Patient Perception on Service Quality Improvement among Public and Private Healthcare Providers in Nigeria and Malaysia

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Abstract Several researches were conducted to test the level of patient's satisfaction with the services of the clinics with results signifying high level of dissatisfaction. The areas of concern include fake drugs, long period of waiting to see medical personnel and over blotted crowd on the queue waiting for the same purpose. Patients search for better treatment from reception to final departure from the clinics are seriously being complain of and form part of the reform objective. This research investigated the level of satisfaction of the Nigerian and Malaysian patients with the services rendered by the public and private clinics operating in the country after the reform in NHS. The areas covered by this research include genuine drugs (quality of service), less waiting time (Patient value) and better treatment (patients satisfaction) in the clinics. The total sample for this research is 750, for the initial quantitative and 12 participants for Nominal Group Technique (NGT) conducted to revalidates the previous data. Stratified random sample was used, and the analysis was conducted using regression with Difference in Difference model. SPSS version 16 serves as the analysis software. The results shows 62.5% genuine drugs, less waiting time, and better treatment in Malaysia better than Nigerian with 28.5%. The results of the overall satisfaction and improvement registered after the reform shows 1.5% genuine drugs, 3.1% reduction in queuing or waiting time to receive treatments in the private clinics more than in public, 5.4% better treatment in the privates more than in the public clinics. The conclusion suggests more time for the reform to records its needed results. The NGT results supported most of the results of the previous data as can be seen in the results of both the relative weight and absolute and ranking by the NGT analysis [Table 1]. Both the result of NGT and that of regression model suggested that more stringent control measures should be put in place to supervised the operations of the public clinics especially not-for-profit public clinics and private for profit to regularized some sharp practices that blocked the recording of the needed success in the reform considering the low percentage success recorded. The whole programme need to be patient centered not profit centered as it seems to be presently.

Keywords: patients, NHS, public-private partnership, satisfaction, perception

1. Introduction

There has been series of researches on healthcare service accessibility, affordability, equity, less waiting time, availability of consultants and specialists in the clinics, drugs availability [1]. Patients to nurse ratio and Medical Doctors to patient's ratio have been top most issues under investigation by the world health professionals [2]. There has also been series of research on healthcare finances and budgetary allocations to healthcare by countries, mortality rate, morbidity ratio and host of other health and healthy condition indices [3]. But very scanty or near absence of studies that really touch on the quality of services by conglomerating the indices mention in the beginning of this section to determine whether the reform being undertaking by different countries is really delivering a qualitative service to myriad of customers attending both public and private for profit or private and public not for profit hospitals. Several studies were conducted in other service industries such as hotels and recreational places to measure the level of the service quality in such places [4]. But little or no research is conducted to check the adverse practices being witnessed in essential services industries like hospitals. With the exception of the few individual encounters, either scantly reported by the media or is left with no record to show anywhere. Recognizing the importance of this sector and the consequences of dearth in data in the area of assessing the level of service quality will do to the sector in the long run prompted this study. This type of

study will serve as a wakeup call for all healthcare service industries to know that the world and indeed the communities their service is impacting on are on the watch. It will also serve as guide to internalizing the concept of service quality and other models that will be mentioned in this research. To expatiate on this, [5] conducted a study which reveals that there exists a relationship between service quality and customer satisfaction with the services rendered.

2. Literature Review

In trying to rate the factors that meets customer satisfaction many scholars have advanced argument citing a number of reasons. Scholars like, Reference [6,7,8], opined that ethical consideration and organizational culture serve as the major gladiators for evolution of service quality, this is in addition to fair treatment of the stakeholders that form part of the organization. Organizational culture if well planned and strictly adhered to will produced an informed result that will meet the needed customer satisfaction notwithstanding the nature of business and organization. It work with positive results in a traditional medicine set up as shown by the study conducted in Bangladesh traditional diabetes medicine [9]. There is no doubt that a number of hypotheses and theories were formulated to describe the element that can best describe the customer satisfaction with the kind of services rendered. Most of the hypotheses try to expatiate on certain tangible variables to make final conclusions. While others believed the customer satisfaction work more in consonant with time, in a nutshell only time will tell since satisfaction is a perceptional product. This type of assertion was corroborated with the study conducted by Reference [10], to determine the applicability of the postulations of the popular SERVQUAL hypotheses to measure hotel service quality. Reference [10] constricted his study on the basic presumptuous position of most customers. The study uses the customer level of expectation and perception about the organization and its services as basis for measurement. The study concentrated on studying the customer level of satisfaction with the services they always receive at the reception on arrival to a hotel. The guiding principle of the research was the basic assumptions in the SERVQUAL model of five dimensions which includes reliability, responsiveness, assurances, tangibility and emphatic approach and response by the staff of the organization. This is so because several other scholars are of the opinion that determination of service quality can best be done by the use of the SERVQUAL five major dimensions, [11-22].

Study to determine the relationship between customer expectation and management perception not customer perception reveals a very big gap; this is in addition to the usual gap existing between service delivery and service quality specification by the organization. Most of the time these considerations triggers dissatisfaction that is likely to affects either the customer repeat visit or the organization in general [23]. The study conducted by Reference [24] on another service industry by testing three presupposes models of service quality model, service quality and culture and institutional food service reveals interesting results. Testing whether there is in existence an influence on the tourist's satisfactory behavior with the various services the tourists guide is introducing them to. A study was conducted by Reference, [25] the research reveals that there is a significant influence on the level of the tourist's satisfaction with the services they were introduced to by the guide. The study reveals that perceptional indices varies based on the tourists regional affiliation, money value of the services, quality of the services, variety of the services, standard of the services, service speed and waiting time became prominent observed perception of the tourists. This same indices guide their decision of satisfaction or dissatisfaction with the services rendered to them.

2.1. Expectation and Satisfaction

Patient's satisfaction is the key element in a healthcare service industry. The belief that the service of the clinics, environment, workers and consultant will cure the patients make the most tool for an enabling perceptional level of the patient rise and remain consistent with the clinic. These types of evaluation about the patient's state of mind as to whether or not the service quality meets his pre-treatment expectations makes his repeat or not visit to the clinic eminent. In essence any services that fails below the patients expectation makes such patients dissatisfied and disillusions his second visit to the clinic. This is supported by the research conducted by References [21,26,28]. The need for all the stakeholders in the healthcare service industry to recognized that the satisfaction of the customer is one prominent aspect of all market oriented organization is now. This is so considering the fact that activities that has direct relationship with marketing of products should never be accelerated towards having head on collision with negative customer outcome. Knowing full well that one very important goal of meeting customer expectation and satisfaction is to make him repeat his visit, attracts new customers, gain higher market returns and share, expand the business and increase profitability [29,30]. Crowning the perceptional direction of the patients as a customer and relying heavily on the assumption of the SERVQUAL model satisfaction connotes patient's judgment on the level of fitness of purpose of the service and the quality of service delivered at that material time [31]. In a more broad explanation satisfaction encompasses the level to which the patient's expectation is met or exceeded by the service provider [32]. While in some other research satisfaction is seen as the defined quality of service that meets all the expected advantages associated with such services rendered where the service is being rendered or elsewhere [33,32]. Critical look at all these assumptions any service oriented industry should take into cognizance the expectations and needs of the customers patronizing their products with the plan in place to satisfy their expectations. [34], entirely presupposes a convenient marriage between service quality and total quality operations. To this research for continuous performance improvement with the goal at hand of attaining an improved service quality to meet the ever changing customer perception, expectation and satisfaction the marriage became eminent.

Reference [31] conducted a research on consumer satisfaction gave more credence to multidimensional approach in understanding the perception of both the

customer and the service provider. In this study the customer satisfaction was x-rayed from the available literature through scientific examination of the Reference [35] effect of perceived performance model. Reference [31] reviewed the view of the two scholars on the alternative conceptualization on the customer comparative standard and disconfirmation level that agree with satisfaction formation process. An analogy of the view was explored to determine the possibility of examining the effects of multiple comparison process in gauging satisfaction perception formation. The result of the research reveals that perceived performance has to a greater degree the ability to influence directly customer satisfaction. At the same time performance expectation has the ability of exerting additional influence and non objective or subjective disconfirmation of customer satisfaction. [36] also agree to this analogy. The researchers concluded by summing up the study with the presentation that subjective disconfirmation and expectation stand out as the best conceptualization that captures customer satisfaction formation process and reality. Therefore the ultimate conclusion remained that multiple comparison processes best interprets satisfaction formation processes [31,34]. A similar result with amendment was obtained by the study conducted by [37]. In essence to understand patient's level of satisfaction with clinical services a multiple comparison process is the best tool to use as conceptualized by, [37].

Further argument and research by a number of researchers bring to note that customer value (less waiting time), Service quality (genuine drugs), and customer satisfaction (better treatment) are increasingly getting serious concerned by service providers and host of other organizations. This is as results of sophistication brought about by competition and scramble for the available customers in a customer oriented business environment of today [36]. The study concludes that customer value (less waiting time), service quality (genuine drugs) and satisfaction (better treatment) are varied and available studies are usually inconsistent in the determination of the intertwining relationship between them [36]. This therefore made the research an inconclusive one especially in the area of the determination of the moderating role or impacts of customer value, on the customer satisfaction and service quality on customer satisfaction and the other way round [36]. This call to question the acclaimed quality impacts factor on the variables investigated in most customer perception and satisfaction studies.

Reference [37], further research, asserts that it seems very difficult to locate convincing studies related to the study of customer value, and customer satisfaction being influence or moderated by service quality supported by convincing evidence to that effect. Neither are there studies that focus on service quality, and customer value, to have strong influences on customer behavior intentions in the healthcare service industry [1].

2.2. Genuine Drugs and Public-Private Partnership in Healthcare Service Delivery

One very serious issue with the Nigerian market is the widespread existence of fake drugs usually imported or locally produced under an unhygienic condition, [1]. The attempt to introduce a new healthcare provision is to limit if not to totally eradicate this type of sharp practices that has the potentiality to jeopardize the life of citizens [38,40]. In trying to ensure an effective transition from the public to some level of private participation in healthcare services provision in which drug supply is one Malayisian government created a health account, [39,40]. The American government under, set aside $320 billion meant to serve as a health care savings for at least a decade in which genuine drug purchase for low income and incapacitated citizens is the target [41]. Part of the plan is to subsidized drugs for low income Americans by requiring manufacturers to cover such citizens using American Part D, prescription drugs and the government will pay the subsidy. Some of those American house leaders and organizations who assisted in this direction include the Simpson-Bowles Debt Commission and Congressmen Henry Waxman and Pete Stark who facilitated legislation to back up the programme [41]. The savings was able to produce an estimated 42% of the total proposed American health care savings, which was an equivalent of $135 billion. In addition to this there was the American best private price for drugs introduced in 2006, alongside Part D rebate system, which requires that Medicaid receive drugs at either the manufacturer sells price or a price 15.1% below the average manufacturer price for that drug, whichever is lower [41,42,43,44,45].

2.3. Better Treatments and Public-Private Partnership in Healthcare Service Delivery

Parliamentary and Health Service Ombudsman [46], conducted a research with several variables to determine the level of satisfaction of the various patients attending health services in the US after the healthcare reform. The variables includes, patients overall satisfaction with the services in the clinics the customer responded I was treated very fairly, I was kept informed of progress in case I have a referral. These aspects scored 70% compared with the previous year's score of complain accounting for about 81%. On the aspects that has to do patients complain with the services the patients responded thus, the workers were polite and professionals, always taken time to listen and understands the patients challenges 93% were satisfied and 7% were neither satisfied nor dissatisfied with the services, while customer service receives commendation from the patients with the assertion that they were available when ever needed or call back when busy. The customer service centre received the following results from the patients assessments that, 14% of the patients believed that the service department can confidently handle patients complain, 79% felt that their complaints are well understood, 42% approves that the customer service kept them informed, 81% felt the customer centre can easily be reached on, 66% believed that the staffs are polite, 36% acknowledge that the staff are extremely helpful [46].

2.4. Waiting Time and Public-Private Partnership in Healthcare Service Delivery

In a study conducted to investigates the impacts of reform in healthcare services delivery and its effects on patients waiting time a number of revelations were [47]. To conduct the research several literatures were consulted

and reviewed using service delivery initiatives (SDI) index on waiting time of the patients. The waiting time of the patients specifically targeted the period of 1995 to 2013 considering the fact that healthcare services are dependent on time. As part of the criteria set up for the research Cochrane EPOC risk bias tool was specifically used in the assessment of the level of bias on selected studies out of which 57 articles pass the test and were included in the study. Of interests to this research are types of studies included to determine the service quality and waiting time in the articles included [47,48]. The articles included cover areas such as extended scope practice, ESP, quality management, productivity enhancement technology PET's, Multiple Intervention MI, outsourcing and pay for performance OPP [47]. The study also used the pre and post reform analysis this is in addition to using meta analysis to cover for the heterogeneity of the of respondents involve, [1,47]. The study concludes that there should be a special study design to investigate the level of patients waiting time and defined the period that can be said to be outrageous [47].

Reference [49] study and revealed that the healthcare service delivery challenges cut across both developed and developing countries with long waiting time before seeing a consultants or professional becoming more intense. These challenges according to Reference [49] necessitated the coming up of different reforms and methods of delivery to reduce the intensity of such challenges. This therefore evolves the integrated care pathways in the developed countries, National Health Insurance Scheme in Nigeria and Ghana, Health Care Accounts in Malaysia and hosts of other systems with hope of improving services delivery, reduce waiting time, ensure genuine drugs and better treatments of patients, [38,39,49]. These policies were plotted with the aim of ensuring that patients receive relevant clinical interventions, the right assessments in a timely manner, and genuine changes in practice. It will serve as a platform 2 ICPs can be effective in improving the documentation of rehabilitation goals, easy communication with patients, care givers, diagnosis, prognosis and eminent follow-up arrangements as well as notification of primary care physicians or discharge [49].

A number of studies confirm that the long the waiting times for some selected patients due to clinical or administrative procedures the more distress condition sets in among patients. The adverse health consequences associated with longer waiting time constitutes or serves as an easier gateway to perceived inappropriate delivery and planning of health care system [50]. To test the level waiting time a study was conducted based on clinical attendance priorities by streamlining certain surgery services. In this study the numbers of semi-urgent patients waiting longer than 90 days were reduced to 28 or more patients, the action recorded no significant effects on waiting time for urgent patient's bill to wait for about 30 days versus the normal 365 days or less for the less urgent patients [50]. To reconfirm whether an intervention can serve a purpose an evaluation of the referral and intake assessment was conducted in seven out of the many studies the results reveals that an open access to laparoscopic sterilization assisted in reducing waiting time of patients with urinary tract syndrome (LUTS) by 30%, but entirely different results was reported for patients with microscopic haematuria [50]. A research conducted on paediatric patients and direct booking system reveals results showing direct reduction of waiting time especially for paediatric of 25.2 days and a follow up later shows a decrease of 3.03 days per month on proportion of patients receiving colposcopy appointment within the recommended time [50].

Reform basically aimed at not only making healthcare available to the citizens but also to reduce waiting time increase financial incentives for providers, reward performance and improve quality service to the patients. Despite this lofty goals studies reveals that the success recorded in the improvement of quality of service in primary care is still very [50].

From the literature it became apparent that the healthcare and safety service providers must concern themselves with the following; the design in mind of meeting customer satisfaction by providing better services, genuine drugs and reducing waiting time [51]. This is also supported by Reference [50,52] and suggests the inclusion of identification of customer needs and expectations and make it become part of the service design and delivery as well as service quality standards. Reference [52] added that in doing this the design of all products and services must meet customer expectations and targets to specific customer needs. The design should also be accepted by the employees and it should cover specific job description or dimension, measured and be reviewed through receipt of feedback and open door for challenges and realistic advices [52].

In this research, much attention is dedicated to testing whether the reform introduced in Nigeria and Malaysia succeeded in improvement the perception of the citizens standing in as (customers) to be satisfied with the services of both the public and private clinics standing in as (providers) in the provision of healthcare service in the countries. This is basically in the area of getting, better treatment by comparing present services with the previous one before the introduction of the reform, obtaining genuine drugs and experiencing less waiting time as part of the variables to measure customer perception, expectation and satisfaction with the services. The three variables mentioned represents the variables mentioned in SERVEQUAL prepositions of customer value (Less Waiting Time), Service Quality (Genuine Drugs) Customer Satisfaction (Better Treatment). The attention in this study concentrated on the dynamism of the relationship between perceived behavior, expected behavior and the customer (citizens) eminent satisfaction with the services based on better treatment, genuine drugs and less waiting time. The other aspects try to establish whether time really matter in the determination of its influence on both customer value, (less waiting time) service quality (genuine drugs) and customer satisfaction (better treatment). This is what guides the formation of the model of this study thus:

3. Material and Method

The study uses a questionnaire and revalidated the data using Nominal Group Technique to collect information on the patient's perceptions of reform in healthcare products delivery in Nigeria and Malaysia. The research targets the perception of patients on the level of their satisfaction

with the services after the introduction of reform in the sector. Specifically the research measures the level of patient's satisfaction with the waiting time before being attended by the medical Doctor or specialists in the clinics, on whether there is an improvement in the treatment being received in the clinics and whether or not are getting genuine drugs from both the private and public hospitals after the reform. The questionnaire items were adopted from previous researches. It was structure in a five likert scale with 1= strongly disagree, 2= disagree, 3= neutral, 4=agree and 5= strongly agree. While the Nominal Group Technique was structured based on the stages mentioned by Reference [53,54,55] thus;

Step 1. Present evaluation questions to the large group of learners

- What were the strengths/highlights of the course?
- What were the weaknesses/suggestions for improvement?
  Step 2. Silent phase
- Form small groups of four to eight participants, each with a flip chart.
- Assign a faculty facilitator, or elect a scribe for each group.
- Issue five pink and five yellow "stickys" to each participant.
- Without conferring or group discussion, participant's record one, strength on each pink sticky and one weakness/suggestion for improvement on each yellow sticky.

Step 3. Round-robin phase

- Participants stick one pink sticky in turn on the flip chart without comment or discussion until all ideas are exhausted.
- The facilitator or scribe groups similar comments together.
- Repeat the process using yellow stickys for suggestions for improvement.

Step 4. Discussion/item clarification

- The group clarifies unclear items and edits the grouped items into themes.
- The facilitator or scribe lists and letters items in order of popularity.

Step 5. Voting phase

- Participants rank their top five suggestions in each list from 1 to 5.
- Participants award 5 points to their top item, 4 to the second, and so on.
- The facilitator or scribe collects these lists for data gathering.

Step 6. Small-group data gathering

- Scribes or facilitators add the total points for each lettered item to produce a rank-ordered, weighted list of the groups' opinions of the strengths and weaknesses of the course.
- Scribes or facilitators write this list (with weightings) on the flip chart to present to the large group.

Step 7. Large-group data combining

- Reconvene the large group and examine the results from the small groups.
- Combine the small-group scores. (Small groups in this exercise usually produce very similar factors and this can be done with minimal discussion).
- Present the cohort's ranked, weighted opinions of the strengths of the course and suggestions for improvement.

Step 8. Large-group discussion around dominant t hemes

- Record or take notes on the rich discussion that now ensues.

Adapted from Reference [56].

3.1. Sample

A random sample of (750) staff of tertiary institutions and professional members from the public and private clinics and patients in both public and private clinics were randomly selected from five institutions each from Nigeria and Malaysia for the research. The questionnaire was distributed through a train research assistant from University Malaya Malaysia and Federal Polytechnic Kaduna in Nigeria from December 2010 to February 2011. Nigeria and Malaysia were chosen based on the fact that the two countries both inherited their medical systems from Britain, both started the effort to allow the involvement of private clinics to participates in healthcare service provision in the early 1980's, both implemented in 2006 and 2005 respectively. Malaysia allows private participation and health care account for that purpose in 2006 and Nigeria's National health Insurance became operational in 2005. While sample of the respondents for the NGT, were purposefully selected to meet the requirement of the technique of respondents with fore knowledge of the problem under investigation and coming from various specialties' and focus. The respondents were 12 lecturers based on the NGT minimum of 5 or 10 per group or session. The lecturers are from different field and are all beneficiaries of NHIS/NHS in Nigeria and Malaysia and are varied in their field and experience. Among them are lawyers, international studies, business education, accountancy, computer science, Entrepreneurship, Environmental Health, Nursing, Insurance and one Medical doctor. They are also from various categories of higher institutions, university, polytechnics, Colleges of Education and Nursing/Environmental Health institutions.

3.2. Respondents' Characteristics

The basic demographic characteristics of the respondents includes, in Nigeria 48.4% of the beneficiaries of the health insurance scheme are within the 38-47 years age bracket while in Malaysia 49.2% are within the 18-27 years age bracket. The above results is partially attributed to the early age under which the Malaysian citizen started working of 18-21 immediately after second or first stage of the schooling period, couple with the fact that there is an existing better opportunities for employment compared to Nigeria [57]. The results also showed that in Nigeria 75.4% of the beneficiaries of health insurance scheme are male while in Malaysia 45.2% are male. This implies more female enjoy the scheme in Malaysia than in Nigeria. And finally it can be seen that in Nigeria 82.4% of the beneficiaries of health insurance scheme are married while in Malaysia 53.6% are married. This implies more married people enjoy the scheme in Nigeria than in Malaysia.

3.3. Method of Data Analysis

The study used statistical inferential tool of log linear regression to analyze the data to determine the differences between the variables under investigation. And to establish whether the factors are really very important in

the determination of the perception of patient's level of satisfaction with the services rendered by the clinics after reform. And the above mentioned stages were used to analyze the NGT data collected from the participants to revalidates the data used for the inferential statistical analysis.

3.4. Hypothesis Testing

The following hypotheses were tested to determine the level of satisfaction of the patients with the new services being provided by both the public and private clinics after reform in NHS in the two countries.

H^{01}=There is no significant differences between service quality received in the private clinics compared with public in terms of having Genuine Drugs from private better than public in Nigeria and Malaysia, before and after the NHS reform.

H^{02}=There is no significant differences between service quality received in private compared with public in terms of having Less Waiting Time from private better than public in Nigeria and Malaysia, before and after the NHS reform.

H^{03}=There is no significant differences between service quality received in Private compared to public or having Better Treatment from private better than public in Nigeria and Malaysia, before and after the NHS reform.

Level of significance
$\alpha = 0.05$
Decision criterion
Reject H_0 if P-value is less than α -value, otherwise accept

4. Results and Discussion

Several researches were conducted to test the level of patient's satisfaction with the services of the clinics with results signifying high level of dissatisfaction. The areas of concern includes fake drugs, long period of waiting to see medical personnel and over blotted crowd on the queue waiting for the same purpose and better treatment from reception to final departure from the clinics are seriously being complain of, [49,50].

Hypothesis 1: The results of this research shows that there is genuine drugs in the private clinics more than in the public clinics in Malaysia higher than in Nigeria $\beta_1 = 26.462$ to expatiate on this results the regression results shows that $\beta_2 = 0.591$ representing the differences achieved by the introduction of reform in NHS in the two countries signifying that the reform has ensured better drugs than before its commencement. This show that time is very important in the determination of the effects of any reform. The results of $\beta'_1 = 0.625$, represents the comparison between Malaysian and Nigerian Genuine drugs available in the private more than in public clinics, with Malaysian private clinics having 62.5% genuity of drugs compared to Nigerian 28.5% genuine Drugs in private than in public clinics. This results is supported by the research conducted MEDICAID in America and the introduction of part-D prescription drug introduced in the US, which recorded 42% increase savings for the purchase

of drugs for the poor and unemployed under Obama health policy (Frank, 2015). In both Nigeria and Malaysia the overall success of the reform in the two countries $\beta'_2 = 0.015$, implying that there is 1.5% increase in the rate of genuine drugs as a results of the change in the healthcare delivery systems better than before. This call to question the euphoria associated with the reform 1.5% change may be too small to warrant such applause. But protagonist of the reform believe that patients satisfaction is what matter the certainty that this improvement is apparent in the privates move the rich and employed citizens to the private creating more chances of the budgetary allocation to afford purchasing better drugs in the public clinics. The debate supported the idea that the reform will succeed better given the time frame [41].

Hypothesis 1: The debates on whether or not reform has the capability of reducing the number of waiting time proves reasonable with the research conducted by [50], which reveals direct reduction of waiting time especially for paediatrics with 25.2 days and a follow up later shows a decrease of 3.03 days per month on proportion of patients receiving colposcopy appointment within the recommended time [9,48]. The results of this research shows a similar outcome with $\beta_1 = 26.458$ signifying that the patients witnessed less waiting period in private hospitals compared to public hospitals in Malaysia more than in Nigeria after the reform. The results further shows that the introduction of public private partnership has ensured fewer queues than before with, $\beta_2 = 1.974$. Comparing the degree of satisfaction by country and the expectation of the patients shows that the Malaysian private clinics witness less waiting time with $\beta'_1 = 0.625$ representing 62.5% level of patient's satisfaction with the level of fewer queues in Malaysian private clinics compared to Nigeria 28.5%. The results representing general satisfaction in the two countries by the patients on the reduction in waiting time is $\beta'_2 = 0.031$ which represents 3.1% queue rates in the private clinics' queue better than before the introduction of the public private partnership initiatives in the two countries. To reconfirm whether an intervention can serve a purpose an evaluation of the referral and intake assessment was conducted in seven out of the many studies the results reveals that an open access to laparoscopic sterilization assisted in reducing waiting time of patients with urinary tract syndrome (LUTS) by 30%, but entirely different results was reported for patients with microscopic haematuria [50].

Hypothesis 1: The results in this part of the research compare the level of patient's satisfaction that meets their expectations after the introduction of the reform in the healthcare systems in the two countries. Regression results using difference in difference model shows that the patients are satisfied with the scheme with, $\beta_1 = 26.487$ revealing that in case of patient's accident/emergency cases the private hospitals are more prompt and better than the public hospitals in Malaysia more than in Nigeria. The results of research conducted in the US shows, the patients attests that the Doctors listen with 93%, and customers service were rated in various areas with multitude of scores, 79% believed their complain was well understood, 14% are satisfied with their services, 42% believed that

they are well informed by the customer service of their case and referrals, 81% believed they are accessible and 60% believed they are polite [46]. This shows that the Malaysian patients are more satisfied with the services of their private's clinics than the Nigerian patients. In furtherance to the investigation on the level of the perception of patients satisfaction the results of regression, $\beta_2 = 2.739$ represents the impacts of the reform by making the hospitals more prompt in attending to accidents all types of patients promptly and better than before the reform. This result was supported [46]. The specific measurement replicated all the other results under the same condition and measurement apparatus with $\beta'_1 = 0.625$, showcasing the percentage of patients satisfaction with the Malaysian private clinics witnessing 62.5% more better treatment and in attending to accidents

victims than Nigerian private clinics with 28.5%. But the general measurement of the patient's satisfaction after the reform reveals $\beta'_2 = 0.054$ implying that the private clinics' treats patients better and are prompt in responding to patients compared to public with the rate of 5.4% better than before the introduction of the health care system reform in the two countries. Parliamentary and Health Service Ombudsman [46], conducted a research with several variables to determine the level of satisfaction of the various patients attending health services in the US after the healthcare reform. The variables includes, patients overall satisfaction with the services in the clinics the customer responded I was treated very fairly, I was kept informed of progress in case I have a referral. These aspects scored 70% compared with the previous year's score of complain accounting for about 81%.

Table 1. Sixteen most important factors that constitute the patients perception on clinics service quality in Nigeria and Malaysia using NGT survey

S/NO	FACTORS	RANKING SCORES	ABSOLUTE WEIGHT	RELATIVE WEIGHT	RANK
1	Public Health care clinics have more consultants than private and private clinics are restricted to available Doctors in their clinics or HMO's in both Nigeria and Malaysia	4, 3,5,1,3,1,4	21	0.12	1
2	More qualified medical personnel are in the public clinics more than in the private in both Nigeria and Malaysia	2,4,5,5,2	18	0.11	2
3	There is less waiting time in private clinics more than in public in both Nigeria and Malaysia	4,3,5,4	16	0.09	3
4	The near absence of control, monitoring and evaluation in public clinics ensued poor drugs dispensement to patients	1,1,1,5,5	13	0.08	4
5	Environmental hygiene and aesthetics is more in private clinics with NHIS/NHS in both Nigeria and Malaysia	5,4.3	12	0.07	5
6	Private clinics provides genuine drugs more than public clinics as a results of financial sharp practices in government and contracts awards in the two countries	5,5	10	0.06	6
7	More laboratory equipments in Public than in private clinics	5,2,3	10	0.06	6
8	Private clinics with National Health Insurance Scheme (NHIS/NHS) provides better treatments than public clinics with the same scheme	5,4	9	0.05	8
9	More genuine drugs in public than in private clinics	4,5	9	0.05	8
10	Private clinics lack specialists compared with public clinics in both Nigeria and Malaysia	3, 3, 2	8	0.05	10
11	Speedy patients/Doctor contacts is more in the private clinics than in the public clinics in both Nigeria and Malaysia	2,4,2	8	0.05	10
12	Private clinics in both Nigeria and Malaysia have genuine drugs but charged higher than the public clinics despite the existence of NHIS/NHS	4, 4,	8	0.05	10
13	Sufficient and qualitative drugs as a results of NHIS/NHS reform in Nigeria and Malaysia	3, 4,	7	0.04	13
14	Medical services provided despite the reform are biased towards urban populace compared to rural populace	5, 2	7	0.04	13
15	Modern equipment are usually found in private clinics more than in public in both Nigeria and Malaysia	3, 1, 3	7	0.04	13
16	More attention to patients in private than in public in both Nigeria and Malaysia	3, 2, 2	7	0.04	13
	TOTAL	**170**	**170**	**1.00**	

4.1. Brief discussion on the findings of the Revalidated data of the research using Nominal Group Technique (NGT)

The normal process of conducting NGT was strictly followed from stage 1-6 i.e. as describe and suggested by Reference [53,54,55,56] thus:

1. Presentation and introduction of the technique and questions to the respondents to start developing an opinion.
2. Period of silent observation to reflect on the question put forward and write individual opinion on the subject under investigation.
3. The facilitator will then requests for the individual responses from individual member in a round robin manner and records the responses in an open place where each member will see and read. This time for recording only no discussion yet.
4. The respondents will then be allow to discuss the ideas listed on the board or cardboard and ask for clarifications of their meaning (this is not an avenue to change the idea or to add to them any issue).
5. The participant will then individually select three, five, or eight most important ideas from the lists generated by the general respondents.
6. And finally rank them by voting individually, the most important in case of five selected will be Voted

5, therefore ranked 5, followed by 4, 3, 2, and 1. This end the participant's session. If the research has enough time after the report is done using the developed ranking matrix as can be seen on Table 1 column 3, from the matrix the most important ideas with higher ranking become the factors voted by the participant for analysis. As in this case 16 factors were selected and are discussed as follows:

From the selected factors it clearly shows that the monitoring section from the ministry of health of the two countries must work towards redistribution of consultant medical doctors to the private clinics in order to record the needed better service the NHIS/NHS is meant to ensure. The second factor touch on the same issue with an absolute weight (AW) of 18 and relative weight (RW) of 0.11 adding it together with the AW and RW of the first facto with amount to 0.23, which is 2.3% of the respondents are reporting that there is lopsidedness on the professionals tilting more to public sector than the private. This therefore agreed with the percentage score obtained from the initial research of 5.4% improvement in better treatment after 5 years this call for attention. Less waiting time has an absolute weight of 16 and relative weight of 0.09. Comparing the result of the data collected in 2010-2011 in this study with 3.2% reduction in waiting time in the private more than in the public in the two countries shows that much need to be done to improve on the already recorded success [59,60,61]. That issue was reechoed by the respondents and it was ranked 4 in terms of importance that near absence of control, monitoring and evaluation must have resulted to this. The AW scored 13 and the RW scored 0.08, which .8% success only in control, monitoring and evaluation of most of the healthcare providers and the HMO in the reform constellation. This is supported by Reference [57]. Environmental aesthetic and hygiene as part of the factor considered for better treatment scored AW 12 and RW 0.07 which is .7% in the private clinics only meaning that the public clinics need to improve seriously in the area of better treatment in a form of clinical hygiene. This report also agreed with the previous result which shows that the private clinics are better in terms of most services compared with the public clinics in the two countries. The results from the previous data shows that genuine drugs are usually more available in the private clinics, the NGT results also agree to the previous results but with only .6% i.e. AW 10 and RW scores 0.06. This also confirms the previous result as supported [58]. The result is also supported by the results in column 6, 9, 12 and 13 on Table 1. This supported the issue of genuine drugs in private clinics more than in public, with few odds against it. Better treatment was also supported by the NGT results as can be seen on column 7, 8, 11, 14, 15 and 16, that better treatment is mostly associated with private clinics more than the public clinics. While column 10 established that no is not a good percentage because public clinics house most of the specialists in both Nigeria and Malaysia. These therefore call to question the issue of better treatment in private clinics, [63,64]. This is true considering the salary associated with most experts to some level only government can afford to shoulder such amount. The 5.2% recorded by the previous data collected in 2010-2011 is still valid considering the percentage of success over 100%. 5.25% is a little small compared with

the euphoria associated with the reform in the two countries. Another very important result revealed by the NGT analysis is the report that medical service provided despite the reform are biased towards urban populace more than the rural community, on column 14 with AW 7, RW 0.04 and ranked 13 in importance shows that the control, monitoring and evaluation units need to improve on the area of the universal coverage of the scheme of all locations and settlements.

5. Conclusion and Recommendation

Patient's perception and expectation for qualitative service that will improve drugs administration, experience less waiting time and a better treatment in the various constellations of clinics in operation scored various percentage of improvement as a result of the new delivery system. But the patients are still not much satisfied considering degree of progress recorded. The need for serious monitoring to improve on the present level of advancement is the sine quo non to be intensified. The public sector needs to be on their toes as vast majority of the citizens are heavily relying on their services when ill. The elitist's nature of the private clinics and serving as an institution that care for only economically buoyant citizens need to be change to look all encompassing.

Future research need to investigate the possibility of incorporating very strongly the patient safety concept for all the clinics in the private for profit and not for profit public clinics. This will reveal the nature and extent of sharp practices that are pulling down the progress of the reform. It will also serve a serious purpose for some of the private sector to be push to the local areas to reduce their over concentration in the urban centers. The reform should focus on affordability not only accessibility. From the results of this study though the clinics at both level are accessible but affordability seem to be a challenge as a results of economic down tune in areas of study. Future research should also investigates the role of location or settlements in terms of getting better clinical services and having access to consultants like any other citizen devoid of class and location type.

Acknowledgement

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