

**DETERMINANTS OF CONSUMER PREFERENCES FOR HEALTH
SERVICES PROVIDED BY PRIVATE HOSPITALS IN NAKURU COUNTY,
KENYA**

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Partial Fulfilment of the requirement for the Award of Master of Business
Administration (Marketing Option) of Kabarak University**

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DECLARATION AND APPROVAL

DECLARATION

This research project is my original work and has never been submitted anywhere for a degree or award in any other University.

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APPROVAL

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DEDICATION

This project is dedicated to my loving parents Mr. & Mrs. Robert Langat, my sisters Feliscus, Florah , Peninah and Naomi not forgetting Titian, Trevor and Calvin for their support and sacrifice which have made this project possible.

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ABSTRACT

Private healthcare system in Kenya have grown tremendously over the last two decades due to various reasons, among them lack of adequate and quality public healthcare services and introduction of user fees. This study therefore aimed at empirically examining the determinants that have influenced consumers' choice for private health service providers in Nakuru County. In achieving this broad objective the study sought to examine the extent to which customer demographics, hospital accessibility, service quality and hospital service cost influences consumers' preference. Descriptive survey design was adopted in the study. Structured questionnaires was be used to gather primary data from in-patients with minor ailments in these hospitals through the assistance of the staff. Study sample size was 136 in- patients, where the sampling technique which was employed on determining individual respondents was convenient sampling method after choosing the hospitals purposively. Descriptive statistics (mean, standard deviation and frequencies) and inferential statistics particularly Pearson correlation and regression were used to test the relationship between variables under study whereas research hypotheses was tested at 0.05 significant levels. Customer demographic was positively related to consumer preference although weak ($r = 0.248, p < 0.05$) and statistically significant, there is a relatively weak positive relationship between hospital accessibility and consumer preference ($r = 0.367, p < 0.05$) which is statistically significant. Service quality have a relatively weak positive relationship with consumer preference ($r = 0.483, p < 0.05$) but statistically significant. The results also revealed that there is a relatively weak positive relationship between hospital service cost and consumer preference ($r = 0.499, p < 0.05$) and statistically significant. This study concludes that patients' preference is determined by a complex interplay between a variety of patient and provider characteristics. Patients often attach greater importance to their own previous healthcare experiences or to doctors' recommendations than to comparative information. Additionally, patients base their decisions not only on outcome indicators but on a variety of provider characteristics. Findings from this study should not be underestimated. It will provide important source of knowledge for managers within the healthcare institutions, as well as the service industry in general. Health Care provider must focus towards the understanding the factors that influence the choice of health services.

Key Words: Demographics, accessibility, quality, choice, service and cost

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LIST OF ABBREVIATIONS AND ACRONYMS

FBO	Faith Based Organization
HMIS	Health Management Information System
KEPH	Kenya Essential Package for Health
MOH	Ministry of Health
NGO	Non- governmental Organization
NHSSP	National Health Sector Strategic Plan
NSHIF	National Social Health Insurance Fund
SPSS	Statistical Package for Social Sciences
UAE	United Arab Emirates
VHC	Village Health Committees
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

This chapter discusses background of the study, statement of the problem, research guiding objectives and hypotheses, significance of the study, the scope of the study and limitations of the study.

1.1 Background of the Study

Globally, the health provider industry has shifted in focus from providing quality care alone to providing both quality and service in their provision for health services. Now more than ever, individuals demand a high level of information, personalization and autonomy when making their health care decisions (Prakash, 2010). Today's patients can access medical records electronically, schedule appointments and order prescriptions through online patient portals, and even communicate with physicians via text message. This increase in the ease of access to information, as well as the newfound rapidity in patient-provider communications, has necessitated a greater concern with overall patient satisfaction. Patient satisfaction has become so critical because it is a motivating factor in patient retention, evidenced by hospitals with higher reported levels of patient satisfaction also claiming high levels of patient loyalty and retention (Prakash, 2010).

According to Motwani&Shrimali (2014), with the growing importance of service marketing mix, hospital administrators are becoming increasingly marketing oriented. Hospital administrators are keen to identify the factors which may affect patients' decision selection of hospital. They also identified that in hospital service price transparency, placing hospital services at convenient location of patients, behavior of medical staff, tangibility and process through technology plays important role in differentiating services from competitors.

The Kenyan health sector comprises of the public system, with major players including the Ministry of Health (MOH) and parastatal organisations, and the private sector, which includes private for-profit, NGO, and FBO facilities. Health services are provided through a network of over 4,700 health facilities countrywide, with the public sector system accounting for about 51 percent of these facilities. The public health system consists of the following levels of health facilities: national referral hospitals, provincial general hospitals, district hospitals, health centres, and

dispensaries. National referral hospitals are at the apex of the health care system, providing sophisticated diagnostic, therapeutic, and rehabilitative services. The two national referral hospitals are Kenyatta National Hospital in Nairobi and Moi Referral and Teaching Hospital in Eldoret. The equivalent private referral hospitals are Nairobi Hospital and Aga Khan Hospital in Nairobi. Provincial hospitals act as referral hospitals to their district hospitals. They also provide very specialized care. The provincial level acts as an intermediary between the national central level and the districts. They populations and between districts and provinces (66 percent of the population of Western Province is below the poverty line, compared with 46 percent in Central Province). They are related to gender, education and disability. The goal to reduce health inequalities can only be achieved effectively by involving the population itself in decisions on priority setting and consequently in the allocation of the resources. (MOH, 2010).

In a renewed effort to improve health service delivery, the Ministry of Health and stakeholders have reviewed the NHSSPI service delivery system in order to devise a new strategy for making it more effective and accessible to as many people as possible (MOH, 2004). The recommended changes are contained in the Second Health Sector Strategic Plan. This plan proposes to improve service delivery by using the following levels of care delivery. Level 1, the community level, is the foundation of the service delivery priorities. Once the community is allowed to define its own priorities and once services are provided that supports such priorities, real ownership and commitment can be expected. Important gains can be reached to reverse the downward trend in health status at the interface between the health services and the community. Village Health Committees (VHC) will be organised in each community through which households and individuals can participate and contribute to their own health and that of their village. Levels 2 and 3 (dispensaries, health centres, and maternity/nursing homes) will handle Kenya Essential Package for Health (KEPH) activities related predominantly to promotive and preventive care, but also various curative services.

Levels 4-6 (primary, secondary and tertiary hospitals) will undertake mainly curative and rehabilitative activities of their service delivery package. They will address to a limited extent preventive/promotive care. In this way, the existing vertical programmes will come together to provide services to the age groups at

these various levels. The plan adopts a broader approach a move from the emphasis on disease burden to the promotion of individual health based on the various stages of the human cycle: pregnancy and the new-born (up to two weeks of age); early childhood (two weeks to five years); late childhood (6-12 years); youth and adolescence (13-24 years); adulthood (25-59); and the elderly (60+ years),(MOH 2010).

This requires a fundamental change in the existing governance structures in order to allow such a community ownership to take place. Future planning needs to recognize that “reversing the trends” cannot be achieved by the government health sector alone. Active involvement and partnership with other stakeholders in the provision of care is needed. A functioning health system should be established that relies upon collaboration and partnership with all stakeholders whose policies and services have an impact on health outcomes. The system should give a frame for sector-wide approach arrangement and bring flexibility for rapid disbursement of budgetary resources. A human resource plan will need to be developed to better staff the lower health facilities for effective primary health care. The new plan should strengthen monitoring evaluation and reporting system. Additional resources should be dedicated to commodity security, especially for vaccines, reproductive health commodities, and essential drugs. Gradually introducing the National Social Health Insurance Fund (NSHIF) to provide universal health care will help to reduce the current inequalities in access to care. (MOH 2010).

As the World Health Organization (WHO) observes, “Private provision is a substantial and growing sector that is capturing an increasing share of the health market across the world.” Today, private health institutions and providers play a major role in both developed and developing countries. Even the National Health Service in the United Kingdom, long an icon of state-funded universal health care, is currently undergoing major structural changes, opening services up to competition with the private sector, ostensibly to improve efficiency. Private provision of health services does not change the role of the state as the ultimate guarantor of the realization of health rights obligations, but it makes implementing its responsibilities more difficult(Chapman, 2014).

Fragmentation of the health system complicates oversight and the promotion of a rights-based approach to health. Segmentation of the health system, with a poorly functioning public sector catering primarily to the poor and better quality private health institutions catering to the more affluent, tends to undermine support for investing in improvements in institutions for the public provision and financing of health care and likely erodes commitment to the right to health as well. Additionally, the goals and priorities of private health care institutions tend to differ, often significantly, from the values and norms in the human rights paradigm. Working effectively with and through private-sector providers also requires management skills and complex health information systems that many governments, particularly those in poor and middle-income countries, often lack (Chapman, 2014).

1.1.2 Private health sector

Private-sector health delivery covers many different realities. It includes both for-profit commercial companies and not-for-profit actors and institutions. It incorporates faith-based and other nongovernment non-profit organizations, as well as individual health care entrepreneurs and private for-profit firms and corporations. It may also entail private sources of financing, such as shifting from public funding of health to private health insurance. In some countries with well-developed public health systems, private health provision plays a relatively minor and supplementary role, but in some others there are extensive networks of private providers for ambulatory, hospital, and in-patient care (Lawson *et al.*, 1999).

In developed countries, private provision usually entails care by well-trained medical professionals in settings with sophisticated equipment. Individual entrepreneurship is also prevalent in middle income countries, but large private firms, including multinational corporations, are capturing a growing share of the market, particularly the high-income segment, and increasingly competing for contracts with public and social security systems. As part of a health care system, the primary health Hospital has enormous importance in the delivery of health care. It has this importance because the primary health Hospital is the first point of care and a major conduit for the delivery of health care to a significant proportion of the population (Lawson *et al.*, 1999).

In the current competitive health care industry, hospital administrators would like to determine how important service attributes are to potential consumers and how those attributes influence consumer preferences decisions. According to Lawson, (2009), the ability to provide accessible and cost-effective health services to patients depends on a thorough understanding of the factors associated with the demand and use of services, especially those factors which can be manipulated to improve the provision of healthcare services. To understand why patients chose one hospital over another, it was important to know the major factors that patients consider.

Earlier studies on factors influencing patient's demand of a hospital were limited in many countries, especially the developing ones. In traditional societies of the developing world, the set of determinant variables for the utilisation of health services seemed to be more complex than in the developed countries. Additional factors were involved due to: cultural differences, which include the change of illness concepts and health behaviour; the existence of a wide range of health services, both in quality and quantity; and the different socio demographic conditions (Dieleman&Harnmeijer, 2006). Therefore this forms a fundamental base for this study.

1.1.3 Consumer Preference

Consumer preferences are the subjective tastes, as considered by utility of various bundles of goods. They permit the consumer to grade these bundles of goods according to the levels of utility they give the consumer. The individual consumer has their own set of preferences and determination of these is based upon culture, education, and individual tastes, among a overabundance of other factors. In today's competitive healthcare industry, administrators and marketers must have to identify these factors and how these factors influence customer choice decision. In their research they attempted to find out various attributes which customer gives preferences in terms of healthcare and their degree of involvement (Verma & Wal 2011).

According to Draper, Cohen & Buchan (2001) in a research study that explained how patient satisfaction surveys provide information that can inform policy and service development. Repeat survey can enables policy makers to access the effectiveness of policies and programs and whether these are adapting to changing

patient needs. At the hospital level, focused internal feedback or benchmarking with similar hospitals can prompt action to improve service.

According to Vaiana & Glynn (2002) Consumer choice requires private health to communicate the relative benefits of their health insurance products, and private hospitals and doctors to provide information about treatment costs. Further, comparative information on hospital and doctor performance would assist consumer choice of hospital and doctor, at least in non-emergency situations. To explore consumer needs for information on products, costs and performance this project engaged a group of consumers and their carers in the development of a performance report for private hospital cardiac services.

1.2 Statement of the Problem

The aim of any private enterprise is to make a profit. Private hospitals are businesses that endeavour to offer health services at a quality reasonable profit. A number of marketing strategies (such as hospital accessibility, resources-qualified personnel), have been adopted in order to attract clients to receive health services from private hospitals. However, despite such initiatives, it remains unclear whether potential clients consider these initiatives in their demand of a health service provider. Hence it is important to establish the determinants of consumer preferences for health services among private hospitals in Kenya. According to Brelje (2015), little research has been done in an effort to pinpoint which factors, if any, hold greater weight in individuals' choice of health care institution or provider. Others studies like Sirisinsuk, Fungladda, Sigthasivanon, Kaewkungwal, & Ratanawijitrasin (2003) have reported that the ability to provide accessible and cost-effective health services to patients depended on a thorough understanding of the factors influencing demand of health Hospital. Hence, the study aimed at establishing the determinants of consumer preferences for health services provided by private hospitals in Nakuru County.

1.3 Research Objectives

1.3.1 General Objective

To examine the determinants of consumer preferences for health services provided by private hospitals in Nakuru County, Kenya.

1.3.2 Specific Objectives

- i. To examine the influence of customer demographics (age, gender and religion) on consumer preferences for health services among private hospitals in Nakuru County, Kenya.
- ii. To determine the effect of hospital accessibility on consumer preferences for health services among private hospitals in Nakuru County, Kenya.
- iii. To examine the influence of service quality on consumer preferences for health services among private hospitals in Nakuru County, Kenya.
- iv. To evaluate the effect of hospital service cost on consumer preferences for health services among private hospitals in Nakuru County, Kenya.

1.4 Research Hypotheses

H₀₁: Consumer demographics (age, gender and religion) does not have a significant influence on demand of health services provided by private hospitals in Nakuru County, Kenya.

H₀₂: Hospital Accessibility does not have a significant influence on consumer preferences of health services provided by private hospitals in Nakuru County, Kenya.

H₀₃: Service Quality does not have a significant influence on consumer preferences of health services provided by private hospitals in Nakuru County, Kenya.

H₀₄: Hospital service cost does not have a significant influence on consumer preferences of health services provided by private hospitals in Nakuru County, Kenya.

1.5 Significance of the Study

Private hospitals are businesses that endeavour to offer health services at a quality reasonable profit and thus it is imperative to keep track of such activities. The study identified the determinants of consumer preferences on health services provided by

private hospitals in Nakuru County, Kenya and therefore contributes positively to the knowledge relative to which activities are more effective.

The study may also contribute to the existing knowledge by determinants examining patients' preferences, influence of accessibility of consumer preferences and service quality on health services provided by private hospitals in Nakuru County, Kenya which has not been well documented. The study in turn unveiled the determinants of consumer preferences on health services provided by private hospitals in Nakuru County, Kenya, and the synergy that exists between these variables considered and the profit in the private hospitals Nakuru County, Kenya which the stakeholders might consider. Moreover, the findings and recommendations contributes to the existing literature in the field of marketing management and other management courses. The study can be a basis of reference and can activate further research in the study area and thus acts as an empirical model for future studies.

1.6 Scope and Limitations of the Study

1.6.1 Scope of the study

The study only focused on Private hospitals in Nakuru. The study used a sample drawn from the patients who visit the private hospitals in Nakuru town and more specifically the in-patients with minor ailments who had given more information on the service quality because of their stay in the hospital. The study considered the determinants of consumer preferences of health services provided by private hospitals in Nakuru County, Kenya in year 2016 between the months of September to November. Nakuru town was chosen because of the larger number of private hospitals and also a place where the county administration is based. The researcher conducted the research to give an understanding of the determinants of demand of health services provided by private hospitals in Nakuru County, Kenya.

1.6.2 Limitations of the Study

The study was limited to private hospitals in Nakuru County, Kenya. This however provides opportunity for further research in the other Counties. Some hospital directors asked to see the authorization letter to conduct research as evidence that the research was authorized. This challenge was overcome by a justification letter that the research was purposely for the study. The respondents who were unwilling

to provide information for fear that the information is sensitive or they considered certain information as classified and confidential, and were unwilling to share the information, the researcher took the necessary steps and measures to ensure that proper communication was made on the purpose of the study and assured the respondents of confidentiality of information provided. Also the researcher sought assistance from the medical staff in these hospitals to easily identify the patients with minor ailments who were willing to fill the questionnaire. The study focused on patients in private hospitals in Nakuru County.

1.7 Definition of Terms

Consumer Demographics: Consumer demographic include characteristics such as gender, age, income level, educational level, etc. play an important role in consumer's purchase decision process and can cause deviation from general patterns of consumer decision making(Lee, 2005).The demographics characteristics considered for the study were age, gender, income and religion.

Consumer preferences: The preferences of the consumers are a positive motivation, expressed by the affective compatibility towards a product, service or trading form (Hansson, 2006). For the study preferences relates to consumption expenditures and to consumer preferences curves. It analyses how consumers maximize the desirability of their consumption as measured by their preferences subject to limitations on their expenditures, by maximizing utility subject to a consumer budget constraint.

Hospital Accessibility: Implies customer's/ patient's ability to easily arrive at and depart from the service location or to experience the service without great difficulty due to effective spatial orientation and layout (Chahal *et al.*, 2004.Hospital accessibility includes the hospital location, service time, information and promotional activities about the hospital.

Hospital service cost: identified that out of pocket payments and the mode of payment adopted by patients (Lindholm & Chuc, 2008).Price the patient is willing to pay in relation to medical services offered.

Private hospitals: Is a hospital that is privately funded through payments by patients or by insurers, e.g.it is not owned by the state or federal governments.(Work Safe Victoria, 2015)

Hospital owned by a for-profit company or a non-profit organization and privately funded through payment for medical services by patients themselves, by insurers, Governments through national health insurance schemes, or by foreign embassies.

Service Quality: Service quality is the difference between customer expectations and perceptions as it is being received by the customer (Grönroos, 2001; Parasuraman *et al.*, 1988; Irfan & Ijaz, 2011). This is the quality of process and quality of infrastructure positively related to patient satisfaction which affects reputation of the hospital positively.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter discusses the theoretical review and the empirical frameworks that explain determinants of consumer preferences for health services provided by private hospitals in Nakuru County, Kenya, as well as the empirical studies that have been done on the area. A conceptual framework is then developed from a review of existing studies. In this chapter, the author seeks to establish an academic foundation from which both further researches will be built upon. Its purpose will be to enhance the readers understanding of the various concepts that influence consumer preference, as well as its theoretical impact on the consumer choice of health service providers.

2.2 Private Healthcare Sector

Healthcare system is to employ healthcare, social and other resources to meet people's needs within a given region (Kerleau & Pelletier-Fleury 2002). Ideally, a healthcare system should encompass everyone, from the individual who is ill and in need of care to the paramedic who brings the individual to a hospital, from the nurses who tend to the sick person to the doctors who diagnose the patient, from the pharmacist who dispenses drugs for the patients' use to the surgeon who performs surgery on the patient (Wei, Polska, Spens & Antai. (2007).

In many countries, the healthcare system also includes the insurance agencies (social or private) that take decisions based on the type and extent of care to be administered. Large differences in healthcare systems exist between countries. These variations are even more evident between developed and developing countries. Numerous developed countries see the providing of healthcare as a social responsibility and provide universal coverage for its citizens, usually financed by the tax or social security system. For most less-developed countries, however, universal healthcare coverage is still more or less a dream. Consequently, many such countries have turned to the private sector for its healthcare needs, basic healthcare as well as health insurance. In low-income countries, private services are popular because they „ are often cheap (and) are adjusted to the purchasing power of the clients as when partial doses of drugs are sold“ (Mills, Brugha, Hanson, &McPake, 2002).

However, one of the problems with the private services has been the fact that the poor quality of these private sector actors has been reported in many studies on developing countries (Uplekar 2000, Chabikuli *et al.*, 2002, Lönnroth 2000, Tuan *et al.*, 2006).

According to Huseyin *et al.*, (2008) there is still a considerable lack of research on service quality in public and private hospitals in developing countries. The access to public healthcare is especially restricted in rural areas, so in rural areas the private sector as well as traditional healing plays a dominant role. This is in line with the study by Jerve *et al.*, (2001), which concluded that the poor quality of curative services at the community level directly contributes to the phenomenon of high levels of self-medication and over-utilization of tertiary healthcare facilities.

According to Muthaka, Kimani, Mwaura & Manda 2004, private healthcare sector comprises the activities of agents who are largely outside the control of government. This includes individuals who privately own health facilities and seek to make profit in the healthcare sector, clinics and hospitals owned by private employers and those operated by religious missions and other non-governmental organizations (NGO's). These agents play a significant role in provision of health services in Kenya. The impression in many countries is that private healthcare is expanding and this has made many countries to adopt a pluralistic health system.

The health care industry in the United States has recently experienced unprecedented challenges and changes. Health care providers now face intensified competition due to the industry's movement towards managed health care systems and maturation with overcapacity (Taylor, 1994). In order to create or sustain competitive advantage, health care providers are compelled to integrate the traditional medical approach, which stresses the effectiveness and efficacy of health service outcomes from the provider's perspective, with a patient-centred principle, which takes into account patients' concerns and interests (Ettinger, 1998). Consequently, consumerism now appears on the health care industry agenda (Williams & Calnan, 1991).

In the consumerism paradigm, service quality and patient satisfaction remain critical issues for health care providers. The impact of perceived health care service quality on the provider's success or failure has been well established Donabedian, 1996,

Gooding, 1995, Headly & Miller, 1993 and Reidenbach & Sandifer-Smallwood, 1990. This significant relationship between service quality and profit is largely imputed to patient satisfaction, which functions as a mediating variable between the two constructs. Satisfaction is crucial when consumers and purchasers of health care services make decisions regarding new enrolment and re-enrolment (Mummalaneni & Gopalakrishna, 1997).

Kenya has followed a strategy of pluralism in the health sector for a long time, allowing a large and diverse non-government healthcare sector to develop. The government, on realizing the potential that exists in the non-governmental sector, has tried to create an enabling environment for private investment in healthcare provision. Private healthcare providers are often assumed to be more efficient and provide a higher quality healthcare alternative than public sector providers. Non-governmental healthcare providers include religious organizations, for-profit private healthcare enterprises, pharmacies/chemists, and traditional practitioners. (Mutaka,*et al.*, 2004).

The growth of private healthcare providers is attributed more to government reforms that took place in the 1980s on the Kenyan health sector. The government was facing a fiscal burden in provision of healthcare, which had to be transferred to private healthcare providers and individuals. The government initiated a cost-sharing program as part of reducing government burden, while it undertook to create a conducive environment for greater private sector involvement in healthcare. This created a two-tier health system in which some people are served by government facilities and others by the private sector. The private healthcare sector has made a remarkable contribution in delivery of healthcare to the public. The sector is used by almost all socioeconomic groups, and appears to have relatively better distribution in both rural and urban areas. Nevertheless, there has not been proper policy formulation for this sector due to its diversity and nature. As Hanson & Berman (1994) note, failure to consider the diversity of private healthcare providers could lead to faulty policy advice because form, behaviour, and importance with respect to both size and range of activities is likely to differ significantly between types of providers.

2.2.1 Classification of Private Healthcare Providers

Many studies on private healthcare providers have cited the existence of confusing arrays of terminologies over their classification (Oduwoet *al.*, 2001; Kumaranayake, 1998; Hursh-Cesar *et al.*, 1994). For instance, some health facilities identify themselves as hospitals whereas others with similar features identify themselves as clinics or nursing homes, although the law stipulates what should be hospitals, nursing homes, and clinics. Terminologies used to define the facilities are important as they dictate the regulatory mechanism to be applied for a particular type. Therefore, confusion arises when different facilities with similar features are regulated differently.

Doctors, nurse practitioners, or clinical officers operate most private healthcare facilities. However, it is very difficult to know how health clinics, for example, are run by these types of practitioners given the proliferation of the use of the title “Doctor” in Kenya. For example, traditional health practitioners and pharmacists, and even clinical officers have adopted the title of “doctor”, particularly in rural areas, ignoring the rules and regulations that govern the profession. This has made the country to have a diverse mix of different types of private healthcare providers, ranging from traditional to modern practitioners and from individual to large hospitals (Hursh-Cesar *et al.*, 1994). Various studies have classified private healthcare providers according to a number of criteria, with each criterion emphasizing a specific aspect of the sector (Kumaranayake 1998; Hursh-Cesar *et al.*, 1994). Commercial orientation, ownership, type of Hospital, and therapeutic system are used to classify various types of private healthcare providers.

The first and main component of classification of private healthcare providers is by economic orientation, which includes for-profit or not-for-profit facilities (Kumaranayake, 1998; Hursh-Cesar *et al.*, 1994). Health facilities run by churches or various religious faiths constitute the main not-for-profit private healthcare providers. Other non-governmental organizations in this sector include single-purpose organizations such as the Family Planning Association of Kenya (FPAK). Health facilities owned by sole proprietors, partnerships, companies and parastatals, pharmacists and traditional health practitioners form the main for-profit private healthcare providers.

The second category of classification of private health providers is by ownership. Economic agents of different types own private healthcare facilities. These agents include religious organizations, companies, parastatals, private enterprises, and individuals such as pharmacists and traditional healers who own private healthcare facilities. Community-based health workers, community-based distributors of contraceptives, and community pharmacies also fall under this classification.

The third classification of private healthcare providers is by type of Hospital. This classification produces three broad categories of health facilities: hospitals, health centers, and sub-health centres'. However, the Health Management Information System (HMIS) database lists the following types of private health facilities: hospital, health centre, sub-health centre, dispensary, health clinic, maternity home, nursing home, medical centre, mobile clinic, special health institutions, health programs and community pharmacies (Government of Kenya, 2001). It is very clear that it is not easy to tell what distinguishes one type of health Hospital from the other as listed in the database. However, a good guide would be the conditions that the health facilities must meet in order to be licensed by the Medical Practitioners and Dentists Board as a particular type of healthcare Hospital. The Medical Practitioners and Dentists Act, Cap 253 of the Laws of Kenya has outlined these conditions.

Traditional healthcare providers do not seem to fit easily into any of the above classification of private healthcare providers. Therefore, these facilities and other similar facilities may be categorized as therapeutic or healing systems. Nevertheless, traditional healthcare practitioners can also be categorized as owners, and may range from herbalists, herbalists' diviners, and herbalists' bonesetters. In studies by Hursh-Cesar *et al.*, (1994) and Berman *et al.*,(1995), healers, charismatics, and birth attendants are indicated as the most accessible and most important source of healthcare in rural areas. They are a "one-stop" source of care— diagnosis, medicine, and treatment.

Traditional medicine includes a diversity of health practices, approaches, knowledge, and beliefs incorporating plant, animal, and/or mineral-based medicines; spiritual therapies; manual techniques and exercises, applied singly or in combination to maintain well-being, and to treat, diagnose, or prevent illness (WHO, 2001). The comprehensiveness of the term 'traditional medicine', and the

wide range of practices it encompasses, makes it difficult to define or describe, especially in a global context.

As evidenced above, there is considerable confusion in the terminologies used to classify private healthcare facilities. No classification presents a sufficiently complete framework for analysis of the private healthcare sector. As indicated in IEA/SID (2001), due to the diversity of the private healthcare sector and a wide array of terminology, it is hard to properly classify and account for all its activities. Although all health facilities in Kenya are required to submit annual returns to the Health Management Information Systems (HMIS), not all of them do this. Furthermore, the HMIS is not clear over the coding and classification of health facilities by ownership (Berman *et al.*, 1995). This is complicated by the different numbers of these providers, which has increased especially in recent years.

2.2.2 Growth of Private Healthcare Providers in Kenya

The private healthcare sector has made a remarkable contribution in the delivery of healthcare services in Kenya. It has filled a resource gap for health development by improving efficiency and quality of care by promoting competition and complementing public sector services. As noted earlier, the growth of the sector in Kenya is partly attributed to the decision by the government in the late 1980s to allow clinical officers, nurses, and pharmaceutical technologists to engage in private provision of healthcare services. The deteriorating conditions in public health facilities, which have forced the public to seek alternatives, are another contributing factor. Leonard *et al.*, (2000) observe that government health services have failed to provide reliable and good quality healthcare despite the fact that patients exhibit willingness to pay for quality healthcare. Non-governmental healthcare providers seem to be running successful healthcare facilities for which even poor patients are willing to pay. There is therefore a substantial private sector activity in healthcare provision in Kenya.

Kumaranayake (1998) provides three main reasons for the increase in private sector activity within the health sector. First, an explicit deliberate policy demand of health sector reforms were carried out purposely to encourage the development of the private sector as an alternative means of healthcare provision. This has been spurred by increasing resource constraints and the poor performance of the public sector.

The second is a response to weak provision of public health services. The public health sector has become inefficient in delivery of health services, accounting for 30% wastage of resources. The poor remuneration of personnel, low morale, lack of ownership of the services by communities, poor logistic support, and little opportunities for continuing education have further degraded the quality of services. Mushrooming of unregistered clinics run by unqualified personnel has slowly taken advantage of the inefficiency in public health services (Oduwo *et al*, 2001; IEA, 1998; IEA/SID, 2001). Poor remuneration in the public healthcare sector has forced doctors to resort to private clinics or seek employment in other countries (Nyangena, 2000). The poor performance of the public healthcare system could also have contributed to the growth in traditional medicine as an alternative source of healthcare.

The third reason for the increase in private healthcare services arises from the need to respond to increased consumer affluence (for example increasing middleclass) and preference for greater quality services. Studies by Berman *et al.*,(1995) and Hursh-Cesar *et al.*,(1994) found that in many low and middle-income countries, the demand for private healthcare has been driven by its perception as a higher-quality service.

Kenya, like most African countries, inherited a small health sector at independence. However, private healthcare provision has grown from a few providers at independence to about 1,446 in 1994. This growth is traced in two periods. The first was the 1970s when the government allowed civil servants to engage in private remunerative activities in their free time, on condition that these activities are not prejudicial to their public service. The second was in the early 1980s when the government sought to withdraw this privilege because of abuses (diversion of public supplies and time of professional staff to the private sector; and admission of private patients in public facilities). Many doctors resigned from government services in 1984 after their part-time licenses were withheld. The policy was later modified to allow specialist doctors to engage in part-time private practice while denying junior doctors this opportunity. This change of rules governing private practice of government health officials saw the setting up of different health institutions ranging from clinics to hospitals.

Today, the government controls about 52% of all health facilities, with private healthcare providers controlling the remaining 48%. By 1994, private healthcare providers owned and operated about 42% of all health facilities in the country that is 50% of all hospitals, 21% of all health centres', and about 50% of all other health facilities. The private healthcare facilities are owned by a variety of agencies and individuals. About 47.3% are owned by the mission sector, 51% by the private/company sector and the remaining 1.7% are owned and operated by the Family Planning Association of Kenya (Berman *et al.*, 1995).

Agha & Do (2009) he concluded that private facilities were superior to public sector facilities regarding physical infrastructure and availability of services. However, the difference between the two sectors is unnoticed in terms of technical quality of care provided (Jofre-Bonet, 2001). Boller *et al.*, (2003) corroborates that private providers of antenatal care in Tanzania were significantly better than public ones with regard to all attributes of quality they investigated. Hiemenz&Amponsah (2009) in line with other studies have demonstrated that private health providers can deliver adequate health services than the public sector (Walker *et al.*,2001; Aljunid, 1995). Yet there are other studies that contend that within the private health care delivery, industrial or urban dwellers are more satisfied than those living in a more distant and marginalized settlement (Bazant& Koenig, 2009).

2.3 Theoretical Literature Review

A theory is a framework for organizing knowledge and providing a blueprint for action. The study focused on two theories that are related to the variables of the study namely; consumer buying behaviour model theory and Service quality theory.

2.3.1 Service quality Theory

Service quality is a concept that has aroused considerable interest and debate in the research literature because of the difficulties in both defining it and measuring it with no overall consensus s emerging on either (Wisniewski, 2001). There are a number of different" definitions" as to what is meant by service quality. One that is commonly used defines service quality as the extent to which a service meets customers' needs or expectations (Lewis & Mitchell, 1990; Dotchin & Oakland, 1994; Asubonteng *et al.*,1996;Wisniewski and Donnelly,1996).Service quality can thus be defined as the difference between customer expectations of service and

perceived service. If expectations are greater than performance, then perceived quality is less than satisfactory and hence customer dissatisfaction occurs (Parasuraman *et al.*, 1985; Lewis and Mitchell, 1990).

Quality should be measured because it allows for comparison before and after changes, for the location of quality related problems and for the establishment of clear standards for service delivery. Edvardsen *et al.*, (1994) state that, in their experience, the starting point in developing quality in services is analysis and measurement. In relation to the study, SERQUAL model is important when consumers are considering quality of the service providers.

2.3.1.1 Model of Service Quality Gaps

According to (ASI Quality Systems, 1992; Curry, 1999; Luk and Layton, 2002), the three important gaps, which are more associated with the external customers, are Gap1, Gap5 and Gap6; since they have a direct relationship with customers.

Gap 1: Customers' expectations versus management perceptions: as a result of the lack of a marketing research orientation, inadequate upward communication and too many layers of management. Gap 2: Management perceptions versus service specifications: as a result of inadequate commitment to service quality, a perception of unfeasibility, inadequate task standard is action and an absence of goal setting. Gap3: Service specifications versus service delivery: as a result of role ambiguity and conflict, poor employee-job fit and poor technology-job fit, inappropriate supervisory control systems, lack of perceived control and lack of teamwork. Gap4: Service delivery versus external communication: as a result of inadequate horizontal communications and propensity to over-promise. Gap5: The discrepancy between customer expectations and their perceptions of the service delivered: as a result of the influences exerted from the customer's idea and the short falls (gaps) on the part of the service provider. In this case, customer expectations are influenced by the extent of personal needs, word of mouth recommendation and past service experiences. Gap6: The discrepancy between customer expectations and employees' perceptions: as a result of the differences in the understanding of customer expectations by front-line service providers. Gap7: The discrepancy between employee's perceptions and management perceptions: as a result of the differences in the understanding of customer expectations

between managers and service providers.

According to Brown & Bond (1995), "the gap model is one of the best received and most heuristically valuable contributions to the services literature". The model identifies seven key discrepancies or gaps relating to managerial perceptions of service quality, and tasks associated with service delivery to customers. The first six gaps (Gap1, Gap2, Gap3, Gap4, Gap6 and Gap 7) are identified as functions of the way in which service is delivered, whereas Gap5 pertains to the customer and as such is considered to be the true measure of service quality. The Gap on which the SERVQUAL methodology has influence is Gap5.

Polsa, Spens, Soneye & Antai (2011) argued that the SERVQUAL model is applicable for research in healthcare setting in terms of the following characteristics: reliability the trust worthiness of service delivery, i.e., keeping Promises being sympathetic and reassuring, and keeping records accurately; responsiveness –the exact delivery of service, willingness to help, and efficient allocation of time; assurance–safeness of diagnoses, politeness, and relevant specialized knowledge; empathy –the ability of personnel to reflect the perceived needs of the patients; and tangibles –the physical environment of the hospital as well as the functional quality of diagnoses, and efficient communication with nurses and doctors, and the understanding of diagnoses (Polsa, Spens, Soneye & Antai, 2011). This theory was relevant to the study since it aided the researcher in understanding patient's perception while choosing health service providers offered by different private hospitals in Nakuru County.

2.3.2 Consumer Buying Behaviour Model

The Consumer Decision Model (also known as the Engel Blackwell-Miniard Model) was originally developed in 1968 by Engel, Kollat, and Blackwell and has gone through numerous revisions. It can be seen that many of the elements of the model are similar to those presented in the Theory of Buyer Behaviour (Howard and Sheth 1969), however the structure of presentation and relationship between the variables differs somewhat. The model is structured around a seven point decision process: need recognition followed by a search of information both internally and externally, the evaluation of alternatives, purchase, and post purchase reflection and finally, divestment. These decisions are influenced by two main factors. Firstly stimuli is

received and processed by the consumer in conjunction with memories of previous experiences, and secondly, external variables in the form of either environmental influences or individual differences. The environmental influences identified include: Culture; social class; personal influence; family and situation. While the individual influences include: Consumer resource; motivation and involvement; knowledge; attitudes; personality; values and lifestyle (Blackwell, *et al.*, 2001).

Entry to the model is through need recognition when the consumer acknowledges a discrepancy between their current state and some desirable alternative. This process is driven by an interaction between processed stimuli inputs and environmental and individual variables. After a need has been acknowledged the consumer embarks on a search for information, both internally and externally through the consumers' memory bank of previous experiences, and externally. The authors argue that the model is suitable for use in explaining situations involving both extended problem solving and limited problem solving by modifying the degree to which various stages of the model are engaged in by the consumer (Loudon & Della Bitta 1993).

The depth of information search will be highly dependent on the nature of problem solving, with new or complex consumption problems being subjected to extensive external information searches, while simpler problems may rely wholly on a simplified internal search of previous behaviour. Information is said to pass through five stages of processing before storage and use, namely: exposure, attention, comprehension, acceptance and retention (Blackwell, *et al.*, 2001).

The alternative consumer preferences are evaluated by the establishment of beliefs, attitudes and purchase intentions. This process of evaluation is influenced by both the environmental variables and the individual variables. Intention is depicted as the direct antecedent to purchase which is the only outcome tolerated by the model. Inhibitors are not explicitly depicted as mediating between intentions and purchase, however the environmental and individual influences are again said to act on purchase. Situation is listed as an environmental influence, and while this factor is not clearly defined, it could include such factors as time pressure or financial limitations which could serve to inhibit the consumer from realising their purchase intentions (VanTonder, 2003). Consumption is followed by post-consumption evaluation which serves a feedback function into future external searches and belief

formation. Divestment is depicted as the final stage in the consumption process acknowledging that the product purchased is likely to be disposed of at some point post consumption. CBB theory is important to give an understanding on the process the patients will follow when decide on which private hospital to attend and the identifying the beliefs, attitudes and purchase intention.

2.4 Empirical Literature Review

There are many empirical researches undertaken by scholars on factors influencing consumer choice on health service providers. The study will build on these empirical studies in making inferences, on research findings consistency with the reviewed past studies.

2.4.1 Determinants of patients' choice for healthcare providers

According to Loney, Aw, Handysides, Ali, Blair, Grivna, Shah, Sheek-Hussein, El-Sadig, Sharif, & El-Obaid(2013) they did a research where they analysed the health status of the United Arab Emirates in relation to the 'Big 4' public health issues. A systematic literature search was conducted to retrieve peer-reviewed articles on health in the UAE, and unpublished data were provided by government health authorities and local hospitals. In their research they acknowledge that composed of a multinational population with varying educational backgrounds, religious beliefs, and cultural practices, which pose a challenge for population-based public health strategies. A number of public health issues significantly contribute to morbidity and mortality in the UAE. This article summarises the findings of a panel of medical and public health specialists from UAE University and various government health agencies commissioned to report on the health status of the UAE population.

Victoor, Delnoij, Friele & Rademakers, (2012) investigated Determinants of patient choice of healthcare providers. In several northwest European countries, they carried out a specific type of literature review known as a scoping review. Scoping reviews tried to examine the breadth of knowledge that was available about a particular topic and therefore do not make selections or apply quality constraints. Firstly, they defined their research questions and searched the relevant literature Secondly, they selected the literature, and finally analysed the summarized information. They study found that patients' choices were determined by a complex

interplay between patient and provider characteristics. A variety of patient characteristics determined whether patients made choices, were willing and able to choose, and how they chose. Patients took account of a variety of structural, process and outcome characteristics of providers, differing in the relative importance they attached to these characteristics.

Ankur & Kuma (2015) in their paper wanted to understand the different factors that influence the patient's choice in selecting a hospital in Haryana. It also explored the factor that persuades consumer the most. They revealed that Good doctors 'was the prominent reason for selecting the hospitals followed by easily available facilities and low cost services. Nearness to the hospitals was on fourth and recommendation from the friends and relatives was on fifth preferred reason while choosing a hospital. Easily available facilities were more important for the less educated respondents and the importance of this factor decreasing with increase in education of the respondents. Further higher educated people were found to be less influenced by low cost of the services but low cost.

In a study by Yip *et al.*, (2010) entitled "Determinants of patient choice of medical provider: case study of rural China" examines the factors that influence patient choice of medical provider in the three tier health care system in rural China: Village health posts, township health centres and county hospitals. The study using the multinomial logit model from a sample of household survey in Syunyi county of Beijing in 1993 showed that relative to self-pay patients, government and labour health Insurance beneficiaries are more likely to use county hospitals, while patient covered by Cooperative Medical System are more likely to use village level facilities. The study also reveals that disease patterns have significant impact on patient choice of providers.

Escarce & Kanika (2009) in a study entitled 'Do Patients Bypass Rural Hospitals? Determinants of Inpatient Hospital Choice in Rural California' examines the hospital characteristics that are associated with patients choosing rural hospitals. Using data from California hospitals, the paper shows that patients were more likely to choose nearby hospitals, larger hospitals, and hospitals that offered more services and technologies.

Yadav (2007) in a cross-sectional study conducted at the Government Medical College Hospital, Miraj shows that owing to inflation and rising costs of commodities, some people from the upper middle class can no more afford the costs incurred in the private medical sector and have to therefore seek medical services of a government hospital. The study shows that patients gave multiple reasons for choosing a government hospital. Sixty percent of the consumers reported that they had learnt from others about the good reputation of services provided by the hospital. Economic reasons, i.e., unable to afford treatment from private sector, were cited by 44% consumers. Twenty-four percent consumers claimed that they had tried private medical establishments but were dissatisfied with them, for various reasons and therefore had turned to the government hospital. In case of 12% consumers, they were referred by primary health centers/ rural hospitals/ private general practitioners for further management.

Grote, *et al.*, (2007) in an online survey of more than 2,000 US patients with commercial insurance or Medicare about their attitudes toward the patient's experience revealed that most of them are willing to switch hospitals for better service and amenities and that many have already asked their physicians to refer them to specific facilities. Blizzard (2005) found that community members do not necessarily have a preferred hospital for all types of conditions. Many people differentiate healthcare facilities based upon their expertise in treating a particular type of illness. Consumers tend to be open to using multiple hospitals based upon their perceptions of the clinical expertise of each. The other big concern for many community members is the relative incidence of medical errors committed in each of the facilities under consideration.

Chen & Kao (2011) found that the top six marketing-related ways influencing consumers' choice of hospitals are: free medical consultation, referral by friends and relatives, free clinic treatments, the mailing of clinic schedules to potential customers, TV news exposure, and providing education in public health and hygiene. The top methods of promotion, yielding the highest consumer loyalty are (in order of importance): high incidence of referral by friends and relatives; TV exposure; free medical consultation; free clinic treatments; and providing education in public health and hygiene.

In a study conducted by Uchendu, Ilesanmi, & Olumide(2013) on factors influencing the choice of health care providing Hospital among workers in a local government secretariat in south western Nigeria they adopted a descriptive cross-sectional study among all 312 consenting staff who were randomly selected Local Government Area (LGA)of the 5 in Ibadan Metropolis where Chi Square and logistic regression analysis was done. The study noted that the increasing awareness of individuals on the importance of obtaining appropriate medical care and the introduction of health insurance have contributed to the need for decision taking on clients choice of health care provider. Choice of care provider is often determined by affordability and availability of drugs, geographical accessibility and appropriate opening hours. Choice of a commodity (product or service) from consumer behaviour theories is determined by preference for that commodity, and preference for a commodity implies choice of that commodity. Satisfaction with services, quality of services and socio demographic/ socioeconomic factors are variables used to determine preference which will then lead to the utilization of the Hospital. Choice of health care providing Hospital is an important decision that involves the interplay of several factors according to Uchendu, Ilesanmi, & Olumide(2013). Unlike decision making for other commodities, the decision making process involved in the choice of health care providing Hospital is determined by factors external to the clients such as quality of services provided by the health care facilities. Satisfaction of services provided is a perception by the clients and must be considered by managers of health institutions when decisions to improve health Hospital services are to be made. They conclude that to increase access to health care the cost of services and the waiting time are important factors to address. They also recommend that there is a need to ensure that patients have easy access to health care by ensuring that health personnel are available when needed. Long waiting times should be discouraged by identifying areas in the health care delivery system that is prone to causing long waiting times with a view to developing alternate health systems that will eliminate long hours.

According to Kamra *et al.*,(2015) they found out that north Indians were influenced by the factors that affect patient satisfaction and revealed factors like appropriate cost and ease of services, completion of medical requirements, caring staff, general

behavior of doctors, registration and other formalities, tangibility, specialized doctors and facilities at outpatient department area.

2.4.2 Customer Demographics: Age, Income, Gender and Religion

According to Solomon *et al.*, (2007), demography refers to the identifiable and measurable statistics of a population. Demographic characteristics such as gender, age, race, ethnic origin, income, family life cycle and occupation, are often used as the basic for market segmentation. Previous studies have investigated patient's socio-economic and demographic characteristics in relation with satisfaction partly because of the ease with which data can be collected. Previous studies on parental satisfaction of health care for children aged under-five regarding the services of a given health provider is virtually non-existent (Hiemenz & Amponsah, 2009). Although the kids are the patients in question, they cannot make their own satisfaction evaluation, and thus the mothers or caregivers make such judgments. Research shows that characteristics such as age, educational level, health status and amount of information conveyed by the health provider are significant predictors of health care satisfaction (Chahal *et al.*, 2004; Cohen, 1996; Hall & Dornan, 1988).

Chahal, *et al.*, (2004) in his study acknowledges that there are control variables that were found to be significant on the patients' choice of health service providers. These variables were sex of the child, maternal age and education, marital status and previous knowledge of health issues (proxied by access to television). He further states that highly educated mothers are found to be less satisfied with their children's health care services. This might be attributable to the fact that they are more critical about health services provided in general coupled with the fact that they are more knowledgeable about social health issues and their "rights" (Agha & Do, 2009; Chahal, *et al.*, 2004; Bara, *et al.*, 2002). According to Chahal *et al.*, 2004; Cohen, 1996; Hall and Dornan, 1988 they stated that characteristics such as age, educational level, health status and amount of information conveyed by the health provider are significant predictors of health care satisfaction.

Field *et al.*, (UK) 2001; Birch, Eyles & Newbold, (Canada) 1993) reported that with an increase in age the odds of utilizing the health care services increase for an individual. This is due to physiological changes that happen with passage of time. Such changes make an individual more vulnerable to health care problems and

therefore lead to greater utilization of healthcare services. Similar results are observed for studies done in developing nations (Pourezza *et al.* (Iran) 2011; Cevallos & Chi, (Ecuador) 2010; Amin, Shah & Becker, (Bangladesh) 2010; Chen & Li, (China) 2009; Majumder, (India) 2006; Chakraborty *et al.*, (Bangladesh) 2003. Narang(2010) found out that income is a factor that affects people preferences for services of the hospitals which was significantly associated with the user perception.

Kephart (2007) have found that in Canada, the level of education of their respondents influenced their healthcare usage practices. People with higher education were more likely to opt for healthcare services as compared to their less educated counterparts. Hendryx (2002) found out that in the United States of America, people with more years of education are more likely to be sensitive towards their health and are better aware about access to healthcare options. In a study done in Greece, Lahana, Pappa & Niakas (2011) found that the level of education not only influence the healthcare usage but also the type of healthcare service provider used by an individual. They report that people with lower education are more likely to use emergency department healthcare services as opposed to people with university education who were more likely to use government funded primary healthcare services for similar needs.

The income influences affordability to spend on health care that in turn influences the type of health care service chosen by an individual. It has been found that with a rise in household income of an individual the likelihood of utilizing healthcare services (Regidor, (Spain) 2008; Asada & Kephart, 2007) and visits to the private practitioners (Lahana, Pappa & Niakas, 2011) are more likely to happen. Forbes & Janzen (2004) report that the tendency to use cheaper healthcare services is found more in individuals belonging to the lower income category as they cannot afford the higher priced services available in hospitals.

Research studies by Ghosh (2004) reported that Muslim women from rural Uttar Pradesh, India are less likely to use modern health care services for maternal health services as compared to Hindu women. Similar results were reported by Thind (2005) regarding female's use of contraceptives health care services in rural Bihar, India. He found that Muslim females were less likely to utilize modern contraceptives for reproductive healthcare services. Rani & Bonu (2003) reported

that in rural areas across India, Hindu women were more likely to seek healthcare services from private providers as compared to Muslim women for gynaecological healthcare issues. Studies done in the developed nations have shown that ethnicity is an important variable in determining healthcare utilization for an individual (Lahana, Pappa & Niakas, 2011; Jatrana & Crampton, 2009; Arcury, 2005; Hendryx, 2002, Kushel, 2002).

2.4.3 Hospital Accessibility

Hospital accessibility is considered as a critical factor for utilization of healthcare (Baker & Liu, 2006). Previous studies indicate the importance of physical access to service providers in influencing an individual's decision to choose healthcare service provider and to utilize health care services. Other previous studies acknowledge that accessibility is represented in terms of physical access of an individual to a service provider in his/her area of residence (Ager & Pepper, 2005). The associated costs of travel, the lost opportunity cost of work day pay and availability of transport mode are all interlinked to accessibility hence affecting the provider choice and utilization. Accessibility is measured as distance in earlier studies to measure its impact on healthcare utilization (Buor, 2003; Dwivedi&Sundaram, 2000). According to Melin&Granath, (2004), accessibility implies the customer's/ patient's ability to easily arrive at and depart from the service location or to experience the service without great difficulty due to effective spatial orientation and layout.

Study by Jung, Feldman, & Scanlon (2011) reveal that the effect of perceived overall reputation and availability of particular clinical services on hospital choice was much larger than the effects of quality scores, perceived cost, or non-profit status. Kotler& Clarke, (1987) argued that layout accessibility is an especially crucial element in services because of its potential effect on the customer's ability to experience and enjoy the service offering, especially through ease of ingress and egress considerations. They noted that having to stand in lines for long periods of time might even cause some customers to miss primary aspects of the service. Time access is another measure of accessibility. Melin&Granath, (2004), explain that it deals with three distinct issues: the opening hours, the length of waiting time (in the service providing waiting area) and the time between calling and having an appointment. In addition Jones (2003), places concern over lengthy waiting times in hospital and out-patient clinics as a consistent source of dissatisfaction to patients.

Patients and visitors coming to a major medical institution have one significant non-health issue on their minds - finding the desired destination. Assistance is often needed but all too seldom found. This problem can be observed at many large medical centres. They depict access related circumstances that are both undesirable and more common than thought (Melin&Granath, 2004).The first impressions that patients and visitors have of a hospital are typically based on these activities: finding a parking space, finding the main entrance or desired door, obtaining directions (either from a staff member or from signs), and finding their way to the final destination. Long before a patient sees the physician, receives medical assistance, or benefits from the most sophisticated medical technology, the initial impression of the hospital and how helpful it is derives from access related functions (Melin&Granath, 2004).

Singh & Shah (2011) revealed that availability of good doctors, nearness to the hospitals, infrastructure of the hospital, recommendation from the friends/relatives and affordability were came out to be the most preferred reason for selecting the particular hospital. Further various researchers identified different factors that are preferably focused by patients while selecting any hospital. According to the patients important factors were found to be appropriate instructions given by the physician (McMullan *et al.*, 2004), health insurance (VafaeiNajar *et al.*, 2006), nearness to the hospital awareness of the services that patients are supposed to take delivery of, supportive surrounding (Mawajdeh *et al.*, 1997 & Heller 1982).

According to Baltussen *et al.*, (2002) provider characteristics particularly distance and waiting time (Chu-Weininger & Balkrishnan, 2006) were found to be inversely and significantly related to consumer satisfaction. The longer the distance to the nearest health Hospital, the lower the level of satisfaction associated with the choice of a given provider's services. Stated differently, proximity to health facilities increases satisfaction while longer distances reduce health care satisfaction. Similarly, longer waiting times are associated with lower levels of satisfaction.

2.4.4 Service quality in healthcare

Ferguson & Lim (2001) argue that quality in general is an “elusive and vaguely-used concept” while discussing clinical governance in healthcare. Parasuraman *et*

al., (1985) argues that: quality of service is the gap between customer's expectations and perception of service. This definition does not directly imply the fact that perception is a subjective opinion and does not take into consideration the fact that in health care the patient participates in the production of the service and so the quality may be affected by the patient's actions.

In the case of a hospital: the facilities, the quality of food, cleanliness, etc. Health is difficult to assess due to the fact that the patient cannot evaluate service because of lack of expertise in the area. This is analogy between healthcare delivery and commercial logistics in order to satisfy the need for balance between supply and demand in this sector. The private health care providers come as an alternative to the public system, growing rapidly in many countries. As Hanson & Berman (1998) say, there is the assumption that the private sector is developing by covering undeveloped areas of the market. The authors study the development of private health care in developing countries. They define private providers as those who are not controlled by the government, privately owned care facilities seeking profits. In fact, in many cases models are conforming to the public one because they rely on public financing. Income and socioeconomic variables such as private and social insurance and the nature of the medical system are influencing the development of the private sector.

Perceived service quality plays an important role in healthcare services utilization (Kim *et al.* 2012; Sharma & Narang, 2011; Narang, 2010; Lindelow, 2004; Mariko, 2003; Andaleeb, 2000). Previous studies done in the context of emergent nations (Sri Lanka -Akin & Hutchinson, 1999; Bangladesh -Andaleeb, 2000, Tanzania - Leonard *et al.*, 2003) have established the importance of perceived quality on the utilization of healthcare services as reporting that with an increase in perception of the healthcare services the likelihood to utilize those services increase. The perceived quality of the healthcare services by individuals utilizing healthcare services have been found to be of importance in India as well; be it in the urban context (Pinto & Udwadia, 2010; Das & Hammer, 2007; Dilip & Duggal, 2004) or rural context (Banerjee, Deaton & Duflo, 2004).

Increasingly, health care stakeholders such as governments, health authorities and consumers are attaching importance to health care quality (Lapsley, 2000; Smith *et*

al., 2006). More and more, patients' satisfaction is recognized as essential component in the evaluation of health care quality (Derose *et al.*, 2001; Donabedian, 1992). Monitoring and evaluating consumer satisfaction with health care is a crucial input to improving the quality of health system and changes in the system as well as providing feedback for health care professionals and policy makers (Bara *et al.*, 2002). Measures of consumer satisfaction with health care can provide important assessment of quality of health care not adequately captured by other health service statistics such as patient throughput, waiting times, consultation times and proximity (Sitzia & Wood, 1997; Williams & Calnan, 1991). In fact, it has been suggested that patient satisfaction is a major quality outcome in itself (Derose *et al.*, 2001). The extent to which health care users are satisfied with their local providers may be a key factor underpinning their health behaviour and health care utilization (Rakin *et al.*, 2002; Hadorn, 1991). It is envisaged that timely, accessible, appropriate health interventions, continuous and effective health services are important components of health care quality (Cambell *et al.*, 2000).

2.4.5 Hospital Service Cost

The economic polarization within the society and lack of social security system make the poor more vulnerable in terms of affordability and choice of health provider (Nyamongo, 2002). Patients incurred health services expenditures have been found to have substitution aspects in terms of mode of payment. Some health service providers allows patients to substitute incurred hospital bills with other medical payment channels available to the patients, such as National or Federal Hospital insurance schemes as well as employers contributions, in meeting the incurred hospital expenditures.(Shaikh & Hatcher,2004). In the Kenyan context patients are relieved the burden of cash medical bills settlement through acceptance windows offered by hospitals to patients to use the National Hospital Insurance schemes and also allowing patients employer's cash contribution in settling the incurred medical bills (MoH,2010).

According to Sirisinsuk *et al.*, (2003) identified the patterns of health seeking behaviours among the participants where he confirms the reality that, although they have health insurance, they may seek care from other health facilities where they have to be financially responsible for the cost. Research studies have identified that out of pocket payments and the individual belief in the competencies of the provider

as important determinants of the choice of healthcare provider (Hibbard & Weeks, 1987; Odwee, Okurut & Adebua, 2006; Ngugi, 2008 and Thuan, Lofgen, Lindholm & Chuc, 2008). Narang, 2010 reveal that income is a factor that affects people preferences for services of the hospitals. Birr & Eggleston (2002), Harris *et al.*,(2002) suggest that service fee affect patients choice negatively in health care systems where providers are heterogonous in terms of qualifications, efficiency and other dimensions.

Hibbard & Weeks, 1987; Odwee, Okurut & Adebua, 2006; Ngugi, 2008 and Thuan, Lofgen, Lindholm & Chuc, 2008 identified that out of pocket payments and the individual belief in the competencies of the provider as important determinants of the choice of healthcare provider. Further, Majumder (2006) found out that that high cost of treatment increases the odds of utilization of modern sources of healthcare services by people in North Bengal, India. The author attributes this result to the fact that high costs of illness indicate presence of complex disease(s) that are beyond the capacity of traditional service providers. More recently, Chaudhuri (2012) observed that high out of pocket expenditures on health is making individuals less likely to utilize healthcare services.

2.5 Critique of Existing Literature

AafkeVictoor *et al.*, (2012) investigated Determinants of patient choice of healthcare providers in several northwest European countries; they carried out a specific type of literature review known as a scoping review. Scoping reviews tried to examine the breadth of knowledge that was available about a particular topic and therefore do not make selections or apply quality constraints. Firstly, they defined their research questions and searched the relevant literature. Secondly, they selected the literature, and finally analyzed the summarized information. They study found that patients' choices were determined by a complex interplay between patient and provider characteristics. A variety of patient characteristics determined whether patients made choices, were willing and able to choose, and how they chose. Patients took account of a variety of structural, process and outcome characteristics of providers, differing in the relative importance they attached to these characteristics. The study only concentrated with demographic features and overlooked other variables such as service quality.

According to Andersen & Newman (2003), paying a visit to a health Hospital is determined by three sets of factors: predisposing factors such as age, gender, race/ethnic group and social status; enabling factors include conditions that facilitate or inhibit the use of health services such as insurance coverage, income, distance to the health centre; availability of regular source of care and, need or health status variables which may include perceived need and urgency, level of distress and presence of psychiatric co-morbidity. The study however did not focus on other factors such as service quality.

Wan & Soifer (2012) summarized the models which were used to explain the use of health services into three major approaches. The first, used individual attributes, incorporates social and behavioural variables to predict utilization behaviour. For example, the above-mentioned Rosenstock's health-belief model, which suggests that the readiness to take health action is determined by perceived susceptibility and severity of a health problem, perceived benefits and barriers to taking action and cause which instigate appropriate behaviour, exemplifies this approach. The second approach variables derived from organizational, economic, and ecological frameworks. The concepts of service availability, coordination, accessibility, and methods of financing refer to ecological and functional relationships between economic or community resources and the recipients of services. The third approach assumes that use behavior is a joint function of both personal attributes and organizational factors. The study however did not focus on other influencing factors such as quality of medical services.

2.6 Conceptual framework

The following is a hypothetical representation of the relationship between dependent and explanatory variables

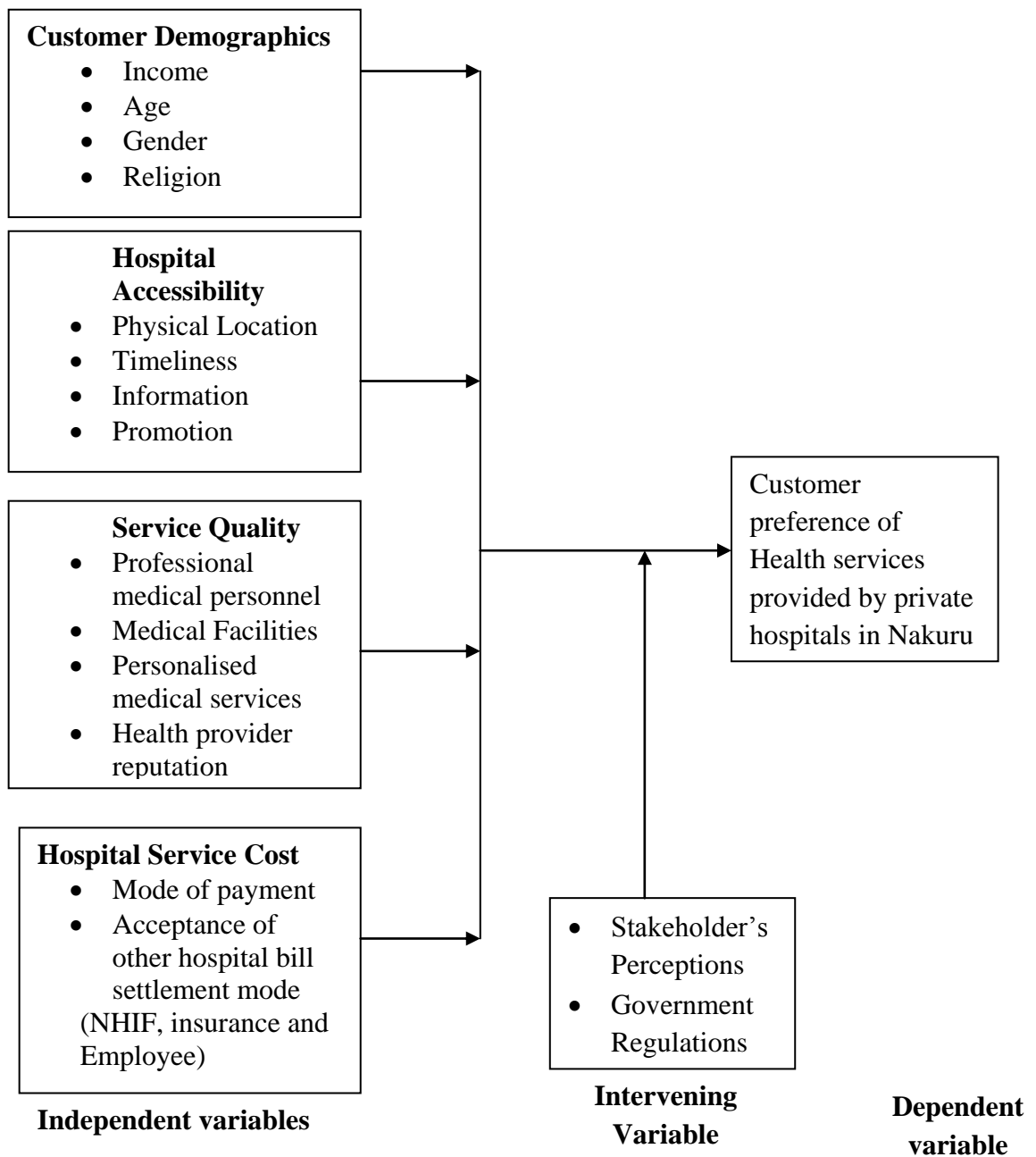


Figure 2.1: Conception framework

Figure 2.1 above presents the relationship between aspects of determinants of consumer preferences which were tested to determine their influence on consumer preferences for private care service providers in Nakuru County.

2.7 Research Gaps

Based on the empirical studies reviewed, it is evident there exists research gap that warrants address. that It could be argued that the most important factors affecting an individual's use of health facilities in any given country do not necessarily have the same significance in other countries because of the differences in environment, socio-cultural aspects, belief systems, the availability of health facilities and technology, differences in levels of knowledge about illness and disease, which all differ between one country and another. Because of such differences, caution must be exercised in generalizing findings from one country to another. That is, the findings of studies reporting on the use of health facilities are inconsistent and the contributing factors vary from one study to another, perhaps because of the varying methodologies used, differing medical care systems, different time periods and the rhetoric of interpretation. This study therefore attempted to fill the gap created by previous studies in the search for determinants influencing the demand of consumer of health service providers.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This section shows the methods that were employed to obtain information for the study. It outlines the nature and sources of data, the techniques that were used in the analysis and interpretation of data.

3.2 Research Design

This study adopted descriptive survey design in which opinions of determinants on consumer choices were sought. The data collected was both quantitative and qualitative in nature. Mugenda & Mugenda(1999) describes a survey design as an attempt to According to (Orodho, (2005) this research design describes the variables as they exist. The design was appropriate for the study because data was collected at one particular point in time without manipulation of variables and this was used to determine the variables that have an effect on the consumer's demands of health services.

3.3 Area of Study

Private hospitals in Nakuru County are 9 within the Central business centre which offer a wide range of health services (Local Authority Business Register, 2016).The proposed study was undertaken among these private hospitals in Nakuru County, Kenya. The main economic activity of the residents in the town and its environs is business and agriculture. The location of the study was chosen because the consideration of the consumers while choosing services offered by these health service providers. These services varied from one private hospital to another thus giving different preference to the consumers (patients) because of their demographics, accessibility, service quality and cost.

3.4 Target Population

Shao (1999) defines a population or universe as the aggregate of all the elements. A population must be defined in terms of elements(patients).Assuming all patients beds are occupied, the study only focused on the 9 Private hospitals in Nakuru which offer in patient services. The study was conducted amongst a population of 206 in-patients assuming all the bed capacity is occupied. The study considered the determinants of consumer preferences of health services provided by private

hospitals in Nakuru County, Kenya in year 2016 between the months of August to October. Nakuru town was chosen because of the larger number of private hospitals and also a place where the county administration is based. The researcher conducted the research to give an understanding of the determinants of demand of health services provided by private hospitals in Nakuru County, Kenya. The accessible population is summarized in table 3.1

Table 3.1: Summary of the bed capacity in private hospitals in Nakuru County

Private Hospitals	Population
Valley Hospital	25
Nakuru War Memorial	36
Nakuru Nursing & maternity Home	30
Mediheal Hospital	20
The Nairobi Women	15
St. Elizabeth Medical Centre	10
Evans Sunrise Medical Centre	40
Baraka Maternity & nursing Home	15
Crater Medical Centre	15
TOTAL	206

Source: Local Authority Business Register, 2016

3.5 Sample Size and Sampling Procedure

Purposive sampling was used to select the desired sample from the population that was involved in the study on the private hospitals in Nakuru County offering a wide range of health services. The method was also used for sampling the respondents (in-patients with minor ailments who were able to fill the instrument) who were expected to provide information on service quality. The customers (patients) and more specifically the in-patients gave information on their customer demographics, hospital accessibility, service quality and hospital service cost in relation to their demands on the private hospitals. The rationale behind this was to ensure that only private hospitals with well-established facilities and have been in operation for a reasonable period of time to take part in the study.

The sample size (n) of the study was determined using Israel (1992) as shown in the equation 1 below:

$$n = \frac{N}{1 + N(e)^2}$$

$$n = \frac{206}{1 + 206(0.05)^2} = 136$$

Where;

n = optimum sample size,

N = number of bed capacity in private hospitals,

e = probability of error (i.e., the desired precision, e.g., 0.05 for 95% confidence level).

Nakuru County, the sample size was the in-patient on their demand of health care providers. Stratified sampling techniques were used to ensure that all hospitals (private) are included in the study. Convenience sampling techniques was used to determine the number of in-patients with minor ailments with assistance from the hospital staff. The patients were selected purposely provided they were willing to give information on the determinants of their demand to the health providers. The distribution of the sample is given in table 3.2:

Table 3.2: Sample size of the Respondents

Private Hospitals	Population	Sampled Patients
Valley Hospital	25	17
Nakuru War Memorial	36	24
Nakuru Nursing & maternity Home	30	19
Mediheal Hospital	20	13
The Nairobi Women	15	10
St. Elizabeth Medical Centre	10	7
Evans Sunrise Medical Centre	40	26
Baraka Maternity & nursing Home	15	10
Crater Medical Centre	15	10
TOTAL	206	136

3.6 Instrumentation

Customers' questionnaire was used to generate the required data. Section A of the instrument captured the respondents' bio-data whereas section B and C elicited data

on determinants of consumer preferences of health services provided by private hospitals in Nakuru County, Kenya. Data collection tool was constructed using close ended Likert type statements (items).

3.7 Validity and Reliability of Research Instruments

Validity is the degree to which a test measures what it purports to measure (Orodho, 2005). It is also used to check whether an instrument is biased, the language, format and the layout of the data collection tool is appropriate (Kasomo, 2006). Before the actual study the customers (in-patients) will be checked for content and construct validity. Content validity ensures that the items in the data collection tool cover the subject area adequately whereas construct validity on the other hand ensures that the instrument actually measures what it is supposed to measure (Fraenkel&Wallen, (2000). Experts from the department of Business Administration, Kabarak University through the supervisor assisted in validating the instruments. Their comments were used to improve the instruments before the actual data collection.

According to Mugenda & Mugenda (2007) reliability is the ability of an instrument to yield the same results when used repeatedly to collect data from the same group. The customers' questionnaire was piloted for reliability using a sample of 20 inpatients drawn from the private hospitals in Nakuru County which did not take part in the actual study. The Cronbach alpha method was used to estimate the reliability coefficient of the data collection tool. This method was appropriate in situations where a tool is administered once (Kothari, 2004). The instruments yielded a reliability coefficient of 0.78 which was acceptable as recommended by Frankel &Wallen (2000).

3.8 Data Collection Procedure

The researcher sought a research permit through Post- Graduate School, KabarakUniversity. Once the permit was granted the researcher formally contacted the customers through their respective private hospitals. The researcher explained to respondents the purpose of the study and sought their consent to participate in the research. The dates and venues for administering the questionnaires were set. The respondents were briefed on how to fill the questionnaires before they are administered. Each respondent were given a questionnaire which he/she was to fill where drop and pick method was employed.

3.9 Data Analysis and Presentation

Collected data was organised, cleaned and coded, coded data was keyed into a computer and analysed with the aid of the Statistical Package for Social Sciences (SPSS) V.20. Qualitative data were analysed and presented using frequencies and percentages. Descriptive statistics which included frequency distribution tables and inferential statistics tables were used to present data. Inferential statistics were employed using multiple regression in testing the relationship between independent variables and the dependent variable. Pearson Correlation was used to test research hypotheses at 0.05 significance level.

The study employed the following regression model

$$Y = a + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon_i$$

Y=Consumer preferences on health service providers

a = Intercept term

$\beta_1, \beta_2, \beta_3$ and β_4 =Slope Coefficients

X_1 =Consumer Demographics

X_2 = Hospital Accessibility

X_3 =Service Quality

X_4 = Hospital service cost

ε_i = Error term which assumes to be normally distributed

3.10 Ethical Considerations

The major ethical issue in this study was privacy and confidentiality of the respondents. Kombo & Tromp (2006), note that researchers whose subjects are people or animals must consider ethical issues associated with carrying out a study. There are several ethical issues that must be considered when designing such studies. Safety of the participants should be one of the primary concerns of the investigator. This was accomplished by carefully considering the risk/benefit ratio, using all available information to make an appropriate assessment and continually monitoring the research as it proceeds. The investigator obtained informed consent from each research participant.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the research findings of the study and the corresponding discussions. These presentations are organized as follows: response rate and the findings for each of the four study objectives on the basis of descriptive and inferential statistical analysis. The results form the basis for discussion on the determinants of consumer preferences for health services provided by private hospitals in Nakuru County, Kenya. Computations of frequencies, averages, statistical tests like correlation, regression and ANOVA tests, were used to analyze the data guided by the research hypotheses.

4.2 Profile of the Respondents

The research focused on the determinants of consumer preferences for health services provided by private hospitals in Nakuru County, Kenya. Descriptive statistics was used to summarize quantitative data. A sample of 136 patients was used for the study out of the total population of 206. Out of the 136 sample units that were targeted, 104 patients duly completed and returned the questionnaires representing a response rate of 85%. According to Mugenda & Mugenda (2003), a response rate of 50% is acceptable for analysis publishing. The sample distribution of the respondents is as shown in table 4.1.

Table 4.1: Response Rate

Response Rate	Frequency	Percent
Returned	104	85
Unreturned	32	15
Total	136	100

4.3 Bio-data Results

This section presents the bio- data of the respondents of the study. The key characteristics of the respondents were factors such as gender, age and education.

4.3.1 Gender of the respondents

This section presents results on the gender on how they gave preferences on the health service providers on private hospitals in Nakuru. Table 4.2 represents 61.5%

who were female, while 38.5% represented the male. This implies that most female prefer going and also accompanying their children to private hospitals to seek medical services. Also most of them will seek medical services for several reasons.

Table 4.2: Sample Distribution of Respondents Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
MALE	40	38.5	38.5	38.5
FEMALE	64	61.5	61.5	100.0
Total	104	100.0	100.0	

These findings concur with Chahal, *et al.*, (2004) who found out that kids' patients cannot make their own satisfaction evaluation, and thus the mothers or caregivers make such judgments.

4.3.2: Age of the Respondents

The study sought to find out the age of respondents. Age is one of the important aspects that tend to influence the choice of hospitals. In Table 4.3, the majority of the respondents were between the age of 26-34 (29.8%), followed by 35-44 (26%), 18-25 (17.3%), 45-54 (13.5%) and lastly 55 and above at 13.5%. This result implies that people below 44 years sought medical services from private hospitals.

Table 4.3: Frequencies on Age of the respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
BTW 18-25	18	17.3	17.3	17.3
26-34	31	29.8	29.8	47.1
35-44	27	26.0	26.0	73.1
45-54	14	13.5	13.5	86.5
55 AND ABOVE	14	13.5	13.5	100.0
Total	104	100.0	100.0	

4.3.2: Education level of the Respondents

The respondents were asked to indicate their education level. Table 4.4 indicates that most of the respondents had Master's degree (29.8%), followed by Bachelors

(28.8%), Diploma (26.9%) and lastly any other qualifications (14.4%). The results suggest that most of the respondents who were highly educated sought medical services from private hospitals. The study findings are consistent with Lahana, Pappa & Niakas (2011) who found out that the level of education not only influence the healthcare usage but also the type of healthcare service provider used by an individual.

Table 4.4: Frequencies on Education Level of the Respondents

	Frequency	Percent
DIPLOMA	28	26.9
BACHELORS	30	28.8
MASTERS	31	29.8
ANY OTHER	15	14.4
Total	104	100.0

Also these results corroborate findings of Lleras-Muney, (2005) who found that those with more years of schooling tend to have better health and well-being and healthier behaviours. Education is an important mechanism for enhancing the health and well-being of individuals because it reduces the need for health care, the associated costs of dependence, lost earnings and human suffering. It also helps promote and sustain healthy lifestyles and positive choices, supporting and nurturing human development, human relationships and personal, family and community well-being.

4.4 Descriptive Statistical results

This section presents the descriptive results emerging from analysis of the specific objectives of the study. The independent variables that were investigated were; to examine the extent to which customer demographics, accessibility, service quality and health service provider's cost influences consumers' choice. The response is ranked from very great extent, great extent, moderate extent, little extent and no extent on the lower side. The tables show the respondent's responses on determinants of consumer preferences for health services provided by private hospitals in Nakuru County.

4.4.1 Consumer Demographic and Consumer preference for health services

Consumer demographic looks at how a person's characteristics and ways of behaving are largely determined by his or her adjustment to the environment. From Table 4.5 most respondents had moderate extent (35.6%), great extent (31.7%), very great extent and little extent (11.5%) and no extent at 9.6% response inclination. This means that consumer demographics factors(age, gender, education and religion)was one of the determinant at ($X=29.558, P<0.05$)when consumers are making preference on which private hospital to attend to a moderate extent.

Table 4.5 Cumulative Descriptive percentage Consumer Demographic

	Frequency	Percent	Valid Percent	Cumulative Percent
Very great extent	12	11.5	11.5	11.5
Great extent	33	31.7	31.7	43.3
Moderate extent	37	35.6	35.6	78.8
Little extent	12	11.5	11.5	90.4
No extent	10	9.6	9.6	100.0
Total	104	100	100	

($X=29.558, P<0.05$)

This study concurs with research conducted by Chahalet *al.* 2004; Cohen, 1996; Hall and Dornan, 1988 who found that characteristics such as age and educational level conveyed by the health provider are significant predictors of health care satisfaction. It is also consistent with Narang 2010 who found out that income is a factor that affects people preferences for services of the hospital.

4.4.2 Hospital Accessibility and Consumer Preference for health services

The distance between the hospital and the patient's residence are considered as measures of accessibility to health care. Health care organisations, whose products are primarily' services, must consider three distribution decisions: physical access, time access, and information all and promotional access. Table 4.6 show that the respondents are affected by distance to a great extent (43.3%), moderate extent (31.7%), little extent (15.4%), very great extent (5.8%) and no extent (3.8%). This findings implies that consumers consider factors like physical access, time access, and information all and promotional access at ($X=60.519, P<0.05$) when making preference on which private hospital to attend to.

Table 4.6 Cumulative Descriptive Percentage on Hospital Accessibility

	Frequency	Percent	Valid Percent	Cumulative Percent
Very Great Extent	6	5.8	5.8	5.8
Great Extent	45	43.3	43.3	49.0
Moderate Extent	33	31.7	31.7	80.8
Little Extent	16	15.4	15.4	96.2
No Extent	4	3.8	3.8	100.0
Total	104	100.0	100.0	

(X=60.519, P<0.05)

The study supports Melin & Granath, (2004) who acknowledges that hospital accessibility implies the customer's/ patient's ability to easily arrive at and depart from the service location or to experience the service without great difficulty due to effective spatial orientation and layout. Also Singh & Shah (2011) found out that availability of good doctors, nearness to the hospitals, infrastructure of the hospital, recommendation from the friends/relatives and affordability came out to be the most preferred reason for selecting the particular hospital which agrees with the findings for the study.

4.4.3 Service Quality and consumer preference for Health services

Quality of service is the gap between customer's expectations and perception of service. Regarding the patient choice of health service providers, Table 4.7 shows that most respondents agree to a moderate extent (34.6%), great extent (32.7%), very great extent (16.3%), little extent (14.4%), and no extent (1.9%) are affected by service quality. This means that patients made a serious consideration on quality at (X=38.788, P<0.05) when making a choice on which hospital to attend. Thus the assumption is that patients are becoming more sensitive on hospital service quality.

Table 4.7 Cumulative descriptive percentage on service quality

	Frequency	Percent	Valid Percent	Cumulative Percent
Very Great Extent	17	16.3	16.3	16.3
Great Extent	34	32.7	32.7	49.0
Moderate Extent	36	34.6	34.6	83.7
Little Extent	15	14.4	14.4	98.1
No Extent	2	1.9	1.9	100.0
Total	104	100.0	100.0	

(X=38.788, P<0.05)

The findings are consistent with Kamgnia (2008) findings who found that most important reason for choosing health service providers is quality. Also it is consistent with Leonard *et al.*, (2003) who established the importance of perceived quality on the utilization of healthcare services as reporting that with an increase in perception of the healthcare services the likelihood to utilize those services increase.

4.4.4 Hospital Service Cost

Table 4.8 illustrates that most respondents agree to a very great extent (36.5%), moderate extent (21.2%), little extent (20.2), great extent (20.2%) and no extent (2.9%) agree that they are affected by hospital service cost of services offered by private hospitals. This implies that patients were concerned with the hospital service cost at (X=29.558, P<0.05)that the hospital gave preference in when settling their medical bills.

Table 4.8 Cumulative Descriptive Percentage on Hospital ServiceCost

	Frequenc y	Percent	Valid Percent	Cumulative Percent
Very Great Extent	38	36.5	36.5	36.5
Great Extent	20	19.2	19.2	55.8
Moderate Extent	22	21.2	21.2	76.9
Little Extent	21	20.2	20.2	97.1
No Extent	3	2.9	2.9	100.0
Total	104	100.0	100.0	

(X=29.558, P<0.05)

This research supports findings by Ngugi (1999), Amaghionyediwe, Aryeetey & Kanbur (2008) that the cost of seeking care both in terms of cash payment and time spent waiting for services affects the decision to seek care from a particular provider. Also it supports Hibbard & Weeks, 1987; Odwee, Okurut & Adebua, 2006; Ngugi, 2008 and Thuan, Lofgen, Lindholm & Chuc, 2008 who identified that out of pocket payments and the individual belief in the competencies of the provider as important determinants of the choice of healthcare provider.

4.5 Pearson Correlation Results

Correlation between variables is a measure of how well the variables are related. The most common measure of correlation in statistics is the Pearson Correlation (technically called the Pearson Product Moment Correlation or PPMC), which shows the linear relationship between two variables. Results are between -1 and 1. A result of -1 means that there is a perfect negative correlation between the two values at all, while a result of 1 means that there is a perfect positive correlation between the two variables. Result of 0 means that there is no correlation between the two variables (Gujarat, 2004).

The study sought to determine the determinants of consumer preferences for health services provided by private hospitals in Nakuru County. The study was determined using two-tailed Pearson correlation analysis. This provided correlation coefficients which indicated the strength of relationships. Thus, both the strength of the relationship between variables and the level of statistical significance were assessed. The p-level represents the probability of error that is involved in accepting the observed result as valid, that is, as a representative of the population (MacColl, 2004). Devore and Peck (2006) provided a guideline for assessing resultant correlation coefficients as follows: coefficients less than 0.5 represent a weak relationship, coefficients greater than 0.5, but less than 0.8, represent a moderate relationship and coefficients greater than 0.8 represent a strong relationship.

The individual research hypotheses documented earlier in section 1.4 of this research were tested. As mentioned earlier, the hypothesis of the study is concerned with determinants of consumer preferences for health services provided by private hospitals in Nakuru County. Thus, it is necessary to use statistical tests to test the strength and direction of the relationship between the variables of the study.

4.5.1 Consumer Demographic and Consumer Preference for health services

H₀₁: Customer demographics do not have a significant influence on demand for health services provided by private hospitals in Nakuru County, Kenya.

Table 4.9 Pearson Correlation results on Consumer Demographics and Consumer Preference for Health Services

Variables		Consumer Demographics	Consumer preference
Consumer demographic	Pearson Correlation	1	.248**
	Sig. (2-tailed)		.039
	N	104	104
Consumer preference	Pearson Correlation	.248*	1
	Sig. (2-tailed)	.039	
	N	104	104

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

From Table 4.9, the results reveal that there is a relatively weak positive relationship between customer demographics and consumer preference ($r = 0.248$, $p < 0.05$). Hypothesis states that customer demographics do not have a significant influence on demand for health services provided by private hospitals in Nakuru County, Kenya. The researcher accepts the alternative hypothesis (H_a) and concludes that there is sufficient evidence, at 5% level of significance that there is a positive relationship between customer demographics and consumer preference of health services provided by private hospitals in Nakuru County, Kenya. There is further evidence socio-economic and demographic conditions play an important role in choosing providers (Bir and Eggleston 2002, Rous and Hotchkiss 2000).

4.5.2 Hospital Accessibility and Consumer Preference for Health Services

H₀₂: Hospital accessibility does not have a significant influence on consumer preferences for health services provided by private hospitals in Nakuru County, Kenya.

Table 4.10 Pearson Correlation Coefficient between Effects Hospital Accessibility on Consumer Choice

Variables		Hospital Accessibility	Consumer Preference
Accessibility	Pearson Correlation	1	.367**
	Sig. (2-tailed)		.002
	N	104	104
Consumer Pref	Pearson Correlation	.367**	1
	Sig. (2-tailed)	.002	
	N	104	104

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

From Table 4.10, the results reveal that there is a relatively weak positive relationship between hospital accessibility and consumer preference ($r = 0.367$, $p < 0.05$). Hypothesis states that accessibility does not have a significant influence on consumer preferences of health services provided by private hospitals in Nakuru County, Kenya. The researcher accepts the alternative hypothesis (H_a) and concludes that there is sufficient evidence, at 5% level of significance that there is a positive relationship between hospital accessibility and consumer preference of health services provided by private hospitals in Nakuru County, Kenya. Hospital accessibility is an important issue most. Generally, patients are averse to travel time and prefer a provider that is close.

4.5.3 Service Quality and Consumer Preference

H_{03} : Service Quality does not have a significant influence on consumer preferences of health services provided by private hospitals in Nakuru County, Kenya.

Table 4.11 Pearson Correlation results on Effects Service Quality on Consumer Preference for Health Services

Variable		Service quality	Consumer preference
Service Quality	Pearson Correlation	1	.483**
	Sig. (2-tailed)		.000
	N	104	104
Consumer Pref	Pearson Correlation	.483**	1
	Sig. (2-tailed)	.000	
	N	104	104

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

From Table 4.11, the results reveal that there is a relatively weak positive relationship between service quality and consumer preference ($r = 0.483, p < 0.05$). Hypothesis states that accessibility does not have a significant influence on consumer preferences of health services provided by private hospitals in Nakuru County, Kenya. The researcher accepts the alternative hypothesis (H_a) and concludes that there is sufficient evidence, at 5% level of significance that there is a positive relationship between accessibility and consumer preference of health services provided by private hospitals in Nakuru County, Kenya. This study supports Burge *et al.* (2005), Lorelei & Nicholas, (2009) where patients were willing to choose to get better quality, but that ease of access was very important in theory and in practice. This factor has to do with the quality of the medical treatment. Whether medical treatment is high quality and whether care is delivered as agreed, the number of cancelled operations and whether patients have a clear care plan. According to Bir and Eggleston, 2002, Lonroth, 2001, Beaulieu, 2002 agree the quality of services affects positively the choice of hospitals by the respondents. Also, these findings conform to those by Kamgnia (2008) that the most important reason for choosing health service providers is quality

4.5.4 Hospital service cost and Consumer Preference

H_{04} : Hospital service cost does not have a significant influence on consumer preferences of health services provided by private hospitals in Nakuru County, Kenya.

Table 4.12 Pearson Correlation results on Hospital service cost on and Consumer Preference

Variable		Hospital Service cost	Consumer Preference
Hospital Service cost	Pearson Correlation	1	.499**
	Sig. (2-tailed)		.000
	N	104	104
Consumer Preference	Pearson Correlation	.499**	1
	Sig. (2-tailed)	.000	
	N	104	104

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

From Table 4.12, the results reveal that there is a relatively weak positive relationship between hospital service cost and consumer preference ($r = 0.499, p < 0.05$). Hypothesis states that cost does not have a significant effect on consumer preferences of health services provided by private hospitals in Nakuru County, Kenya. The researcher accepts the alternative hypothesis (H_a) and concludes that there is sufficient evidence, at 5% level of significance that there is a positive relationship between cost and consumer preference of health services provided by private hospitals in Nakuru County, Kenya. This research supports findings by Ngugi 1999; Amaghionyediwe 2008; Aryeetey & Kanbur (2008) seeking care both in terms of cash payment and time spent waiting for services affects the decision to seek care from a particular provider. Also, income reflects people's ability to pay. As income grows, people are increasingly willing to pay higher cost to obtain better quality service from hospitals.

4.6 Multivariate Regression Analysis Results

The study sought to determine consumer on health services in Nakuru County. Regression analysis was conducted between independent variables and the dependent variable. To determine the determinants of consumer preferences for health services, multiple regressions were used to address this objective.

4.6.1 Test for Model Significance

The results in table 4.13 Shows Model Summary of multiple regression analysis of Independent variables and dependent variable.

Table 4.13 Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df 1	df2	Sig. F Change	
1	.629 ^a	.396	.365	.902	.396	12.862	5	98	.000	2.181

a. Predictors: (Constant), Hospital service cost, Consumer Demographics, Hospital Accessibility, Service Quality

b. Dependent Variable: Consumer Preference

According to Table 4.1339.6% variation in the dependent variable (preference for health service) is explained by the independent variable (Determinants). The static

value of $F=12.86$ and its $p=0.0000$ proves there is a significant relationship between study variables. Durbin-Watson of 2.181 indicates that there is no serial correlation between variables. Thus this suggests that the model fits the data significantly.

Table 4.14 Anova^a

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	52.301	5	10.460	12.862	.000 ^b
	Residual	79.699	98	.813		
	Total	132.000	103			

A. Dependent Variable: Consumer Preference

B. Predictors: (Constant), Hospital service Cost, Consumer Demographics, Hospital accessibility, Service Quality

ANOVA results are presented in Table 4.14. The results indicated that the overall model was significant, that is, the independent variables provided a good fit of the model on determinants of consumer preference for health services provided by private hospitals in Nakuru county ($F=12.862$, P value =0.000). Moreover table 4.14 indicates that mean square of residual is very small (0.813) compared to regression mean square (10.460). This means that the regression line fits actual data.

4.6.2 Regression Results

Table 4.15 indicates the regression result of consumer preference and the explanatory variables.

Table 4.15: Regression Result of Consumer Preference and the Explanatory Variables

Coefficients^a

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.	Collinearity Statistics	
	B	Std. Error				Tolerance	VIF
(Constant)	.345	.334		1.033	.304		
Consumer Demographics	.021	.090	.021	.238	.012	.790	1.266
Hospital Accessibility	.109	.111	.090	.978	.031	.726	1.378
Service Quality	.279	.105	.245	2.662	.009	.726	1.377
Hospital service Cost	.258	.085	.284	3.024	.003	.701	1.427

a. Dependent Variable: Consumer preference

Regression results in table 4.15 indicated that there exist a positive relationship which is statistically significant ($\beta = 0.021$, $P < 0.05$). This implies that an increase in consumer demographics by one unit leads an increase in consumer preference by 0.279. Hospital accessibility was also found to have a positive relationship which is statistically significant with consumer preference ($\beta = 0.109$, $P < 0.05$). This shows that improvement in hospitals accessibility by one unit leads to consumer preference increase by 0.109. The results also indicate there exists a positive relationship between service quality and consumer preferences which is statistically significant ($\beta = 0.279$, $P < 0.05$). Numerically this implies that that a unit increase in service quality leads to an increase in consumer preference by 0.279. Hospital service cost showed a statically positive relationship with consumer preference ($\beta = 0.258$, $P < 0.05$)

The Estimated Regression Equation was;

$$Y = 0.345 + 0.021 X_1 + 0.109 X_2 + 0.279 X_3 + 0.0258 X_4, \text{ where;}$$

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

This study sought to examine the determinants of consumer preferences for health services provided by private hospitals in Nakuru County, Kenya. Specifically, the study investigated four independent variables; to examine the extent to which customer demographics, hospital accessibility, service quality and hospital service cost influences consumers' choice. This chapter summarizes the findings of the study, draws conclusions and makes recommendations for further studies. The conclusions drawn are on the basis of the specific objectives and research hypotheses of the study.

5.2 Summary of the Findings

This section summarizes the findings of the study on the basis of the specific research objectives of the study.

5.2.1 Influence of customer demographics on consumer preferences for health services among private hospitals.

The first study objective of the study was to examine influence of customer demographics on consumer preferences for health services among private hospitals. The results indicate that the patients considered income, current age, gender and religion when making choices on whichever private health care to attend. Customer demographic was positively related to consumer preference although weak ($r = 0.248, p < 0.05$) and statistically significant.

5.2.2 Effect of hospital accessibility on consumer preferences for health services among private hospitals.

The second study objective of the study was to examine the effect for hospital accessibility on consumer preferences of health services among private hospitals. The results indicate that the patients considered the hospital location, time spent in the hospital, information access and promotional activities when making choices on whichever private health care to attend. The results reveal that there is a relatively weak positive relationship between Hospital accessibility and consumer preference ($r = 0.367, p < 0.05$) and statistically significant.

5.2.3 Influence of Service Quality on consumer preferences of health services among private hospitals.

The third study objective of the study was to examine influence of service quality on consumer preferences of health services among private hospitals. The results indicate that the patients considered staff professionalism, medical facilities, personalised medical services and hospital's reputation when making preferences on whichever private health care to attend. According to the results there is a relatively weak positive relationship between service quality and consumer preference ($r = 0.483, p < 0.05$) and statistically significant.

5.2.4 Effect of hospital service cost on consumer preferences of health services among private hospitals.

The fourth study objective of the study was to examine influence hospital service cost on consumer preferences of health services among private hospitals. The results indicate that the patients considered the mode of settling hospital bill and hospital's acceptance of NHIF card when making preferences on whichever private health care to attend. The results reveal that there is a relatively weak positive relationship between hospital service cost and consumer preference ($r = 0.499, p < 0.05$) and statistically significant.

5.3 Conclusion

Based on the findings, the study concludes that patients' choices are determined by a complex interplay between a variety of patient and provider characteristics. There is no such thing as the typical patient: different patients make different choices in different situations. Patients often attach greater importance to their own previous healthcare experiences or to general patient recommendations than to comparative information. Additionally, patients base their decisions not only on outcome indicators but on a variety of provider characteristics. In relation to the objectives, it is concluded that:-

5.3.1 Influence of customer demographics on consumer preferences for health services among private hospitals.

Customer demographics play a key role in influencing consumer preferences for health service providers. The study concludes that consumer demographics influences

consumer preference for health service providers; if the private hospitals articulate and understand these factors well hospitals will know what variables to concentrate on.

5.3.2 Effect of hospital accessibility on consumer preferences for health services among private hospitals.

It can be concluded that the effects of hospital accessibility has a significant effect on consumer preference for health service provider on private hospitals in Nakuru county Kenya. This was articulated by hospital location, time spent in the hospital, information access and promotional activities.

5.3.3 Influence of Service Quality on consumer preferences of health services among private hospitals.

Service quality was found to have a weak positive relationship and consumer preference for health service providers in Nakuru County. The patients considered staff professionalism, medical facilities, personalised medical services and hospital's reputation when making preferences on whichever private health care to attend.

5.3.4 Effect of hospital service cost on consumer preferences of health services among private hospitals.

Hospital service cost on consumer preferences of health services among private hospitals in Nakuru County has a positive relationship. It can therefore be concluded that if there is a great consideration by patients on the mode of settling hospital bill and hospital's acceptance of NHIF card when making preferences on whichever private health care to attend which a positive relationship has.

5.4 Recommendations for Policy

Based on the results, findings and conclusions the following recommendations have been made.

Private hospitals play a key role in the provision of health service to people in Kenya. Therefore the findings from this study should not be underestimated. It can provide important source of knowledge for managers within the healthcare institutions, as well as the service industry in general. Health Care provider must focus towards the understanding the factors that influence the choice of health services.

The study findings indicated that consumer demographics, hospital accessibility, service quality and hospital service cost can be emphasized by private hospitals management to influence the choice of patients in hospitals.

The study recommends that private hospitals in Nakuru, should ensure they evaluate the factors that patients consider when making choices on health service providers which and competitive variables that will make the attain sustainable competitive edge. Also these findings suggest hospitals that provide quality services will be competent businesses. Further research should be carried out on macroeconomic factors and how they influence consumer preference in the health sectors.

5.5 Suggestions for Further Research

The area of determinants of consumer preferences for health services provided by private hospitals is vast and very little research has been done especially in the Kenyan context. One area for research would be a study on the other factors that were not considered in this particular study. Another study that could be carried out is on the challenges facing consumers when making preference on health service provided by private health service providers in Kenya. Another study would be on a determinant of consumer preferences for health services provided by private hospitals in other places other than in Nakuru County.

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**APPENDIX 1: LETTER OF PERMISSION TO CARRY OUT RESEARCH
WORK**

Kabarak University

Private Bag,

KABARAK

Dear Sir/Madam,

RE: PERMISSION TO CARRY OUT ACADEMIC RESEARCH

I am a Master of Business Administration student at Kabarak University conducting a research study entitled **“DETERMINANTS OF CONSUMER PREFERENCES FOR HEALTH SERVICES PROVIDED BY PRIVATE HOSPITALS IN NAKURU COUNTY, KENYA”**. The purpose of this letter is to request you for permission to interview members of your organization using the questionnaire copies attached. You are kindly requested to fill in the questionnaire with precision and accuracy. The questionnaire is supposed to assist in answering specific objectives of the research which is being undertaken as part of the University requirement. Any information given herein will be treated with utmost confidentiality and only be used for the purpose of research. So kindly feel free to fill the questionnaire.

Thank you.

Yours faithfully,

Lydia . C. Langat

APPENDIX 2: RESEARCH QUESTIONNAIRE

Please answer all the questions honestly and exhaustively. Tick (✓) or fill up the box at the appropriate blank

SECTION A: GENERAL INFORMATION

1. Kindly indicate your gender

Male Female

2. Age

Between 18-25 26-34 years 35-44 years 45-54
55 and above

3. Highest education level

Diploma Bachelors Masters Any other

4. For how long have hospitalized.....

5. Attributes used to measure the hospitals quality. Do you agree that these factors influence on a scale of 1-5, where 1=Very Strongly agreed, 2= Strongly agreed, 3=Moderate agreed, 4= Slightly agreed, 5= Disagreed?

SN	Statements	Very Great Extent	Great Extent	Moderate Extent	Little Extent	No extent
1	Cost consideration affect your choice on which private health care to attend					
2	Infrastructure consideration affect your choice on which private health care to attend					
3	Availability of specialist physicians & surgeons affect your choice on which private health care to attend					
4	Patient urgency affect your choice on which private					

	health care to attend					
5	Suggested by friends & relatives affect your choice on which private health care to attend					
6	Referred by consulted doctors affect your choice on which private health care to attend					
7	Security consideration affect your choice on which private health care to attend					
8	Media influence affect your choice on which private health care to attend					
9	Reimbursement affect your choice on which private health care to attend					

SECTION B: CONSUMER DEMOGRAPHICS

1. To what extent does consumer demographics affect your preference of health on a scale of 1-5, where 1=Very Great Extent, 2=Great Extent, 3=Moderate Extent, 4= Little Extent, 5= No Extent?

SN	Statements	Very Great Extent	Great Extent	Moderate Extent	Little Extent	No extent
1	I normally consider my income level when making a decision on which private health care to attend					
2	I normally consider my current age when making a decision on which private health care to attend					
3	I normally consider my gender when making a decision on which private health care to attend					
4	I normally consider my religion when making a decision on which private health care to attend					

SECTION C: HOSPITAL ACCESSIBILITY

1. To what extent does influence accessibility to health care affect your preference on a scale of 1-5, where 1=Very Great Extent, 2=Great Extent, 3=Moderate Extent, 4= Little Extent, 5= No Extent?

SN		Very Great Extent	Great Extent	Moderate Extent	Little Extent	No extent
1	I normally consider hospital location when making a decision on which private health care to attend					
2	I normally consider medical service time spent in the hospital when making a decision on which private health care to attend					
3	I normally consider ease of information access when making a decision on which private health care to attend					
4	I normally consider hospital's promotional activities when making a decision on which private health care to attend					

SECTION C: SERVICE QUALITY

1. To what extent does influence on service quality affect your preference on health on a scale of 1-5, where 1=Very Great Extent, 2=Great Extent, 3=Moderate Extent, 4= Little Extent, 5= No Extent?

SN	Statements	Very Great Extent	Great Extent	Moderate Extent	Little Extent	No extent
1	I normally consider medical staff professionalism when making a decision on which private health care to attend					
2	I normally consider medical facilities available when making a decision on which private health care to attend					
3	I normally consider personalised medical services when making a decision on which private health care to attend(e.g. access to doctor of choice)					
4	I normally consider hospital's reputation when making a decision on which private health care to attend					

SECTION D: HOSPITAL SERVICE COST

1. To what extent does influence on cost/price affect your choice of health on a scale of 1-5, where 1=Very Great Extent, 2=Great Extent, 3=Moderate Extent, 4= Little Extent, 5= No Extent?

SN		Very Great Extent	Great Extent	Moderate Extent	Little Extent	No extent
1	I normally consider mode of settling hospital bill when making a decision.					
2	I normally consider hospital's acceptance of NHIF card when making a decision.					

SECTION E: CONSUMER PREFERENCES FOR HEALTH SERVICES IN CASE OF SICKNESS

1. To what extent does these factors influence on a scale of 1-5, where 1=Very Great Extent, 2=Great Extent, 3=Moderate Extent, 4= Little Extent, 5= No Extent?

SN	Statements	Very Great Important	Great Important	Moderate Important	Little Important	Not Important
1	I prefer this hospital because of its accessibility					
2	I prefer this hospital because of its service cost					
3	I prefer this hospital because level of service quality					
4	I prefer this hospital because of its reputation					