AN ASSESSMENT OF USER SATISFACTION WITH PUBLIC PRIVATE PARTNERSHIP (PPP) PROJECTS IN SELECTED UNIVERSITY TEACHING HOSPITALS

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NIGERIA

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DEPARTMENT OF QUANTITY SURVEYING,
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AUGUST, 2015

DECLARATION

I declare that the work in this Dissertation entitled AN ASSESSMENT OF USER SATISFACTION WITH PUBLIC PRIVATE PARTNERSHIP (PPP) PROJECTS IN SELECTED UNIVERSITY TEACHING HOSPITALS has been carried out by me in the Department of Quantity Surveying, Faculty of Environmental Design, Ahmadu Bello University, Zaria.

The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this dissertation was previously presented for another degree or diploma at this or any other institution.

Funmilola Helen OYEDELE _____ _____

Signature Date

CERTIFICATION

This dissertation entitled "AN ASSESSMENT OF USER SATISFACTION WITH PUBLIC PRIVATE PARTNERSHIP (PPP) PROJECTS IN SELECTED UNIVERSITY TEACHING HOSPITALS" by Funmilola Helen OYEDELE meets the regulations governing the award of the degree of Master of Science (Quantity Surveying) of the Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

Prof. A.D. IBRAHIM (Chairman, Supervisory Committee)	_____ Signature	_____ Date
Dr. K. J. ADOGBO Member, Supervisory Committee	_____ Signature	_____ Date
Dr. Y.M. IBRAHIM Head of Department	_____ Signature	_____ Date
Prof. A.Z. HASSAN Dean, School of Postgraduate Studies	_____ Signature	_____ Date

DEDICATION

This dissertation is dedicated to My Husband, Mr. Babajide Omoniwa; My Son, Oluwaseyi Omoniwa; My Parents Prof. and Mrs. E. Oyedele; My in-laws, Dr. and Mrs M. Omoniwa; and My Siblings.

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ABSTRACT

Government at all levels are forced to prioritise and restrict public expenditures due to budget deficits and the inefficient management of large infrastructure projects. Due to the shortage of resources for healthcare delivery leading to decline in the quality of care, there is considerable interest in PPP initiatives for the provision of finance and management of health care to ordinary people. The PPP option due to its complexities has led to some projects failure leading to wastage of huge resources and time. Studies have shown that majority of these project failures are as a result of public opposition leading to outright cancellation of the projects. Due to the lack of empirical studies on user satisfaction with PPP projects in Nigeria, this study assessed the satisfaction of users of PPP projects from both employees and patients' perspectives of two university teaching hospitals in Nigeria. A total of 580 questionnaires were distributed to Employees and Patients of University College Hospital, Ibadan (Oyo state) and Lagos University Teaching Hospital, Lagos (Lagos state). The data received from these respondents were analysed using both descriptive and inferential statistics with the aid of SPSS to determine their levels of satisfaction with the facilities and services provided. It was observed that the patients were more satisfied with the projects than the employees. The patients rated the staff members the highest implying that they were quite confident in the healthcare providers' reliability and expertise. The employees were most satisfied with the reliability of the facilities in maintaining confidentiality. The study also observed that there is a positive significant relationship between quality parameters and overall satisfaction. The study therefore concluded that necessary improvement adjustments need to be done in all areas of quality performance especially the facilities to increase the satisfaction of the users of these projects.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Endemic budget deficits and the inefficient management of large infrastructure projects and services within the public sector are a few reasons why the traditional procurement method of governments funding infrastructure projects through fiscal budgets is increasingly considered unviable (Alitheia, 2010).

In the past few decades, developed economies (e.g. the United Kingdom) have modelled a variety of public private partnerships (PPPs) for the delivery of infrastructure, public utilities and large services projects, achieving significant successes from harnessing the competences and expertise from both sectors. Emerging markets such as India and South Africa are also recording successes using tried and tested PPP templates to create, expand and modernise infrastructure (Workshop Report, 2008). It is apparent that these dynamic partnerships between the public and private sectors have become inevitable across the globe.

Nigeria's infrastructure challenge is huge. Reports suggest that the country requires between US$12 billion to $15 billion annually for the next six years to meet the infrastructure requirements (Izuwah, 2010). The World Bank estimates that every 1% of (government) funds invested in infrastructure leads to an equivalent 1% increase in gross domestic product (GDP). Nigeria has not had a consistent history of investment in infrastructure; however, government agenda show that infrastructure development is gaining momentum. In the past 10 years, over 25 major infrastructure projects have been rolled out through PPPs. The Federal Government of Nigeria, state and local government

areas (LGAs) have contributed over N10 trillion ($66 billion) to these. However, the total investment required to meet the vision 2020 target for infrastructure projects is N32 trillion ($210 billion) (Izuwah, 2010).It has become evident that the government alone cannot muster the resources (finance and expertise) to meet this need and the involvement of the private sector is not just desirous, but necessary.

Governments at all levels are forced to prioritize and restrict public expenditures to health. Leading to some government (owned and operated) hospitals in dire financial state and having shortage of resources for health care delivery. These include meeting patients' expectations in terms of demand for modern medical facilities; the need to provide care for an aging population; improve quality of care; and also invest in expensive medical technology. Therefore, there has been considerable interest in Public-Private Partnership (PPP) initiatives in the health sector in light of the challenges the public sector is facing in financing, managing and providing health care to ordinary people (Alitheia, 2010; Asoka, 2014; Anyaehie, Nwakoby, Chikwendu, Dim, Uguru, Oluka and Ogugua, 2014).

The concept of Public Private Partnership (PPP) is underpinned by a government's desire to resolve financial constraints by joining forces with the private sector to increase efficiency and effectiveness in the delivery of public services and facilities, whilst ensuring better risk management and increasing certainty of outcomes. PPPs are also often aimed at accelerating economic growth, development and infrastructure delivery; and achieving quality service delivery and good governance (Akintoye, 2006), especially in developing countries.

The structure of PPPs are built around two main types - in one case, the cost of providing the facility/service is borne exclusively by the users of the service and in the other, the

private company invests alongside government to provide a service and the cost of providing the service is wholly or partly carried by the government (Alitheia, 2010).

Overwhelming evidence in the past 50 years of the use of PPP structures indicate that these arrangements are relatively cost efficient, foster best practices for sharing and transfer of risk, assure superior value for money, saves time, streamline contracts and simplifies procurements, facilitates innovation through public-private cohesion, eradicates bureaucratic and political processes, encourages technology transfer and acts as vehicles which adopt life cycle approaches to delivering infrastructure and services (Alitheia, 2010).

PPP is rapidly becoming the preferred method for public procurement for delivering infrastructure projects throughout the world, thus gaining importance as a vehicle to finance much-needed public infrastructure across the globe (Gunnigan and Rajput, 2010), despite the conspicuous absence of systematic evaluations of quality improvement and/or customer satisfaction in the PPP context (Jamali, 2007), thereby leading to a number of unsuccessful projects reported as a result of users dissatisfaction (Levy, 1996; El-Gohary, Osman and El-Diraby, 2006; Gunnigan and Rajput, 2010).

The fierce competition in the wake of globalization is pushing companies to improve continuously in order to stay in the business. It is a very challenging task to meet the ever-increasing and diversified customer (user) requirements. To tackle this challenge effectively and efficiently, the alignment of the business processes with the customer requirements is vital (Jochem, Menrath and Landgraf, 2010).

El-Gohary *et al.* (2006) stated that stakeholders are individuals or organisations that are either affected by or affect the development of the project. Therefore, capturing their

input is a crucial component of the project development process. It is important to gauge stakeholder opinion and concerns to better facilitate the development of a project that will meet the needs of those stakeholders.

Tangkitsiri, Ogunlana, Oyegoke and Oladokun (2013) opined that customer satisfaction begins when the customers' service expectations are met i.e. when the level of service provided by the service provider meets the expectations of the users. The importance of customer satisfaction in a PPP project is based on the assumption that the private sector can be more efficient in service delivery than the public sector. And also, if citizens are now being expected to pay for services they have been delivered free-of-charge in the past; they should have the right to expect better quality services.

In order to measure levels of stakeholders' satisfaction, it is necessary to study the real benefits from existing projects (Tangkitsiri *et al.*, 2013) that is, project monitoring. They further described Project monitoring as a tracking process, comparing actual outcome to predicted outcome, analysing impact, and making appropriate adjustments.

Positive attitudes towards bringing users' ideas into the product development process of design, delivery and after-care can change the whole situation. Innovative approaches such as this can lead to new and more user-friendly forms of products and services which reflect user requirements. Specific requirements of end-users have to be captured in order to achieve a maximum level of customer satisfaction, which ultimately will contribute to the success of the business. Therefore, we need to know who the users are, what their requirements are and how they can be involved in the product development and design process. Various users need to be part of not only the image and vision of the project, but also the physical design, which should reflect the way they work. The new culture,

images and visions need to be fully shared among all the stakeholders during the consultation, rather than only after the implementation (Ozaki and Yoshida, 2007).

El-Gohary *et al.* (2006) opined that PPP infrastructure projects vary in the level of contention that they raise among stakeholders. Moreover, the involvement of the private sector - with its profit-making mindset - usually raises concerns that are not usually likely when the asset is publicly owned (e.g. quality assurance, safety, rate hikes, transfer agreement, etc.).

There are many studies that have been carried out in various aspects of PPP projects both nationally and internationally. Some of these studies have shown that the dissatisfaction of users of some PPP projects have led to the cancellation of some projects which has led to loss of time and resources (Levy, 1996; El-Gohary *et al*., 2006; Gunnigan and Rajput, 2010).

1.2 STATEMENT OF THE PROBLEM

Alienation of actual users of the asset and lack of public support have increased project costs, delayed project completion, and ultimately jeopardized the sustainability of public services. Lack of communication and poor stakeholder management could become deal-breakers: a predominant reason for this is lack of effective communication with the principal stakeholders of the project (Levy, 1996; El-Gohary *et al*., 2006; Asian Development Bank, 2007; Gunnigan and Rajput, 2010). Users are critical to the sustainability of PPP projects they need to communicate their ability and willingness to pay for the service, express priorities for quality and level of service and also identify existing strengths and weaknesses in services provided (Inter-American Development Bank, 2014).

Alrubaiee and Alkaa'ida (2011) recommended that analysis of service quality should enable management to better direct resources to improve hospital operations that will impact on customer perceptions of service quality. They also recommended that the perception of employees on the Hospital and the services need to be evaluated. They speculated that the perceptions of patients might not match the perceptions of employees. They also said that hospitals need to have a commonly held quality model to guide employees in their continuous quality improvement efforts.

However, few studies exist that measures the success of existing PPP projects in Nigeria from the users' perspective. Amissah (2013) reported that studies in the area of customer satisfaction and quality have been carried out mostly in developed countries (King and Cichy, 2006; Faullant and Matzler, 2008; Markovi´c and Raspor, 2010; Alrubaiee and Alkaa'ida, 2011) leaving developing countries such as Ghana and Nigeria with limited empirical studies. Therefore, a key approach to success is to understand the different aspects of service quality and satisfaction and the interactions of these aspects. This study seeks to fill the gap in service quality and user satisfaction knowledge in Nigeria and provide useful information for hospital managers as well as private partners to improve on the PPP projects.

1.3 NEED FOR THE STUDY

In the absence of this study, it is difficult for government agencies and private partners to adequately analyse the success of PPP projects. The dearth of comprehensive studies in the area of users satisfaction with successful PPP projects in Nigeria has affected the development of successful PPP projects due to its capital and risk intensive nature.

PPP hospital projects by their very nature should deliver quality services to their customers. Thereby making patient satisfaction one of the most important indicators because satisfying patients can save hospitals money by reducing the amount of time spent resolving patient complaints (Alrubaiee and Alkaa'ida, 2011) and also avoid cancellation of the project(s) due to their opposition.

To deliver quality services it is important, to first, understand what constitutes this concept. Hence, the study presents a detailed description of factors and measures of quality in PPP healthcare context. The quality of healthcare services is related to patient satisfaction which is an important measure of performance.

Furthermore, the growing population of Nigeria is expected to place greater demands on the country's health care services. Unless healthcare quality is improved through PPP option, the consequences are worrying which can include: preventing patients from quick recovery while increasing their costs, poor quality also prevents the use of local healthcare providers and the patients search for alternatives mainly in other countries that assure better quality of care which renders the aim of a PPP option futile.

"In the face of the constraints faced by the public sector, there is now a huge opportunity for engaging the private sector in a more constructive manner" (Owumi, Adeoti and Taiwo, 2013) in which these university teaching hospitals are currently tapping into. However, due to all the complexities involved in the PPP procurement process it will be cost efficient if the areas of contention or dissatisfaction are known and handled before the agreements are signed. Therefore, from this study, the users will be able to express their opinions concerning their perceptions of the facilities they are working with in other to carry out their services more efficiently, which could then be used as recommendations for policy decisions.

Also, feedback and consultations with the stakeholders will ensure support, client focus, and improved coordination of the project. Therefore, management of these hospitals and their private partners through this study will have a better understanding of the satisfaction level of the users of these facilities and services provided and then know how to make necessary improvement adjustments consequently.

Lastly, with the rate of accelerated growth in private involvement in healthcare, it is necessary that adequate structures are put in place for other teaching hospitals to benefit in this win-win strategy. Hence, the findings of the study can be used in other teaching hospitals and the government as a whole to incorporate PPP sections in their healthcare schemes, to enable them start well and get it right the first time. The study highlights factors that they can incorporate to enable them provide sustainable structures and ensure stakeholders involvement throughout the projects lifecycle in their policy decision making process.

1.4 AIM AND OBJECTIVES

1.4.1 Aim

The aim of this study is to assess user satisfaction with PPP projects in selected University Teaching Hospitals (UTHs).

1.4.2 Objectives

To achieve the aim, the objectives of the study are to:

1. Identify parameters for assessing satisfaction of PPP facilities and services;
2. Assess the level of users' satisfaction with PPP facilities and services in selected UTHs;

3. Evaluate the relationship between quality dimensions and satisfaction.

1.5 SCOPE AND LIMITATION

1.5.1 Scope

The study covered the perception of users' of PPP projects in two government Hospitals situated in Ibadan (Oyo state) and Lagos (Lagos state) using product- and service-quality dimensions for the assessment of the facilities and services rendered. The quality dimensions were used to determine the level of satisfaction of the users of this section of the hospital due to the fact that previous studies carried out in this domain have been conducted successfully.

1.5.2 Delimitation

The study is delimited to University Teaching Hospitals in South-western Nigeria due to the fact that this particular PPP arrangement in healthcare delivery is currently predominant in that region.

1.5.3 Limitation

The study encountered limitations in the responses that were collected. The measurement of customers' expectations is a difficult task and the fact that a customer's short-term and long-term evaluations may differ (Reeves and Bednar, 1994; Karna, 2004). Another limitation of this study is that customers may not know or care about how well the products and/or services conform to internal specifications; customers want their needs and expectations met or even exceeded. So they might have given arbitrary and biased rating which might have affected the results obtained. Consequently, the study asked them few concise questions and asked employees for their professional opinion.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 OVERVIEW OF PPP

The National Council of Public-Private Partnerships of Washington DC (NCPPP, 2008) defined PPP as "a contractual agreement between the public agency (federal, state, or local) and a private sector entity. Through this agreement, the skills and assets of each sector (public and private) are shared in delivering a service or facility for the use of the public. In addition, to the sharing of resources, each part shares in the risks and rewards potential in the delivery of the service and/or facility". Firstly, they stated that it is a contractual agreement. Then they pointed out the tools that the sectors have and use (i.e. skills and assets) in order to achieve the goal(s) and they stated that risks and rewards arising from the delivery of this service and/ or facility is shared between the two parties.

The user of the projects as defined by NCPPP (2008) are not actively involved in the process. Jefferies and McGeorge (2008) defined a PPP consortium as ‘a temporary organization with complex network of stakeholders each with competing goals and objectives'. This definition is more technical and it accommodates all the participants including the users. Therefore, PPP is not restricted to only the public and private partners as defined by Jefferies and McGeorge (2008) .

In general, PPPs are a sort of collaboration to pursue common goals, while leveraging joint resources and capitalizing on the respective competences and strengths of the public and private partners (Widdus, 2001; Pongsiri, 2002; Nijkamp *et al*., 2002; Jamali, 2004 and 2007).

The concept of PPP aims to build mutually agreed and concrete relationships and strategies to obtain collective benefits for all the stake holders (Famakin, Kuma-Agbenyo,

Akinola & Onatunji, 2014). According to Zakari (2001), partnerships could be conceived as a mutual relationship, alliance, cooperation, collaboration or agreements between two or more interested parties, individuals, groups or organizations etc. each with its predetermined areas of interest, competence, expertise, and specialization which is aimed at integrating the parties to achieve common goals and aspirations.

The separation of policy and regulation (which would remain the government's responsibilities) from the provision of services (which would become the responsibility of the private operator) would provide accountability through an arm's-length relationship that was largely missing under public provision (traditional procurement). The gains from reforming poorly performing utilities were expected to be large enough to allow private operators to directly finance the investments that were needed to improve service quality and expand access for the poor (Famakin *et al*., 2014).

2.1.1 Advantages of PPPs

Norment (2004) stated that the PPP option has the following advantages:

i. Maximizes the use of each sector's strength;

ii. Reduces development risk;

iii. Reduces public capital investment;

iv. Mobilizes excess or underutilized assets;

v. Improves efficiencies/quicker completion;

vi. Better environmental compliance;

vii. Improves service to the community;

viii. Improves cost effectiveness;

ix. Shares resources;

x. Shares/allocates risks; and

xi. Mutual rewards.

2.1.2 Considerations for entering into a PPP option

PriceWaterhouseCoopers (PWC) (2005), warned that any public sector authority considering PPPs must understand that there may be situations when they should exercise caution. Once the public sector authority has chosen to use a PPP, there may be significant difficulties to overcome. While there will be some cases where the difficulties and costs will overshadow the perceived benefits of PPPs, there will be other instances when the benefits will outweigh the difficulties indicating that they are not all the same.

According to PWC (2005), there are issues to be considered by the public sector before pursuing a PPP approach, they are as follows:

Does sufficient private sector expertise exist to warrant the PPP approach?

For PPPs to be attractive, the private sector must have the necessary expertise.

Private sector players must be:

I. Able to provide a more efficient and effective service. For example, if there is an incumbent public sector operator, the private sector should have proven additional management skills to realise service improvements and efficiency gains.

II. Sufficiently numerous, with enough potential private sector bidders to allow for

an effective competition.

III. Experienced in pricing life cycle costs in the particular field.

IV. Experienced enough to allow them to manage and absorb the particular risks of the project, country or sector in which the PPP is proposed, thereby reducing the likelihood that large risk factors are included in their prices.

It is important that any public sector authority understands that PPP procurement is only one of several options for procuring infrastructure. Consideration must be given as to whether a project is suited to a PPP structure, and whether there is strong political support for a PPP solution. The principal reason for using PPPs is that, where the project is suitable, they can deliver better value for money than the alternatives. All arguments for and against PPPs must be considered within the context of that overriding objective (PWC, 2005).

2.1.3 Critical success factors as efficiency measures

The concept of critical success factors (CSF) was developed by Rockart and the Sloan School of Management with the phrase first used in the context of information systems and project management. Rowlinson (1999) stated that, critical success factors are those fundamental issues inherent in any project, which must be maintained in order for team working to take place in an efficient and effective manner.

More specifically, the efficiency measures correspond to the strong management and internal organizational structures (adherence to schedule and budget, and basic performance expectation) which means getting the project out on time, on budget and

meeting a quality threshold. On the other hand, the effectiveness measures refer to the achievement of objectives, users' satisfaction and the use of the project.

The above perceptions are also in line with the opinion of Concerdo (1990) who proposed a model of performance measurements in terms of outputs and resources to be measured at different levels. Outputs are measured to determine whether they help to accomplish objectives (effectiveness) and resources are measured to determine whether a minimum amount of resources are used in the production of outputs (efficiency). Given the above, when considering exactly what defines a successful project, it is essential to emphasize both the aspects of project outputs (efficiency) and outcomes (effectiveness).

However, cost, time, quality standard, safety, maintenance and promotion of harmonious relationships among project stakeholders and participants' satisfaction have been widely accepted as the main indices for measuring the overall success of different projects (Zhang, 2004; Abdel Aziz, 2007; Cheung, 2009). Although, Norment (2004) outlined seven Keys to Successful PPPs as:

i. Public Sector Champion: Political leadership must be in place which should include elements such as top administrative officials, leading political figure, a strong policy statement, and they serve as the spokesperson to promote the PPP.

ii. Statutory Environment: There should be a means of identifying creative and innovative approaches, a basis for authority for a PPP contract, and also transparency and open competitive process.

iii. Organized Structure: Dedicated group (tied to the purpose of the partnership), dedicated and trained personnel to monitor implementation, Conducts Request For Interest (RFI), Request For Qualification (RFQ) and/or Request For Proposal

(RFP) processes that is, performance, not design specifications, Best Value vs. Lowest Price that is, may include Value for Money analysis which may be difficult to administer but worthwhile, need for good governance which should include assurance of open and fair procurement process, consolidate staff which will make them easier to monitor and also, independent authority (domestic/internal or international).

iv. Detailed Business Plan: Performance goal oriented- allowing for innovative plans, Best Value vs. Lowest Price, the Plan/Contract should include: Specific milestones and goals, reporting of metrics and frequency, also, risk allocation which if shifted to the private sector can raise costs, identifying best prices to retain and which to shift, Dispute Resolution Methodology and also, workforce development which develops in-country resources and/small businesses.

v. Clearly Defined Revenue Stream: Funds to Cover the Long-Term Financing which could be through tolls/fees (real or shadow), intelligent transportation systems which could include a form of tax district, Long-Term maintenance contracts, availability of payments, underutilized assets, concession model (limited application) and other creative approaches.

vi. Stakeholder Support: They include End Users, Private Sector, Labor Unions, those with competing interests and Public Sector Employees. It requires open and frank discussion between sectors, knowing the FACTS (not myths) and translating each other's language.

vii. Pick Your Partner Carefully: As this is a long-term relationship, the technical capability and experience of the partner(s) need to be verified; also their financial

capability should be checked. Each member's motivation should be put in mind such as genuine need (market value to the project), political / statutory environment, the reasonable return on investment and manageable risks and timely and effective execution vs. development costs.

Norment (2004) also stated that the critical component is strong leadership which makes all the other factors come together.

In Nigeria, the main critical success factors for selecting the appropriate private partner are: favourable legal framework, well-organized public agency to negotiate on behalf of government and strong private consortium (Ibrahim, Price and Dainty, 2006a).

2.1.4 Types of PPPs

There are many different kinds of PPP and approaches to PPP. Robles *et al*. (2009) reported that these different types and approaches are permanently evolving in order to meet the conditions of the projects and specific requirements of the stakeholders, such as size, complexity, funding sources, and finance needs. Variables may include:

i. the degree of involvement of the public authority in the funding and financing of the scheme (such as direct contributions, subventions, shadow tolls, state guarantee, direct tolls, or other forms of direct user fees);
ii. the length and nature of the contract between the public authority and the private PPP contractor (public contract or a concession contract);
iii. risk sharing between the private and public parties;
iv. the tasks included (design, build, finance, operate, maintain, property, transfer);
v. the financial scheme;

vi. a mix of green-field projects and takeover projects.

They stated that there might be problems encountered when breaking down PPP into homogeneous types due to the fact that each specific scheme has a substantial number of particular conditions that make it unique. This categorization is to help decision makers to qualify a particular PPP scheme according to a number of key attributes. In this respect, the variables that are considered more relevant are those referred to in the definition stated earlier, i.e. the share between the public and the private parties in terms of risk, funding, and finance.

However, Ibrahim, Ali and Musa – Haddary (2007) reported that the different types of PPPs include; private finance initiative (PFI), joint venture, privatization and build-operate- transfer (BOT). The BOT type has a number of variants; these variants reflect the participation and varying risk arrangements amongst the stakeholders. The major variants of BOT are Build Own Operate (BOO), Build Transfer Operate (BTO) and Build Lease Transfer (BLT).

Other variants of PPP include: Build-Transfer (BT), Contract-Add-and-Operate (CAO), Develop-Operate-Transfer (DOT), Rehabilitate-Operate-and-Transfer (ROT), Rehabilitate-Own-and-Operate (ROO) (Public Private Partnership Volume One, 2012).

2.1.5 Risks in PPP

One of the primary objectives of PPP is to facilitate the delivery of high quality public facili ties and services by the private sector over an extended period of time at a cost that represents value for money, whilst at the same time transferring an appropriate level of risk to the private sector (Lane and Gardiner, 2003. quoted by Ibrahim, Price and Dainty,

2006b). However, transfer of risk and achievement of value for money need to be balanced appropriately through practical implementation of the basic principles of risk allocation, which assigns risks to the party best able to mitigate and manage it (Ibrahim *et al.*, 2006).

2.1.5.1 Types of Risks in PPP

Generally, there are different types of risk classification obtained from literature. Xenidis and Angelides (2005), classified risk into two types; according to the lifecycle phase that is a risk occurs during the concession period and according to the source or origin of each risk. Another type of risk classification by Elbing and Devapriya (2004) is global (independent of the project) or project risk (Ibrahim *et al*., 2006b).

However, in Nigeria, the risks factors have been classified as either exogenous (risks which are external to the particular project under consideration) or endogenous (risk event and consequences of which occur within the system boundaries of the projects being considered, and includes risks occurring in the relationships between the stakeholders due to the inherent differences between the working practices and strategies of the private and public sectors). This type of classification is to further facilitate a strategic approach to comprehensive management of risks on PPP projects (Ibrahim *et al*., 2006b).

Akerele and Gidado (2003) outlined the common risks in PPP schemes as follows:

I. Availability Risk: This is the risk that the services provided by the private sector party may fall below the standard required by the public sector client. The risk is borne by the private sector company and contract conditions will penalise the private sector provider should a problem occur.

II. Completion Risk: This also includes construction and design risk and generally results in time and/ or cost overruns that will require a substantial increase in capital and/or interest expenses during construction. It may be attributable to weather, labour strikes or late delivery of equipment and supplies.

III. Construction Risk: The PPP will seek to place the construction risk with the bidder. There may be some limitations of risk due to events outside the control of the parties; however, any limitations are likely to be few. Any defects within the construction will need to be rectified by the bidder, an important point for those putting together a team to bid on a project. The contractor within the team will not want defects in the building to impact on the relationship with others in the consortium. Funding banks may require contract monitoring on their behalf to minimise likely problems during the operational phase. Defects will impact negatively on investment value and on the ability of various parties to dispose of their interest in the project.

IV. Technical Risk: : There is a range of technical risks to be factored into bid calculation. While the PPP seeks to encourage innovation, in a technical context there is a bias against the use of new products or procedures if these have not been thoroughly tested. The risk areas are not unrelated to each other and construction and technical specification must work together. A bidder may build to a higher initial standard in the hope of reducing maintenance costs.

V. Revenue Risk: This risk is associated with all the areas in the contract that relate to payment. Payment may be reduced because public sector demand for the services decreases; this is a volume risk. There is also an availability risk, given

the need to make a specified type and amount of accommodation available to certain standard for occupation and use.

VI. Tax Risk: this risks are divided into two groups. The first group comprises tax changes that occur while a project is being developed. Tax risks that occur after project construction or during operation comprise the second grouping. These tax risks are sub-categorised into three areas. The first is the introduction of a new tax or, less likely, the removal of an existing tax. The second relates to changes in tax rate for a particular tax, e.g. the VAT rate on fuel payments being increased. The third area is an action that leads to a tax being paid.

VII. Political Risk: There is always a political risk with a contract that is to last in the region of 30 years such as PPPs. The risk can be minimised, but not eliminated. PFI/PPP projects are being explored in other countries where the political risk may well be different.

VIII. Contract Risk: Unfortunately parties do default on contracts, sometimes deliberately, sometimes through little or no fault of their own. The contract structure will attempt to cover all circumstances and to provide a means by which the agreement operates. There is a risk that these provisions may be called upon. There is a further risk that a different legal interpretation may be put on the contract clause than that which the parties envisaged.

IX. Currency Risk: this is, to a large extent, a part of the construction and operating risk of the project. Currency risk occurs when the revenue or turnover and expenses (operating or interest) of a project are in different denominations. Foreign investors will generally use their primary operating currency in

determining the Internal Rate of Return (IRR) or Net Present Value (NPV) of a project.

X. Technology Risk: This risk refers to the possibility of changes in the technology resulting in the services being provided with sub-optimal technology. This risk is difficult to control. However, when better technology decreases the cost of providing the services, the private sector provider will almost certainly implement such changes (Blackwell, 2000; DOFSA, 2000).

2.1.6 Problems Faced in PPP Project Execution

Ahadzi and Bowles, (2004) identified some of the problems faced in PPP execution as follows;

i. The inability of parties to manage their risk which can be due to inexperience in risk management.
ii. Lack of good financial market.
iii. The delays and associated cost overruns at the bidding stage are severe for both public sector client and private sector bidder.
iv. A factor influencing the tendering process is external environment; the elements include such things as the legal, political, social and technological factors, the organizational strategies and structures and cultures and characteristics of the project itself.

Public clients use private funds and draw in managerial skills and operational efficiencies from the private sector in various types of PPP arrangements.

Several drivers thus help account for the recent proliferation of PPPs, including the desire to improve the performance of the public sector while avoiding fully-fledged

privatization, reducing and stabilizing costs of providing services, and increasing service quality levels (Miller, 2000; Savas, 2000). Two areas in particular are frequently referred to when the benefits of PPPs are discussed, namely improvements in efficiency -usually measured in direct financial terms or productivity and effectiveness -usually indicated by quality (Ancarani and Capaldo, 2001; Dean and Kiu, 2002). But while various studies have tackled the efficiency component, resulting in apparent consensus, effectiveness outcomes in the PPP context remain open to debate (Domberger, 1998; Hodge, 1998; cited in Jamali, 2007). Factors of quality and co-operation have a strong effect on overall satisfaction. Therefore, these factors can be used as a basis for improving overall satisfaction.

2.1.7 Application of Public Private Partnerships (PPP) in Nigeria

In Nigeria, the JV and BOT models are increasingly being implemented at the Federal, State and Local government levels. These project delivery systems are the most commonly used for the provision of public infrastructure in Nigeria. An example of projects procured using BOT method is the operation and management of international conference centre and eagle square (Ibrahim *et al*., 2007).

2.2 PAST EMPIRICAL RESEARCH ON PPPs

Past studies on health and social services PPPs often make use of qualitative methods to include case studies and in-depth probing (European Commission, 2004; Vining, Boardman and Poschmann, 2005; Smith and Wohlstetter, 2006). Many studies focus on government and non-profit organizations at the local level (Gazley, 2008). Smith and

Wohlstetter (2006) developed a typology in order to provide a framework for the on-going study of PPPs and networks in California charter schools. These researchers grouped interview data across four categories:

I. Origin refers to the circumstances under which PPPs are created; and
II. Form is defined according to whether a formal agreement exists for the partnership. Gazley (2008) found a large proportion of government-non-profit collaboration in Georgia operating without a formal agreement;
III. Content pertains to the resources provided by each partner and can be financial, human, informational or managerial; and
IV. Depth which concerns the level of shared governance and is determined through identification of organizational members actively involved in the PPP. Just as Sowa (2008) classified inter-agency collaboration into "shallow collaboration", "medium collaboration", and "deep collaboration," similarly, PPPs can be classified according to the typological criteria outlined above. In other words, resource-sharing, information-sharing, power-sharing and even profit-sharing can be important criteria for PPPs.

Radically different from the leadership in a closed-system, hierarchical structure, some research suggests that PPP leadership requires shared governance, "consensus-oriented decision making" (Ansell and Gash, 2008), "depersonalized leadership techniques" (Page, 2003), and "softguidance" (Agranoff 2007). PPPs, as in network settings, require collaborative leadership. "It is conceivable that the collaborative leader must exhibit behaviours that are substantively different from practices in a hierarchical setting." Such differences relate to teamwork, resources, understanding, stakeholder support, and trust (Silva, 2011).

The empirical literature also suggests that PPPs should emphasize accountability and transparency. PPPs may cause what is called "diffusion of accountability" (Agranoff, 2007). Establishment of performance measures and implementation of performance management in a partnership setting is challenging. As in a network setting, performance evaluation criteria should be made at different levels and for each different partnership program. PPPs present a different set of transparency issues from programs administered by individual governmental and nongovernmental agencies. Information disclosure and audits may not be required for less formal PPPs. On the other hand, parties to contractual PPPs are increasingly expected to have contract management expertise.

In her survey of local governments in Georgia, Gazley (2008) noted that PPPs tended to be concentrated in several service areas including social, health, and human services, public safety, emergency response and economic development. Further, she found a trend toward informal agreements which resulted in "more frequent exchange of information, sharing of volunteers, joint recruitment of staff and volunteers, and non-profit service on a public board." Formal contractual agreements for activities involved government funding, information exchange and equipment which would certainly make sense in terms of compliance with federal accountability regulations. Government agencies overall provided the bulk of financial, material and human resources in almost all PPPs studied; public managers maintained a fairly high level of control within all PPPs. Gazley emphasizes that staff are much more likely to be shared in the context of informal, non-contractual arrangements, a large number of which have been in place for many years and are characterized by many respondents as "longstanding relationships." Indeed, these seemingly institutionalized arrangements range from nine to twenty-four years and are treated as "implied contracts." Gazley's detailed study indicates that factors such as

trust, a certain level of environmental stability, institutional capacity, shared governance and quality of leadership all matter in a collaborative network setting.

2.2.1 An Integrated Framework

Based on the above literature review, it is clear that a more comprehensive framework of PPPs should incorporate the intersectoral network and collaboration perspectives and the findings from the empirical research. To synthesize these different perspectives, apparently one assumption is needed. It is assumed that PPPs are those networks and collaborations that involve both public and private sectors.

A comprehensive model of PPPs should examine the characteristics of PPPs, organizational factors of PPPs, characteristics of individual PPP organizations, key management issues and major complicating factors that bring additional complexity to PPPs. It is clear that characteristics of PPPs include origins and motivations of creating and sustaining PPPs, forms, content, depth, and durability/length of PPPs. Organizational factors include the leadership, governance, and social capital in the PPPs. The characteristics of individual participants in the PPPs, including goals of participating organization's operations and organizational strategies, also matter. Complicating factors for PPPs are types of services provided through PPPs, number of participants and stakeholders, degree of differentiation and integration, and environmental variables. Management issues such as accountability and transparency are constant challenges for PPPs. Additional insights can be gained through borrowing from other fields, including economics, sociology, and organization theory (Xu, Yeung, Chan, Chan, Wang and Ke, 2012).

2.3 QUALITY IN PPPs

Quality as defined by ISO 8402, is the degree of excellence in a competitive sense, such as reliability, serviceability, maintainability and individual characteristics (Ibrahim and Sodangi, 2007). Quality performance (QP) has been divided into two categories: corporate-level and project-level, while the project-level QP is further divided into product and service quality dimensions (Ibrahim and Sodangi, 2007). QP at corporate-level, can be viewed as the quality culture comprising of organizational value system that encourages quality-conscious work environment, establishing and promoting quality and continuous improvement through values, traditions and procedures (Geotsch and Davis, 2000; Ibrahim and Sodangi, 2007).

According to Parasuraman, Zeithaml and Berry (1988), there is the SERVQUAL instrument for measuring customer satisfaction. The SERVQUAL instrument was originally categorised under 5 dimensions which are tangibility, reliability, responsiveness, assurance and empathy further explanations for each category are given below. QP at project-level includes the quality of the constructed facility (product) as well as the quality of the services. Below are the product and services interpretations from literature.

2.3.1 The Product Dimension

The product quality dimensions are enumerated below:

i. Performance - is the basic function of the facility to which it meets the end-user's needs and intents;

ii. Features - they are the characteristics that supplement the basic functions of the facility;

iii. Reliability - it is the level of confidence with which the end-user may use the facility, to the end of its design life, without failure;

iv. Conformance - it is the degree to which construction operations meet the design standards and specifications;

v. Durability - the amount of use end-users get from the facility before replacement is preferred to continued use;

vi. Serviceability - speed, courtesy, competence, with which maintenance on facility can be carried out;

vii. Aesthetics - the level of satisfaction the end-user experiences with the facility's look, feel, sound, taste or smell; and

viii. Perceived quality - the level of satisfaction the end-user experiences with the facility's image and publicity (Gavin, 1988).

2.3.2 The Services dimension

They include:

i. Time - the duration of the contract, including the wait for mobilization on site;

ii. Timeliness - completion of the contract on the scheduled date;

iii. Completeness - the amount of items on the punchlist upon completion of the project;

iv. Courtesy - the degree of respect, politeness, friendliness and kindness of the site and other personnel;

v. Consistency - the ability to repetitively provide the same level of service to all clients;

vi. Accessibility and convenience - the ease with which the contracting service is obtained;

vii. Accuracy - the ability to provide the right service the first time with minimum amount of work;

viii. Responsiveness - the ability to react to the unexpected problems encountered during the contract. Willingness and readiness to provide prompt service;

ix. Reliability - ability to perform the promised service dependably and accurately;

x. Communication - keeping customers informed in a language they can understand and listening to the customer when necessary;

xi. Credibility - honesty, trustworthiness;

xii. Security - physical, financial and confidentiality;

xiii. Competence - possession of required skills and knowledge of all employees;

xiv. Tangibles - the physical facilities and equipment, and appearances of employees;

xv. Understanding - the ability to comprehend the client's needs and requirements;

xvi. Assurance - knowledge and courtesy of employees and their ability to inspire trust and confidence;

xvii. Empathy - the degree of caring, individualized attention the firm provides its customers; and

xviii. Recovery - the ability to regain momentum and improve after each project completion (Parasuraman, Zeithaml and Berry, 1985; Parasuraman *et al*., 1988; Gronroos, 1988; Evans and Lindsay, 2005; Ibrahim and Sodangi, 2007; Delgado and Aspinwall, 2008).

Yasamis, Arditi and Mohammadi (2002) described quality in construction as quality of both design and level of conformance to design. He further described performance as requiring the following:

i. a combination of criteria (not a single measurement),

ii. a level of analysis (such as end-users, employees, etc.),

iii. a certain focus (kind of performance desired),

iv. a time frame (short or long range), and

v. a measurement system (quantitative versus qualitative, objective versus subjective) (Szilagyi, 1988 cited by Yasamis *et al*., 2002).

2.4 QUALITY PERFORMANCE IN RELATION TO CUSTOMER/USER SATISFACTION

Generally, quality can be viewed from two approaches: conformance to requirements and customer satisfaction. In terms of conformance to requirements, quality refers to how well the constructed facility conforms to design specifications. This is the contractors'

view of the definition of quality. On the other hand, the customer satisfaction approach defines quality as the extent to which a product or service meets and/or exceeds a customer's expectations. The strength of this approach is that it captures what is important for the customers rather than establishes standards based on management judgments that may or may not be accurate (Karna, 2004). Torbica and Stroh (2001) however opined that, it is possible to have dissatisfied, or at least not satisfied, customers even though explicit time, cost, and performance criteria have been met. From their study, it was found that service is the most important component for overall satisfaction and is also the area the providers performed the poorest. They are of the opinion that services deserve the most attention and positively influence customer satisfaction.

Customer satisfaction thus approaches quality from a customer's point of view, that is, the customer defines quality (Beatty, Richmond, Tepper and DeJong, 1998; Dansky and Miles, 1997; Braunsberger and Gates, 2002). Customer satisfaction can be used for the evaluation of quality and ultimately for assessment of the success of a company's quality improvement programme (Karna, 2004). According to Torbica and Stroh (2001), a quality improvement effort will lead to a higher product and service quality, which will lead to improved customer satisfaction.

In order for clients and end-users of completed facilities to realize the best value, the concept of quality culture must be stressed in the industry to improve the QP offered by various organizations (Ibrahim and Sodangi, 2007). Yasamis *et al.* (2002) said there is the assumption that the product quality dimensions are mostly associated with the end-user, whereas the owner is the most direct recipient of all service quality processes. In some cases the owner and the end-user are the same entity. When they are not, the

product and service quality dimensions reflect the perceptions of the party that most directly experiences the product or the service associated with the construction process.

Performance objective states the performance levels that the stakeholders expect the PPP project to achieve. It can assist the public sector to establish a clear relationship with the private sector, facilitate the private sector to develop an innovative PPP method, and make both adhere to the PPP project's budget, programme planning and performance measures (Yuan, Skibniewski, Li and Zheng, 2009).

A model produced by Alrubaiee and Alkaa'ida (2011) indicating the relationship between quality dimensions, patients satisfaction and patients trust is a good example to buttress the point that customer satisfaction is very much related to quality. The authors looked at the mediating effect of patient satisfaction in the patients' perceptions of healthcare quality – patient trust relationship. They verified that there is indeed a direct, positive relationship between quality performance and patients satisfaction and patient trust. Below is the model indicating the relationships.

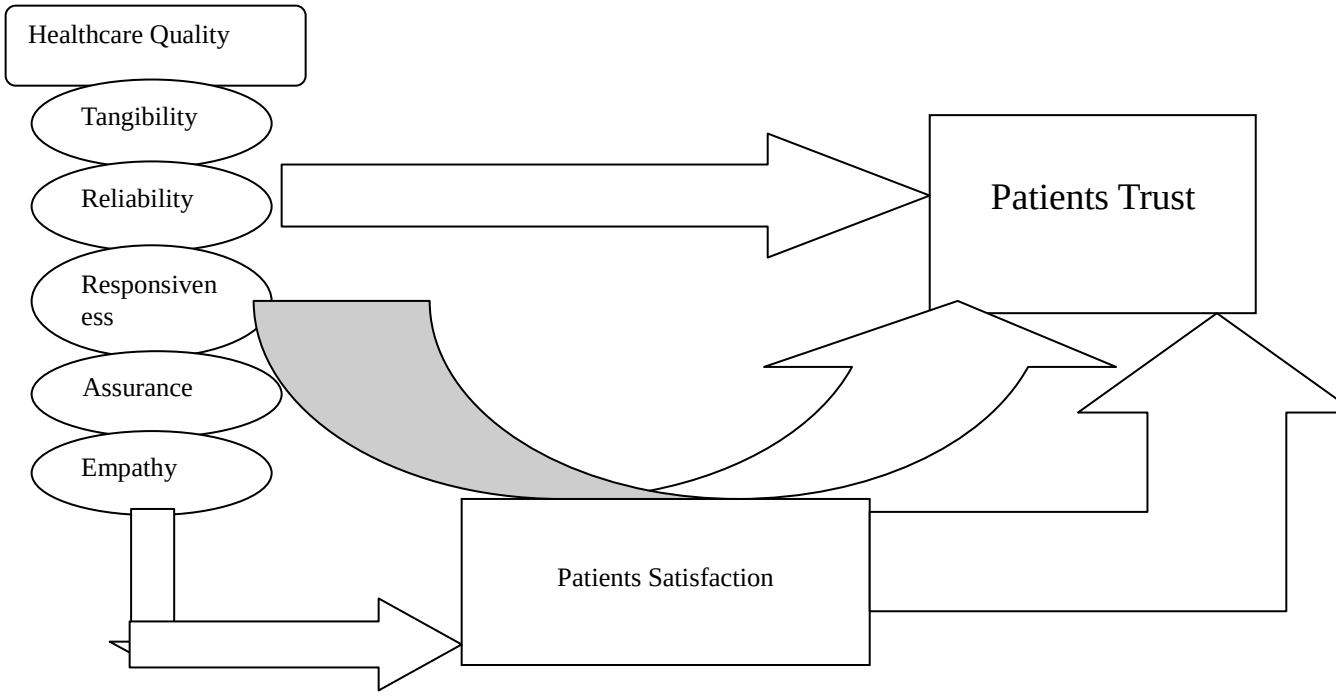


Figure 2.1: The Path Model of Patients' Perception of Healthcare Quality, Patients' Satisfaction and Patients' Trust.

Source: Alrubaiee and Alkaa'ida (2011).

The above model incorporates a factor not explicitly highlighted in this study which is *Patient Trust.* The researchers viewed it as the patients being able to check the process of healthcare delivered to them even when honest mistakes (which are possible), are spotted and corrected, they continue to trust even if harmed. This term in other domains can be viewed as customer loyalty, however, in this study, it is inferred that a patient should continue to use these facilities and services only if it trusts the service providers.

This model is cited in this study due to its relevance to the study. It is a study that was carried out in a hospital environment similar to this study, it was carried out on patients and also, the study has both quality dimensions and Patient satisfaction as variables for the study. Although the above model is holistic in its domain, it is quite inadequate to be adopted for this study as it is, this is due to the fact that the hospital used for the study

was owned by the public sector while this study is looking at the PPP project within a government hospital and the employees assessment of the quality of the facility(s) they used were not evaluated. Therefore, this study has identified other quality dimension that will be better suited for a PPP project type due to its peculiar trait of multiple stakeholders. Also, as recommended by the above researchers, the employees were included in this study not only to assess the facility(s) but to do so in relation to how it enables them carry out their work better.

2.5 QUALITY PERFORMANCE IN PPP HEALTHCARE DELIVERY

Patients' quality perceptions have been shown to account for 17-27 percent of variation in a hospital's financial measures such as earnings, net revenue and asset returns. There is evidence that several constructs make up the overall care quality and satisfaction model. Researchers have called for empirical cross-cultural studies of healthcare quality and patient satisfaction (Badri, Attia and Ustadi, 2008; Alrubaiee and Alkaa'ida, 2011).

According to Braunsberger and Gates (2002), the quality of healthcare traditionally has been defined from the provider's point of view (Berwick, 1997; Kramer, 1997) due to the fact that healthcare professionals felt that patients lack the required knowledge to evaluate care intelligently. In recent times, the focus has shifted to patients' perspective of care delivery due to rapidly changing competitive market and increasingly sophisticated patients/customers demanding more focus on their needs and wants (Decker, 1999). However, Eiriz and Figueiredo (2005) opined that health care services quality should not be evaluated exclusively by customers, due to the complexity, ambiguity and heterogeneity of health care services. They consequently developed a

framework for health care evaluation based on the relationship between customers (patients, their relatives and citizens) and providers (managers, doctors, other technical staff and non-technical staff). It is also the conclusion of Terry and Israel (2005) that customer satisfaction is influenced by employees' performance.

Lee (2011) asserted that the healthcare industry has undergone changes in healthcare service deliveries in the last two decades due to higher service expectations from patients, ever-advancing technology, greater access to health information through the internet and the digital media, and a holistic approach to health and well-being concerns as identified by Francis (2010). The Institute of Medicine (IOM) established six aims for improving healthcare quality, they are: Safe- avoiding injuries to patients from the care that is intended to help them; Effective - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit; Patient-centered - providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions; Timely - reducing waits and sometimes harmful delays for both those who receive and those who give care; Efficient - avoiding waste, including waste of equipment, supplies, ideas, and energy; Equitable - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographical location, and socioeconomic status (IOM, 2001). They are of the view that a health care system that achieves major gains in these six areas would be far better at meeting patients' needs. Also, health workers would benefit through their increased satisfaction at being better able to do their jobs and thereby improve health, greater longevity, less pain and suffering, and increased personal productivity to those who receive their care (IOM, 2001).

Eiriz and Figueiredu (2005) opined that patient's expectations and priorities vary among countries and are highly related to cultural background and to the healthcare system. Furrer, Liu and Sudharshan (2000) indicated that weak customers in large power distance cultures placed less importance on reliability, empathy and responsiveness. Alrubaiee and Alkaa'ida (2011) highlighted studies that indicated that customers in different countries evaluate good service in different ways - differences in service quality perceptions between customers - and therefore, measures and scales developed in one culture may not always work as well in other cultures. The studies further noted that due to differences in response styles and interpretation of items, not all measures of service quality and satisfaction are equivalent across cultures. Therefore, countries and cultures must evaluate service quality perceptions before adopting other countries or cultures systems.

2.6 CUSTOMER/USER SATISFACTION

Kamara (2000) describes the 'customer' as a body that incorporates the interests of the buyer of construction services, prospective users and other interest groups (Karna, 2004).

El-Gohary *et al*. (2006) defined a stakeholder as "any person or organization that has a legitimate interest in a project". They further described an impacted stakeholder as "an organization or individual who is directly or indirectly affected by the development process; and can be classified into three main sub-domains: residents, users and owners". Customer satisfaction is a function of perceived quality and disconfirmation - the extent to which perceived quality fails to match repurchase expectations (Karna, 2004).

Some researchers defined a satisfied customer as "one who receives significant added value" to his/her bottom line. Customer satisfaction differs depending on the situation and the product or service (Oliver, 2010; Tangkitsiri *et al.*, 2013). Customers compare the perceived performance of a product (service, goods) with some performance standard. Customers are satisfied when the perceived performance is greater than the standard (positively disconfirmed), whereas dissatisfaction occurs when the performance falls short of the standard (negatively disconfirmed) (Ozaki, 2003; Karna, 2004; Tangkitsiri *et al.*, 2013).

Definitions of satisfaction view satisfaction as a post-consumption evaluation containing both cognitive and affective elements, distinguishing for example between "satisfaction as contentment", "satisfaction as pleasure", and "satisfaction as relief" on the basis of level of reinforcement and arousal (Oliver, 1989; Jamali, 2007).

According to Karna (2004), understanding the customer's requirements is essential in ensuring customer satisfaction, and the demand for the construction product must be viewed in relation to the intended use of the facility. However, Partnerships UK (2006) highlighted that though user satisfaction is relevant in the determination of service performance, it can be problematic especially in areas involving multiple layers of users such as hospitals. They cited an example of a hospital manager who observed that more complaints received were from the hospital staff than from patients, but then they felt that faults should be prevented or rectified before they affect the end user.

Alrubaiee and Alkaa'ida (2011) are of the opinion that satisfied customers are likely to exhibit favorable behavioral intentions, which are beneficial to the healthcare provider's long-term success. Measuring the degree of patient satisfaction can help facilitate

hospital service provision and management, as well as increase and maintain the quality of the service provision.

2.6.1 Effect of socio-demographic characteristics

Socio-demographic variables such as: age; gender; occupation; period of using the facility; years of practice, and so on have varying effects on satisfaction. Results, however, are inconsistent and sometimes contradictory, other than the finding that older patients consistently tend to report higher levels of satisfaction than do younger ones (Calnan, Katsouyiannopoulos, Ovcharov, Prokhorshas, Ramic and Williams, 1994; Braunsberger and Gates, 2002). Nguyen, Briancon, Empereur and Guillemin (2002) found that men tended to be more satisfied than women (Braunsberger and Gates, 2002) and women tended to complain more often than men do. Priporas, Laspa and Kamenidou (2008) found that males and young patients tend to rate satisfaction a little higher than females and older patients which is contrary to the reports of the previous studies. Tucker (2002) found significance of patient's demographic variables in moderating their satisfaction. Consistent with previous studies, patient age was found to be the most frequent predictor of satisfaction of all the socio-demographic factors considered (Calnan *et al*., 1994). Older patients tend to be higher in rank, more educated, and married. Individual factors positively associated with patient satisfaction are health status and education.

Younger, less educated, lower ranking, poorer health and high-service use were associated with lower satisfaction. Angelopoulou, Kangis and Babis (1998) found that patients in private hospitals were more satisfied than patients in public hospitals. On the contrary, Jabnoun and Chaker, (2003) found that public hospitals have higher overall healthcare quality than private hospitals. Another study found that the patient's health

quality assessment appeared to change with the introduction of patient's socio-demographic characteristics. Buttle (1996) found that gender and age significantly predicted patients' quality perceptions, but on only one dimension – facilities. Females valued the facilities more than males. Perceived facility-related quality was found to be better for older than younger respondents (cited in Alrubaiee and Alkaa'ida, 2011).

Tucker and Adams (2001) produced an integrative patient evaluation model showing how caring, empathy, reliability, responsiveness, access, communication and outcome dimensions predict satisfaction and quality as moderated by the patients' socio-demographic characteristics. Conway and Willcocks' (1997) integrated model applies service quality to healthcare settings. It incorporates influencing factors such as patient personality and socio-economic factors with measurement issues (i.e. reliability, responsiveness, and so on). A study in Ohio, reported better patient assessments in nonteaching hospitals and in hospitals with fewer beds, fewer deliveries and fewer caesarean deliveries (Janssen *et al*., 2000). Despite the extensive validity and reliability tests that were conducted in Badri *et al*. (2008) study, it was recommended that such tests should be repeated in different countries to ensure their validity and reliability and also could be used to compare the performance of public against private hospitals (Alrubaiee and Alkaa'ida, 2011).

2.7 USER SATISFACTION IN PPP PROJECTS

Various problems have been encountered on PPP initiatives around the world that have eventually led to project failure. Public opposition from civil societies, local media, and other stakeholders (Gunigan and Rajput, 2010) due to various factors has been reported

as the main reason for failure in several instances. PPP projects both before and after the concession award have reportedly been cancelled due to stakeholder opposition. Alienation of actual users of the asset (Gunigan and Rajput, 2010), lack of adequate awareness of the concept of PPP and lack of public support (Anyaehie *et al.*, 2014) have increased project costs, delayed project completion, and ultimately jeopardized the sustainability of public services (El-Gohary *et al.*, 2006). Lack of effective communication with the principal stakeholders of the project is a crucial gap towards success (Gunigan and Rajput, 2010).

2.7.1 User Involvement

There are difficulties in meeting user demands especially when there are so many users with diversified and sometimes conflicting requirements (Ozaki and Yoshida, 2007). Therefore, one important question in construction projects is how to reflect user requirements in the planning and production of the actual physical buildings. In order to produce a building on users' terms, the product must have a certain degree of flexibility to meet individual aptitudes and interests. This can be achieved by increasing customer choices in design and increasing user involvement in the decision-making process (Yasamis *et al*., 2002).

El-Gohary *et al*. (2006) affirms that a positive involvement with stakeholders can be a decisive factor that can ‘make or break' a project and that understanding the concepts that underlie Stakeholder involvement in infrastructure projects is an essential step towards creating a strong involvement programme that will help project proponents and stakeholders to communicate effectively. From ADB (2007) the stakeholders include: the

political decision makers; the company management and staff; the consumers; investors; and strategic consultants.

Political decision makers: Establish and prioritize goals and objectives of PPP and communicate these to the public, they approve decision criteria for selecting preferred PPP option, and also approve recommended PPP option, approve regulatory and legal frameworks.

Company management: Identify company-specific needs and goals of PPP and staff, they provide company-specific data, assist in marketing and due diligence process and also implement change.

Consumers: Communicate ability and willingness to pay for service, express priorities for quality and level of service, identify existing strengths and weaknesses in service.

Investors: Provide feedback on attractiveness of various PPP options, they follow rules and procedures of competitive bidding process, perform thorough due diligence resulting in competitive and realistic bidding.

Strategic consultants: Provide unbiased evaluation of options for PPP, review existing framework and propose reforms, act as facilitator for cooperation among stakeholders.

Another classification of stakeholders according to NPPPP (2009) is: the government, the private sector and non-state actors which include: financial institutions, academic institutions, non-governmental organizations (NGOs), community based organizations (CBOs), faith based organizations (FBOs), employees, trade unions, environmentalists, political leaders, community groups, sector interest groups and the general public. Whereas, Cheung (2009) summarizes the key parties involved in PPP projects as: the

government/public sector, the consortium/private sector, the employees of the project and the users of the facility or service. The above categorization suits this research more due to the fact that it distinguishes the employees from the users (that is, customers/patients).

Therefore, Hashimoto (2009) describes interaction of stakeholder interests as a loop; that is, conflicts among parties enhance cost schedule inefficiencies, more cost schedule inefficiencies leads to less user satisfaction, less user satisfaction leads to more revenue risk of the private partner and more revenue risk of the private partner leads to more conflicts among parties.

Therefore, we need to know who the users are, what their requirements are and how they can be involved in the product development and design process for different project types.

For quality improvements to be effective and long lasting, they need to be supported by all parties involved in all the processes. Hence, it is critical for owners to make sure that their and the end-users' expectations are well represented in contractor evaluation and selection systems (Yasamis *et al*., 2002).

The Public-Private Advisory Group on PPPs (2001) stated steps that should be taken in stakeholder consultation. They include:

i. Stakeholders include employees and their trade unions, the public, the people who will use the assets and services provided, local community groups and sectorial interest groups. In selecting, developing and implementing PPP projects, the economic, social and environmental concerns of those directly affected at local level should be taken into account along with the statutory rights

and legitimate economic interests of stakeholders in line with the stated recommendations.

ii. Existing structures and agreements should be used to ensure extensive consultation and open communication in respect of PPP projects. Public service employees should be informed at the earliest possible stage of proposals for the introduction of PPPs and of significant developments throughout the process. They should also have the opportunity to contribute positively to the development of projects, building on progress in the development of workplace partnerships under the PPP. The partnership approach should be maintained throughout the project's lifetime.

iii. All parties to a PPP arrangement should have regard to appropriate industry norms in terms of pay and conditions and of prevailing national and/or industry-wide agreements including health and safety regulations. Such an approach should be consistent with protections provided under the Transfer of Undertakings (Protection of Employees) Regulations and the Acquired Rights Directive. PPPs should be approached on the basis that no less favourable terms than the Transfer of Undertaking Regulations apply.

2.8 PPP IN HEALTHCARE DELIVERY IN NIGERIA

The Nigerian Medical Association (NMA) stated that the aggregate performance of the nation's health sector in 2013 was not remarkably different from that of 2012 despite some efforts made to address the challenges carried over from 2012. They attributed the

poor performance to the unsatisfactory amount allocated to the health sector in the 2013 National budget and also the slow process of release of funds (Enabulele, 2013).

There has been considerable interest in private sector participation in health care delivery in Nigeria as a result of the challenges faced by the government in providing qualitative health care to the people (Owumi *et al.*, 2013). Presently, the private sector is involved in all aspects of healthcare delivery from hospital-based services, ambulatory care, diagnostic centres, laboratories, retail pharmacies, and to ancillary services as well (Owumi *et al*., 2013) and they are preferred because of responsiveness to consumer preferences and accessibility (Anyaehie *et al*., 2014).

Meanwhile, the public sector is still struggling with the backlog of unmet health needs for the control of infectious diseases, malnutrition and other poverty-related diseases; it is continuously saddled with a growing threat of non-communicable diseases such as diabetes, high blood pressure and cancer (Akinkugbe, 1992; Ajayi, and Adebamowo, 1999, Ezzati, Vander Hoorn, Lawes, Leach and James, 2005). Therefore, the private sector appears to be the main source of health care for majority of the population including the poor (Ogungbekun, Ogungbekun and Orobaton, 1999; Owumi *et al*., 2013). Leading to a large proportion of citizens' income spent on health services in the private sector with variable levels of quality (Soyibo, 2004). These have resulted in the outcry for government at all levels to consider partnership with private sector for the provision of the much needed healthcare services (Adirieje, 2013; Uduaghan, 2014).

Akinci and Sinay (2003) opined that with increasing competition in the local and regional healthcare markets, and growing interest in assessing the effectiveness of services and patient outcomes, satisfaction measures are becoming prominent in

evaluating the performance of healthcare system. While Olakunde (2012) stated that in Nigeria, achieving the objectives of good health outcome, equity, patients and providers' satisfaction is very challenging.

In terms of stakeholder participation, it is important for the project sponsors to disseminate information among the various stakeholder groups about the virtues of partnership options and convince them about the benefits that would accrue to them. Feedback and consultations with the stakeholders will ensure support, client focus, and improved coordination of the project. It is also observed that the degree to which the formation and stewardship of the rules is undertaken without harming or causing grievance to people will populate decency. It will also provide transparency within the PPP process with a degree of clarity and openness with which decisions are made leading to accountability to which political actors are responsible to society for what they say and do (Gunnigan and Rajput, 2010).

Therefore, partnership with the private sector, when properly structured and executed can lead to increasing the resources available to the health sector as well as expand the delivery of vital services to targeted populations and underserved areas. This is in addition to making effective use of the private sector's expertise and comparable advantage in undertaking certain organizational functions such as marketing, communications, enhancement of service quality and a potential to attract and retain better performing staff. In the past, government ministries of health paid little or no attention to the private sector; the approach to the private sector has rarely gone beyond enacting legislations and issuing regulations that were usually not enforced (Soyibo, 2004).

There are several PPP projects already completed or are currently in progress in developing countries (Ofori, 2007), some PPP initiatives domiciled in public health institutions are on-going in Nigeria, such as the Lagos State University Teaching Hospital (Anyaehie *et al.*, 2014) and University College Hospital, Ibadan. Other projects have just been signed or are currently in the procurement stage such as a separate Dialysis Unit in the Delta State University Teaching Hospital, Oghara (Frontiersnews, 2014) and the Ekiti State Teaching Hospital PPP Diagnostic Centre was at tender stage in February, 2014 (InfraPPP, 2014).

2.9 SUMMARY OF PPP PROJECTS FOR THE STUDY

The PPP projects that were used for the study are the University College Hospital, Ibadan; and Lagos University Teaching Hospital, Lagos. The facilities provided are of different types, some of the structures are newly constructed while some are remodelled to suit the healthcare intention. The facilities provided are outlined below.

2.9.1 University Teaching Hospital (UCH), Ibadan (Project 1)

The PPP facilities include:

- Stress Eco Suite;
- Endoscopy Suite;
- Cardiac theatre;
- Cardiac Intensive Care Unit (ICU); and
- Computerized Axial Tomography (CAT) laboratory.

2.9.2 Lagos University Teaching Hospital (LUTH), Lagos (Project 2)

The PPP sections include:

- Magnetic Resonance Imaging (MRI) Suite,
- PATHCARE Laboratory,
- Marvina Neuro Diagnostic Centre,
- LUTH Guest House.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 RESEARCH APPROACH

Research approach as defined by Creswell (2003) are the plans and procedures for research that span the steps from broad assumptions to detailed methods of data collection, analysis, and interpretation. Creswell (2003) further stated that the selection of a research approach can be based on the nature of the research problem or issue being addressed, and then categorized the approaches to research into three which are: Quantitative, Qualitative and Mixed methods. Creswell, (2003) also described the relationship between the approaches as a continuum with qualitative approach at one end and quantitative on the other end thereby having the mixed method in the middle of the continuum.

The study began with literature review to develop a good theoretical background on PPPs, user satisfaction, quality performance, user involvement, healthcare delivery and relationships between them.

The quantitative approach which makes use of closed-ended questions, numerical expressions and statistical tools to analyse data was used for the study. This approach is used for examining the relationships among variables, measuring such variables on instruments and analysing them using statistical procedures (Creswell, 2003). The study assessed the satisfaction of the users of the facilities provided for healthcare under a PPP arrangement in University teaching hospitals of University of Ibadan, in Oyo state and University of Lagos, Lagos state using the survey (questionnaire) method. According to Creswell (2003), "a survey is a quantitative or numeric description of some fraction of

the population - the sample, which enables researchers to generalize their findings from a sample of respondents to a population within the limitations of the sampling method".

3.2. THE STUDY POPULATION

To ensure adequate and reliable data collected, the sample is required to be homogenous and comprehensive and should give a true representation of the population. Therefore, the target populations of this study were the employees (medical and non-medical staff) and patients of the two teaching hospitals in south western Nigeria. The medical staff comprise of doctors, pharmacists, laboratory staff and nurses. The non-medical staff comprise of administrative and other support staff all referred to as administrative staff. The patients considered in the study were those conversant with the projects (i.e. the structures and services rendered) at the time of conducting the research. The employees should be able to assess the facilities from a professional point of view. In other words, how satisfied are they as professionals in delivering their services using the facilities provided? Also, patients should be able to assess the structures and the services they receive in the facilities in line with their expectation(s).

3.2.1 University Teaching Hospital (UCH), Ibadan (Project 1)

The University College Hospital, (UCH) Ibadan was established by an act of parliament in November 1952 in response to the need for the training of medical personnel and other healthcare professionals for the country and the West African Sub-Region. The establishment of the Hospital was sequel to a Visitation Panel in 1951 to assess the clinical facilities for the clinical postings of medical students registered for M.B.B.S.

degree of the University of London. The visitation panel, led by Dr T. F. Hunt of the University of London rejected the enhanced facilities provided by the Government/Native Authority Hospital at Adeoyo, Ibadan following the establishment of a Faculty of Medicine in the University College, Ibadan (now University of Ibadan) in 1948.

3.2.2 Lagos University Teaching Hospital (LUTH), Lagos (Project 2)

LUTH and the Medical School Complex grew out of a Cabinet decision of April, 1961 when the Council of Ministers set up a Cabinet Committee to consider the recommendations of Sir Eric Ashby's Commission on Post-Secondary Education in Nigeria. Two of the many recommendations of the Committee approved by the Council of Ministers were:-

- The effective and rapid re-organization of hospitals in Lagos, Surulere, Ibadan, Kaduna and Enugu for teaching clinical medicine;

- The establishment of a full-fledged Medical School in Lagos as soon as possible to make use of the existing medical institutions.

The objective was to train at least 100 Doctors annually in Medical Schools in Nigeria from 1975 onwards. The Cabinet reshuffle of June that year saw two of those who served on the Committee being appointed to implement these decisions. These were Senator (Dr.) M.A. Majekodunmi, Minister of Health and Mr. C. O. Lawson, Permanent Secretary, Ministry of Health.

3.3 SAMPLING

Cochran (1963) said that there are two broad types of sampling, they are probability sampling (representative samples) and non-probability sampling (non-representative samples). Sampling can be defined as a representative picture of the population without studying the entire population. For the sample frame of the study, the convenience sampling method was used. A convenience sample is a study of subjects taken from a group that is conveniently accessible to a researcher (Molenberghs, 2011). This method was used in order to further separate the required employees (those in the PPP sections) for the study from the general employee (all workers in the UTHs) population and also the required patients. Therefore, the survey was carried out within and around the PPP facilities, the advantage of this method is that it was easy to access the required respondents with little effort and time. Which can be viewed as a disadvantage for other studies considering this method due to the fact that it is not an accurate representation of the entire population, thereby skewing the results quite radically.

In the collection of data for patients, the purposive sampling technique was further used. Purposive sampling is also known as judgmental**,** selective or subjective sampling and is a type of non-probability sampling technique**.** Non-probability sampling focuses on sampling techniques where the units that are investigated are based on the judgment of the researcher (Molenberghs, 2011).

This method was chosen to increase precision and to ensure that the respondents are only those who have utilized the PPP facilities for a period of time and not random first timers. The reason for this categorization is because the study requires the information from those who are quite conversant with the facilities to provide valid assessment and not arbitrary responses.

Sample size is the number of units in the sample (Molenberghs, 2011). Evborokhi (2003) cited by Dandajeh (2011) stated that three factors determine the size of an adequate sample: the nature of the population, type of investigation and degree of precision desired. These factors were considered in the choice of the sample size. The circumstance of the study should determine what number or what percentage of the population is ideal for sample size (Nwana, 1999). Also, Borg (2000) recommended that a minimum of 20% of a population that is under 1,000 subjects; 10% of a population that is up to 5,000 and 5% of a population that is up to 10,000 and above. Also, Mendenhall, Reinmuth and Beaver (1993) and Leedy (1997) asserted that 'a minimum sample size of 30 is considered sufficient to provide an effective normal approximation as a general rule of thumb, regardless of the shape of the population frequency distribution'. Therefore, the sample size of 580 respondents was drawn as shown in Table 3.2. The population of the various users are as shown in Table 3.1.

Table 3.1 Sampling Frame of Employees in the Hospitals.

Hospitals	**Doctors**	**Pharmacists**	**Nurses**	**Lab Staff**	**Admin Staff**	**Patients**
UCH	32	24	75	110	106	1961
LUTH	45	20	65	86	87	1214
Total	**77**	**44**	**140**	**196**	**193**	**3175**

From the Table 3.1, 40% (medical and non-medical staff) and 10% (patients) of the population was used as recommended by Borg (2000) and the selected numbers from each hospital are shown in Table 3.2. Note that the admin staff in Table 3.1 are all the non-medical workers. Also, the patient population in Table 3.1 was determined based on

the registered patients collected daily during working hours (8am – 4pm) over a period of five days (Monday-Friday) of each hospital.

Table 3.2 Summary of Sample Distribution According to the Hospitals.

Hospitals	**Medical Staff (40%)**	**Non-Medical Staff (40%)**	**Patients (10%)**
UCH	96	42	196
LUTH	86	35	121
Total	**182**	**77**	**317**

3.4 INSTRUMENT FOR DATA COLLECTION

There are several research instruments which include case studies, content analysis, evaluation research, interviewing, surveys and a host of others. The questionnaire adopted for the study was obtained majorly from two research works; Parasuraman *et al*., (1985); and Gavin, (1988) others include; Johnson (1995); Qin *et al*., (2010); Cappelli, Guglielmetti, Mattia, Merli and Renzi, (2010); Hoxley (2000); and Yuan *et al.* (2010). The questionnaire was customized to focus on user satisfaction with product- and service-quality dimensions of the two projects considered.

3.4.1 Questionnaire Design

The questionnaire started with a brief summary of the purpose of the survey, the importance of responding and the fact that data of individual respondents would be kept confidential. It was divided into two types and both divided into three sections. The two

types are: members of staff, that is, those using the facilities and providing the services and patients experiencing both. The first section categorized the respondents' demography that is, in terms of age, gender, occupation, and so forth. While the second section focused on the assessment of customer satisfaction based on product and service quality dimensions and the third section provided an avenue for the respondents to express themselves freely concerning any aspect within the research area. For the questionnaires, a total of 21 questions were in the second section for the patients and 28 questions for employees comprising all close-ended questions. They all were derived from literature but customized and simplified for this study. The questions were used to assess the quality performance of the facilities in the respondents' hospital unit and also the services provided by rating their satisfaction levels on a five-point Likert scale.

Simple questions were formulated to tackle each dimension in view of the need for quick understanding of the questions asked and to capture their satisfaction levels as accurately as possible.

The Questionnaires were administered to the users as they utilised the facility. Service delivery was not disrupted for questionnaire administration purposes, and data gathering did not influence user evaluations.

The study used Likert style rating, using a five-point scale to elicit respondents' opinions of their agreement to each nominated variable. The scale intervals are interpreted as follows: Excellent = 5; Very good = 4; Good = 3; Fair = 2; Poor = 1 (Amissah, 2013).

The questionnaires were administered to members of staff and patients using the facilities, the members of staff include: Doctors; Pharmacists; Nurses; medical laboratory scientists; Laboratory Attendants; administrative staff, maintenance department staff

members as well as other relevant staff members using the facilities were included in the survey. The inclusion criteria was that respondents must have used/be using the facility for some time. This is to obtain a good assessment of these facilities and discourage arbitrary or biased evaluations.

From data collected, Statistical Package for Social Sciences (SPSS) analytical tool was employed to analyse individual responses on the indicators for evaluating the users' satisfaction. This was used to assess the quality of the facilities provided by and for PPP projects in the selected UTHs. Hence, the interactions between quality dimensions and satisfaction were evaluated thereafter from the data obtained.

3.5 DATA COLLECTION PROCEDURE

The questionnaire administration took place in February 2015 and was carried out by field workers with the assistance of some professionals working in the study areas. The ethical clearance received by the ethical committees of the two teaching hospitals assisted in getting access to records and all other requirement the study requested for that could be granted. Out of the 580 questionnaires administered in both UCH Ibadan and LUTH Lagos (i.e. 260 for employees and 320 for patients respectively), 437 (216 and 231 respectively) were returned from which 355 (173 and 182 respectively) were found suitable for analysis. This represents 61.2% of the total number of questionnaire sent which is suitable for the study based on the opinion of Moser and Kalton (1971) that the result of a survey could be considered unsuitable and of little significance if the rate of return was lower than 30-40%.

3.6 METHOD OF DATA ANALYSIS

Appropriate methods of data analysis are necessary to process the data collected from the field survey. The data collected was analysed using SPSS analytical tool to analyse individual responses from the descriptive perspective. Descriptive statistics simply segregate and aggregate the data and use various methods to present the data such as measures of central tendency (mean, median, and mode), frequency distribution, graphically (e.g. histograms, pie charts, tables, etc.). The study used frequency count for the demographic section of the questionnaires.

The level of users' satisfaction was assessed using Mean and Standard deviation (SD). The Mean value is the average of the total responses received from respondents on each question asked. SD is the measure of dispersion of a set of data from its mean. The more spread apart the data, the higher the deviation. SD was used to measure the extent to which individual scores deviated from the population mean. The scale for the remark is as follows: Less than 3.0 = Fair, 3.0 - 3.5 = Average, 3.6 - 4.0 = High, 4.5 - 5.0 = Very High.

Lastly, the regression analysis was used to examine the combined effect of the product and service variables (independent) with customer satisfaction (dependent variable). Regression analysis generates an equation to describe the statistical relationship between one or more predictors and the response variable (Frost, 2013) as seen in Tables 4.7 and 4.8.

CHAPTER FOUR

4.0 DATA ANALYSIS AND DISCUSSION OF RESULTS

4.1 DATA ANALYSIS

This section provides details of the data collected from the field survey. The respondents were categorized into two groups namely the patients and the employees as mentioned earlier in the study.

4.1.1 Socio-demographic Characteristics of Patients

Table 4.1 shows the frequency distribution for each of the Socio-Demographic characteristics for the respondents (Patients) of the study.

As shown in Table 4.1, there were more responses from patients in UCH Ibadan than from LUTH Lagos. The patients that responded were skewed to the younger ages of between 21-30 years indicating that the results are not even across all age groups as studies carried by Braunsberger and Gates (2002) indicates that older patients as compared to younger patients are more satisfied with the healthcare they receive. There is also the problem of gender being skewed towards the females with a response rate of 65.4% against males with 34.6% response rate also indicating that the overall satisfaction might not be evenly distributed. Braunsberger and Gates (2002) in their study opined that male patients as compared to female patients are more satisfied with the healthcare they receive. For the 'period of using the facility' factor, the patients who have used the facilities between 7 – 11 months have the highest response rate of 48.9% which is good for the study due to the fact that the study requires that the respondents should be conversant with the PPP facilities.

Table 4.1 Frequency Distribution for the Socio-Demographic characteristics of Patients

	Frequency	%
Location		
Ibadan	97	53.3
Lagos	85	46.7
Age		
Less 20yrs	11	6.0
21 to 25yrs	54	29.7
26 to 30yrs	43	23.6
31 to 35yrs	28	15.4
36 to 40yrs	22	12.1
41 to 45yrs	16	8.8
46yrs and above	8	4.4
Gender		
Male	63	34.6
Female	119	65.4
Period of Using the Facility		
1 to 6 months	39	21.4
7 to 11months	89	48.9
1 to 2years	33	18.1
3 to 4yrs	21	11.5
Respondent		
Patient	30	16.5
Patient's family	133	73.1
Others	19	10.4
Total	**182**	**100.0**

In the case of respondents, the patients family ranked the most with response rate of 73.1% this might also affect the results adversely due to the fact that the respondent might be rating the facility and services rendered from his/her point of view and not from the patient's viewpoint which might defer for a variety of reasons such as: difference in

gender, age, perception, and a host of other reasons.

4.1.2 Socio-demographic Characteristic of Employees

Table 4.2 shows a tabular representation of the frequency distribution for the Socio-Demographic characteristics of the employees that participated in the study.

As shown in Table 4.2, there were more responses from employees (53.8%) in UCH Ibadan than from LUTH Lagos (46.2%).

Also, similar issues were observed in the employees age and gender distribution as seen in the patients category. For the ‘years of practice’ factor, the employees who have worked for 6 – 10 years have the highest response rate of 52.6% which indicates that they are professionally apt for the survey. The ‘period of using the facility’ factor, has the results skewed to respondents who have used the facilities for 1 – 2 years with a response rate of 59.5% which is useable for the study due to the fact that the study requires that the respondents should have been using the PPP facilities for some time. The data under ‘occupation’ revealed that 56 representing 32.4% of the respondents are Nurses which implies that majority of the medical respondents were Nurses while the non-medical staff were the overall highest (33.5).

Table 4.2: Frequency Distribution for the Socio-Demographic characteristics of Employees

	Frequency	%
Location		
Ibadan	93	53.8
Lagos	80	46.2
Age		
Less than 20yrs	8	4.6
21 to 25yrs	60	34.7
26 to 30yrs	31	17.9
31 to 35yrs	8	4.6
36 to 40yrs	21	12.1
41 to 45yrs	29	16.8
46 yrs and above	16	9.2
Gender		
Male	69	39.9
Female	104	60.1
Years of Practice		
1 to 5yrs	34	19.7
6 to 10yrs	91	52.6
11 to 15yrs	40	23.1
16 to 20yrs	8	4.6
Period of Using the Facility		
1 to 6 months	3	1.7
7 to 11months	13	7.5
1 to 2years	103	59.5
3 to 4yrs	8	4.6
5 to 6 yrs	27	15.6
7yrs and above	19	11.0
Occupation		
Doctor	9	5.2
Pharmacist	14	8.1
Nurse	56	32.4
Laboratory Staff	36	20.8
Admin Staff	58	33.5
Total	**173**	**100.0**

4.2 ASSESSMENT OF THE LEVEL OF USERS SATISFACTION WITH PPP PROJECTS

4.2.1 Patients level of satisfaction with the PPP projects

The patients had the mean of their lowest rating to be 3.45 (appearance of the facility) which as stated above shows that they are quite satisfied with both the structures and services received at this section of the hospital. The mean of the highest rating was on the individual attention given to them which was 3.94 approximately 4.00 implying that they were quite impressed in that area. Generally speaking, the patients reported that the competence of staff members was commendable that is, the behaviour of staff members instilled confidence in them, the staff members were willing to help them, the staff members were friendly and courteous towards them, they felt safe in the staff members care, the general knowledge of the staff members in understanding their predicaments was very good. And also the time spent waiting to be attended to as well as on laboratory investigations was acceptable.

The Table 4.3 shows the SD closest to its Mean to be Competence (0.397) indicating that the individual responses in that group were close to each other confirming that their individual and collective assessment of quality in competence of staff members is around 3.70.

The next section that was rated high is convenience. The highest in that section was the accessibility of the facility followed by clarity of guidance around the facility and then the amount they were charged for their treatment. The reliability of the staff members in rendering their professional services as well as promptness of services alongside scheduling and booking time for services were the next in the rating hierarchy. The

farthest SD to its mean is 'the facility meeting their healthcare needs' (1.074), this indicates that the individual responses on that question were more disperse than the other questions that is, the respondents have varied views on the reliability of the facilities to meet their healthcare needs.

Table 4.3. Patients Level of Satisfaction with PPP Facilities and Services

	Mean	**S.D**	**Remarks**
Rate the overall performance of this facility	3.59	1.062	Good
TANIBILITY	**3.52**	**.682**	Average
Rate the appearance of the facilities	3.45	1.016	Average
Rate the personal appearance of staff members	3.59	1.056	Average
RELIBILITY	**3.60**	**.549**	High
Rate the facility in meeting your healthcare needs	3.62	1.074	High
Rate the professional services provided	3.69	1.059	High
Rate the promptness of the services provided	3.53	1.034	Average
Rate the scheduling and booking time of services required	3.57	1.016	Average
COMPETENCE	**3.70**	**.397**	High
Assess staff members willingness to help you	3.69	.999	High
Does the behavior of the staff members instill confidence in you	3.80	.977	High
Rate your feeling of safety in their care	3.67	1.062	High
Rate their friendliness and courtesy towards you	3.70	1.015	High
Assess their general knowledge to answer your questions	3.69	1.048	High
Assess the individual attention given to you	3.94	.981	High
Rate their understanding of your specific needs	3.66	1.010	High
Assess the duration of waiting time before being attended to	3.63	1.036	High
Assess the time spent on laboratory investigations	3.52	.846	Average
CONVENIENCE	**3.65**	**.506**	High
How accessible is the facility	3.81	.968	High
Rate the clarity of guidance and information sign for the facilities	3.53	.852	Average
Assess the general quality of service received	3.62	.913	High
How will you rate the cost of care	3.62	.790	High
Rate the overall performance of the PPP section	3.63	.999	High

Less than 3.0 = Fair, 3.0 - 3.5 = Average, 3.6 - 4.0 = High, 4.5 - 5.0 = Very High.
SD = Standard Deviation

The questions under the group; Tangibility were found to be rated the lowest in the patients survey. This area consists of the appearance of the members of staff as well as the facilities and they rated how satisfied they were with them. Their individual SD are high (1.056 and 1.016 respectively) although the SD as a group (0.682) dropped drastically.

The questionnaires inquired of the users general satisfaction twice which was at the beginning and the end of the second section of the questionnaire. Their rating of this question was higher at the end than the beginning indicating that the quality questions asked, made them appreciate the facilities and services better thereby, increasing their overall satisfaction.

4.2.2 Employees level of satisfaction with the PPP projects

The employees were not quite satisfied from the ratings they did. The mean of their highest rating was 3.39 in terms of the facility maintaining confidentiality which is vital in their profession. The mean of the lowest rating was 2.83 in terms of health and safety provisions available for them as a parameter for assessing their productivity. Also, their SD further confirms their rating due to the fact that only one question had its SD greater than 1 (i.e. facility assisting in provision of care: SD = 1.006) as shown in Table 4.4.

From Table 4.4, it is observed that the security group under the services dimension has the highest average rating which indicates that from their perspective, the facilities maintain confidentiality as well as protection against danger, risks, etc.

The next group under product dimension is aesthetics; they rated the appearance of the facilities as well as how it influences their work purpose. The next group is productivity; they rated their satisfaction with the PPP projects in terms of promotion and career

development opportunities; job security; the work environment (location, space, and amenities); salary and remuneration; reward and recognition scheme; level of job satisfaction; training and re-training programs as well as health and safety provisions, in descending order.

Table 4.4: Employees Level of Satisfaction with PPP Facilities and Services

	Mean	S.D	Remark
Rate the overall performance of the facility	**3.05**	**0.936**	Average
PRODUCT DIMENSION	**3.06**	**0.422**	Average
Rate the basic function of this facility to meet your professional purpose	3.01	0.946	Average
Rate your satisfaction on the characteristics that supplement the basic functions of the facility (restroom, lounge etc.)	2.97	0.885	Fair
Rate the availability of special facilities for the elderly/disabled	2.99	0.924	Fair
Rate the structure in term of its frequency of repairs	2.99	0.839	Fair
Rate the appearance of the facility	3.16	0.942	Average
How well does the facility advertise itself	2.98	0.895	Fair
SERVICE DIMENSION	**3.14**	**0.402**	Average
Rate the facility in creating a friendly environment to make you willing to help patients professionally and promptly	2.93	0.893	Fair
How does the facility rate in providing individual attention to patients such as privacy	3.05	0.948	Average
How conducive is the appearance of the facility to your work need/purpose?	3.27	0.983	Average
How does the facility assist in provision of care	3.15	1.006	Average
Rate the facility in providing ease to carry out services to parents	3.07	0.962	Average
Rate the ease of accessibility around the environment and clarity of route	3.04	0.936	Average
Rate the neatness of the facility and its environment	3.00	0.921	Average
Rate the facility and environment in relieving patients pain	3.24	0.79	Average
Rate the facility in inspiring, pride, diligence and thoroughness	3.10	0.998	Average
Rate the facility in terms of meeting your professional requirements	3.32	0.82	Average
Rate the facility in terms of freedom from danger, risks etc.	3.23	0.89	Average
Rate the facility in terms of maintenance of confidentiality	3.39	0.79	Average
PRODUCTIVITY	**3.11**	**0.450**	Average
Training and re-training program	3.07	0.86	Average
Reward and recognition scheme	3.09	0.878	Average
Promotion and career development opportunities	3.28	0.831	Average
Work environment: location, space, amenities	3.14	0.911	Average
Health and safety provision	2.83	0.936	Fair
Job security	3.23	0.85	Average
Salary and remuneration	3.12	0.895	Average
Level of job satisfaction	3.09	0.917	Average
Taking into account the above, rate the performance of the PPP section	**3.05**	**0.92**	Average

Less than 3.0 = Fair, 3.0 - 3.5 = Average, 3.6 - 4.0 = High, 4.5 - 5.0 = Very High.
SD = Standard Deviation

Furthermore, the features group (product dimension) was next as they rated the facilities in providing supplementary functions such as special features for elderly/disabled people.

Following that group closely is the responsiveness group (service dimension) which rated the facilities environment in terms of neatness, relieving patients' pains and also in inspiring them to do a thorough work. Accessibility was rated the next in terms of ease of carry out their duties and also the ease of finding ones way around the environment. The sections rated lowest are performance and reliability of the structures (product dimension).

4.3 EVALUATION OF THE RELATIONSHIP BETWEEN QUALITY DIMENSIONS AND SATISFACTION

The relationship between quality dimensions and satisfaction can be evaluated using the equation derived from the regression analysis carried in Tables 4.5 and 4.6 for both patients and employees respectively.

Table 4.5 The Impact of Quality Dimensions on Satisfaction of Patients.

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.223	.608		2.012	.046
	Tangibility	.531	.074	.484	7.210	.000
	Reliability	.086	.093	.063	.921	.358
	Competence	-.092	.126	-.049	-.730	.466
	Convenience	.150	.099	.102	1.513	.132

Table 4.5 shows mathematically the combined effect of all the independent quality variables on satisfaction using regression analysis. The equation derived from the relationship is as shown below.

$S = c + 0.531(T) + 0.086(R) + (-0.092)(Cp) + 0.150(Cv)$ ……(i)

Where; c = constant, T = Tangibility, R = Reliability, Cp = Competence, Cv = Convenience and the numbers to three decimal places are the coefficients of the independent variables.

The constant 'c' in the equation does not change, the other variables can be changed but the constant remains unchanged. Therefore, the implication is that if there is no quality input, there will still be satisfaction which is 1.223.

Tangibility 'T' has a coefficient 0.531 as shown in equation (i), this implies that the impact of tangibility on satisfaction is half (0.531). in relation to other quality dimensions, it indicates that tangibility impacts satisfaction six (6) times more than reliability and competence and three (3) times more than convenience.

Competence as shown in equation (i) is negative, this indicates that it has a negative impact on satisfaction although small but present. Its implication is that when competence quality improves or increases, satisfaction decreases.

Therefore, giving the independent variables a value between 1 and 5 (Likert scale rating used for the study) to test the equation. Using 2.00 across, we have;

$S = 1.223 + 0.531 (2) + 0.086 (2) + (-0.092)(2) + 0.150 (2)$

$S = 1.223 + 1.062 + 0.172 + (-0.184) + 0.300$

$S = \underline{2.573.}$

From the equation above, it shows that when the independent variables are increased by 2, the impact they make on satisfaction is 2.573. Therefore it is clear that there is a positive collective relationship of the independent quality variables on satisfaction.

Also to test the competence variable, using T = 2, R = 3, Cp = 1 and Cv = 2, we have;

S = 1.223 + 1.062 + 0.172 – 0.092 + 0.300

S = 2.665

Therefore, the lower the competence variable the higher the satisfaction

Table 4.6 The Impact of Quality Dimensions on the Satisfaction of Employees.

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.904	0.486		3.92	0
	PRODDIM	-0.033	0.135	-0.02	-0.245	0.807
	SERVDIM	0.284	0.163	0.167	1.749	0.082
	PROTVY	0.114	0.151	0.075	0.757	0.45

Table 4.6 shows mathematically the combined effect of all the independent quality variables of employees on satisfaction. Using the same equation derived from the relationship shown for the patients, the employees equation will therefore be as shown below.

S = c + (-0.033)(PD) + 0.284(SD) + 0.114(PTy) ……(ii)

Where; c = constant, PD = Product Dimension, SD = Service Dimension, PTy = Productivity.

Here the constant ‘c’ is 1.904, that is, if there is no quality input, satisfaction is 1.904. also, the equation indicates that product dimension ‘PD’ negatively impact satisfaction.

Hence, when product quality increases, satisfaction decreases as shown in the patients category. On the other hand, service dimension 'SD' impacts satisfaction twice as much as productivity 'PTy'.

Therefore, giving the independent variables a value 2.00 also, to test the equation. We have;

S = 1.904 + (-0.033) (2) + 0.284 (2) + 0.114 (2).

S = 1.904 + (-0.066) + 0.568 + 0.228

S = 2.634

From equation (ii) above, it shows that when the independent variables are increased by 2, the impact they make on satisfaction is 2.634. Therefore, it is clear that there is also a positive collective relationship of the independent quality variables on satisfaction.

4.4 DISCUSSION OF RESULTS

Wiess (1988) and AlQatari and Haran (1999) are of the opinion that regularity of using the health facilities is a predisposing factor for satisfaction. The familiarity of the patients with the health personnel reflects the relationship with the personnel in the health facilities which is a reflection of satisfaction (AlQatari and Haran, 1999).

Studies have shown that socio-demographic characteristics have an impact on users satisfaction (Braunsberger and Gates, 2002; Butt and Run, 2010; Alrubaiee and Alkaa'ida, 2011) however, Seraj, Ghadimi, Mirzaee, Ahmadi, Bashizadeh, Ashofteh-Yazdi, SahebJamee, Kharazi and Jahanmehr (2014) opined that some socio-demographic

characteristics such as gender might not significantly affect satisfaction. Therefore, this study noted that some of the socio-demographic factors such as gender and age distribution were skewed in a particular direction which might have affected the results obtained. Butt and Run (2010) observed that the ages of their respondents were skewed towards the younger generation (<20 – 35 years) similar to this study (<8 – 30years) it was stated that this might affect the results as they are least expected to visit medical facilities. It means that a more stratified sample might produce a more applicable result to represent all demographic groups (Butt and Run, 2010).

The quality dimensions have varying impact on the overall satisfaction of respondents as observed from previous studies as well as this study. This study observed that the highest rating for patients was on the competence of staff members which is contrary to the results of Butt and Run (2010), they reported staff members competence lowest indicating that they did not trust them and also they doubted that they will receive the right service the first time. However, Alrubaiee and Alkaa'ida (2011) reported that this factor has the greatest impact on customer satisfaction. It has therefore been confirmed from this study, as shown in Table 4.7, that the competence of staff members has the highest impact on overall satisfaction as stated by Alrubaiee and Alkaa'ida (2011).

The section which was rated next to the highest was convenience of the facility as well as services rendered to them, this section was not highlighted in the SERVQUAL instrument for measuring satisfaction. Hence it was included from literature to capture specific issues such as cost of care which is usually an issue in PPP projects. In this study, the cost of care was rated 3.62 which is good indicating that they were quite pleased with the amount they were charged for healthcare which is in line with studies carried out by Sharif (2012), they observed that price had an insignificant impact on satisfaction

although Sharif (2012) reported that western European markets showed an inverse relationship between price and customer satisfaction. The results of this study is contrary to the general belief that PPP projects are usually on the high side and unaffordable.

The next section in descending order is reliability of both staff members and the services provided. This was contrary to reports from Butt and Run (2010) and Alrubaiee and Alkaa'ida (2011) who observed low ratings for reliability of staff members. This study reported tangibility the lowest in the hierarchy but Alrubaiee and Alkaa'ida (2011) reported tangibility immediately after responsiveness and Butt and Run (2010) reported that reliability was the least.

The employees as earlier stated were not quite satisfied with the PPP projects from the ratings they did. This study confirms the speculation Alrubaiee and Alkaa'ida (2011) made in their study that the perceptions of patients might not match the perceptions of employees. Their highest rating was on 'the facility's maintenance of confidentiality factor'. Their lowest rating was under the productivity category the 'health and safety provisions' available for their use.

The ratings of employees on productivity was averagely 'good' as also reported by Seraj *et al.* (2014) study in which they were 'somewhat satisfied' with their general occupational conditions. The employees rated 'promotion and career development opportunities' the highest under the productivity section which was quite different from Seraj *et al.* (2014) as they rated interactions with fellow colleagues highest. Their greatest dissatisfaction was as earlier stated, the 'health and safety provisions' available for their use followed by training and re-training program. Seraj *et al.* (2014) stated that their respondents greatest dissatisfaction were in the areas of salaries, benefits, promotion, acknowledgement and recognition.

From the results obtained in this study, it was observed that competence and product dimensions (under patients and employees categories respectively) had negative impacts on overall satisfaction, this could be as a result of sampling error, probably from the sampling technique used (might not have been suitable for the study). Also, it can be confirming the law of diminishing return from economics which states that "when any factor of production is increased while the other factors are held constant, the output per unit of the variable factor will eventually diminish (Mankiw, 2008).

Due to the level of dissatisfaction especially from the staff members, steps need to be taken to improve the work environment and also enhance job satisfaction (Seraj *et al.*, 2014) to increase productivity as well as general user satisfaction levels in these PPP projects.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATION

5.1 SUMMARY OF FINDINGS

- The patients using the PPP facilities were generally more satisfied with the projects than the employees.
- The patients were most satisfied with the competence of the staff members in carrying out their professional duties especially in the individual attention staff members gave to them. They were least satisfied with the appearance of the facilities.
- The patients rated their overall satisfaction at the end of the survey more than they did in the beginning indicating that they appreciated the projects more after they had assessed the individual quality dimensions.
- The employees were most satisfied with the reliability of the facilities and rated the maintenance of confidentiality the highest factor. They were least satisfied with the health and safety provisions put in place for them.
- The employees generally rated their overall satisfaction with the PPP projects the same both at the beginning and end of the survey implying that the individual quality aspects of the projects had no influence on their satisfaction level.

5.2 CONCLUSION

The study has attempted to shed some light on the satisfaction of users with the quality of facilities and services provided for two PPP projects from a conceptual and practical perspective. It concludes that the satisfaction of users of a particular facility as in this

case PPP projects, is very important and should be considered seriously. Generally, the overall perception of users' satisfaction of these projects as obtained by this study is that the healthcare quality is 'good'. However, the patients rated the competence of staff members a little bit higher than other factors indicating that their satisfaction levels were not the same for all the factors evaluated. It also indicates that the patients are quite confident in the healthcare service providers' reliability and expertise. On the other hand, the employees indicated lower levels of satisfaction as compared to the patients, indicating that they may have higher expectation from PPP projects than they are experiencing.

Therefore, management at all levels are required to note the areas with low ratings and come up with improvement strategies to increase their quality levels. Also they should carry out user satisfaction surveys constantly to ensure that quality is not only maintained but improved upon regularly to ensure good productivity and customer satisfaction.

5.3 RECOMMENDATION

i. In terms of the methodology used for the study, attention should be paid to the socio-demographic distributions of respondents to avoid the results being skewed to one direction.

ii. The structures need to be looked into due to the fact that both employees and patients had their lowest ratings on the appearance and functionality of the facilities.

iii. Also, the employees need to be motivated; their overall ratings were quite low generally which might begin to affect their output which was well rated by the patients.

iv. Lastly, the customised questions used for the research can be used periodically to assess the satisfaction levels of users of PPP projects.

5.3.1 Recommendation for further studies

1. Studies can also be carried out to compare the satisfaction of users of the other sections of the hospital with the users of the PPP section to assess the benefits of PPP projects in the health sector.
2. Finally, studies can be carried out to investigate the impact of patients' satisfaction on the employees to find out how the satisfaction of patients affects the employees in carrying out their work.

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APPENDICES

APPENDIX I

QUESTIONNAIRE (PATIENTS)

Assessment of users' satisfaction with Public Private Partnership (PPP) Projects in selected University Teaching Hospitals.

Good day, I am OYEDELE FUNMILOLA HELEN a Master of Sciences (MSc) student from the Department of Quantity Surveying, Ahmadu Bello University, Zaria. I am conducting a study on the above subject and hereby, request your voluntary participation. The results from this study will help for probable interventions to improve Public Private Partnership project delivery in Healthcare in Nigeria.
All the information you provide will be kept confidential.
Thank you.

GENERALINFORMATION								
	A SOCIO-DEMOGRAHIC CHARACTERISTICS OF RESPONDENT **Please indicate with a tick where necessary**							
A1	Age	20 & Below 21-25 26-30 31-35 36-40 41-45 45 & above						
A2	Gender	Male Female						
A3	Period of using the Facility	1-6 months 7-11months 1-2 years 3-4years 5-6years 7years& above						
A4	Respondent	Patient Patient's family Others						
	A4.1	Other(s), please specify _____						
	C. QUALITY PERFORMANCE OF THE PPP FACILITIES AND SERVICES PROVIDED **Please indicate with a tick your chosen response where 5 is Excellent; 4 - Very Good; 3 - Good; 2 - Fair; 1 - Poor.**							
C	**PATIENTS WILL ASSESS THE PERFORMANCE OF THE FACILITIES AND STAFF MEMBERS TO THEIR NEEDS**		**5**	**4**	**3**	**2**	**1**	
C1	How would you rate your overall satisfaction of this facility?							
C2	***TANGIBILITY***							
2.1	How would you rate the appearance of the facilities?							
2.2	How would you rate the personal appearance of staff members?							
C3	***RELIABILITY (patients are required to assess members of staff)***							
3.1	How would you rate the facility in meeting your healthcare needs?							
3.2	How would you rate the professional services provided?							

3.3	How would you rate the promptness of the services provided?						
3.4	How would you rate the scheduling and booking time of services required?						
C4	***COMPETENCE (patients are also to assess members of staff)***						
4.1	Assess staff members' willingness to help you.						
4.2	Does the behaviour of the staff members instill confidence in you?						
4.3	How would you rate your feeling of safety in their care?						
4.4	How would you rate their friendliness and courtesy towards you?						
4.5	Assess their general knowledge to answer your questions.						
4.6	Assess the individual attention given to you.						
4.7	How would you rate their understanding of your specific need(s)?						
4.8	Assess the duration of Waiting time before being attended to.						
4.9	Assess the time spent on laboratory investigations.						
C5	***CONVENIENCE***						
5.1	How accessible is the facility?						
5.2	How would you rate the clarity of guidance and information signs for the facilities?						
5.3	Assess the general quality of service received.						
5.4	How will you rate the cost of care?						
C6	How would you rate your overall performance of the PPP section?						

Section D

We appreciate your kind participation!

Please state your suggestions and comments about other factors that may be missing at the time but are also important for the performance of these facilities as well as the services provided by the members of staff of this section:

……

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…….

QUESTIONNAIRE (EMPLOYEES)

Assessment of users' satisfaction with Public Private Partnership (PPP) projects in selected University Teaching Hospitals.

Good day, I am OYEDELE FUNMILOLA HELEN a Master of Sciences (MSc) student from the Department of Quantity Surveying, Ahmadu Bello University, Zaria. I am conducting a study on the above subject and hereby, request your voluntary participation. The results from this study will help for probable interventions to improve Public Private Partnership project delivery in Healthcare in Nigeria.

All the information you provide will be kept confidential.

Thank you.

GENERALINFORMATION								
	A SOCIO-DEMOGRAHIC CHARACTERISTICS OF RESPONDENT **Please indicate with a tick where necessary**							
A1	Age	20 & Below 21-25 26-30 31-35 36-40 41-45 45 & above						
A2	Gender	1 Male 2. Female						
A3	Years of Practice	1-5 6-10 11-15 16-20 21-25 25 &above						
A4	Period of using the Facility	1-6 months 7-11 months 1-2 years 3-4 years 5-6 years 7 years & above						
A5	Occupation	Doctor Pharmacist Nurse Laboratory Staff Admin Staff Others						
	A5.1	Other(s), please specify _____						
	B. QUALITY PERFORMANCE OF THE PPP FACILITIES PROVIDED **Please indicate with a tick your chosen response where 1 - is Poor; 2 - Fair; 3 - Good; 4 -Very Good; 5 - Excellent.**							
B		**1**	**2**	**3**	**4**	**5**		
B0	How would you rate the overall performance of the project?							
	PRODUCT DIMENSION							
1.1	How will you rate the basic function of this facility to meet your professional purpose (medical care)?							
1.2	Rate your satisfaction on the characteristics that supplement the basic functions of the facility (reception, restroom, lounge, etc).							
1.3	Rate the availability of special facilities for the elderly/disabled.							
1.4	How will you rate the structure in terms of its frequency of repairs (maintenance)?							
1.5	How will you rate the appearance of the facility?							

1.6	How conducive is the appearance of the facility to your work needs/purpose?						
1.7	How well does the facility advertise itself?						
B2	**SERVICE DIMENSION**						
6.1	Rate the facility in creating a friendly environment to make you willing to help patients professionally and promptly						
7.1	How does the facility rate in providing individualized attention to patients such as privacy						
7.2	How does the facility rate in assisting in provision of care?						
8.1	How will you rate the facility in providing ease to carry out services to patients?						
8.2	Also the ease of finding one's way around the environment and clarity of route.						
9.1	How will you rate the neatness of the facility and its environment.						
10.1	How will you rate the facility and its environment in enhancing relief from pain of patients.						
11.1	How will you rate the facility in inspiring pride, diligence and thoroughness.						
12.1	Rate the facility in terms of meeting your specific professional requirements (e.g wash hand basin where you need it).						
13.1	Rate the facility in terms of freedom from danger, risks etc.						
13.2	Also rate the facility in terms of maintenance of confidentiality						
B3	**PRODUCTIVITY**						
	How would you assess your level of satisfaction in the following areas?						
3.1	Training and Re-training program.						
3.2	Reward and Recognition Scheme.						
3.3	Promotion and Career Development Opportunities.						
3.4	Work Environment: location, space, amenities.						
3.5	Health and Safety provisions.						
3.6	Job Security.						
3.7	Salary and Remuneration.						

3.8	Level of job satisfaction.						
B4	Taking into account the above aspects, how would you rate the performance of the PPP section?						

Section C

We appreciate your kind participation!

Please state your suggestions and comments about other factors that may be missing at the time but are also important for the performance of these facilities as well as the services provided by the members of staff of this unit:

……
……
……
…….