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Hofstede et al. (1990, p.314) state that “the popular stress on customer orientation (becoming more pragmatic) is highly relevant for most organizations engaged in services and the manufacturing of custom-made, quality products”. The essence of the turnaround was that the new leadership of the organization changed its focus “from a product-and-technology to a market-and-service orientation” and that a “discipline of service toward customers” (pp.293–294) was built. The case of Hofstede et al. (1990) suggests that the commitment for a market or customer orientation needs to come from the top management and the employees should be strongly encouraged to focus on the customer, assess their needs and provide the highest quality of service. “The president recognized that in the highly competitive air transport market, success depended on catering to the needs of current and potential customers. These needs should be best known by the employees with face-to-face customer contact”. (Hofstede et al., 1990, pp.293–294) “The employees demonstrate a problem-solving attitude toward clients: they show considerable excitement about original ways to resolve customers’ problems, in which some rules can be twisted to achieve the desired result”. (Hofstede et al., 1990, p.294). Researcher believe that this customer-oriented organizational culture would involve: focusing on and assessing the customer needs through effective market orientation and thereafter making the customer feel good by delivering high-quality services in response to those needs. It is only when the services provided meet the needs of the customer that the customer perceives the quality of service to be high organizational culture of customer care.

Over the past 40 years, several authors have attempted to develop coherent classification Schemes for services. The intent of such schemes is to bring parsimony and order to allow a better understanding of the characteristics that differentiate services and the organizations that provide them. The following section reviews some of these schemes. Service typology and service quality Cook et al. (1999) chronicled the previous work in the development of service typology, and presented both the marketing-oriented and operations-oriented views of service dimensions. These authors argued that: “although information gathered through the process analysis of services can be utilized for future service process design, this design should also take into account the marketing-oriented dimensions of the service product. Similarly, future service product design should take into account both the marketing-oriented and operations-oriented aspects of the service”.

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Marketing-oriented views used in the literature to classify service dimensions include intangibility, differentiation, object of transformation, type of customer, and commitment. Classification schemes based on the operations-oriented view include customer contact, customer involvement, labour intensity, degree of customization, degree of employee discretion, and production process (please see Cook et al. (1999) and Fitzsimmons and Fitzsimmons (2004) for a more detail discussion of each of the service classifications outlined above). Definitely, issues that affect service quality have both marketing and operations orientations. Therefore, there is a need to explore classification schemes that may assist in understanding the nature and dimensionality of the service quality construct. On the other hand, the customer contact/customization axis consists of a joint measure of customer contact (degree to which customer interacts with the service process) and customization (the degree to which the service is customized for the customer).

This system divides classified services into four quadrants:

1. Service factory – LOW labour intensity and LOW in customer interaction/customization (e.g. airlines, trucking, hotels, resorts and recreation).
2. Service shop – LOW labour intensity and HIGH customer interaction/customization (e.g. hospitals, restaurants (excluding fast food), auto and other repair services).
3. Mass service – HIGH labour intensity and LOW customer interaction/customization (e.g. commercial banking, retailing, schools, wholesaling).
4. Professional service – HIGH labor intensity and HIGH customer interaction/customization (e.g. law firms, accounting firms, medical clinics).

4.1 How to evaluate Market Orientation and Service Quality?

4.11 Market Orientation

Kohli and Jaworski (1990) defines market orientation as the organization-wide generation of market intelligence pertaining to current and future needs of customers, dissemination of intelligence within an organization and responsiveness to it. These authors therefore define (and measure) this concept through three basic components activities / processes) dealing with marketing information: their generation, dissemination and responsiveness.
A slightly different definition was proposed by Narver and Slater (1990). They define market orientation as the organizational culture that most effectively and efficiently creates the necessary behaviours for the creation of superior value for buyers and thus superior performance for business. These authors define three basic (content / focusing) components of the construct as: customer orientation, competitor orientation and inter-functional coordination. To the three basic components they also added two decision criteria: long-term focus and profitability.

Deshpande, Farley and Webster (1993) challenged both conceptions. They see market orientation as being synonymous with customer orientation, being distinguishable from competitor orientation. Putting customer interests first is the central part of their definition of customer (market) orientation and they argue that competitor orientation can be almost antithetical to customer orientation when the focus is more on the strengths of the competitor than on the unmet needs of the customer. This view is consistent with other authors from the marketing and strategic management field. They emphasize a need for a strategic focus which should be on the customer (Ruekert, 1992, Christoper et al., 1991, Karloef, 1993, Day, 1994, Doyle, Wong, 1996).

Critical discussion stimulated different improvement efforts in measuring market orientation. Deng and Dart (1994) developed a four-factor instrument, consisting of the three factors of Narver and Slater (1990), to which they add (actually, put back) profit orientation as a fourth substantive dimension.

Gray et al. (1998) proposed a five-factor instrument which combines the Kohli and Jaworski (1990) and Narver and Slater (1990) dimensions. The dimensions of their instrument are inter-functional co-ordination, profit emphasis, competitor orientation, customer orientation and responsiveness. Lado et al. (1998) added distributor orientation and environmental orientation to the concept, and proposed a nine-component model which encompass two stages of the market orientation process: analysis and strategic actions (each consisting of four components), plus an additional component, intra-functional coordination. Altogether the nine components proposed by Gray et al. (1998) are: Analysis of the final client, Analysis of the distributor, Analysis of the competition, Analysis of the environment, Inter-functional co-ordination, Strategic actions directed toward the final client, Strategic actions directed toward the distributor, Strategic actions directed toward the competition, Strategic actions directed toward the environment.
“Market Orientation is not a “culture” (as Deshpande and Webster originally suggested in 1989) but rather a set of “activities” (i.e., a set of behaviours and processes related to continuous assessment and serving of customer needs). Market Orientation involves the organization-wide responsiveness to marketing intelligence and is characterized by multiple departments sharing information and engaging in activities designed to meet customer needs (Kohli and Jaworski, 1990).

“A business is market-oriented when its culture is systematically and entirely committed to the continuous creation of superior customer value. The three major components of market orientation - customer orientation, competitor focus, and cross-functional coordination - are long-term in vision and profit-driven.” Slater, Narver (1994)

A market orientation is (1) the systematic gathering of information on customers and competitors, both present and potential, (2) the systematic analysis of the information for the purpose of developing market knowledge, and (3) the systematic use of such knowledge to guide strategy recognition, understanding, creation, selection, implementation, and modification.” Hunt, Morgan (1995)

The MOTRN scale was carefully developed by Deshpande and Farley (1998). They said that Market Orientation focuses on (potential and current) customer related activities rather than non customer related behaviours (e.g., collecting intelligence on competitors).

Focusing on and assessing customer needs Market orientation is an important precursor to effective customer care. For this research, we adopt the definition by Deshpande and Farley (1998, p.213) for market orientation as, ‘the set of cross-functional processes and activities directed at creating and satisfying customers through continuous needs-assessment’.

Narver et al. (1998) suggests that market orientation could be developed through organizational learning. He suggests two approaches for improvement of market orientation – each of them represents a different form of learning. The first approach is focused on establishing market orientation principles that are later communicated and trained for development of necessary skills and knowledge. A are particularly important for conceptual development of the market second approach focuses on direct interaction with the market and stresses personal involvement and experimentation as a learning method. Deshpande (2001) also emphasizes the importance of creation, diffusion and utilization of marketing information, but under a different term - knowledge management.
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However, empirical studies on the effect of market-orientation on superior performance revealed inconsistent results (Han et al., 1998). For instance, Narver and Slater (1990) and Ruekert (1992) found a positive relationship, Hart and Diamantopoulos (1993) found no relationship, and Kohli and Jaworski (1993) found mixed results. Accordingly, scholars attempted to identify the mechanisms or factors that transform market-orientation behavior into firm performance in their theoretical and empirical models (Han et al., 1998).

One of the most studied factors, which has synergy with market-orientation, is learning-orientation. Many researchers (e.g. Slater and Narver, 1995; Baker and Sinkula, 1999; Farrell, 2000), for instance, argued that market-orientation only enhances performance when it is combined with a learning-orientation. According to Baker and Sinkula (1999, p. 412), learning-orientation is a mechanism that directly affects a firm’s ability to challenge old assumptions about market and how a firm should be organized to address it.” Specifically, since market-oriented firms focus on customers and their feedback in the established markets, they ignore the emerging markets, technologies, and competitors. However, learning-orientation, embracing the commitment to learning, shared vision, open-mindedness and inter-organizational knowledge sharing, fosters a set of knowledge-questioning and knowledge-enhancing values that leverage the adaptive behaviors provided by market-orientation to a higher-order learning that leads to the development of breakthrough products, services, and technologies, and the exploration of new markets (Farrell, 2000; Slater and Narver, 1995).

In addition, to learning-orientation, another mechanism emphasized by the management and marketing scholars is firm innovativeness, which refers to that portion of a firm’s culture that promotes and supports novel ideas, experimentation, and openness to new ideas (Calantone et al., 2002). For instance, Slater and Narver (1995) propose innovation as one of the core-value creating capabilities that drives the market-orientation and performance relationship. Kohli and Jaworski (1993) note that market-orientation provides something new or different in response to market conditions, which can be seen as a form of innovative behavior. Also, by investigating 134 banks, Han et al. (1998) found that innovativeness mediated the relationship between.
4.12 Service Quality

The quality of healthcare service is evaluated in a variety of ways (Ford et al., 1997). Some methods collect patient feedback and information on levels of satisfaction, other types of assessments measure service and clinical quality as well as efficiency of care (Devebakan, 2005). Within that context, patient expectations and satisfaction are crucial, because those factors can influence both the health status of the patient and medical outcomes. Although they are not perfect, such studies provide important data for researchers and hospital managers who are forward looking.

Healthcare services differ in specific ways to other service sectors. The most important of those differences is that patients often find evaluating healthcare providers difficult, both during and after treatment. “Clinical quality” refers to aspects of the actual healthcare process, such as surgical skill, that are directly related to outcomes, and “service quality” refers to all other aspects of the patient experience, such as hospital comfort. Patients can judge service quality more accurately than clinical quality, except for some inputs or the credentials of their caregivers (Devebakan, 2005). The dimensions of service quality can be classified under three groups. The first one is interpersonal characteristics, which includes respect, emotional support and cultural appropriateness, the second one is access with locations, waiting times, service hours and appointment delays and the third one is amenities including physical environment, food and furnishings. For the clinical quality we can list the factors affecting the patient satisfaction as providers, nonhuman and systems factors (Lin and Kelly, 1995; Batchelor et al., 1994; Hall and Dornan, 1988; Lewis, 1994).

Service quality can be broadly defined as meeting customer expectations or providing perfect service. It can also be defined as “the ability of an institution to meet or surpass customer expectations”. Customers’ expectations and perceptions are therefore very important to service providers. The main characteristics of healthcare services are variability, heterogeneity and simultaneous production and consumption (inseparability). According to Parasuraman et al. (1994), who have provided a wider definition of service quality and have developed a conceptual service model, the perceived service quality is a result of the customers’ expectations of the service and service performance (Parasuraman et al., 1994; Babakus and Mangold, 1992). Service quality in patient care is related to the delivery of healthcare services to the patient. Factors such as the attitudes of physicians and nurses...
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toward the patients, the cleanliness of the healthcare facility, and the quality of hospital food influence the service quality of healthcare facilities. Because most patients lack information about evaluating clinical healthcare quality, they tend to rate the quality of services according to their perception of how those services are performed (Buttle, 1996; Dursun and Cerci, 2004).

Service quality may be considered to be the ‘feel good’ factor, which is perceived by customers during the process of service delivery. It is what the customer perceives while receiving services from the provider. Through high-quality service, an organization can show its customer that it truly cares.

Service providers need to have up-to-date equipment, visually appealing facilities and well-dressed and neat employees. The customer-focus dimension of market orientation includes the ability of the service provider to show that it exists primarily to serve customers (Green and Inman, 2006).

Ghobadian et al. (1994) posit that most of the service quality definitions fall within the “customer led” category. Juran (1999) elaborates the definition of customer led quality as “features of products which meet customers’ needs and thereby provide customer satisfaction.” As service quality relates to meeting customers’ needs, we will be looking at “perceived service quality” in order to understand consumers (Arnauld et al., 2002). Grönroos (1984) and Parasuraman et al., (1985) looks at perceived quality of service as the difference between customers’ expectation and their perceptions of the actual service received.

Other researchers look at perceived service quality as an attitude. Arnauld et al., (2002) defined perceived quality “whether in reference to a product or service” as “the consumers’ evaluative judgment about an entity’s overall excellence or superiority in providing desired benefits” (p. 327). Hoffman & Bateson (2001) defines service quality as an attitude “formed by a long-term, overall evaluation of a performance”. Attitude is defined as “a consumer’s overall, enduring evaluation of a concept or object, such as a person, a brand, or a service.” (Arnauld et al, 2002) Service quality as “an attitude” is consistent with the views of Parasuraman et al., (1988), Cronin & Taylor (1992) & Sureshchandar et al., (2002). Basis of the view is elaborated by the latter:
Feinburg & de Ruyter (1995) pointed the importance of adapting the definition of service quality in different cultures. Ueltschy & Krampf (2001) contended that differences in culture affect measure of quality in a service sector. They encapsulated service quality measures as “culturally sensitive” and “may not perform properly or comparatively in a culturally diverse group domestically or abroad” (p.22). Cultural factors are said to have greater influence on people’s evaluation of services than on their evaluations of physical goods due to involvement of customer contact and interaction with employees while a service is delivered (Mattila, 1999). Feinburg & de Ruyter (1995) postulated that the differences “require adapting service quality to an international setting” (p. 4).

Several studies seem to conclude that satisfaction is an affective construct rather than a cognitive construct (Oliver, 1997; Olsen, 2002). Rust and Oliver (1994) further defined satisfaction as the “customer’s fulfillment response,” which is an evaluation as well as an emotion-based response to a service. It is an indication of the customer’s belief on the probability of a service leading to a positive feeling. While Cronin et al. (2000) assessed service satisfaction using items that include interest, enjoyment, surprise, anger, wise choice, and doing the right thing.

According to a model present by ZBP (1996), behavioral intentions can be captured by such measures as repurchase intentions, word of mouth, loyalty, complaining behavior, and price sensitivity. High service quality (as viewed by the customer) often leads to favorable behavioral intentions while a low service quality tends to lead to unfavorable behavioral intentions. ZBP (1996) further emphasized that behavioral intentions can be seen when a customer decides to remain with or defect from the company. Burton et al. (2003) concluded that customer experience is related to behavioral intentions. The more positive the customer’s experience, the more likely he or she is willing to reuse the service.

Quality is another factor that has a significant impact on business performance. A number of studies have provided valuable empirical support for a positive quality-profitability relationship (e.g., Buzzell and Gale, 1987; Phillips et al., 1983). For services, Zeithaml et al. (1996) found that service quality has a strong positive effect on respondents’ loyalty to the company and a negative effect on propensity to switch. Rust et al. (1995) suggested that superior service quality helps to generate greater revenue and yield greater profitability. In short, superior service quality has a positive effect on business profitability. Because both market orientation and service quality moderate offerings and have a positive impact on
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business profitability, a subsequent question is how market orientation and service quality are related. Conceptually, one immediate effect of the offering modifications is a firm’s improved ability to satisfy customers’ needs effectively by realizing what they want. Better served customers are likely to make repeat purchases and spread out positive word-of-mouth information to potential new customers. Another direct effect of the offering modifications is the increased capability to serve customers efficiently by eliminating or reducing nonessential services by learning what customers do not need. The enhanced effectiveness and efficiency of the service offering can then lead to stronger profits due to higher revenue and lower cost. Consequently, the strength of the market orientation-business performance relationship will depend on how much added effectiveness and efficiency can be accomplished by the market oriented effort. And a direct gauge of the effectiveness for service firms is service quality. ("A conceptual framework of service quality in healthcare Perspectives of Indian patients and their attendants" Panchapakesan Padma, Chandrasekharan Rajendran and L. Prakash Sai).

The results are expected to shed some light on how market orientation and service quality are related and to offer important managerial implications for marketing practitioners.

4.2 Effect of socio-demographic characteristics on patient perceptions of Quality of services.

Socio-demographic variables showing positive association with patient satisfaction include: Age; Education; Health status; Marital status; Social class. However, Tucker (2002) states that unclear, contradictory and inconclusive relationships exist between: Satisfaction and gender; Marital status; and Social class.

Individual factors positively associated with patient satisfaction are health status and education. Younger, less educated, lower ranking, married, poorer health and high-service use were associated with lower satisfaction (Tucker, 2002). Another study found that the patient’s health quality assessment appeared to change with the introduction of patient’s socio-demographic characteristics. However, the effect produced only a 1 percent variation (Tucker and Adams, 2001). Butler et al. (1996) found gender and age significantly predicted patients’ quality perceptions, but on only one dimension – facilities. Females valued this dimension more than males. Perceived facility-related quality was found to be better for older than younger respondents (Butler et al., 1996). Earlier studies showed satisfaction differences
between health service users and observers (Strasser et al., 1995). However, Butler et al. (1996) found no significant differences in health quality perceptions between users and observers (friends and families of patient). A significant difference, on the other hand, was found on facility quality dimension – where users criticised the hospital’s tangible characteristics more than observers (Butler et al., 1996).

Earlier work also suggests that patient’s expectations and priorities vary among countries and are highly related to cultural background and to the healthcare system (Eiriz and Figueiredu, 2005). Income was the only socio-demographic characteristic found to have an influence on patient satisfaction (Mummalaneni and Gopalakrishna, 1995); this study included socio-demographic characteristics such as age, gender, occupation, employment status, education and income. It revealed that only income influenced patient satisfaction; upper income customers appeared more concerned with personal health delivery such as answers they receive to medical queries, waiting time for appointments and medical care. Lower income consumers, on the other hand, were more concerned with costs and overall physical facilities, indicating value orientation.

4.3 How to evaluate healthcare quality?

Some believe healthcare quality should be studied from the patient’s perspective. Patients provide valid and unique information about the quality of care (Ware and Stewart, 1992, p. 3, 291, 373). Another school believes that patient satisfaction rather than health status is the primary healthcare measure. This line of research focuses primarily on the attitude towards service performance by confirming/disconfirming expectations (Taylor and Cronin, 1994). The SERVQUAL instrument has been empirically evaluated and found to be reliable and valid for hospital use (Babakus and Mangold, 1992). Generally, the tool and adapted versions are suitable for measuring patient satisfaction (Sohail, 2003; Parasuraman et al., 1988, 1991). However, some authors question its applicability for healthcare (Butler et al., 1996). Consequently, in some studies, the tool has been modified by dropping irrelevant or adding relevant dimensions (Fowdar, 2005; Sohail, 2003). It is generally felt that SERVQUAL should be adapted as required (Parasuraman et al., 1988).
4.31 Different way of measuring health care quality at the organisational level

Besides establishing a definition for health care quality, it is important to develop a framework for evaluating and defining operational measures. There are many difficulties with this type of measurement. According to Lawton (1998), these include:

1. Complexity of collecting and interpreting a large source of data quickly;
2. Defining the objectives of complex services where multiple objectives conflict;
3. Lack of correlation between overall organisational objectives and specific objectives;
4. Inexperience of managers in developing and using performance indicators;
5. Lack of relevant and measurable targets for final outputs and outcomes;
6. Lack of resources to build data;
7. Staff resistance to data collection;
8. Lack of staff evaluation training;
9. Cost of performance measurement;
10. Lack of interest

Within health services, such evaluations raise further problems owing to the size, complexity and heterogeneity of national health care systems, including the large range of expertise and specialisations within health care organisations (Carter et al., 1992). Rubin et al. (2001b, p. 490) associated the measurement of health care quality with the audience or information consumer. These authors identified different types of audiences such as accreditation agencies, patients, administrators, regulators, doctors, and provider organisations. They pointed out that indicators are designed as a means to improve clinical, service, and economic performance. In terms of clinical performance measures, they stressed the importance of choosing the clinical area to evaluate and its impact on morbidity, mortality and costs. When analysing service performance measures, we can use the traditional customer quality perspective of services, through which patients may use qualitative measurements such as the doctor’s communication and interpersonal interactions. Traditionally, as discussed in the last section, measuring health care quality at the organisational level is focused on customers. For instance, based on the SERVQUAL model developed by Parasuraman et al. (1988), Lytle and Mokwa (1992) viewed health care services as a set of three types of benefits:
(1) Core benefits (the nucleus of the product offering or the outcome that the patient is seeking);

(2) Intangible benefits (interactions between doctor and patient largely based on reliability, empathy, assurance, and responsiveness); and

(3) Tangible benefits (physical surroundings such as the location, decor and appearance of facilities and personnel).

Ware et al. (1978), cited in Sargeant (1999), studied the measuring and meaning of patient satisfaction and identified four satisfaction dimensions that affect patients’ perceptions:

(1) Doctor conduct;

(2) Service availability;

(3) Confidence; and

(4) Efficiency/outcomes.

Other studies on customer satisfaction in health care stressed the importance of convenience, access, waiting times, choice, quality of information, range of services, nature of the patient’s medical problems, and patients’ demographic background (Brown and Swartz, 1989; Singh, 1990; Sage, 1991). Finally, Coddington et al. (2000) suggested “value added” as an alternative measure, which includes service, convenience, access, relationships with doctors, innovation, unit prices, and volume or intensity of use of certain resources. Nevertheless, measuring quality in health care has its drawbacks, as noted by Coddington et al. (2000, p. 51): “the unexplained large variations in medical practice in different communities with the same demographic characteristics are a continuing embarrassment to medicine”.

Different theoretical perspectives on service quality were developed during the 1980 s. Gro¨onroos (1982), for example, distinguished two types of service quality:

(1) Technical quality refers to core service delivery or service outcome (i.e. what is offered and received); while

(2) Functional quality refers to service delivery processes or the way in which the customer receives the service (i.e. how the service is offered and received).

Technical quality can relate to the surgeon’s performance, while functional quality may consist of the doctor’s waiting room, doctor’s office hours and secretary’s behaviour. Lehtinen and Lehtinen (1982), on the other hand, discussed three kinds of quality:
Physical quality includes structural aspects associated with services such as the reception area, examination room and medical equipment. Interactive quality involves contact between the customer and service personnel.

Corporate quality includes image and reputation. From these earlier writings, it can be seen that service quality notions arise from a comparison of what customers feel a seller should offer (i.e. customers’ expectations) with the seller’s actual service performance (Parasuraman, 2000). This idea was supported by exploratory research conducted by Parasuraman et al. (1985) using twelve consumer focus-groups in four industries (banking, credit card, securities brokerage, product repair and maintenance). Topics discussed with focus group members included the meaning of quality in the service’s context, service quality characteristics and the criteria used by customers when assessing service quality. The study revealed that customers used the same general criteria to arrive at an evaluative judgement regarding service quality. Consequently, Parasuraman et al. (1985) defined service quality as an overall evaluation, similar to but not the same as an attitude, which refers to the degree and direction of discrepancy between customers’ perceptions and expectations. The researchers also identified two inter-related service quality dimensions, “outcome” quality and “process” quality, which correspond to the dichotomy proposed by Gronroos (1982) and to the “physical” and “interactive” quality characteristics identified earlier by Lehtinen and Lehtinen (1982). Along the same line, Zeithaml (1988) later defined service quality as the consumer’s assessment of overall excellence or superiority of the service. Olshavasky (1985) also viewed quality as a form of overall service evaluation similar in many ways to attitude. Parasuraman et al.’s. (1985) study was the most extensive research carried out into customer service quality perceptions. The 22-item SERVQUAL instrument, developed by Parasuraman and his colleagues, included five service quality dimensions described above. Parasuraman et al. (1985) defined service quality as the difference between what a service company should offer and what it actually offers or the discrepancy between expectations and perceptions of the service performance. Zeithaml et al. (1990) reported, in their study of credit-card, repair and maintenance, long-distance telephone and retail banking services, that customers rated all five SERVQUAL dimensions important. Respondents considered reliability as the most
important and tangibles the least important dimension. This finding consistently cropped up in other studies such as Zeithaml et al. (1990). In a study of 1936 customers in two banks, two insurance companies and a long-distance telephone company, Zeithaml et al. (1990) reported service reliability as the most critical dimension perceived by customers, followed by responsiveness, assurance, empathy and tangibles. However, other studies (Carman, 1990; Mowen et al., 1993) demonstrated that service encounter situational characteristics such as customers’ prior experience, time or day of the week or whether customers are given an expectation about waiting time may affect the relative importance of various quality dimensions. Turner and Pol (1995) also reported that quality dimensions are not equally important. They suggest that environment, customer’s physical or emotional status and other non-medical characteristics can influence customers’ service quality perceptions.

The SERVQUAL instrument is described by Parasuraman et al. (1991) as a reliable and valid service quality measure with relatively stable dimensions that apply across many service industries. Despite its widespread use, the instrument has been criticised conceptually and methodologically. One main criticism is the applicability of the five SERVQUAL dimensions to different service settings. That is, replication studies by other investigators failed to support the five-dimensional factor structure obtained by Parasuraman et al. (1988). For example, Groönroos (1982) conceptualised service quality as a two dimensional construct comprising technical and functional quality. On the other hand, Lehtinen and Lehtinen (1982), defined service quality as three constructs: interactive, physical and corporate quality. McDougall and Levesque’s (1994) study also did not support Parasuraman et al.’s (1985) five service quality dimensions. They revealed only three underlying elements: tangibles, contractual performance (outcome) and customer-employee relationships (process). Moreover, research indicates the possibility of two public utility sector dimensions (Babakus and Boller, 1992) and up to nine (Carman, 1990) in a dental school patient clinic, business school placement centre, motor care tire centre and acute care hospital, which underpin service quality. Because some service quality determinants are perceived generically, while others are industry- or situation-specific, Babakus and Mangold (1989) argue that SERVQUAL’s dimensional instability results from the type of service sector under investigation.
In Parasuraman et al.’s (1985) well-known SERVQUAL model, a single expectation standard, desired expectations (what the consumer feels a service provider should offer) was used as a comparison against which service performance was assessed.

Lately, however, some researchers such as (Boulding et al. (1993) and Parasuraman et al. (1993, 1994) suggest that multi-expectation standard approaches may be more appropriate in service quality models. Attempting to capture the essence of various comparison standards, Zeithaml et al. (1993) pooled insights from past expectation conceptualisations with findings from a multi-sector focus-group study to develop an integrative customers’ service expectation model. This service quality framework combines adequate, desired and predicted expectations along with perceived performance. The new model separates expectations into an adequate standard (which is influenced by predicted expectations) and a desired standard that customers use to evaluate service quality. A desired service is defined as the level representing what customers hope to receive or a combination of what customers believe “can be” and “should be” provided. However, most customers are realistic and understand that company staff cannot always deliver the preferred service level. Hence, customers also have an expectation threshold, termed adequate service, or the minimum level of service customers are willing to accept without dissatisfaction. Separating these two expectation levels is a “tolerance zone” that represents a service performance range a customer would consider satisfactory. A performance below the tolerance zone (or below the adequate service level) will engender customer frustration and dissatisfaction and decrease customer loyalty (competitive disadvantage). A performance level above the tolerance zone (or above the desired service level) will surprise and create customer delight and strengthen their loyalty (customer franchise), (Berry and Parasuraman, 1991).

On the other hand, customers will be satisfied if performance falls within their tolerance zone (competitive disadvantage). In other words, the tolerance zone is a service range within which customers do not pay explicit attention to performance. The tolerance zone thus not only improves multiple expectation comprehension that consumers may use in service evaluations but also provides practitioners better opportunities to optimise resource allocations in their continual attempt to meet or exceed customer expectations (Walker and Baker, 2000). Moreover, Parasuraman et al. (1994) found that tolerance zone measures had convergent and predictive validity.
Convergent validity is the extent to which the scale correlates positively with other measures of the same construct. Predictive validity is assessed by comparing data on the scale at one point in time and data on the criterion at a future point in time. If the correlation between two measures is high then the initial measure is said to have predictive validity. The tolerance measures were also less susceptible to response errors compared to single expectation measures. Additionally, the tolerance zone provides detailed and probably more accurate managerially diagnostic information and thus better strategy decisions (Teas and DeCarlo, 2004). The latest SERVQUAL modification, therefore, incorporates this expanded expectation conceptualisation. For each SERVQUAL attribute, three values (on a nine-point scale) are measured:

(1) Customers’ desired service level;
(2) Service level adequacy; and
(3) A specific company’s perceived service.

Previous SERVQUAL tests in health care settings yielded mixed findings. Babakus and Mangold (1992) found the instrument reliable and valid in hospitals. Bowers et al. (1994), on the other hand, reported two major additional dimensions not captured by SERVQUAL: caring and patient outcomes. The “caring dimension” implied a “personal, human involvement, with emotions approaching love for the patient” and an “outcomes” dimension that included “pain relief, life saving, anger or disappointment with life after medical intervention”. On the other hand, research conducted by Haywood-Farmer and Stuart (1988) suggested that SERVQUAL was inappropriate for measuring professional service quality since it excluded “core service”, “service customisation” and “knowledge of the professional” dimensions.

Additionally, Brown and Swartz (1989) identified “professional credibility”, “professional competence” and “communications” as factors significant for both physicians and patients in service quality evaluation. Peyrot et al. (1993) separated service attributes into three factors using factor analysis:

(1) Staff behaviour (friendliness, helpfulness, explanation);
(2) Pre-examination comfort (e.g. waiting room, waiting time, user-friendly forms); and
(3) Examination comfort (physical comfort and time in the examination room).
Using principal components analysis and Varimax rotation, Gabott and Hogg (1994) reported six factors that affect consumer satisfaction:

1. Service range (e.g. specialists, facilities for disabled);
2. Empathy (e.g. receptionist’s manner, bedside manner, home visits);
3. Physical access (e.g. parking, access by public transport; appointment time convenience);
4. Doctor specific (e.g. age, sex, number of doctors);
5. Situational (e.g. waiting room facilities, decoration); and
6. Responsiveness (time spent with doctor and time spent in waiting room).

Dean (1999) identified four stable dimensions using SERVQUAL to compare service quality dimensions in two different healthcare settings (medical centre, maternal and child health centres): Assurance; Tangibles; Empathy; and Reliability and responsiveness.

Loaded together these dimensions accounted for approximately 68 per cent of the variance in both settings. Kilbourne et al.’s (2004) study also showed that SERVQUAL captures service quality multidimensionality:

1. Tangibles;
2. Responsiveness;
3. Reliability and empathy; as well as an
4. Overall (second order) service quality factor.

Recently, using factor analysis, Morrison et al. (2003) identified five main service attributes that explain people’s GP service preferences:

1. Communication;
2. Doctor-patient relationship;
3. Same gender as the patient;
4. Advising; and
5. Empowering patients to make decisions.

However, few studies including Babakus and Mangold (1992), Lam (1997) and Taylor (1994a, 1994b) reported that SERVQUAL was a consistent and reliable one-dimensional scale. Therefore, research indicates that perceived service quality is contingent upon service type, which implies that one generic service quality measure is inappropriate for all services.
In short, studies show that SERVQUAL does not cover all healthcare services dimensions that are important to patients. However, there has been limited recent published work on service quality dimensionality after the mid 1990s.

### 4.32 Multi-dimensional approaches in Health Care

More complex conceptual models to understand and measure patient satisfaction and healthcare quality include Turner and Pol’s (1995) multidimensional approach to measuring healthcare quality, representing experts and other stakeholder judgements. The authors incorporated Donabedian’s (1986) and Ware and Stewart’s (1992, p. 3, 291, 373) patient satisfaction perspective in a model for measuring service quality including two more care dimensions: access and personnel. Additionally, the model incorporates contexts in which quality is measured, thereby providing an explanation for the level at which outcome or degrees of satisfaction are measured. Within each quality dimension, these contexts affect how different components are weighted. The authors suggested two contexts – micro and macro. Macro includes delivery modes (where care is delivered), “provider ship” (the mechanism through which care is delivered such as managed care, fee-for-service, insured care) and technology. Micro context factors are those accounting for individual differences such as values, beliefs and maladies, etc. Furthermore, each quality dimension comprises general and specific construct/measurement. General context such as inpatient versus outpatient service is also considered. The researchers measured quality dimensions including access, personnel, clinical outcome and patient satisfaction. Thus, the model brings out patient satisfaction as a multi-dimensional concept needing to be operationalized and considered under the relevant contexts (Turner and Pol, 1995). Second, Tucker and Adams’ (2001) integrative patient evaluation model shows how caring, empathy, reliability, responsiveness, access, communication and outcome dimensions predict satisfaction and quality as moderated by the patients’ socio-demographic characteristics. Third, Conway and Willcocks’ (1997) integrated model applies service quality to healthcare settings. It incorporates influencing factors such as:

- Patient knowledge and experience;
- Perceived risk/pain/distress level;
- Affiliated parties’ experience;
- Provider information;
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- Provider image;
- Affiliated parties’ information;
- Patient preference;
- Patient personality; and
- Socio-economic factors with measurement issues (reliability, responsiveness, tangibles, assurance, empathy, information, access, redress and representation). For each, the degree of confirmation/disconfirmation is incorporated with expectations and service-quality gaps (Parasuraman et al., 1985) to arrive at patient satisfaction levels.

4.33 Trust in the context of healthcare

There has been an increased awareness, via media reporting, of harm associated with healthcare errors. With this came an increased concern amongst policy makers, hospital administrators and professionals about patient safety. Hall (2005) explains that those who trust have an expectation that the trusted person will behave with goodwill towards them and with competence in the domain in which he or she is trusted (or in caring for that with which he or she is entrusted). Patient safety concerns may lead customers to stop using a particular hospital’s services owing to negative word-of-mouth. Basic principles outlined in healthcare studies include:

Trusting patients are vigilant, i.e. trust is not simply a vague hope or thinking optimistically; health service providers must keep patients alert to errors in the course of their care. Some checking by the patient is appropriate even when there is trust particularly when honest mistakes are possible, which may be easily spotted and corrected.

Patients may continue to trust even if harmed. Healthcare provider’s trust in their patients may positively affect healthcare experience and outcomes. Entwistle and Quick’s (2006, p. 411) study reviews patient safety developments and suggests avenues for further research: suggested, in principle, trust can be understood in such a way that it is well placed, morally appropriate and compatible with current understandings of safety problems in health care.
4.34 Factors responsible for customer switching behaviour in health care

Rising healthcare consumerism is changing the traditional physician-patient relationship into a provider-consumer one. By taking a consumerist stance, patients are now more inclined to ask questions, contribute to decision making, “shop” for doctors, sample healthcare providers and switch services if they experience dissatisfaction. Service industry brand switching behaviour is influenced by price, inconvenience, and core service failures, inadequate employee responses to service failures, competitive issues, ethical problems and involuntary factors. Of the few studies that focus on patient switching behaviour, one found that dissatisfaction with emergency access increases the probability of switching healthcare providers (Ho et al., 1998). This factor includes attributes such as emergency care procedures, getting care without appointment and a 24-hour phone consultation. Individual factors such as marital status and education also determine switching behaviour. People with higher education are more health conscious and more aware of their consumer rights – they are more inclined to challenge medical advice and ask questions. The study provides healthcare managers an opportunity to make improvements such as better emergency care, installing a 24-hour phone consultation, etc. (Ho et al., 1998).

4.35 Characteristics of health care delivery services

Health care systems and hospitals in particular exist as the centre for patient/consumer care delivery and are the organizational hub of a much larger health care provider network. In this latter capacity the modern hospital must now compete in an ever-expanding role as the provider of outpatient/consumer care, a more competitive health care environment, as well as a the leader of the much larger comprehensive managed care system. Consequently, hospitals are providers of services, which are intangible, inseparable, variable, and perishable. Moreover, existing consumer marketing research has found that production and consumption of the service occur simultaneously, so strategies that acknowledge the importance of the consumer must be integrated into the hospital health care delivery systems process (Craig et al., 2007; Glass et al., 1981; Pugh et al., 2007).

When gathering the information about these systems, patient/consumer/consumers of health services rely more on personal and intimate sources such as stories and anecdotes because of
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the very nature of the service. Then, the providers in the choice set are evaluated yet again by the patient/consumer before the latter is able to reach a decision. In particular, consumer marketing studies reveal that the patient/consumer is not alone in the decision execution; there is a decision-making unit that influences this choice. In fact, in the healthcare industry, research shows that the decision-making unit likely include an initiator (family member), an influencer (physician), a decider (physician, patient/consumer or insurance), a buyer (third party insurance or employer), and the user (patient/consumer). As a final point, additional research has shown that patient/consumer involvement in decision making related to his or her health choices is increasing as patient/consumers are exposed to an increasing number of health care system providers (Laffel and Blumenthal, 1989; Shortell et al., 2007; Porter and Teisberg, 2007a, b).

Health care services are particularly complex in their characteristics, are heterogeneous in their range of medical specialisations and associated services, and ambiguous in the sense that the average customer has no technical knowledge to understand his or her particular needs or the services available to satisfy them. Thus, accepting this complexity, heterogeneity and ambiguity, quality should not only be assessed from the customer’s point of view, but also from that of the providers. An approach based on both customers and providers offers a much more complete picture of health care quality than simply measuring customer satisfaction.

The whole focus of healthcare industry is patients’ well-being (both physical and mental). Patients are usually in a physical or a psychological discomfort when they consume health services. Further, due to high degree of intangibility involved in providing care and high professionalism (e.g. physician specialization, skills, etc.) demanded, healthcare services are difficult to evaluate patients/consumers in healthcare. Healthcare has numerous consumers: patients, who actually consume the service provided; physicians, who recommend healthcare providers for their patients; third-party payers, who dictate patients’ choice of hospitals by their substantial financial influence. Keeping pace with technological advances, there is a fundamental shift in healthcare consumerism – patients are becoming better informed, more involved in their own healthcare and more demanding.

Here due to the nature of medical care, consumers use health care systems such as hospitals out of need and not choice. Thus, healthcare service, unlike other non-professional services, is low in search attributes; that is to say, attributes that can be evaluated by the customer
before selecting a hospital or alternative health care provider or experiencing service. Likewise, medical care is also low in experience (familiarity) attributes, or attributes that can be evaluated after experiencing the service but not before; instead, the medical service has more credence (credibility) attributes, which cannot be confidently evaluated sometimes even after experiencing the service, because of the technical nature of the service. So here focus for evaluation of quality of services is only on perception of quality of services of patients or attendants instead of finding gap between Expectation and Perception of quality of services.