Using the Servqual Model to Evaluate the Impact of Public Service Reforms in the Provision of Primary Health Care in Botswana

JALONI PANSIRI and REBANA N. MMEREKI

Department of Management, Faculty of Business, University of Botswana, Gaborone, Botswana

The health sector is pivotal to any national development initiative; hence, Botswana has taken seriously the principle of primary health care as contained in the the Alma-Ata declaration of 1978. As a demonstration of their commitment, the government of Botswana has passed a number of National Development Plans, health policies, and numerous reforms with a view of enhancing service quality in this sector. Many reforms and restructuring exercises are still ongoing. This study uses the SERVQUAL model to evaluate the implementation of Work Improvement Teams (WITs) in the hospitals/clinics as a reform initiative adopted by the Botswana government to enhance the productivity, efficiency, and performance of the public sector (particularly the health sector). This discussion will demonstrate that the SERVQUAL model can be used to review the impact of public policy. This will be achieved by measuring the level of service quality and customer satisfaction using the SERVQUAL model through data that were collected from 151 hospital/clinic customers in Gaborone, the capital city of the Republic of Botswana. Descriptive and inferential statistics were used to analyze the data, and the findings indicate that the adoption and implementation of reforms in the public health sector have not improved the level of service quality and customer satisfaction as indicated by a significant gap between customer expectations and perceptions.

Address correspondence to Rebana N. Mmereki, Department of Management, Faculty of Business, University of Botswana, 4775 Notwane Rd., Gaborone, Private Bag, UB 0022, Botswana. E-mail: mmerekirn@mopipi.ub.bw

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INTRODUCTION

The Botswana government has taken the provision of health care as part of the overall socioeconomic development to improve the quality of life of its citizens. Although Botswana's health system (composed of all health facilities owned or supported by the government, as well as facilities open to the public such as mine hospitals, private health services, and nongovernmental organizations that provide health care) has expanded significantly over the years, the government still remains the main provider of health care. Central to the health care system has been the provision of primary health care as contained in the Alma-Ata Declaration of 1978. Local government (district/town councils) through the council health departments (district health teams) and a network of clinics (248), health posts (339), and mobile stops (810) run the primary health care system.

The foundation of the provision of health care in Botswana is the 1995 National Health Policy. The policy notes that the Botswana Health Care System shall be based on the principles of primary health care as contained in the Alma-Ata declaration of 1978, which strives to provide affordable and accessible health care to all citizens with special measures taken in respect of high-risk groups, such as children, adolescents, pregnant women, the elderly, disabled persons, and workers whose occupations or professions justify such measures (Ministry of Health, 1995).

While the policy lists the responsibilities of the various players in the provision of health, it gives districts as well as city and town councils the responsibility for planning, evaluating, and providing basic health services for residents in their respective areas. These services include health promotion and avoidance of ill health, health care curative service, community health services, and family health care services.

Toward Efficiency and Quality Health Care

The Botswana public sector has generally undergone drastic changes over the past years because of the demands placed by the public on the system. As Pansiri (2004, p. 26) argues, "these problems and challenges facing the public service have produced a search for ways of maximizing scarce resources to provide at least basic levels of service. While reasons for this shift in managerial practice may be complex and dynamic, it could be argued that they were based on the belief that the public sector should demonstrate flexibility, efficiency and competence in delivering economic outcomes."

The Botswana government has in the past 20 years embarked on many reform initiatives based on the Singaporean productivity model, and many more initiatives are under way. The government of Botswana, through the Directorate of Public Service Management, adopted Work Improvement Teams (WITs) as one of the reform initiatives. This resulted in the creation of the Botswana National Productivity Centre (BNPC) by the 1993 National Productivity Act, as well as the formulation of the "Strategy for Productivity Improvement in the Botswana Public Service" in 1994; the strategy acknowledges the creation of WITs in the public service (Republic of Botswana, 1994). It further lists the terms of reference for WIT members and estimates that, eventually, every civil servant will belong to a team.

The BNPC and WITs were adopted as two complementary strategies to address productivity problems in the country. While WITs are limited to the public sector, the BNPC's mandate is with respect to the whole country and all economic domains. As summarized by Hope (1995, p. 47), the BNPC's objectives include:

> stimulating and generating productivity consciousness in Botswana; promoting increased productivity in all sectors of the economy; improving standards of management; fostering good labour-management relations; promoting the concept of employer responsibility toward the welfare of employees; introducing suitable management practices and techniques; assisting organizations in identifying areas where there is a deficiency in skills, or where performance can be improved, and thereafter advising on how to deal with these; and facilitate equitable sharing of productivity gains among management, employees, and the client public.

Definition of Work Improvement Teams

Senge, Roberts, Ross, Smith, and Kleiner (1994, p. 354) define a *team* as any group of people who need each other to accomplish a result, while Sincliar (1992, p. 611) sees it as a distinctive class or group, which is more task oriented than other groups, and which has a set of obvious rules and rewards for its members. Work teams have also been defined as "small groups of employees who have day-to-day responsibility for managing themselves and their work. [They] handle job assignments, plan and schedule work, make production-related decisions, and take action on problems" (Wellins, 1994, p. 165).

The government of Botswana defines WITs as a group of civil servants or other public officers from the same unit irrespective of their divisional status, who meet regularly to identify, examine, analyze, and solve problems pertaining to work in their department or work unit; identify and examine improvement opportunities, propose and implement improvement measures; help to adapt the work unit and hence the department to changing

circumstances; discuss and conduct studies on how to improve their working environment, efficiency, effectiveness, quality of service, knowledge and skill, teamwork, work performance, use of resources, work goals, objectives and targets, systems, methods and procedures, etc.; and implement improvement ideas or recommend them for implementation (Republic of Botswana, 1994).

WITs have faced various problems and challenges (Pansiri, 2004), and the government has since adopted yet another reform initiative, Performance Management System (PMS), to reinforce the activities of WITs. However, it can be argued that recently more emphasis has been placed on PMS at the neglect of WITs, which many people believe have failed although the government believes that WITs have made tremendous improvement in the public service. PMS is a governmentwide reform initiative, which is meant to enhance productivity and service quality throughout government ministries and departments. Units for implementing it have already been established in the Ministries of Health and local government. The introduction of these reforms is in line with the recommendations of de Jager and Grundling (2007), who posit that in order to meet the needs of their customers, hospitals need to develop performance monitoring and evaluation plans.

The Problem

The Botswana government has, over the past years, adopted a number of reform initiatives primarily concerned with improving efficiency, equity, quality, cost, effectiveness, and consumer satisfaction. Most of these reforms have either been abandoned or hailed as successful without much rigorous empirical investigation. No research has focused on the measurement and management of service quality and customer satisfaction in the public sector, as though such issues are only peripheral to the public sector domain. The health sector remains one of the most important sectors in Botswana's economy, particularly with the HIV/AIDS epidemic, which means that more people are visiting clinics than ever before. The Botswana government has also embraced the concept of *Botho* in its Vision 2016, and it is in this sector that this concept will be highly tested. Botho/ubuntu is a mind-set that has glued Botswana communities together for a long time (Pansiri, 2006, 2009). Its philosophy is that "A person is a person through other persons." In the words of the former Archbishop of Cape Town, Desmond Mpilo Tutu (1999, p. 31), botho/ubuntu

> ... speaks of the very essence of being human.... It is to say, 'My humanity is caught up, is inextricably bound up, in yours.' We belong in a bundle of life. We say, 'A person is a person through other persons'. It is not 'I think therefore I am.' It says rather: 'I am human because I belong. I participate, I share'. A person with *ubuntu* is open and available to others, affirming of others, does not feel threatened that others are able and good, for he or she has a proper self-assurance that

> comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed, or treated as if they were less than who they are.

In addition to these problems, the Ministry of Health confirms that there is a gap between the perception of the providers and the consumers of health care. This tends to frustrate both sides. The health workers consider themselves as providing "good quality" care, while the consumers complain of such matters as "negligence" and "bad attitudes" (Republic of Botswana, 1997). In order for this gap to be closed, the government, through the Ministry of Health, has recommended and adopted a number of reforms, which include WITs, strengthening of the health policy, introduction of PMS, and the development of performance standards.

The purpose of this paper is, therefore, to measure perceived service quality and level of customer satisfaction in government-owned hospitals/clinics, and to investigate whether public sector reforms necessarily lead to improved service to the customers.

HEALTH CARE QUALITY AND CUSTOMER SATISFACTION

Quality is sought by all organizations (public or private sector). It is defined by the Botswana Ministry of Health as the totality of characteristics of an entity that bear on its ability to satisfy stated and implied needs (Ministry of Health, 1995). It extends beyond the care process to include health outcomes–the result of the procedure or treatment (Fischbacher & Francis, 1999, p. 20). It has been suggested that there are two aspects of service quality–technical quality and functional quality (Fischbacher & Francis, 1999; Parasuraman, Zeithaml, & Berry, 1985, 1988). Technical quality refers to the extent to which a product (e.g., a surgical procedure) conforms to specifications (i.e., clinical care), while functional quality refers to the way in which the service is delivered (i.e., care management) (Fischbacher & Francis, 1999, p. 20). Therefore, Fischbacher and Francis (1999) conclude that the quality of a service does not depend only on the systems in place (functional quality) to treat the patient but also on the skills of the health care practitioners/service providers (technical quality). Accordingly, this would ensure customer satisfaction. However, such an evaluation targeting customer satisfaction has not been undertaken on the Botswana public service delivery systems, especially by the government itself.

THE SERVQUAL MODEL

One way of overcoming the problems of framing of questions, the avoidance of evaluation of clinical practice, the inadequate ways in which samples relate to the populations from which they are drawn, the cavalier treatment of

nonresponse rates, and the superficiality of traditional surveys (Hart, 1999, p. 68) is to use the SERVQUAL methodology. Hart (1999, p. 68) argues that "unlike the quality of goods, which can be measured objectively by such indicators as durability and number of defects, service quality is an abstract and elusive construct because of three features unique to service: Intangibility, heterogeneity and inseparability of production and consumption." Hence many researchers attest that the SERQUAL model is the most prevalent and widely accepted perspective on service quality (Hart, 1999; Parasuraman, Berry, & Zeithaml, 1991; Parasuraman & Zeithaml, 1994; Parasuraman et al., 1985, 1988; Parasuraman, Zeithaml, & Berry, 1994; Temtime, Pansiri, & Belayneh, 2002).

The SERQUAL model is primarily developed to measure satisfaction and is premised on the assumption that service quality is critically determined by the variation between consumers' expectations and perceptions of service. Service quality is perceived as a function of prepurchase customer expectations, perceived process quality, and perceived output quality. Service quality is therefore defined as the gap to be distinguished between customers' expectations of a service and perceptions of a service as actually experienced.

SERVQUAL DIMENSIONS

Parasuram et al. (1988) have shown that regardless of the type of service, clients use basically similar criteria in evaluating service quality, and these fall into 10 key categories of service quality determinants: reliability, responsiveness, competence, access, courtesy, communication, credibility, security, understanding/knowing the customer, and tangibles. A further examination of the content of the 10 service quality determinants allows a construction of five dimensions in SERVQUAL, which may be analyzed to determine the gap between expectations and perceptions of customers:

- *Tangibles*—refer to the physical evidence of service like physical facilities, equipment, and appearance of personnel. Customers want to be comfortable and delighted with their experience as consumers of hospital/clinic services.
- *Reliability*—concerns the ability of the service provider to perform the promised service dependably and accurately. Nothing upsets customers faster than a promise made but unfulfilled. As Temtime et al. (2002) observes, breaking the service promise is the single most important way service companies like [hospitals/clinics] fail their customers.
- *Responsiveness*—concerns the willingness or readiness of employees to help customers and provide prompt service. When a customer experiences problems with a service (when something goes wrong), the customer's confidence is jarred but probably not destroyed unless the problem reflects a pattern of negative experience with the clinic/hospital.

- *Assurance*—this includes communication, credibility, security, competence, and courtesy. It involved instilling confidence in customers by being consistently courteous to them, by being resourceful and knowledgeable in the various aspects of health services, and by answering all customer questions satisfactorily.
- *Empathy*—including understanding/knowing customers and access; refers to the provision of caring and individualized attention to customers by the service provider. Customers will not only be at ease when employees understand their specific needs but will also feel comfortable when they receive individualized attention and when employees show that they have the customers' best interest at heart (Parasuraman et al., 1985, 1988).

RESEARCH DESIGN AND METHODOLOGY

A survey research method was used to produce this paper. Structured questionnaire were distributed to 200 randomly selected customers in Gaborone, the capital city of Botswana, to collect primary data. The questionnaire was adapted from Parasuraman et al. (1991) and designed to have two sections. Part I of the questionnaire contained 44 SERVQUAL items under the five service quality dimensions; that is, 22 questions on expectations and 22 questions on perceptions. In responding to this section, respondents were asked to use their experiences as a customer of a hospital/clinic and think about the kind of hospital/clinic that would deliver excellent quality service and the kind of hospital/clinic with which they would be pleased to go for consultation. Then they were asked to rank each of the features on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). Furthermore, intermediate scale points were not labeled. Respondents were further asked to indicate their perceptions regarding their feelings about a hospital/clinic's service. For each statement they were asked to show the extent to which they believed the hospital/clinic had the feature described by the statement on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). Once again, intermediate scale points were not labeled. Part II of the questionnaire wanted the respondents to allocate points out of 100 to the five dimensions in the SERVQUAL model.

DISCUSSION AND RESULTS

This discussion is based on the responses obtained from 151 hospital/clinic customers (75.5% response rate) out of 200 in Gaborone, Botswana. Statement E9 (Excellent hospitals/clinics will insist on error-free records) had a very high missing response rate and was removed from the analysis. To make the analysis reasonable, its counterpart P9 (Botswana hospitals/clinics insist on error-free records) was also excluded from the analysis. Reliability analysis

was conducted on the nine sets of items to measure the internal consistency of the items loaded onto each factor. Tables 1 and 2 show that the Cronbach's alpha values for all the nine components were in excess of the required .5

TABLE 1 Customer Expectation

	Mean	Std. Dev	Cronbach α
Tangibles			.819
Excellent hospital/clinic will have modern-looking equipment	5.48	1.650	
The physical facilities at excellent hospitals/clinics will be visually appealing.	5.38	1.583	
Employees of excellent hospitals/clinics will be neat in appearance	5.75	1.582	
Materials associated with the service (such as pamphlets or statements) will be visually appealing in an excellent hospital/clinic.	5.46	1.549	
Reliability			.849
When excellent hospitals/clinics promise to do something by a certain time, they will do so.	5.67	1.756	
When patients have a problem, excellent hospitals/clinics will show a sincere interest in solving it.	5.79	1.588	
Excellent hospitals/clinics will get things right first time.	5.22	1.638	
Excellent hospitals/clinics will provide their services at the time they promise to do so.	5.51	1.735	
Excellent hospitals/clinics will insist on error-free records			
Responsiveness			.897
Employees of excellent hospitals/clinics will tell patients exactly when services will be performed.	5.57	1.723	
Employees of excellent hospitals/clinics will give prompt service to patients	5.78	1.597	
Employees of excellent hospitals/clinics will always be willing to help patients	5.93	1.545	
Employees of excellent hospitals/clinics will never be too busy to patients' requests.	5.42	1.731	
Assurance			.884
The behavior of employees of excellent hospitals/clinics will instill confidence in patients.	5.92	1.510	
Patients of excellent hospitals/clinics will feel safe in their dealings with the hospital/clinic	5.95	1.488	
Employees of excellent hospitals/clinics will be consistently courteous with patients.	5.75	1.529	
Employees of excellent hospitals/clinics will have the knowledge to answer patients' questions.	5.57	1.548	
Empathy			.868
Excellent hospitals/clinics will give patients individual attention.	5.51	1.664	
Excellent hospitals/clinics will have operating hours convenient to all their patients	5.25	1.844	
Excellent hospitals/clinics will have employees who give patients personal attention.	5.38	1.689	
Excellent hospitals/clinics will have the patients' best interest at heart.	5.64	1.819	
The employees of excellent hospital/clinic will understand the specific needs of their clients.	5.62	1.464	

TABLE 2 Customer Perceptions

	Mean	Std. Dev	Cronbach α
Tangibles			.742
Botswana hospitals/clinics have modern-looking equipment.	3.47	1.715	
Botswana hospitals/clinics' physical facilities are visually appealing.	3.35	1.746	
Botswana hospitals/clinics' employees are neat in appearance.	4.18	1.693	
Materials associated with the service (such as pamphlets or statements) are visually appealing at Botswana hospitals/clinics.	3.70	1.705	
Reliability			.898
When a Botswana hospital/clinic promises to do something by a certain time, it does so.	2.51	1.633	
When you have a problem, the Botswana hospitals/clinics show a sincere interest in solving it.	2.57	1.645	
Botswana hospitals/clinics get things right the first time.	2.22	1.425	
Botswana hospital/clinic provides its services at the time it promises to do so.	2.65	1.620	
Responsiveness			.888
Employees of a Botswana hospital/clinic tell you exactly when service will be performed.	2.85	1.773	
Employees of a Botswana Hospital/clinic give you prompt service.	2.71	1.831	
Employees of a Botswana hospital/clinic are always willing to help you.	2.43	1.595	
Employees of a Botswana hospital/clinic are never too busy to respond to your requests.	2.59	1.652	
Assurance			.921
The behavior of employees of a Botswana hospital/clinic instills confidence in patients.	2.27	1.669	
You feel safe in your dealings with a Botswana hospital/clinic.	2.34	1.576	
Employees of a Botswana hospital/clinic are consistently courteous with you.	2.34	1.686	
Employees of a Botswana hospital/clinic have the knowledge to answer your questions.	2.76	1.742	
Empathy			.887
Botswana hospital/clinic gives you individual attention.	2.76	1.845	
Botswana hospitals/clinic have operating hours convenient to all its patients.	2.77	1.767	
Botswana hospitals/clincs have employees who give you personal attention.	2.59	1.753	
Botswana hospitals/clinics have your best interests at heart.	2.64	1.754	
Employees of a Botswana hospital/clinic understand your specific needs	2.45	1.644	

criterion for reliability, which, according to Nunally (1978), meets the requirements for basic survey research. As a consequence, a cut-off value of .50 was used to measure reliability and all the themes were accepted. Therefore, all the five themes for expectations and perceptions were accepted to be used for further analysis. Furthermore, Tables 1 and 2 also show the means and standard deviations of all variables measuring expectations and perceptions.

TABLE 3 Correlations of Service Quality Variables

		1	2	3	4	5	6	7	8	9	10
1	Expected Tangibles	1									
2	Expected Reliability	0.609**	1								
3	Expected Responsiveness	0.560**	0.813**	1							
4	Expected Assurance	0.502**	0.726**	0.811**	1						
5	Expected Empathy	0.545**	0.673**	0.756**	0.855**	1					
6	Perceived Tangibles	−0.054	−0.085	−0.130	0.002	−0.063	1				
7	Perceived Reliability	−0.148	−0.082	−0.081	0.031	−0.040	0.601**	1			
8	Perceived Responsiveness	−0.168*	−0.168*	−0.201*	−0.096	−0.137	0.493**	0.767**	1		
9	Perceived Assurance	−0.178*	−0.109	−0.146	−0.066	−0.076	0.419**	0.651**	0.767**	1	
10	Perceived Empathy	−0.108	−0.060	−0.104	0.001	−0.013	0.440**	0.631**	0.806**	0.804**	1

**Correlation is significant at the 0.01 level (2-tailed); *Correlation is significant at the 0.05 level (2-tailed).

TABLE 4 Correlations Between Five Service Features and Service Quality Variables

No.		Mean	DS	1	2	3	4	5
1	The appearance of the hospital's physical facilities, equipment, personnel and communication materials	22.63	13.40	1				
2	The hospital/clinic's ability to perform the promised service dependably and accurately	14.49	11.69	−0.177	1			
3	The hospital/clinic's willingness to help patients	14.89	11.91	−0.320**	0.454**	1		
4	The knowledge and courtesy of the hospital/clinic's personnel	13.92	10.83	−0.329**	0.487**	0.614**	1	
5	The caring, individualized attention the hospital provides its patients	12.60	10.35	−0.359**	0.532**	0.479**	0.568**	1
6	Expected Tangibles	5.52	1.28	0.049	0.102	0.085	0.027	0.125
7	Expected Reliability	5.53	1.39	0.066	0.028	0.115	0.063	0.005
8	Expected Responsiveness	5.66	1.43	0.058	−0.006	0.106	−0.076	−0.053
9	Expected Assurance	5.78	1.32	0.052	0.042	0.131	0.068	−0.004
10	Expected Empathy	5.41	1.49	−0.026	0.036	0.088	0.102	0.049
11	Perceived Tangibles	3.66	1.30	0.086	0.156	0.063	0.115	0.171*
12	Perceived Reliability	2.49	10.40	−0.007	0.025	0.091	0.092	−0.062
13	Perceived Responsiveness	2.65	1.50	−0.003	0.024	0.096	0.096	−0.016
14	Perceived Assurance	2.43	1.50	−0.056	0.017	0.082	0.080	−0.026
15	Perceived Empathy	2.65	1.50	−0.069	0.014	0.103	0.135	0.014

Table 3 presents results of two-tailed Pearson correlation coefficients that indicate the level to which service quality variables are correlated. All the expectation variables are correlated at 99% significance level, indicating that they are basically measuring the same theme–expectation. The largest correlation between the expectation items was found between empathy and assurance ($r = 0.855$, $p < 0.01$), followed by the correlation between reliability and responsiveness ($r = 0.813$, $p < 0.01$). Furthermore, all the perceived service quality variables are correlated at 99% significance level also indicating that they are measuring the same theme–perceived service quality. The largest correlation between the perceived service quality items was found between perceived responsiveness and perceived empathy ($r = 0.806$, $p < 0.01$), followed by the correlation between perceived assurance and perceived empathy ($r = 0.804$, $p < 0.01$). It is important to note is that this study found no significant relationships between expected service quality and perceived service quality and that almost all the "r" figures are negative. Although distinctive, the correlations among expected service quality and those among perceived service quality point to the fact that these action items measure the same concept, while it is true that expected service quality and perceived service quality items do not measure the same concept.

Respondents were further asked about the importance of five features pertaining to hospital/clinics' services they offer. They were asked to indicate the importance of each of the five features by allocating a total of 100 points among the five features according to how important a feature was to them. The more important the feature was, the more points they allocated to it (Parasuraman et al., 1991). Table 4 shows the correlations of such variables and the means and standard deviations. The means for the five features shows that tangibles are perceived as more important while empathy is the least important. This is also supported by perceived tangibles, which also attracted the highest mean. Furthermore, most of the five features are correlated at 99% significance level. Another important thing to note is that this study found no correlations between the five service features and service quality variables (expected and perceived).

SERVICE QUALITY GAP ANALYSIS

Based on responses to the multiitem scale, Table 5 provides a summary of the weighted means of customers' expectations and perceptions about the quality of services in public hospitals/clinics under each SERVQUAL scale item. This table presents only the grand mean for each SERVQUAL dimensions. Table 5 indicates that the overall evaluation rating across the five SERVQUAL dimensions for customers' perception of actual quality of services received is lower (overall mean = 2.78) than their expectations of service quality (overall mean = 5.57). Therefore, the perceived gap (overall gap = −2.80) attests to

TABLE 5 Service Quality Gap Analysis

Dimensions	Weight	Perceptions	Expectation	Gap
Tangibles	22.63	3.66	5.52	−1.86
Reliability	14.49	2.49	5.53	−3.02
Responsiveness	14.89	2.65	5.66	−3.01
Assurance	13.92	2.43	5.78	−3.35
Empathy	12.60	2.65	5.41	−2.76
Weighted averages	($n = 151$)	2.78	5.57	−2.80

the fact that service quality level is far below customers' expectations. This gap is very high given the fact that most of the researchers who have used this model have not found a gap smaller than this. Zeithal et al. (cited by Hart, 1999) found −0.99 (U.S. general sample 1990), Hart (1999) found −0.48 (East Midlands, UK, outpatients July 1995), −0.41 Vaasa, Finland, outpatients January–February 1996), and Temtime et al. (2002) found −1.76.

The major contributor to this difference between customer expectation and perception of service quality is Assurance (Assurance gap = −3.35), which consisted of the courtesy of employees (particularly physicians and nurses) and their trustworthiness, respect for confidentiality, knowledge in helping customers, ability to explain services and policies, and ability to inspire trust and confidence. Assurance scored the highest mean (expectation mean = 5.78) and the second lowest perception (mean = 2.43), compared to the other four dimensions of the SERVQUAL model. What this implies is that above all, customers not only need courteous and knowledgeable service providers (physicians and nurses) but also they should inspire them with trust and confidence.

The second major contributor to the rather unusually wide expectation–perception gap is the Reliability dimension (gap = −3.02). Responsiveness dimension (Responsiveness gap = − 3.01) based on customers' evaluation of the service provider's willingness or readiness to help and to provide prompt service was the second contributor. In most of Botswana's government hospitals/clinics, customers have always complained of lack of service promptness, willingness of employees to help customers, and politeness of employees in providing services and always keeping patients informed. These are the crucial dimensions of service quality. Responsiveness was also ranked the second highest of all the dimensions (weight = 14.89), which means that above all customers need a very responsive service provider. This is consistent with the findings of de Jager and Grundling (2007) that "patients want to be informed about the total service package they will receive with admission and after they are discharged from the hospital. Patients also demand prompt service" (p. 57). The gap for Empathy (gap = −2.76) was narrower than that for the other dimensions. However, the least contributor to this wide expectation–perception gap is the Tangibles (gap = −1.86), which

consist of physical evidence of the service like physical facilities, equipment, and appearance of personnel. In general, the Public Sector in Botswana does not see itself as in competition with any business. Therefore, the designs of its Hospitals/Clinics are standardized with no appealing appearance. However, customers want to be comfortable and pleased with their experience as consumers of hospital/clinic services. The results here are synonymous with those of Hart (1999), where tangibles were the lowest (−0.03 in East Midlands, UK, outpatients July 1995), (−0.41 in Vaasa, Finland, outpatients January–February 1996), and in the banking industry where Temtime et al. (2002) found tangibles to be the second lowest with (mean = −1.65).

CONCLUSIONS AND IMPLICATIONS

The findings of this study are important for those interested in the SERVQUAL model and public policy researchers in general. For SERVQUAL researchers, this study has looked at an aspect that has previously been neglected. This aspect has to do with relationships between the constructs of the model. It is interesting to note is that while there were significant correlations between the variables forming the expectation and perception contracts, no significant correlations were found between expectation and perception. This is in important finding in that it appears that these two (expectation and perception) measure totally different phenomena. Secondly, this study did not find any significant correlations between the five features proposed by Parasuraman et al. (1991) as part of the model and the expectation and perception constructs. There was an expectation by the researchers, based on the theoretical understanding of the five features, that there would be significant relationships between the five features and perception constructs. More research is needed to investigate such relationships. This study is also important for public policy researchers. It is one of the few attempts where the SERVQUAL model has been used as a policy evaluation tool. It is possible to broaden this further when considering public policy impact assessment.

The findings also indicated that there are significant differences between customer expectations and perceptions, which require immediate attention of hospital/clinic management. This is so despite the fact that a lot of money was used to implement reforms, particularly WITs. While WITs as a strategy had noble objectives evolving around enhancing quality service, their implementation has failed to reduce the expectation–perception gap as shown by this survey. Moreover, WITs as a strategy have been used successfully by many organizations internationally. Therefore its failure in the Botswana public sector (particularly hospitals and clinics) has to do with its implementation. The government health sector, through the Ministry of Health, has proposed more reforms envisaged to take root in the next

NDP 9. These reforms are likely to go the same way if due care is not taken during implementation. Any reforms in the public health sector meant to improve the quality of care, efficiency, and cost effectiveness of health care delivery should be done within the understanding of the broader macro level. The macro level is strategic and fundamentally the responsibility of the Designer (central government).

The service providers (employees of hospitals and clinics) implement the reforms within the broader macro-level framework, which should be supportive of such reforms. This indicates the level of successful implementation. WITs were implemented not only in an environment of lack of commitment by top government officers but also faced with acute shortage of manpower worsened by brain-drain (particularly nurses, many of whom migrated to greener pastures in Europe and the United States). In November–December 2002, the public health service was hit by a wave of countrywide strikes by nurses and other Botswana Unified Local Government Service Association (BULGSA) members. These strikes, which paralyzed health services, was sparked by the 14-year-old Job Evaluation Exercise, which the courts said was not properly done by the local government authorities. The Job Evaluation Exercise was yet another government reform that failed because it was not properly designed by central government. Therefore, the expectation–perception gaps of Reliability (−3.02), Responsiveness (−3.01), Assurance (−3.35), and Empathy (−2.76) are a direct result of embarrassingly lower wages, poor industrial relations, lack of participative decision making, and generally poor working conditions to which employees of public health hospitals/clinics have been subjected for years.

Manpower development has remained a top priority during both NDPs 7 and 8. However, unless such programs as the General Nursing, Midwifery, Health Education, Environmental Health, The Community Health Nursing Programmes, etc. are strengthened with courses on service quality, customer care, marketing, and total quality management, the government's concepts of "commitment to primary health care," "health for all," and "Botho" would remain slogans to decorate top government officials' speeches in high national and international forums.

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