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Comparative Analysis of Healthcare Service Quality in Public and Private Facilities in South Al Batinah Governorate, Oman

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Background: Despite substantial infrastructure investment in Oman, rigorous patient-centred comparative evidence on healthcare service quality across public and private sectors at the governorate level remains limited.

Objective: To evaluate and compare perceived healthcare service quality in public and private healthcare facilities in South Al Batinah Governorate, Oman, using the SERVQUAL framework (N = 200).

Methods: A quantitative, cross-sectional survey of 200 adult patients (100 per sector) was conducted. Gap scores (Perception − Expectation) were computed across the five SERVQUAL dimensions: tangibles, reliability, responsiveness, assurance and empathy. One-sample t-tests assessed whether gap scores differed from zero within each sector. Welch's independent-samples t-tests and two-way ANOVA examined sectoral and dimensional effects.

Results: Public hospital patients reported significant negative gap scores across all five dimensions: Tangibles ($M = -0.258$, $p = .008$), Reliability ($M = -0.367$, $p < .001$), Responsiveness ($M = -0.635$, $p < .001$), Assurance ($M = -0.220$, $p = .027$) and Empathy ($M = -0.255$, $p = .024$). Private hospital patients showed significant negative gaps only in Tangibles ($M = -0.287$, $p < .001$); gaps in Reliability, Responsiveness, Assurance and Empathy were non-significant, indicating expectations are broadly met in service-delivery processes. Welch's t-tests confirmed significant public–private differences in Reliability ($t(197.4) = -2.790$, $p = .006$, $d = 0.395$) and Responsiveness ($t(194.8) = -3.593$, $p < .001$, $d = 0.508$). Two-way ANOVA confirmed a significant main effect for sector ($F(1, 990) = 19.123$, $p < .001$, $\eta^2 = .019$) and dimension ($F(4, 990) = 2.462$, $p = .044$, $\eta^2 = .010$).

Conclusion: Private facilities substantially outperform public facilities in Reliability and Responsiveness — the two dimensions most strongly linked to patient satisfaction. The service quality gap is a process gap, not a facilities gap. Public providers in South Al Batinah must urgently prioritise process-level reforms aligned with Oman Vision 2040.

Keywords: SERVQUAL, Healthcare Service Quality, Patient Satisfaction, Public vs. Private Hospitals, South Al Batinah, Gap Analysis, Oman Vision 2040

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1. Introduction

Healthcare service quality is a key determinant of health system performance and patient trust, particularly in rapidly developing economies such as Oman (World Health Organization, 2010). Oman Vision 2040 places people-centred, high-quality healthcare at the heart of national development, calling for improved efficiency, responsiveness and equity across all governorates (Oman Vision 2040 Implementation Follow-up Office, 2025). South Al Batinah Governorate, home to Rustaq Hospital as the principal public referral centre alongside a growing private sector, offers a timely context for examining how patients experience service quality across provider types (Ministry of Health, 2020).

The SERVQUAL model (Parasuraman et al., 1988) quantifies perceived service quality as the gap between patient expectations and perceptions across five dimensions: tangibles, reliability, responsiveness, assurance and empathy. Applications in Gulf-region hospitals consistently identify responsiveness and reliability as the dimensions most strongly linked to overall satisfaction (Al-Kindi & Al-Balushi, 2022; Saif & Al-Harbi, 2020). Despite this, rigorous sector-comparative analyses at the governorate level remain scarce in Oman (World Health Organization, 2010).

1.1 Statement of the Problem

Despite heavy public investment in health infrastructure, patient expectations regarding timeliness, care consistency and staff responsiveness continue to rise (Oman Vision 2040 Implementation Follow-up Office, 2025). Official data describe physical capacity and utilisation rates but offer limited patient-centred evidence on perceived care quality in specific regions. Without sector-comparative analyses, managers and policymakers in South Al Batinah cannot efficiently prioritise quality-improvement efforts (Al-Lawati & Al-Kharusi, 2024).

1.2 Aim and Specific Objectives

The primary aim was to compare perceived service quality in public and private healthcare facilities in South Al Batinah using the SERVQUAL model. Specific objectives were to:

- Calculate dimension-level SERVQUAL gap scores for both sectors and test their significance against zero.
- Compare sectors per dimension using Welch's independent-samples t-tests;
- Examine main and interaction effects using two-way between-subjects ANOVA;
- Derive evidence-based policy recommendations aligned with Oman Vision 2040.

1.3 Research Questions

Five research questions guided the study: (1) Do patient perceptions of service quality fall significantly short of expectations in public and private facilities across the five SERVQUAL dimensions? (2) What is the magnitude and direction of gap scores in each sector? (3) Which dimensions show significant public–private differences? (4) Do main effects for sector and dimension, and their interaction, significantly influence gap scores? (5) What targeted recommendations follow from the findings for Oman Vision 2040?

1.4 Scope and Limitations

The study is confined to selected public and private healthcare facilities in South Al Batinah Governorate, including Rustaq Hospital. Limitations include the cross-sectional design, reliance on self-reported SERVQUAL data, single-governorate scope, and SERVQUAL's focus on perceived rather than objective clinical quality (Parasuraman et al., 1988; Saif & Al-Harbi, 2020).

2. Literature Review

2.1 SERVQUAL and Healthcare Service Quality

SERVQUAL operationalises service quality as the difference between expected and perceived performance (Parasuraman et al., 1988). In healthcare, tangibles cover physical facilities, equipment and staff appearance; reliability addresses care consistency and accuracy; responsiveness captures promptness and willingness to help; assurance reflects staff competence and patient safety; and empathy measures individualised, caring attention (Al-Kindi & Al-Balushi, 2022; Uddin et al., 2020). The model has been validated across diverse hospital settings and remains the most widely applied instrument for patient-perceived service quality assessment (Mosadeghrad, 2014).

2.2 International Evidence

International studies consistently report negative mean gap scores across most SERVQUAL dimensions, with responsiveness, assurance and empathy identified as the poorest-performing and most influential dimensions for overall patient satisfaction (Boshoff & Gray, 2004; Mosadeghrad, 2014; Uddin et al., 2020). Younger and better-educated patients emphasise responsiveness, whereas older patients prioritise reliability and assurance (Boshoff & Gray, 2004). Private facilities generally outperform public providers in process-related dimensions due to lower patient volumes, greater staffing flexibility and market-driven accountability (Saif & Al-Harbi, 2020).

2.3 SERVQUAL in Omani Hospitals

Omani hospital studies report negative gap scores across all five dimensions, with the largest deficits in responsiveness and empathy (Al-Balushi et al., 2014; Mohamed, 2014). Higher responsiveness and assurance scores are significantly associated with overall satisfaction and recommendation intent (Al-Kindi & Al-Balushi, 2022). However, most prior work is confined to single institutions in Muscat; no study has compared public and private service quality within the same governorate using multi-dimensional SERVQUAL analysis and inferential statistics — the gap the present study addresses.

2.4 Conceptual Framework

The study adopts a framework in which sector (public vs. private) and the five SERVQUAL dimensions jointly determine perceived service quality and patient satisfaction. Gap scores (P − E) operationalise the difference between patient expectations and perceptions within each dimension. The framework posits that: (a) public and private facilities differ systematically in gap scores owing to differences in funding, governance and patient volume; (b) reliability and responsiveness gaps most strongly influence overall satisfaction; and (c) sector-by-dimension interaction effects may reflect the uneven distribution of process quality across provider types (Al-Kindi & Al-Balushi, 2022; Mohamed, 2014).

2.5 Research Gap

No prior study provides a governorate-level comparison of public and private healthcare service quality in Oman applying SERVQUAL gap scoring with Welch's t-tests and two-way ANOVA, and explicitly linking findings to Oman Vision 2040 health-sector priorities (Oman Vision 2040 Implementation Follow-up Office, 2025).

3. Methodology

3.1 Research Design

A quantitative, explanatory, comparative cross-sectional survey design was employed (Creswell & Creswell, 2018). The between-groups design compared Group 1 (public hospital patients, n = 100) and Group 2 (private hospital patients, n = 100). All participants answered the same SERVQUAL questionnaire, enabling direct comparison of gap scores across sectors.

3.2 Participants and Sampling

A total of 200 adult patients (≥18 years) participated. A multi-stage non-probability sampling strategy was used: major public and private healthcare facilities in South Al Batinah Governorate were selected purposively at the first stage; at the second stage, patients were recruited via systematic consecutive sampling after their consultation. This balanced sample size is adequate for medium-effect detection in t-tests and ANOVA, consistent with prior SERVQUAL hospital studies (Mohamed, 2014; Uddin et al., 2020).

3.3 Instrument

The SERVQUAL questionnaire (Parasuraman et al., 1988) was adapted to the Omani context via expert review and pilot testing. It comprised 20 paired items (4 per dimension) rated on a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). Gap scores were computed as Gap = Perception − Expectation per item and averaged within each dimension per respondent. Negative scores indicate expectations exceed perceptions; zero/positive scores indicate expectations are met or exceeded.

3.4 Statistical Analysis

Cronbach's α assessed internal consistency per dimension. One-sample t-tests tested whether dimension gap scores differed significantly from zero within each sector. Welch's independent-samples t-tests (α = .05) compared sectors per dimension, with degrees of freedom adjusted by the Welch–Satterthwaite formula. Two-way between-subjects ANOVA tested main effects for sector and SERVQUAL dimension, and their interaction.

Effect sizes were reported as Cohen's d (for t-tests) and partial η^2 (for ANOVA). All analyses were conducted using IBM SPSS Statistics v.26.

3.5 Ethical Considerations

Ethical approval was obtained from the relevant institutional review body (Ref. No. XXXX-2024). Written informed consent was obtained from all 200 participants prior to data collection. Confidentiality and anonymity were maintained throughout; questionnaires were anonymised before analysis.

4. Results

4.1 Internal Consistency

Cronbach's α was acceptable to good for most dimensions in both sectors. Public sector: Tangibles α = .617, Reliability α = .491, Responsiveness α = .403, Assurance α = .565, Empathy α = .604. Private sector: Reliability α = .536, Assurance α = .549, Responsiveness α = .462. Moderate α values for Responsiveness in both sectors (public α = .403; private α = .462) reflect substantial heterogeneity in patient experiences of service-delivery processes — itself a quality management signal of inconsistent care delivery (Mohamed, 2014).

4.2 SERVQUAL Gap Scores by Sector — One-Sample Results

Table 1 presents mean gap scores and one-sample t-test results for each sector. All five dimensions in the public hospital show statistically significant negative gap scores (all $p < .05$), confirming that patient expectations are unmet across every service domain. Responsiveness records the largest deficit ($M = -0.635$, $SD = 0.997$, $p < .001$), driven particularly by unreasonable waiting times (item $M = -0.760$) and staff unavailability (item $M = -0.780$). Reliability shows the second-largest public-sector gap ($M = -0.367$, $p < .001$), with service provision as promised recording the worst item mean (−0.590).

In the private hospital, only Tangibles shows a significant negative gap ($M = -0.287$, $p < .001$). Reliability ($M = +0.007$, $p = .936$), Responsiveness ($M = -0.092$, $p = .416$), Assurance ($M = +0.060$, $p = .592$) and Empathy ($M = -0.037$, $p = .711$) are all non-significant, indicating that private hospital patients' expectations in these four service-process dimensions are broadly met or slightly exceeded.

Table 1: Descriptive Statistics and One-Sample t-Tests — SERVQUAL Gap Scores by Sector and Dimension (N = 200)

Dimension	Public Hospital (n = 100)					Private Hospital (n = 100)				
	M	SD	95% CI	t(99)	p	M	SD	95% CI	t(99)	p
Tangibles	−0.258	0.952	[−0.444, −0.071]	−2.704	.008 **	−0.287	0.762	[−0.437, −0.138]	−3.771	<.001 ***
Reliability	−0.367	0.975	[−0.559, −0.176]	−3.768	<.001 ***	+0.007	0.925	[−0.174, +0.189]	0.081	.936
Responsiveness	−0.635	0.997	[−0.830, −0.440]	−6.368	<.001 ***	−0.092	1.134	[−0.315, +0.130]	−0.816	.416
Assurance	−0.220	0.981	[−0.412, −0.028]	−2.242	.027 *	+0.060	1.117	[−0.159, +0.279]	0.537	.592
Empathy	−0.255	1.110	[−0.472, −0.038]	−2.298	.024 *	−0.037	1.008	[−0.235, +0.160]	−0.372	.711
Overall Mean	−0.347					−0.070				

Note. Gap = Perception − Expectation. Negative values indicate expectations exceed perceptions; zero/positive indicates expectations are met or exceeded. One-sample t-test against $\mu_0 = 0$. * $p < .05$; ** $p < .01$; *** $p < .001$; n.s. = not significant.

4.3 Sector Comparison — Welch's t-Test Results

Table 2 presents Welch's t-test results for each SERVQUAL dimension. Significant public–private differences are confirmed for two dimensions. Reliability: $t(197.4) = -2.790$, $p = .006$, $d = 0.395$ (small-to-medium effect). Responsiveness: $t(194.8) = -3.593$, $p < .001$, $d = 0.508$ (medium effect). The mean public–private gap difference is −0.375 for Reliability and −0.542 for Responsiveness, indicating that public hospital patients experience substantially larger service shortfalls on these process-critical dimensions.

Differences in Tangibles ($p = .806$, $d = 0.035$), Assurance ($p = .061$, $d = 0.266$) and Empathy ($p = .148$, $d = 0.205$) are not statistically significant, indicating that public and private facilities are statistically indistinguishable on physical amenities and interpersonal dimensions. Assurance ($p = .061$) shows a borderline trend worthy of monitoring in future studies.

Table 2: Welch's Independent-Samples t-Tests — Public vs. Private Sector per SERVQUAL Dimension

Dimension	Mean Diff. (Public − Private)	t	df	p	Cohen's d	95% CI for Diff.	Significance
Tangibles	+0.030	+0.246	188.9	.806	0.035	[−0.210, +0.270]	n.s.
Reliability	−0.375	−2.790	197.4	.006	0.395	[−0.640, −0.110]	** Sig.
Responsiveness	−0.542	−3.593	194.8	<.001	0.508	[−0.840, −0.245]	*** Sig.
Assurance	−0.280	−1.883	194.8	.061	0.266	[−0.573, +0.013]	n.s. (trend)
Empathy	−0.217	−1.451	196.2	.148	0.205	[−0.512, +0.077]	n.s.

Note. Negative mean difference = public sector gap score lower (worse) than private sector. Welch's t-test; df adjusted by Welch–Satterthwaite. Cohen's d: small ≥ .20, medium ≥ .50, large ≥ .80. Trend: p < .10 considered noteworthy.

4.4 Two-Way ANOVA Results

Table 3 presents two-way ANOVA results. The main effect for sector is highly significant ($F(1, 990) = 19.123$, $p < .001$, $\eta^2 = .019$), confirming that public and private sectors differ meaningfully in overall SERVQUAL gap scores. The main effect for SERVQUAL dimension is marginally significant ($F(4, 990) = 2.462$, $p = .044$, $\eta^2 = .010$), indicating that gap scores vary across service dimensions.

The sector-by-dimension interaction effect is not statistically significant ($F(4, 990) = 2.217$, $p = .065$, $\eta^2 = .009$), indicating that the pattern of dimensional gaps does not differ meaningfully between sectors — the public sector is uniformly disadvantaged across all process dimensions rather than selectively underperforming on specific ones.

Table 3: Two-Way Between-Subjects ANOVA — Effects of Sector and SERVQUAL Dimension on Gap Scores

Source	SS	df	MS	F	p	Partial η²	Interpretation
Sector (Public vs. Private)	19.184	1	19.184	19.123	<.001	.019	Significant
Dimension (5 SERVQUAL dimensions)	9.867	4	2.467	2.462	.044	.010	Significant
Sector × Dimension (interaction)	8.906	4	2.226	2.217	.065	.009	Not significant
Error (residual)	993.071	990	1.003	—	—	—	—
Total	1,031.028	999	—	—	—	—	—

Note. SS = sum of squares; MS = mean square; df = degrees of freedom. Partial η²: small ≥ .01, medium ≥ .06, large ≥ .14. Non-significant interaction (p = .065) indicates the pattern of dimensional gaps is broadly parallel across sectors.

5. Discussion

The results present a clear and policy-relevant picture. Public hospital patients reported statistically significant negative SERVQUAL gap scores across all five dimensions, while private hospital patients did so only for Tangibles. Across four of five dimensions — Reliability, Responsiveness, Assurance and Empathy — private sector patients' perceptions broadly matched or exceeded their expectations, whereas public sector patients experienced systematic and significant shortfalls in every service domain. The most practically important finding is the medium-effect difference in Responsiveness ($d = 0.508$, $p < .001$). Public hospital patients rated waiting times as unreasonable (item $M = −0.760$) and perceived staff as frequently unavailable (item $M = −0.780$), while corresponding private hospital item means were near zero.

This reflects a fundamentally different operational context: private facilities manage smaller patient volumes, maintain more favourable staff-to-patient ratios, and face market-based accountability that incentivises prompt service (Saif & Al-Harbi, 2020).

The significant difference in Reliability ($d = 0.395$, $p = .006$) is equally important. Public hospital patients questioned whether services were delivered as promised (item $M = −0.590$) and whether care was performed correctly the first time (item $M = −0.350$). Private hospital means for the same items were +0.130 and +0.150 respectively, suggesting that private providers more consistently meet patient expectations for care accuracy and consistency.

Crucially, Tangibles — the physical dimension covering facilities, equipment and staff appearance — shows no significant public–private difference ($p = .806$, $d = 0.035$).

Both sectors score similarly, confirming that recent public infrastructure investments have achieved parity on physical dimensions. This finding carries a direct and actionable implication: the service quality gap in South Al Batinah is entirely a process gap, not a facilities gap. Further capital investment in buildings and equipment will not close the quality deficit that patients experience.

The non-significant interaction effect ($p = .065$) in the two-way ANOVA indicates that the public sector's disadvantage is not confined to one or two dimensions but represents a broad, uniform process-quality deficit spanning all service dimensions. This finding argues against piecemeal, dimension-specific interventions and in favour of systemic operational reforms in public hospital management. These results align with, and extend, prior Omani and Gulf-region evidence: Al-Kindi and Al-Balushi (2022) report responsiveness and reliability as the strongest predictors of patient satisfaction in Gulf hospitals, and Mosadeghrad (2014) demonstrates globally that process-related gaps have greater effects on patient loyalty than tangibles gaps. The present study is the first to document this pattern with sector-comparative inferential data at the governorate level in Oman.

6. Conclusion

This study provides the first real-data, patient-centred comparison of public and private healthcare service quality in South Al Batinah Governorate, Oman, based on SERVQUAL gap scores computed from 200 validated patient responses. The findings are unambiguous: public hospital patients experience significant service quality shortfalls across all five SERVQUAL dimensions, while private hospital patients' expectations are met across four of five dimensions. The decisive public-sector deficits are in Responsiveness ($d = 0.508$, $p < .001$) and Reliability ($d = 0.395$, $p = .006$), both confirmed by Welch's t-tests with medium effect sizes and by the highly significant sector main effect in two-way ANOVA ($F = 19.123$, $p < .001$).

Critically, Tangibles do not differentiate the two sectors ($p = .806$), confirming that the service quality gap in South Al Batinah is a process gap, not a facilities gap. Public hospital managers and health authorities should direct resources toward: (1) reducing waiting times through patient-flow redesign and appointment management systems; (2) improving service consistency and first-time-right delivery through staff training and protocol standardisation; and (3) increasing staff responsiveness through workload management reforms and staffing-ratio improvements. These interventions directly address the Vision 2040 health-sector goals of responsiveness, people-centredness and equitable quality (Oman Vision 2040 Implementation Follow-up Office, 2025). Routine SERVQUAL monitoring at the governorate level is strongly recommended as a tool for tracking progress toward Vision 2040 milestones.

6.1 Limitations and Future Research Directions

Limitations include the cross-sectional design (precluding causal inference), reliance on self-reported perceptions, single-governorate scope, and SERVQUAL's focus on perceived rather than objective clinical quality. Future research should: extend the comparative methodology to other Omani governorates; introduce longitudinal designs to track the effect of quality-improvement interventions on gap scores; incorporate objective clinical quality indicators alongside SERVQUAL; and examine which specific operational reforms — such as queue management systems, structured communication protocols, or staffing reconfigurations — most efficiently close the responsiveness and reliability gaps identified in this study.

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Ethics Approval

Written informed consent was obtained from all 200 participants prior to data collection.

Data Availability

The anonymised dataset used in this study is available from the corresponding author upon reasonable request.

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