own experience and intuition.

The applicability of above mentioned dimensions and their elements would be verified through quantitative approach.

Service quality is not perceived in the same manner by the service providers and service recipients. In course of the interaction conducted by Project to Prepare Public Administration for State Reforms, this researcher observed that the views about the service quality from service providers and recipients were different on the same kinds of the service. Such difference may cause contentment or need of improvement of service quality not draw the same level of urgency. There is a need of verifying the dimensions of public service quality and their elements as well.

2.4.1 Description of dimensions of public service quality

The elements of dimensions and how it has been used in study is presented below.

i) Reliability

This is one aspect of quality included in SERVQUAL Model. This aspect means that the service providers are able to provide promised service dependably and accurately. As per this aspect, the service providers should be technically able, equipped with authority and equipment, thus would be able to 'reliable' service.

In the questionnaire, five elements under this dimension were included: commitment, interest, authority, skill and resources.

ii) Assurance

This aspect includes knowledge and courtesy of employees and their ability to inspire trust and confidence. For this, service providers should have relevant knowledge, courteousness and behaviour should be moral and ethical. Service users expect to be confident because they think that the provided service is safe, service provider's behaviour is friendly and courteous and moreover, they answer the question pleasantly and that answer is correct. In gather perception on it, in the questionnaire under this aspect, following elements were included – knowledge (technical), courteousness, feeling of safeness, and behaviour is moral or ethical.

iii) Tangible

That aspect which can be seen is tangible. People do not go to service centre (the office that provides service) to see attractive and clean hospital building premises, well-attired and handsome/beautiful service providing staffs, but it is true that the

'look' of persons would be perceived as the service is of quality. No need to emphasize that how differently people would perceive the services provided by a clean and tidy hospital and not well-attired staffs. In the questionnaire, following elements were included – look of building and premises (of service providing organization), cleanliness (e.g. toilet and provision of water in toilet), uniform or attire of staffs, provision related waiting for own turn to receive service (time consumed in queue and sitting arrangement while waiting).

iv) Empathetic responsiveness

The SERVQUAL Model has included empathy and responsiveness as two different dimensions of service quality. As they are very close in relation because empathy leads to responsiveness and responsiveness emanates from empathy, this researcher has combined them together for this study purpose. If it is not done, the respondents may confuse due to very tiny differences. This aspect of service qualityincludes the service provider's attitude towards service user – how much attention is given towards individual specific need/want and willingness is shown to address those need/wants and for this how much time is given. In the questionnaire, four elements were included within this dimension. Those elements are – sensitivity towards the needs and wants of service user, willingness to address the need and wants, time taken to solve the problem and willingness in the preferable time of service users.

v) Access

Access is not included in refined elements of SERVQUAL Model. This aspect of service may not be much significant for private service, but for public service it is not only significant, but pre-requisite. Public service should be accessible to all, irrespective to any ground. It could be an argument - access is pre-requisite not the matter of quality dimension. But, access can be measured by a valid scale. If a person can reach a service by walking 15 minutes than another person who can reach the service centre by walking 30 minutes, the first service user will perceive service is better in terms of access. In the questionnaire, three elements of access are included: distance to travel to receive service, fee rate for service and difficulty to face by disabled and weaker section of the society.

vi) Standard

Standard is added aspect by this researcher taking account of its nature and importance. In many cases, service users may not know the appropriateness and

standard of the service, it should be guaranteed or certified by competent authority. For example, in case of health service, the expiry date of vaccine, medicine and accuracy of blood pressure measuring equipment cannot be known or judged by service user, but it should be of certain standard, else quality of service cannot be ensured. In the questionnaire, technical, professional and procedural elements of service are included.

2.4.2 Determinants of service quality

What factors determine the service quality is important for this study. Once the determinants are identified, it would be instrumental to intervene for the improvement of the quality. Parasuraman et al have mentioned 10 determinants of service quality (as mentioned earlier under Table 2.1). In this researcher's view, instead of considering them determinants, it would be more appropriate to consider them attributes because latter are inherent elements whereas determinants are external factors. Then what could be the determinants? From the nature of service, the determinants are drawn for this study.

As one of the features of service is inseparability between production and consumption, means production and consumption occur at the same time and interaction between service recipients and service provider play vital role in service quality. Thus, public service quality determinants are related with both parties and their interaction. The table below presents the schematic view of public service quality determinants.

The brief elaboration of determinants and how they are used for data collection through questionnaire is presented below. The determinants are derived from mulling over meticulously the very nature of service. One nature of service is *inseparability* (see above under 2.1 Service quality), that means service is produced and consumed at the same time, it cannot be stored. In addition, in service production, service user also plays the role, s/he has to demand service fulfilling all pre-requisites like fee, information, documents, behaviour along with smart eyes on whether services are provided as it should be. Thus, at service transaction level, front line service provider and service user and their interaction can be considered as service determinants.

i) Service provider

The resourcefulness and readiness (preparedness) are major factors that plays vital role in service quality. At first, to provide service, service providing unit should be resourceful with adequate number of staff member, logistics and finance. Further, as human resource is the key in providing services, staff member should be competent, that means staffs should have relevant knowledge, skill and attitude. In the questionnaire, three elements were included – knowledge and skill, authority and physical and financial resources.

ii) Service user

Service is co-production of service user and service provider, thus how much demanding, known and cooperative is service provider, and service quality would be accordingly. We have seen that a service user, who knows about service, own rights and provider's obligation and can put pressure can get better service. Educated receive better than uneducated, people having capability to political and legal demand receives better service. Realizing this fact, in the questionnaire, two elements are included – service user's awareness level on own right and service along with demanding capacity based on law and political basis.

iii) Interaction between service provider and service user

As when both parties are together, then service is produced, then their transaction – how it happened plays significant role in influencing service quality. During interaction, the provision and practice to give information to service user and the provision of standing the service provider for service provided/not provided and service quality. In the questionnaire, these two are included.

Table 2.5

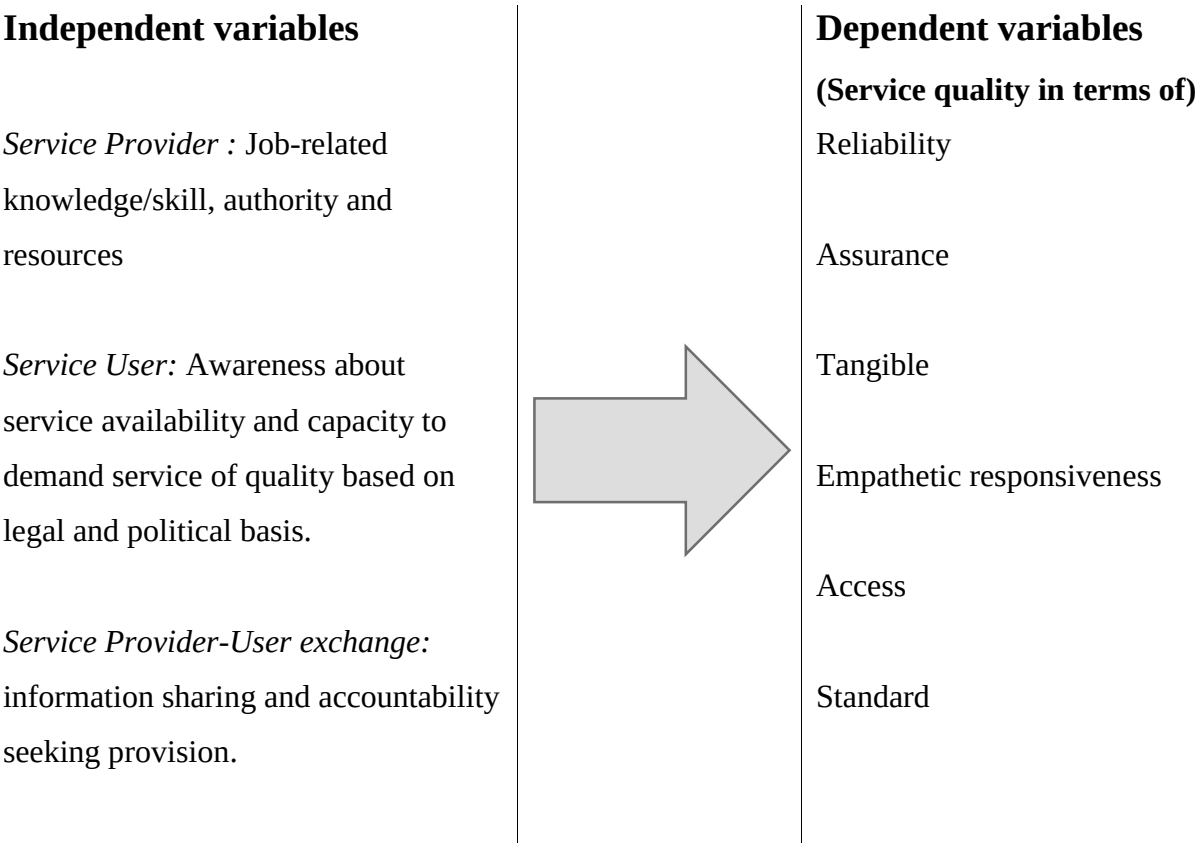
Public service determinants: Schematic view

Aspects	**Factors**	**Description**
1. Service recipient or users	Demanding capacity (whether demand is put or not)	- Information (people have information related with availability of service and their rights) - Political capacity (number and organizing capacity to put pressure)
	Zone of tolerance (threshold for	

	satisfaction and dissatisfaction. Above the threshold, service recipients become satisfied and below become dissatisfied).	
2. Service provider	Resourcefulness (how much service provider is capable to provide service)	- Competency (relevant knowledge, skill and attitude) - Resource (logistics and finance, adequate number of staff)
3. Interaction between service recipient and service provider	Accountability	Need to give answer. Mechanism of answer seeking is established.
	Transparency	Information related with person involved in service provision and the process is open to people.

2.4.3 Variables

Variables are the factors that either get influenced or do influence other factors.



(**Note**: First five dependent variables are adapted from SERVQUAL Model and Access variable added by the researcher considering that in case of public service it is indispensably necessary).

Above conceptual framework is drawn from the literature review and own experience as well. As per the nature of service described earlier, service is produced as service provider and user are together, it cannot be stored as goods. In many cases, service user is also a service producer, for example, unless s/he gives accurate information to doctor, cooperate in undergoing investigation and follow treatment regime, mere a medical doctor can treat a patient. Thus, intended result can be achieved only when both parties – service provider and users have certain attributes and they interact as it intended to be.

Service providers' knowledge, skill, ethics, as well as service providing organization's physical facilities affect dimensions of service quality. Similarly, service users' awareness about service and demanding capacity make them empowered to claim own rights – following Citizen's Charter, put political pressure and also claim through legal remedy in case of severe problem. In addition, professional practice to give information to service user and service user's practice to ask questions that makes service providers accountable.

For this study, among many kinds of public services, medical service is envisaged to be the most appropriate because all segments of population remain concerned with medical service, determinants service recipients they feel more keenly about service quality. Unit of analysis will be individuals.

Chapter 3 : Research Design

3.1 Research design

Research design is a plan or proposal to conduct research. It involves intersection of philosophy, strategies of inquiry and research methods (Cresswell, 2009). By choice of best combination of options of this study is presented below.

Research plans and procedures spans the decision from broad assumptions to detailed methods of data collection and analysis (Creswell, 2011). So, without having appropriate research design, evidence-based findings and logical conclusion, research cannot add value to knowledge inventory.

In order to carry out the research to find answer as mentioned under the statement of the problem, this research design has been thought.

For this study, descriptive research design has been applied because this is a type of study which is generally conducted to assess the opinions, behaviours … (Pant, 2012). This design is appropriate because the study intends to identify what people perceive about service quality along different dimensionsand also about the service quality determinants. The research intends to know perception of different people – service provider and service user – on service quality. Their perception received from service transaction or exchange level is supplemented by broader picture.

For this study, following is the philosophy of study, strategies of inquiry and research methods related with this research are presented as below.

3.2Philosophy of study

It helps to categorise any particular study what is its nature and knowledge intended to generate from it. For this particular study comes in the category of social construction. This philosophy assumes that individuals seek understanding of the world in which they live and work. Individuals develop subjective meanings of their experiences – meanings directed toward certain objects or things. The meanings are varied and multiple, leading the researcher to look for complexity of views rather than narrowing meanings into a few categories or ideas (Cresswell, ibid.).

This study is based on people's views on public service quality. Perception, demand and satisfaction related with public service is subjective to a large extent. Because, someone may

satisfy by the prescription of a medical doctor if his/her sickness is cured though waiting time is long and behaviour was rude. Another person may need all above, only correct treatment may not be enough. Thus, it is considered that public service quality is people's perception related, so its philosophy is social construction related. Another one, this study intends to build theory related with public service quality drawing theoretical and methodological basis from private service quality related model SERVQUAL with a level of modification.

The research is descriptive as mentioned earlier. The research findings are expected to contribute in knowledge building as well as problem solving, so it would be basic and applied research at the same time.

3.3 Strategy of inquiry

As the philosophy of the study is social construction, the strategy of inquiry would be mixed for this study. Qualitative methods will be used to collect perception or views of service recipients on quality of public service whereas quantitative methods will be used for testing and validating the factors incorporated in the study.

3.3.1 Research methods

Mixed method is followed in which both –quantitative and qualitative methods are used.

i) Quantitative data collection

As the dimensions of public service quality are identified through the analysis of above information, it has been tested and validated through quantitative data collection. For quantitative data collection, following tools are used:

- Questionnaire (self-administered or facilitated as per appropriateness).

The questionnaire includes three types of questions.

First question is to rank the service quality dimensions as per the preferences of respondents. The purpose of such ranking is to know whether there is a difference in between the preferences between the service providers and users among six dimensions selected for this study. It is envisaged that the differences in preferences make people think, choose and prioritize the decision. The Gap 1, i.e. the difference in perception about service quality of manager and consumer mentioned above under Gap Model suggested by Parasuraman et al (refer to point 2.1 of this paper) clearly indicates that the gap in perception of service provider or manager between what actually service user needs/wants poses major barrier in providing quality service.

Besides, secondary data is also substantiated to validate the factual information.

Second in row are a set of questions related with service quality dimensions. Each dimension of service quality are composed of some elements as mentioned above. Those questions are put in Likert scale that means offering option to choose anywhere in the continuum – beginning from own extreme to another extreme having 5 choosing points. The Likert scale prepared is ranged the service quality is *Very Bad* to *Very Good* with option not to give response. The perception of service providers and users on each element of service quality is expected to be helpful to know how much differences are on service quality dimensions. Perception on the status of service make both parties proactive or contented. If service users perceive service quality is bad, they would take initiative to put pressure on politicians and administrators to improve the service quality. If service user perceive service quality is bad but provider perceive good, it would need more effort to pressurise the service quality. It would be easier, if both think the same.

Third type of questions are related with determinants of (public) service quality. There are also prepared following Likert scale beginning from one element of determinant is *Very Needed* to *Absolutely Not Needed* having 5 choosing points.

ii) *Qualitative data collection*

The purpose of qualitative data collection is to collect people's perception and views on public service quality. For qualitative data collection, appropriate person who is decision maker or leader of frontline service provider has been interviewed.

Observation

For qualitative data collection, this tool is also used. As when oneself or someone in the family fell sick, the researcher visited the one hospital frequently. There and at that time, this researcher also felt what is expected from hospital staffs including medical ones and other facilities are available, what makes as service user negative feelings. This observation has reflected even in designing the dimensions of service quality and also in inputs for analysis.

Interviewing with service recipients and service providers

For collection of information in detail and for semi-structured information collection, interviews are conducted. Such interviews help to collect information without being restricted to researcher's preoccupation and limited thinking and knowledge.

Information collection through news reports published in newspapers

Information collection through the reports published in newspapers have significant significance to gather information from across the country and from the perspective from general public not limiting to transaction point level status of service quality but above from that level of policy level. It means the unit of analysis goes above the level of organization selected for the study.

3.3 *Data analysis*

Quantitative data analysis will be analysed by using SPSS. It includes univariate and bivariate analysis.

The answers of questions can be acquired only based on perception, because real assessment of service quality by an outside researcher, who is even non-technician (non-health sector technician for medical service) is difficult to assess service quality related with medical service.

The data collected against each element using the Likert scale is first coded to two categories removing extreme values, then computed aggregate of each broad dimension and determinant and then again recoded using the facility available in SPSS.

Table 3.1

Schematic presentation of research design

Research Design	Objective	Respondent	Data collection tool	Number of respondents	Sampling method
1. Qualitative	Collection of views on public service quality dimensions and determinants.	Patients and their attendants	1. Observation	1	Deliberate sampling: Civil service hospital, 1 Public Health Centre
		Hospital Chief heads frontline health provision	2. Interview - Open	1	Deliberate sample: Director of Civil Service Hospital
			1. Content analysis: Analysis of news reports published in newspapers to identify service quality dimensions and determinants.		Dailies – national broadsheet. Reports published related with health service
2. Quantitative	Collection of perception and experience on public service quality by service users and providers	Service users and providers	Questionnaire	1. Service users visited selected PHC in 2 days and who can fill up the questionnaire 2. PHC staffs	Accidental sampling

Chapter 4 : Analysis

In this Chapter, the information – quantitative and qualitative - collected is analysed with view to find answers of research questions. The quantitative information were collected from service providers and service users through the questionnaires. The qualitative data are collected from observation, interview and content analysis of relevant reports published in broadsheet dailies in vernacular Nepali.

Quantitative data has been collected from *10 service providers and 28 service users*. Quantitative data collected data collected from a Primary Health Centre (PHC) of Tahun, Palpa on convenience. PHC is considered a typical service providing outlet in rural and small towns of Nepal where medical doctor, nurses are deployed.

4.1Ranking of service quality dimensions

It is very significant to know how the service provider and user rank the service quality dimensions as per their preferences. Following table shows the ranking. This ranking is made based on the highest percentage of respondents give rank to which dimension.

Table 4.1

Ranking of dimensions by service providers and service users

Dimensions	**Service Provider**	**Service User**
Reliability	1	1
Assurance	1	2
Tangible	2	5
Empathetic Responsiveness	2	4
Access	1	3
Standard	1	2
Number	**10**	**28**

Source: Field Study, 2015

The ranking denotes the highest preference is 1 in descending order lowest is 5. The table above shows equal number of service providers have given first rank to reliability, assurance, access and standard dimensions whereas a bit lower number of respondents give preference to tangible and empathetic responsiveness dimensions. This means service providers are more different opinions on the dimensions of services. It means for the same numbers of service providers have opinions that reliability, assurance, access and standard are the dimensions of first priority. This is not the same in the case of service users. Their numbers vary to give preference to different dimensions.

Highest number of service users give preference to reliability dimension and lowest number see tangible aspect is the first priority.

4.2 Perception on service quality dimensions

Under this, the perception of service providers and service users on 6 dimensions of service (especially health) has been analysed. At first, the data received on each element of service quality recoded and computed using the SPSS.

4.2.1 Reliability dimension

As above, reliability is one dimension of service quality. For this study, the operational definition of reliability is the ability to perform the promised service dependably and accurately. Reliability is made of five elements – commitment, interest, authority and responsibility, job related skills and resources. The respondents expressed their perception on each element in Likert Scale – within the range of 1 to 5 (1 for very bad, 2 for bad, 3 for neutral, 4 for good and 5 for very good). By transforming 1 to 5 ranking to renaming Satisfactory and Unsatisfactory, and then computing the scores to one, following table is made.

Table 4.2

Reliability

(in percentage)

Response	**Service Provider**	**Service User**
Unsatisfactory	0	15
Satisfactory	100	85
Number	**10**	**28**

Source: Field Study, 2015

The table above shows that perception of service provider and service user on reliability is not the same, it differs. All service providers have perception that service is reliable, but service user do not have the same perception, only 85 percent of respondents are found having similar opinion.

As per the conceptual framework, service quality is influenced by service user and service provider along with their transaction. This has been evidenced from the qualitative data. As the above data collected from one rural PHC of Palpa, where above factors might have played role in having 85 percent of service users have perception that service quality is Good, as it is different in other location, that is urban area of Tarai, in respect of reliability, people may not perceive reliability of service does not seem high. As per the news report published in *Kantipur* daily on Fagun 5, 2071 (February 17, 2015), about 10 percent only of pregnant women go to government hospital for delivery service provided in hospital, 90 percent of women go to private hospital or nursing homes because doctors and paramedic staffs pay more less attention in public hospital service because the

payment made there is lucrative and case basis whereas in government hospital, such a provision of incentive does not exist, thus service provider's commitment and interest remain low. To see the glaring example of exorbitant fee being charged by private hospital for the same service provided in the government hospital, one example in the form of news report see from Chitwan. Report says patients are bound to pay ten-fold higher fees in private service provider. As the medical service is directly related with human life, no one would dare to take risk against human life. Realizing this sensitivity, unscrupulous practices thrive in health services. To see, in detail, refer to Annex 2.

4.2.2 Assurance dimension

Assurance is another dimension of quality. The operational definition of assurance is knowledge and courtesy of employees and their ability to inspire trust and confidence. For the study, four elements were incorporated in the questionnaire. Those elements are: relevant knowledge, courteousness, feeling of safety and ethical behaviour. The same method of data collection and analysis was followed for this dimension and also for dimensions that follow below.

Table 4.3

Assurance

(in percentage)

Response	**Service Provider**	**Service User**
Unsatisfactory	18	11
Satisfactory	82	89
Number	**10**	**28**

Source: Field Study, 2015

The table above shows that service providers themselves acknowledge that they are not entirely confident on this dimension. Even the percentage of service provider is higher than service user to acknowledge service quality is unsatisfactory on this dimension. This could be the reason that they feel some weakness. Still the percentage to perceive that service quality is satisfactory is very high in comparison to feeling unsatisfactory.

As feeling of assurance is relative term. Someone who is much sensitive about the knowledge level of service provider, s/he prefers to go to specialist doctor for medical check-up and whereas uneducated person do not bother whoever (specialist doctor or just an MBBS doctor) is examining her/him. In that case, as one is assured, another one may be suspicious about the quality of service.

On ethical ground, medical service is questioned from different corners. Reports published in newspapers and people are found complaining that doctors undertake those cases which should be

referred to appropriate doctors. Handling those cases that does not fall within own specialization domain puts patients in risk though it gives monetary benefits of a doctor and his/her private organization. To see the news report, refer to Annex 3.

4.2.3 Tangible dimension

Tangible aspect is also considered one dimension of service quality. It is normally said that that no one goes any service outlet to see its beauty and facilities, but these factors affect the quality of service and satisfaction. So, this cannot beignored. The operational definition of tangible for this study purpose is physical facilities, equipment and appearance of personnel. Three elements are identified of this dimension – beauty of the premises and building, physical cleanliness as well as toilet and water facility, profession apt dress of service provider and waiting modality, duration and physical facility while waiting. The responses of service provider and service user are strikingly different. More than double service providers in percentage expressed service quality is bad based on this dimension. Only data does not show the reason but in course of interaction it came to know that poor condition of tangible aspect is felt sternly by service providers than by users, because they live with dismal quality longer than the users.

Table 4.4

Tangible

(in percentage)

Response	**Service Provider**	**Service User**
Unsatisfactory	36.4	14.8
Satisfactory	63.6	85.2
Number	**10**	**28**

Source: Field Study, 2015

In one interaction, Local Development Officer of Surkhet had said that one Assistant Health Worker of one Health Post situated in remote village once asked him to provide one unused or broken chair, so he could carry it to his office spending money from his pocket, then he would be able to sit on the chair while examining patient or doing his office job. It is glaring example of poor physical condition of health service outlets, which certainly make service providers dissatisfied and perceive bad quality of service.

As formal question is asked to patients, they give less priority to tangible aspect of service quality (See point 4.1, ranking of tangible aspect 5 by service users), but in reality they look for this

aspect as well. Despite the same and doctor and medical staffs provide services, but patients and h/her family members admit a patient for *pay beds*, *high pay beds*and pay *clinic*.

4.2.4 Empathetic responsiveness dimension

Empathetic responsiveness is another important dimension of service quality. The operational definition is caring, individualized attention towards own service users, willingness to help them and provide prompt service.This dimension seems contrasting to the value of doing uniform behaviour towards own service users, however, still there remains room for empathy and responsiveness, which demands tailor the service provision as per the needs and demand of service user. For example, normally patients coming for check-up in health institute have to wait one turn in queue, but if any patient is serious or of old age, the health institution can make a system of giving priority to that kind of patient. For this study, four elements were included within this dimension – sensitivity towards the needs and desires of service user, readiness to give service accordingly, time taken to respondto needs and desires.

Table 4.5

Empathetic Responsiveness

(in percentage)

Response	**Service Provider**	**Service User**
Unsatisfactory	9.1	11.1
Satisfactory	90.9	88.9
Number	**10**	**28**

Source: Field Study, 2015

Both service provider and service users are found strong perception that services are good. Normally, people feel that government employees are pathetic or even indifferent towards people's need and desire, the responses they expressed through questionnaire do not show it. The reason could be that as this study was conducted in PHC at remote location, normally service providers behave better way with service users and latter ones are less demanding. It is true that higher the expectation, higher the dissatisfaction. It could be the subject of further study to see whether the perception of urban and rural population differs in this dimension.

4.2.5 Access dimension

Access is important dimension of quality, however, there is a big question whether it should be a prerequisite of public service rather than considering it so (dimension of quality). Operational meaning of access is that without any restriction, people should be able to use public service. Restriction could be on geographical distance, service fee rate or physical structure that may impose restriction to certain group of peoples. As public service needs to be within the reach of

all, access is indispensable aspect of quality. The question about this dimension had included three elements. The responses are quite similar of service provider's perception.

Table 4.6

Access

(in percentage)

Response	**Service Provider**	**Service User**
Unsatisfactory	18.2	18.5
Satisfactory	81.8	81.5
Number	**10**	**28**

Source: Field Study, 2015

Regarding this dimension, perception of service provider and users is quite similar. More than 80 percent respondents of both groups are found saying access is "Satisfactory". As the questionnaire was given to those service users who came to the health institution for service, so it is obvious to guess that they did not feel service is inaccessible. To know really what people say about access, it would be appropriate also to collect and analyse the perception of people who do not go to service providing centre. The researcher acknowledge this weakness of the study. To know about the access to health service in terms of distance, following data give a picture. In respect of access dimension of health service, it would be pertinent to present data from secondary source. It gives a picture of how long people have to travel to access health service in Nepal.

Table 4.7:

Access: Distance to travel to receive health service

Service Unit	**Location**	**Distance to travel to receive service**				
		Up to 30 minutes	**30 minutes to 1 hour**	**1-2 hours**	**2-3 hours**	**3 hours or more**
HP/SHP	Urban	85.9	12.2	1.8	0.0	0.1
	Rural	59.0	22.0	14.3	2.8	1.1
	Nepal	61.8	21.0	13.0	2.5	1.7
PH/PHCC	Urban	82.6	11.5	5.3	0.4	0.1
	Rural	20.6	22.5	23.9	11.6	21.5
	Nepal	33.6	20.2	20.0	9.3	17.0
PClinic/PvtH	Urban	92.0	5.4	2.3	0.2	0.1
	Rural	43.2	16.6	14.7	8.3	17.3
	Nepal	53.4	14.2	12.1	6.6	13.7

Note: HP=Health Post, SHP=Sub-health Post, PH=Public Hospital, PHCC=Primary Health Care Centre, PClinic=Private Clinic, PvtH=Private Hospital

Source: Nepal Living Standard Survey 2010/11 Vol 1, p. 56, 57 and 58

The above table shows that still today, in rural Nepal, people have to travel more than 3 hours to receive service from Primary Health Care Centre or Public Hospital. On one hand, government has called people to go health service providing unit for receiving delivery service with aim reduce maternal and child health mortality, but if people have to travel such a long distance, how can they receive the service in delicate condition.

4.2.6 Standard dimension

Standard is synonymous to quality – normally it is understood in general term but it is not so. This dimension of service quality normally is not known by service user for example technical and procedural aspect. Technical aspect means use of appropriate knowledge, diagnostic and treatment tools/methods used. Similarly, procedural aspect refers most appropriate procedural protocol being followed. If in case of this aspect is ignored, there is caveat of erosion of ethics, malpractices and mismanagement. Service users are normally unable to define and describe – what should be the standard, however they can expect as well as perceive – what standard should ensure and look like. Taking accounts of these, questionnaire was designed in respect of this dimension.

Table 4.8

Standard

(in percentage)

Response	**Service Provider**	**Service User**
Unsatisfactory	18.2	7.4
Satisfactory	81.8	92.6
Number	**10**	**28**

Source: Field Study, 2015

As per the assumption that service provider know better about standard whereas service user remains less aware about standard, this has been reflected also in responses. 18 among service providers, 18.2 percent expressed that service standard is unsatisfactory whereas 7.4 percent service users expressed so.

From the aspect of service standard, many times there are reports that medicines and vaccines of spurious quality are purchased and distributed. Not long ago, more than dozens of responsible health personnel of the Government of Nepal were investigated and sued by Commission on the

Investigation of Abuse of Authority being found to be involved in purchasing low quality medicines. Similarly, last year in southern part of Parbat district, in course of monitoring and investigation, it was found that in Huwas Health Post and Uram Pokhara Sub-Health Post, the date expired medicines were distributed. The investigation found that absence of assigning responsibility to someone for the storage of medicines and proper mechanism of dispose the expired medicines were the reasons behind that kind of anomaly. (Agandhar Tiwari, Kantipur, 19 September 2014). It is clearly evidenced that, one dimension of service quality is maintaining minimum standard and that is subject to internal factor.

4.3 Service quality determinants

Based the theoretical basis, for this study three determinants of service quality are identified. As service is produced when service providers and service users are together, it cannot be produced and provided like in case of goods even though there is consumer/customer is present. Realizing this very reality, service determinants are identified – service provider, service user and their relationship.

As a determinant of service quality, service provider as an individual and organization matter significantly. As an individual, a service provider at first must be present to provide service. In Nepal, many health organizations are without designated health personnel. Once health personnel is present, his/her knowledge, skill, organization's authority and resources availability are considered important. As quality of health service is collective product of a team along with other factors, knowledge and skill not only of one person but also all people in the team is important. Following finding of one study conducted in Nepal, does also prove it.

> *The effectiveness of public service delivery depends in large part on the capability, resources and inputs, and the motivation of frontline service providers at the local level.*
>
> (SASGP, World Bank, April 2014)

As mentioned if effectiveness is understood as the quality because both have features to yield result, capability, resources/inputs and motivation at frontline are factors of service quality. For this study service quality determinants are identified in line with above.

In respect of service user, two elements are considered determining factors for service quality – awareness level of service user on right over service and its quality along with demanding (service) capacity on political and legal basis.

Another determinant service quality is interrelationship between service provider and user. Under this, two elements are included – provision and practice of giving information about availability of service and its standard to service user and another one is accountability mechanism. In absence of these two, service user remains passive in respect of service provision which obviously turns as whatever given is gratis instead of giving feeling rights on service quality.

Respondents were asked to respond to questionnaire designed from 1 to 5 scale beginning from *very much needed* to *absolutely not needed*. The responses received from respondents recoded to two (1 and 2) and computed all elements to one. Following this analytical statistical tool with support of SPSS, tables are prepared and analyses are done.

i) Service provider

Service provider is the major service producer. Service producer does not imply only to a person of official, but also an organization. The knowledge and skill of an official (who is responsible for providing service), responsibility and resources of the organization are major elements that affect service quality.

Table 4.9

Service quality determinant: Service provider

Determinant	**Need level**	**Response about service quality (in percentage)**		**Number**
		Unsatisfactory	**Satisfactory**	
Service Provider	Needed	100	76	29
	Not needed	0	24	7
Total respondents		**100**	**100**	**36**

Source: Field Study, 2015

Respondents who felt service quality is *Unsatisfactory*, all of them hold opinion that to improve service quality, it is needed that frontline service providers are with job related knowledge and skill, authority of the service providing organization and essential resources.

This is not the same with the people, who perceive that service quality is *Satisfactory*, it means seventy- six percent respondent opined that service providers were equally

important for the sake of quality service. On other hand, hundred percent of respondent opined that there would not be service quality even if there were service provider. Here it should be understood that service providers means the provider with the elements mentioned in the questionnaire.

From the service provider's perspective, Dr. Bimal Kumar Thapa, the Director of Civil Service Hospital has opined that following are main factors to ensure service quality. This hospital is gaining popularity in providing quality service in short duration.

- ✓ Quality service can be ensured only by holistic approach. A good doctor cannot provide quality service unless other elements of entire gamut of service compliments with the same level of quality.

- ✓ Communication skill is very important in providing medical service because without it neither a doctor know the suffering of a patient correctly, nor s/he could make understand his message to patient.

- ✓ Service cannot be a subject of choice due to technical reason but also other reasons like just how long to wait for own turn.

- ✓ In our Nepali public sector one big missing element to improve service quality is that service provider do not have business like behaviour, i.e. service user's satisfaction is his/her measurement of success.

His opinion that service quality can be ensured only by holistic approach emphasizes that seeing only on one aspect is imperfect. A medically competent doctor only cannot ensure good service unless fellow staffs and investigation system does not support, for instance. His interview is given in Annex 4.

Besides, in Nepal, big concern on the quality of health personnel has been raised. The 7 rounds of fast-on to – death hunger strikes of Dr. Govind KC raised the issue of being knowledge and skill of medical doctors in stake because of excessive business-motive being involved in medical education. One example of deteriorating quality of medical education is being 24.5 percent of MBBS graduates being failed in licensing examination. One report, published in Nagarik daily on

1 September 2015 gives a pathetic data that in licencing examination on Bhadra 5 (2072) conducted by Nepal Medical Council (NMC) for specialist doctors, in which 165 out of 670 (24.6 percent) candidates appeared in examination failed.In licencing examination, basic knowledge is tested, let alone the test of skill. Then also, such big percentage failed. For detail, see Annex 5.

ii) Service User

Service user also plays important role in the production of service, s/he is not only passive receiver of service. The service user's awareness about own rights over service and service standards along with capacity to put demand through political and legal means make them able to improve service quality. If one patient asks genuine question about service, a doctor becomes bound to answer his/her queries, otherwise, they may do what they like without having feeling someone is conscious about his/her decision and action.

Table 4.10

Service quality determinant: Service user

Determinant	**Need level**	**Response about service quality (in percentage)**		**Number**
		Unsatisfactory	**Satisfactory**	
Service User	Needed	86	52	19
	Not needed	14	48	13
Total of respondents		**100**	**100**	**32**

Source: Field Study, 2015

In respect service users' role on the level of service quality, 86 percent of respondents have opinion thatservice quality would be *Unsatisfactory* if service user are not with features as mentioned in the questionnaire, i.e. service users are to be aware of own rights and should hold demanding capacity on legal and political basis. It emphasizes that empowered service recipients in terms of knowledge and demanding capacity, can play significant role in improving service quality. 52 percent of respondents who perceive that service quality is *Satisfactory*, even though service users are not with qualities as mentioned. The reason of such a difference in perception about the determinants between respondents is not clear.

iii) Service provider and service user relation

Service is produced as service provider and user are together or as service user puts the effective demand and another party responds. Thus, their relationship quality play significant role in determining the state of service quality. To operationalize the relationship, two elements are identified – first one is giving information about service to its potential users, which may be by

different means including citizen charter and second one is answerability/accountability mechanism regarding availability and service quality.

Table 4.11

Service quality determinant: Service provider and user relationship

Determinant	**Need level**	**Response about service quality (in percentage)**		**Number**
		Unsatisfactory	**Satisfactory**	
Service Provider and Service User relation	Needed	100	74	30
	Not needed	0	26	8
Total of respondents		**100**	**100**	**38**

Source: Field Study, 2015

From the data collected through field study, all the respondents who perceive that service quality would be *Unsatisfactory*if there is no service user and service provider relation. Whereas 74 percent people have opinion that service provider and user's relationship is equally important in ensuring *Satisfactory* service quality and 26 percent say not needed, that means even without such relationship.

Chapter 5 : Summary and conclusion

5.1 Summary

Public service is the major reason of State-citizen relationship. State provides necessary services to its people and citizens support the State by abiding by rules, regulations and providing resources in the form of taxes and fees. Public service is what State provides to its people – it could be tangible (park, road, water etc) or intangible (health service, education etc) in the form and direct (running public schools and hospitals by oneself) or indirect (by regulation, policy guidance etc) in the modality of provision.

As State's obligations towards its people ranges from womb to tomb and people's socio-economic status depends on the quality of public service. As Nepal normally ranks most of time at the lower rung in the global ranking, it raises questions about the quality of public services. Most of the articles written and studies conducted focus on service delivery aspect, which also consider one or two dimensions of service quality but there are comparatively low studies conducted on composite dimensions of public service quality. It is not only Nepal's case but global case. This becomes clear from the fact that practice-related studies conducted in the field of public service quality borrow the tools developed to study private service quality. As there are basic differences between private and public service, the tool could be different. Just to indicate, private sector performance that may also include quality aspect is judged mainly by profit earned; in case of public sector performance, increased public trust and gradual improvement in quality of life of people could be the indicators. Another example is – for private sector access on service could not be a big requirement because it assumes whoever like to take private service may visit to service-provision outlet, they have to think about efficiency and profitability and confine itself to those service outlets which are profitable whereas such kind of value should not apply to public sector. It has to enhance access to all people even though efficiency aspect is compromised. It is the nature of public sector which has contrasting goals.

Taking into accounts that public service quality related study is relevant to assist policy makers and administrators in identifying the problems and find solutions, this study is undertaken. This study does not claim to contribute in theory building, rather it focuses on application aspect.

The objectives of the study are to understand the perception of service providers and service users ranks the dimensions or aspects of (public) service quality, do they perceive the same or different about each service quality dimension and what the determinants of service quality are.

As the difference in perception on service quality and its dimensions impose barrier in improving the quality. In the article of Parasuraman et.al., they have identified one major hurdle in terms of gap identified in improving service quality is the difference in understanding about the service quality – service users have emphasis on one aspect and providers give emphasis on another one. So, identifying the ranking of dimensions and perception differences on the status of each dimension would help to know to what extent is the gap. In addition, the perception about the determinants of service quality would highlight what kind of action is required. If service providers who are at decision making level think certain determinant is strongly causing problem in improving service quality, they would make decision easily. If staffs at lower rung or frontline think that their behaviour is problem, they may change behaviour to some extent. If it needs the attention of higher level, they have to raise demands and advocate like service users do. Six dimensions (reliability, assurance, tangible, empathetic responsiveness, access and standard) of the service quality identified for the study. Out of six, 4 were identified for application of refined SERVQUAL Model, last two added by the researcher taking accounts of the nature of public service.

From theory, it has been identified that public service quality is the result of combined efforts of service provider, user and their interaction; service quality determinants are these three. To prepare the information collection tool, i.e. questionnaire, each determinant further unbundled to 2, 2 and 3 elements.

The study is exploratory and descriptive. Mixed approach has been followed. The quantitative approach is followed to find out what respondents would say to the structured question. Questions are prepared based on the theory and knowledge acquired by other researchers. The responses are confined within the boundary of framework prepared by the researcher. This has helped to understand what most of the people say. In this study, the framework for quantitative study centers at service quality the service exchange level. The respondents were also selected who provide and receive service. The qualitative approach surrounds the service exchange level and even policy level. This has helped to understand bigger picture of service quality determinants.

To conduct the study, health service is chosen because it is among one of the most important public services and service providing outlets are from capital to small units of VDCs across the country. Considering the limitation of resource and time, field study conducted in Primary Health Care Centre (PHC). Such centres are opened across the country even in villages, not in all but in few centres. PHC staffs as service providers and patients or their visitors as service users were

asked by giving questionnaire to express their perception about quality of service. Service users were selected following accidental sampling method, that choosing them for answering who came to the PHC. Questionnaire were prepared in Nepali and given only to them who could read.

To analyse the data, SPSS (a computer-based software) has been used. Data entered and for analysis data recoding, results combining (computing) and again recoding done. Ranking, comparing data through cross-tabulation and bivariate analysis has been conducted.

On analysing the data, it was found that service users and service providers have different ranking of service quality dimensions. Service providers ranked the six dimensions only in two ranks whereas users ranked them in 5. It means service users are more meticulous and sensitive towards service quality dimensions rather than service providers. It shows that service users and providers do not rank quality dimensions in the same manner. Regarding the perception of each dimension of service quality, perception of service providers and users varied on four dimensions – reliability, assurance, tangible and standard.

Responses on the determinants of service quality, it has service provider, service recipient and their relation has been analysed to know what respondents think about theirs relevance and role in affecting service quality. It has been found that all three determinants have high relevance or role if service quality is bad. Respondents believe that above mentioned determining factors play high role in service quality.

To understand, the determinants of service quality from higher perspective, interview and content analysis from broadsheet newspapers conducted. This approach reinforce the dimensions and determinants of service quality.

5.2 Conclusion

- As we see the ranking of service quality dimension by service provider and user, there is a glaring difference is that service provider give only 1 and 2 ranks whereas service users have given 1-5 ranks. It means service users are more sensitive and meticulous on service quality. For example, service providers rank access at first place whereas service users give it 3rd place. Such a difference indicates that both sides think about the problem differently and so, would also see about the solution differently like one Nepali proverb – *Bhokobhanchhadandawarikhaaun, aghayekobhanchhadaandaparikhaaun* (a hungry person wants to eat something without delays whereas a satiated person says to eat not now, afterwards). As service quality related concern is more important for service users, their perception should be understood first, but to understand standard which is more internal

matter, service providers understand better, so their perception is more important. To take remedial action for improving service quality, the difference in perception may play significant role. If service providers think, service quality is poor in certain dimension they may take internal correction mechanism whereas service users have to take action through lobbying, advocacy and more by legal or political action.

- The perception of service user on reliability dimension is quite different from service provider. It means service providers perceive health service provided is reliable but 15 percent of service users do not agree with it. Reliability dimension is composite of commitment, interest, authority, skill and resources. Thus, service providers think – service is questionable against these elements. It is necessary to think. As per the report published in Nagarik daily about not purchasing or maintaining medical equipment in hospitals of Chitwan complements this fact. Reliability dimension calls for attention of policy makers.
- As the service quality is determined by service provider, service user and their interactions. To improve service quality – it is necessary to think about all these determinants. It means there arenecessities of technically sound human resources, resource and authority in respect of service provider; awareness about right and service standard and service demanding capacity (in terms of political and legal basis) in respect of service user; and the provision to give information to service user and accountability mechanism in respect of service user-provider interrelationship.
- On broader perspective, uncontrolled practices of profit or money making through health service practices have affected service quality. In such activity, high-powered persons are involved as accomplice, so the problem has become more complex to solve. There is even voices that man-killing licences are distributed by weakening the system of controlling quality medical education. As high money is involved in medical education, medical ethics is eroding thereby quality is affected.

Annexes

Annex 1

Questionnaire

Mr/Ms. .....

.....

I am a student of Master of Philosophy (MPhil) level of Central Department of Public Administration, Tribhuvan University. I am researching on the topic of "Public Service Quality: Dimensions and Determinants" as the part of fulfilment of the course. My focus is on the health service quality.

In connection with collecting information and views to conduct the research, I humbly request you to kindly support the research work by filling up the questionnaire attached. The opinion or information you provided will be kept confidential and used only for research purpose.

Sincerely,

Dhruba Nepal

Questionnaire on different aspects of service quality

For this study, following are the operational definitions of service quality determinants. Kindly answers the questions considering following definitions of the terms used.

	Dimension	Definition of terms for this study purpose.
☐	Reliability	Provide service in a reliable manner.
☐	Assurance	Provide service in courteous manner being sensitive towards the need of service user.
☐	Tangible	Conducive, clean and tidy physical condition of service providing organization for target service users. Additionally, staffs are in service-matching attire.
☐	Empathetic Responsiveness	Provide services understanding the need and problem of service users.
☐	Access	All people have easy access on the services.
☐	Standard	Appropriate standard related with technical and procedural aspects being maintained.

1. Please kindly put in descending order following aspects of service quality based on your perception on service quality.

☐Reliability

☐Assurance

☐Tangible

☐Empathy and responsiveness

☐Access

☐Standard

2= Please tick as you perceive the status of each element of service quality dimension/aspect based on your perception.

1=Very Bad, 2=Bad, 3=Fair, 4=Good, 5=Very good, and 9=Do not want to say

a) Reliability

Commitment– Provide service as prescribed by law and citizen charter within time and following the procedure.	1 2 3 4 5 9
Interest – Service providers are interested and willing in solving the problems related with service.	1 2 3 4 5 9
Authority (Authority to take decision and perform accordingly)	1 2 3 4 5 9
Skill – staffs have skill to carry out own responsibilities,	1 2 3 4 5 9
Resources – financial and other resources are available to carry out the assigned duties/responsibilities.	1 2 3 4 5 9
Other (if anything else, please add.)	1 2 3 4 5 9

(b) Assurance

Knowledge – job related technical knowledge of the staff member.	1 2 3 4 5 9
Courteousness (politeness of service provider towards service users	1 2 3 4 5 9
Feeling of safe and secure by services provided or by behaviour.	1 2 3 4 5 9
Ethics – compliance with professional and socal ethics	1 2 3 4 5 9

(c) Tangible

Beauty of premises and building of service providing outlet	1 2 3 4 5 9
Physical cleanliness (provision of toilet with water)	1 2 3 4 5 9
Job-suited attire worn by service provider	1 2 3 4 5 9
Provision of waiting own turn, duration and sitting arrangement	1 2 3 4 5 9

(d) Empathetic responsiveness

Sensitivity towards service users' needs and wants	1 2 3 4 5 9
Willing to deliver service as per the need of service users	1 2 3 4 5 9
Time taken to address demand and wants.	1 2 3 4 5 9
Provision to provide service in the time service users prefer.	1 2 3 4 5 9

(e) Access

Distance to travel to receive service	1 2 3 4 5 9
Service fee rates	1 2 3 4 5 9
Difficulty in using services by disable and other difficulty facing people.	1 2 3 4 5 9

(f) Standard

Technical and professional quality of the service	1 2 3 4 5 9
Process standard	1 2 3 4 5 9

3. In your understanding - what are the things that affect the quality of public services? Kindly mark round what you think apprropriate as you think.

1.Very needed 2.Needed 3.Does not matter much 4. Not required 5. Absolutely not required

9. Do not want to say

a) Service provider related

a1) Knowledge and skill of service provider

1 2 3 4 5 9

a2) Authority of service providing organization

1 2 3 4 5 9

a3) Resources available to service providing institutions

1 2 3 4 5 9

b) Service user related

b2) Service users' awareness about rights over and standard of service

1 2 3 4 5 9

b2) Demanding capacity of service on political and legal basis

1 2 3 4 5 9

c) Interrelationship between service provider and service user

c1) Provision to give information about availability and standard of service

1 2 3 4 5 9

c2) Provision of making accountable to availability and standard of service

1 2 3 4 5 9

Annex 2
Unfair and unethical practices in medical field

a) Patients bound to pay ten-fold higher fees to buy service from private service provider

Ramesh Kumar Paudel

Despite having equipment in two government hospitals, the responsible officials of those hospitals do not take initiative to repair and maintain them because they can make easy and more money in the form of lucrative commissions by referring needy people to go private service providers, who charge them ten folds than government hospitals. Such malpractice has been continuing in Bharatpur Hospital and BP Koirala Memorial Cancer Hospital for a long, and there is no effort being made to put end of it.

"If a surgical operation of spinal cord is conducted in Bharatpur Hospital, a patient need to pay just Rs 15 thousand but private hospitals charges from Rs 40 to 150 thousandfor such operation. The existing machine required to conduct such an operation can be repaired at the cost around Rs 20-30 lakhs but no one is taking initiative," says Dr. Krishna Poudel, ex-Head of Orthopaedic Department and Chair Person of Nepal Medical Association, Chitwan Chapter.

An equipment for mammography, required to investigate breast cancer, costs around Rs one crore has not been purchased by BP Koirala Cancer Hospital so far though need is dire. People say its covert reason is that the Chair Person of this Hospital Dr.Bhaktaman Shrestha is indulges in his private practice in Narayani Community Hospital, which has mammography equipment.

(Nagarik daily, September 6, 2014)

b) Business of surgery

Sujit Mahat, Kathmandu.

Sushila Dahal from Bijulikot, Ramechhap underwent a surgery of her uterus by a doctor Amila Shrestha. The biopsy test it was showed the same result which was already confirmed by blood test that she had cancer. In her blood test, the level of CA 125 was found 1287 u/ml (unit per mililiter) which very high than the threshold level of 35 u/ml. There was no doubt about the presence of cancer. Despite that Dr Amila, gynaecologist, operated Sushila and asked to do biopsy instead of referring her to cancer specialist (oncologist). The greed of doctor to earn more money makes him/her take those cases that should not be done. It is ethical protocol to refer those cases to appropriate specialist doctor instead of handling oneself which normally does not fall within own scope of specialization. In addition, such a trend to ask patient to do many diagnostic tests because against them they receive commissions.

(From Kantipur, February 7, 2015)

c) Government hospitals are sick themselves

Empty hospital bed. Wide duty counter in the hospital and on the side, there is toilet. This is the scene of Maternity Ward of Siraha District Hospital.

About ten pregnant women go to private hospital for delivery (of baby) each day but normally government hospital remains almost without delivery case. Hospital records show only 35 cases per month admitted to the hospital which is quite lower than the actual delivery need. As per the data there happens 300 deliveries in Siraha and only about ten percent served by the government hospital. The reason of such low flow of patients with delivery needs to the government hospital is low trust of service user in government because reliable and quality service is not provided.

“Service seekers choose to go there where required and quality service is provided. As this hospital does not provide quality service, we are bound to advise patient to go private hospital being a staff of government hospital,” says Nurse Seeta Pandit.

Government spends quite a whopping share of budget in health sector but service providing units like hospitals are like sick themselves. This is happening because medical doctors and other staffs spend less time in hospital and longer time in their clinics.

(Mithilesh Yadav from Lahan, Raju Adhikari from Jhapa, Amar Khadka from Sunsari and Mahesh Das from Mahottari)

Kantipur daily, Fagun 5, 2071 (February 17, 2015)

Annex 3

Preference to get examined in private clinic

It is very common in Nepal that a medical doctor of government hospital also get indulged in private practice that means being remunerated by each individual patient. In hospital practice, the remuneration of a doctor does not vary whether there are ten or eleven patients, whereas in private practice it certainly matters whether s/he examines ten or eleven patients in terms of amount of money earned.

Every patient and his/her relative wants a doctor should give his/her fullest expertise and sincerity while treating a patient. Though a doctor does not say that his/her expertise is compromised whether it is provided in a government hospital or a paying clinic. Despite this, a patient prefers to get examined in paying clinic because s/he doubts doctor's fullest expertise and sincerity might be compromised while examining in government hospital. There are also additional reasons – even in Pay Clinic of the same hospital, first, patients' queue remains short, and so doctor may pay more attention to a patient than when there is a rush of patients. Second, the Pay Clinic runs in odd hours, so for some patients odd hours may be comfortable to get doctor's service.

Above case shows that in case of health service-user of does not think technical expertise of doctor is enough ensure service quality, but is expected more.

(Source: Based on observation and chat with patient visiting government hospital).

Annex 4
Interview

A talk on health service quality with the Executive Director of Civil Service Hospital - Dr. Bimal Kumar Thapa

What Is the quality in health service?

For a person who seeks health service, the quality of service means is to be cured of a disease. If s/he is cured or his/her health problems solved or reduced, then only s/he can feel the service is with quality. Thus, service quality means the need or problem is addressed. Unless the problem is not solved or in the way of solution, no one would say service is of the quality.

What affects service quality?

Unless the health personnel including medical doctors, nurses, paramedics like laboratory, radiology and others are technically competent in their respective responsibilities, service cannot be of quality. Service quality is holistic concept, not individual one. One very good doctor alone cannot ensure quality unless other health personnel and entire system does not support him/her.

Job related knowledge and skill is most important aspect of service quality. The technical knowledge and skills can be effective only when they listen to clients and understand them perfectly. As much correctly health personnel listen their clients, that much correctly they would be able to address their problems. In addition, they have to advise very correctly and comprehendible way to patient and someone knowing their culture, habit and understanding level who come along with a patient.

Supplemental factors

Technically sound knowledge and skill are most important factor to ensure quality service but it is not all. For example, if patients are not treated politely, courteously and wait long for own turn, they may prefer to seek alternative. Thus, to avoid long queue in waiting for own turn, patients go to private clinic of the same doctor of public hospital. Realizing this very fact, Civil Service Hospital has introduced digital queue system recently and trying even to be so exact in giving exact appointment time with a doctor, thus waiting time is minimized and no crowd of patients and their visitors in hospital will remain.

Business like behaviour

What I have seen that people working in public sector do not behave keeping business motive that means clients' satisfaction is most important. They ignore this aspect, so clients' loyalty is not maintained. It is big challenge to overcome in public sector.

Note: Dr.Bimal's view is supported by researcher's observation about people's choice even to go to private clinic of a doctor:

Annex 5

How long life killing licence be distributed?

Deepak Dahal

Nepal Medical Council (NMC) conducted licencing examination on Bhadra 5 (2072) for specialist doctors, in which 165 out of 670 (24.6 percent) candidates appeared in examination failed. On cursory look, failure rate is quite lower than pass rate but the failure rate is quite high because the candidates were those who intensively studied three years specialization course. Licencing examination is conducted to test whether a candidate has acquired basic understanding of own subject.

Similarly, on Shrawan 9 (2072) NMC conducted licencing examination of MBBS passed candidates. 24 percent candidates could not get through that examination as well. In that examination, 651 candidates were appeared. Sometime 50 percent of candidates become failed. There is an example of one eligible candidate failed in licencing examination for 25 times.

Licencing examination is conducted with view to ensure basic standard of knowledge of a medical doctor who conducts medical practices. In respect of knowledge test, so dismal result is seen; the result would be worse if even the skill is also tested.

“Licencing examination is so basic that to fail this examination means a student has not learned basic things. So high rate of failure indicates that medical institute do not teach students what is expected. Thus, our health teaching institutes are giving away man-killing licences,” says Dr.Jagadish Agrawal, medical teaching expert.

Dr.Govind KC, Senior Orthopaedic Surgeon argues that the main reason of eroding quality of medical education is infiltration of business motive. He is on fast-onto-death strike for 6th time. His demands zeros in on enhancing access in medical education also of talented but poor students and improve the quality of medical education.

Nagarik daily, 1 September 2015

Annex 6
Examples of deficiency of basic health service requisites

Patients flow outnumber doctors' number and beds of hospital

Amrita Anmol

Butwal - Flow of pregnant women seeking services exceeds the capacity of hospital in terms of medical doctors and beds in hospital that mars service quality. In an average, 21 pregnant women go to Lumbini Zonal Hospital for delivery service but there are only 14 beds available for such patients. Medical Recorder Laxmi RamRegmi says, "As per national policy, mother and neonatal baby should stay in the hospital for 24 hours of the delivery for safety reason, but lack of seats exert pressure to discharge them immediately after delivery of baby putting them in risk. For Gynaecology and Obstetrics Department, one specialist and one medical doctor are designated which is too low than the requirement.

(Source: Kantipur daily, March 6, 2015)

People happy because of Surgeon

KashiramDangi

Rolpa – People of Rolpa are happy on receiving one specialist doctor who can conduct caesarean surgery in the hospital of remote district. In one month period, two babies are born by caesarean. Chief of Hospital Dr.Umashankar Prasad Chaudhary expresses happiness, "We have succeeded to add such service also in the hospital.

Specialist doctor Pranay Rana Magar hails from Kathmandu. He is paid Rs 2 lakh as monthly salary.

(Source: Kantipur daily, March 6, 2015)

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